



Special Bulletin

Monday, August 3, 2015

CMS RELEASES FY 2016 FINAL RULES FOR THREE POST-ACUTE CARE SETTINGS

LTCHs, IRFs & SNFs

The Centers for Medicare & Medicaid Services (CMS) late last week issued final rules for three post-acute care settings for fiscal year (FY) 2016. Below are highlights of the final rules for: [long-term care hospitals](#) (LTCHs), [inpatient rehabilitation facilities](#) (IRFs) and [skilled-nursing facilities](#) (SNFs).

Watch for detailed Regulatory Advisories for each final rule. In addition, calls will be held on each rule. See below for more information.

LONG-TERM CARE HOSPITALS

Implementation of the New Dual-rate Payment System: The final rule implements the Bipartisan Budget Act of 2013 mandate to add a site-neutral payment component to the LTCH prospective payment system (PPS), beginning with cost-reporting periods that start on or after Oct. 1, 2015. Under this two-tiered system, a standard LTCH PPS rate will be paid for cases with higher complexity, and other cases will be paid a lower “site-neutral payment” based on inpatient PPS rates. CMS estimates that the combined fiscal impact of FY 2016 changes to both tiers of the dual-rate system will be *negative* 4.6 percent (-\$250 million) compared to FY 2015.

We believe that, in general, CMS has complied with congressional intent in implementing this transformative change to the LTCH field. Further, we appreciate the improvements the agency has made to its original proposal. However, we are concerned that the final rule falls short of ensuring accurate payments for site-neutral cases that will receive a high-cost outlier payment.

FY 2016 Update for Standard LTCH PPS Rates: CMS estimates that the final rule will increase payments by 1.5 percent (\$50 million) for the subset of cases paid a standard LTCH PPS rate in FY 2016. This net update accounts for the mandatory market-basket update of 2.4 percent, two mandated cuts (0.5 percentage points for productivity and an additional 0.2 percentage point), a decrease for high-cost outliers of 0.1 percentage

points, an increase for short-stay outliers of 0.2 percentage points, an increase of 0.1 percentage points for a wage index budget-neutrality adjustment, and other unspecified adjustments. The standardized payment for FY 2016 for LTCHs reporting required quality data will be \$41,762.85; the FY 2015 standard rate is \$40,043.71.

High-cost Outlier Cases. Under the two-tiered system, CMS implements separate high-cost outlier policies for standard LTCH PPS cases and site-neutral cases. For the former category, CMS finalized an 8.0 percent outlier pool with a fixed-loss amount of \$16,423, lower than the proposed \$18,768 amount, which will enable more cases to qualify for a high-cost outlier payment. The AHA advocated for this lower fixed-loss amount to account for the FY 2016 cases that will meet site-neutral criteria but, due to the rolling implementation of the policy, will still receive a standard LTCH PPS rate. Details on the high-cost outlier fixed loss amount for the site-neutral payment tier are below.

Identifying Standard LTCH PPS Cases: To be eligible for the higher LTCH PPS rate, a case must be “immediately discharged” from an inpatient PPS hospital to an LTCH; not have a principal LTCH diagnosis related to a psychiatric or rehabilitation condition; and receive at least three days of care in an intensive care unit (ICU) or coronary care unit (CCU) during the prior hospital stay or be assigned to an LTCH condition group for 96+ hours of ventilator care.

CMS finalized the following criteria to identify cases eligible for a standard LTCH PPS payment:

- *Immediate Discharge.* The AHA is pleased that CMS withdrew its proposed requirement that “immediately discharged” cases have discharge status code 63 or 91 for the prior hospital stay. Rather, under the final policy, CMS will use only the prior hospital discharge date and LTCH admission date to identify “immediately discharged” cases that transfer to an LTCH within one day.
- *ICU/CCU Revenue Codes.* As recommended by the AHA, CMS finalized without modification its proposal to use the full set of ICU (020x) and CCU (021x) revenue codes when counting a patient’s ICU and CCU days during the prior general acute-care hospital stay.
- *Ventilator Criterion.* CMS also finalized without changes its proposal to identify qualifying LTCH ventilator cases using a particular procedure code, ICD-10 code 5A1955Z, which indicates that a patient received greater than 96 consecutive hours or respiratory ventilation in a hospital.
- *Psychiatric and Rehabilitation Cases.* CMS finalized its proposal to use the following 15 MS-LTC-DRGs to define the psychiatric and rehabilitation cases that will be excluded from LTCH PPS payment:

