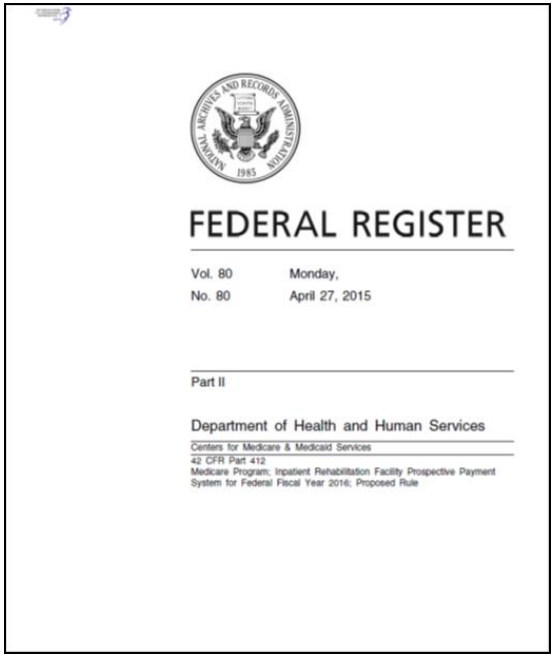
LTCH PPS
FY 2016 Final Rule

Rochelle Archuleta & Akin Demehin
AHA Policy

August 2015

LTCH
Payment Update &
Site-Neutral Payment Implementation



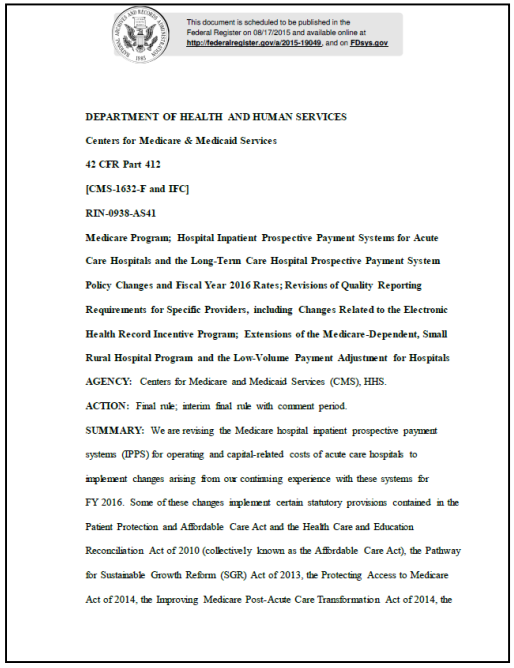
FEDERAL REGISTER

Vol. 80 Monday,
No. 80 April 27, 2015

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services
42 CFR Part 412
Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016; Proposed Rule



This document is scheduled to be published in the Federal Register on 08/17/2015 and available online at http://federalregister.gov/a/2015-19049, and on FDsys.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS-1632-F and IFC]

RIN-0938-AS41

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, including Changes Related to the Electronic Health Record Incentive Program; Extensions of the Medicare-Dependent, Small Rural Hospital Program and the Low-Volume Payment Adjustment for Hospitals

AGENCY: Centers for Medicare and Medicaid Services (CMS), HHS.

ACTION: Final rule; interim final rule with comment period.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from our continuing experience with these systems for FY 2016. Some of these changes implement certain statutory provisions contained in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively known as the Affordable Care Act), the Pathway for Sustainable Growth Reform (SGR) Act of 2013, the Protecting Access to Medicare Act of 2014, the Improving Medicare Post-Acute Care Transformation Act of 2014, the

American Hospital Association

NEW Dual-Rate Structure & Estimate of Fiscal Impact

Standard LTCH PPS Cases

(54% of 2014 Cases)

- **No rehab or psych principal diagnosis; and**
- **Immediately discharged from inpatient PPS hospital; and**
- ***Either* 3 ICU/CCU days during prior inpatient PPS stay; *OR* >=96 hours of ventilator services during LTCH stay**

Site-Neutral Cases

(46% of 2014 Cases)

Paid the lesser of:

Inpatient PPS-Comparable Per Diem, with any outlier payment

OR

100% of Estimated Cost

CMS's Estimate of Fiscal Impact:

- ***Standard LTCH PPS Cases: +1.5%***
- ***Site-Neutral Cases: -14.8%***
- ***NET CHANGE: -4.6% (-$250 million)***

American Hospital Association

Identifying Standard LTCH PPS Cases

CRITERIA FOR STANDARD LTCH PPS RATE:

Psych & Rehab Cases: 15 MS-LTC-DRGs are prohibited.