1. MS-LTC-DRG 876 (O.R. Procedure with Principal Diagnoses of Mental Illness);
2. MS-LTC-DRG 880 (Acute Adjustment Reaction & Psychosocial Dysfunction);
3. MS-LTC-DRG 881 (Depressive Neuroses);
4. MS-LTC-DRG 882 (Neuroses Except Depressive);
5. MS-LTC-DRG 883 (Disorders of Personality & Impulse Control);
6. MS-LTC-DRG 884 (Organic Disturbances & Mental Retardation);
7. MS-LTC-DRG 885 (Psychoses);
8. MS-LTC-DRG 886 (Behavioral & Developmental Disorders);
9. MS-LTC-DRG 887 (Other Mental Disorder Diagnoses);
10. MS-LTC-DRG 894 (Alcohol/Drug Abuse or Dependence, Left Ama);
11. MS-LTC-DRG 895 (Alcohol/Drug Abuse or Dependence, with Rehabilitation Therapy);
12. MS-LTC-DRG 896 (Alcohol/Drug Abuse or Dependence, without Rehabilitation Therapy with MCC);
13. MS-LTC-DRG 897 (Alcohol/Drug Abuse or Dependence, without Rehabilitation Therapy without MCC);
14. MS-LTC-DRG 945 (Rehabilitation with CC/MCC); and
15. MS-LTC-DRG 946 (Rehabilitation without CC/MCC).

LTCH Site-neutral Payment: The final rule implements a site-neutral payment rate that is based on the lower of the inpatient PPS-comparable per-diem amount, including any outlier payments, or 100 percent of the estimated cost of the case. The AHA projects that three out of four site-neutral cases will qualify for the per-diem rate, rather than be paid based on cost. For each LTCH, site-neutral payment reductions will be phased in on a rolling basis, according to its cost reporting period start date. In addition, for cost-reporting periods from Oct. 1, 2015 through Sept. 30, 2017, site-neutral cases will be paid a 50-50 blend of the standard LTCH PPS rate and the applicable site-neutral rate. Following the two-year transition period, site-neutral cases will be paid fully site-neutral rates.

High-cost Outlier Cases. As proposed, site-neutral high-cost outlier cases will be subject to the inpatient PPS fixed-loss amount for FY 2016 of \$22,544, which is lower than the proposed amount of \$24,485. For these cases, CMS will apply a negative 5.1 percent budget-neutrality adjustment to the site-neutral portion of the blended payment. **This site-neutral budget neutrality adjustment appears to duplicate CMS's 5.1 percent inpatient PPS budget neutrality adjustment, which is applied to the operating portion of the inpatient PPS rates that serve as the basis for LTCH site-neutral rates.** The agency's rationale for this extra budget-neutrality adjustment is to avoid increasing aggregate LTCH PPS payments in FY 2016. **The AHA is very concerned about this adjustment and is further evaluating its impact and accuracy.**

CMS's Impact Estimate for Site-neutral Cases. Both CMS and the AHA estimate that approximately one out of two LTCH cases will meet LTCH site-neutral criteria. CMS estimates that the final rule will lower payments for site-neutral cases by 14.8 percent, or \$300 million, below FY 2015 payment levels. This estimated reduction is calculated separately from the agency's estimate of a 1.5 percent increase in FY 2016 for standard LTCH PPS cases.

25% Rule and Interrupted-stay Policy. CMS finalized its proposals to apply the 25% Rule and interrupted-stay policy to site-neutral LTCH cases. However, as proposed, these cases will not be subject to short-stay outlier policy, as they will already be paid the inpatient PPS-like rate under the site-neutral policy.

LTCH Quality Reporting Program (QRP): CMS finalizes three measures for the FY 2018 LTCH QRP – all of which are currently in the program – to satisfy the requirements of the Improving Medicare Post Acute Transformation (IMPACT) Act of 2014. The measures assess skin integrity, falls with major injury and all-cause readmissions. CMS also will begin publicly reporting certain LTCH QRP quality data by the fall of 2016.

AHA Member Call and Additional Information: Our comprehensive review of the final rule is still underway, and we will follow-up with a full Regulatory Advisory, which we will distribute to our LTCH members and discuss during **an upcoming member call on Wednesday, Aug. 26 at 2 p.m. ET. We also plan to re-calculate and distribute each LTCH's estimate of fiscal impact, incorporating the provisions in the final rule.** AHA's LTCH members will be invited to join the invitation-only call in a separate email.

INPATIENT REHABILITATION FACILITIES

FY 2016 Payment Update: The final rule increases IRF PPS rates by 1.8 percent, or \$135 million, in FY 2016 compared to FY 2015. This net increase includes a 2.4 percent update under the new, IRF-specific market basket; mandatory cuts of 0.5 percentage points for productivity and an additional 0.2 percentage points, and a 0.1 percentage point increase for the updated outlier threshold.

IRF-specific Market Basket: The final rule modifies the proposed, new market-basket methodology in response to concerns from the AHA and other stakeholders. Specifically, the final rule corrects errors in the agency's proposed methodology for deriving cost weights for wages and salaries and employee benefits.

IRF QRP: To address the IRF QRP changes mandated in the IMPACT Act, CMS re-adopts one skin integrity measure and finalizes six new measures assessing functional status and falls with injury. The reporting of these measures will be tied to FY 2018 payment. CMS also will begin publicly reporting certain IRF QRP data in the fall of 2016.

The AHA is very disappointed that CMS has finalized functional status measures that duplicate existing IRF reporting requirements and fail to capture important functional changes in the IRF patient population. We will urge the agency to delay implementation of the new measures and find a less burdensome approach to fulfill IMPACT Act requirements.

AHA Member Call: AHA's IRF members will be invited to join a member-only call on Tuesday, Aug. 25 at 2 p.m. ET during which AHA staff will review the rule and discuss concerns with members. IRF members will be invited to join the invitation-only call in a separate email.

SKILLED NURSING FACILITIES

FY 2016 Payment Update: The rule provides an overall 1.2 percent update (\$430 million) compared to FY 2015 payments, which includes a 2.3 percent market-basket update, a 0.6 percentage point forecast error reduction that accounts for the difference between the FY 2014 market-basket update and the actual market change for that year, and the statutorily mandated 0.5 percentage point productivity cut. The net update for rural hospital-based SNFs is estimated to be 0.6 percent, while the net update for urban hospital-based SNFs is 1.4 percent.

SNF QRP and Value-based Purchasing (VBP) Program: To meet the requirements of the IMPACT Act, CMS establishes a SNF QRP that would include three initial measures assessing skin integrity, patient falls and functional status. Beginning with FY 2018 payment, SNFs must meet reporting requirements for these measures to avoid a 2.0 percentage point reduction to their annual payment update factor.

In addition, as required by the Protecting Access to Medicare Act of 2014, CMS finalizes an all-cause readmission measure for use in the SNF VBP program. Beginning in FY 2019, the SNF VBP program will provide incentive payments to SNFs with higher levels of performance on the readmissions measure, and penalties to lower-performing SNFs.

AHA Member Call: AHA's SNF members are invited to join a member-only call on Wednesday, Aug. 19 at 12:00 p.m. ET during which AHA staff will review the rule and discuss concerns with members. SNF members will be invited to join the invitation-only call in a separate email.



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FOR FURTHER QUESTIONS

For questions on the payment provisions in these final rules, contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org. For any questions regarding the quality provisions, contact Akin Demehin, senior associate director of policy, at ademehim@aha.org.