IMPROVED

Immediate Discharge: Must transfer from inpatient PPS hospital to LTCH must occur within 1 day. *(Removed requirement for inpatient PPS discharge status codes 63 or 91.)*

ICU/CCU Revenue Codes: Must have 3 ICU/CCU days during prior IPPS stay. All ICU/CCU codes (020.x and 021.x) will be counted.

Ventilator Criteria: ICD-10 code 5A1955Z for 96+ consecutive hours of ventilator services in LTCH. *(Must contact MAC re cases receiving exactly 96 hours)*

American Hospital Association

Standard LTCH PPS Rate

Final FY 2016 Update

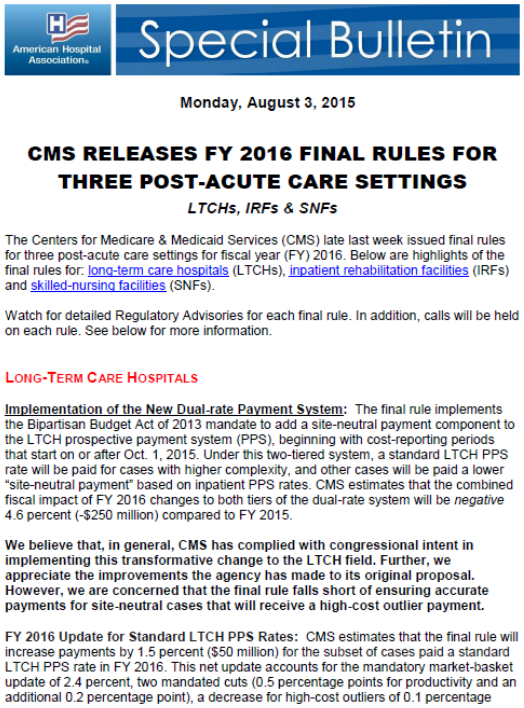
- +2.4% LTCH Market basket
- -0.5% ACA productivity cut
- -0.2% ACA additional cut
- *[-0.3% adjustment to remove SSO's, which are not paid federal rate]*
- -0.1% HCOs
- +0.2% SSOs

NET CHANGE: +1.5% ($50 million)

- Standard rate: $41,762.85 ($41,043.71 in FY 2015)

Other LTCH PPS Standard Rate Changes

- Labor related share: 62.0% (62.306 in FY 2015)
- Outlier fixed loss of $16,423 ($14,972 in FY 2015)
  - Based on only standard LTCH PPS cases
  - 8% outlier pool for only LTCH PPS cases



American Hospital Association

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

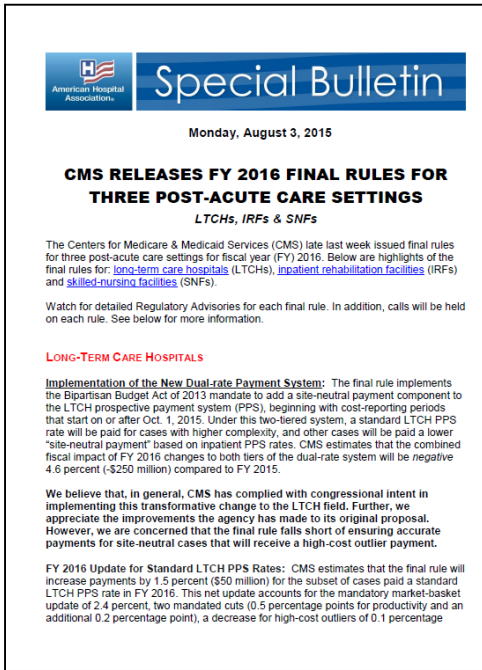
Implementation of the New Dual-rate Payment System: The final rule implements the Bipartisan Budget Act of 2013 mandate to add a site-neutral payment component to the LTCH prospective payment system (PPS), beginning with cost-reporting periods that start on or after Oct. 1, 2015. Under this two-tiered 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

Site-Neutral Payments

- **Site-Neutral Payments Implemented on a Rolling Basis**
  - Based on each LTCHs cost reporting period start date.
  - AHA analysis: Approx. half of "site-neutral cases" would be paid a site-neutral blend due to rolling basis implementation.
- **2 Site-Neutral Payment Options, per slide 4**
- **Blended Payments in FYs 2016 and 2017**
  - 50/50 blend of standard LTCH PPS rate and site-neutral payment.
- **Site-Neutral Per Diem w High-Cost Outliers**
  - Fixed loss amount: $24,485 ($16,423 for LTCH PPS)
  - (Site-neutral cases paid cost receive no outlier payment)
- **Interrupted Stay**
  - Will apply to site-neutral cases.
- **25% Rule**
  - Will apply to site-neutral cases.
- **Short Stay Outlier Policy**
  - Will not apply to site-neutral cases.



American Hospital Association

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.

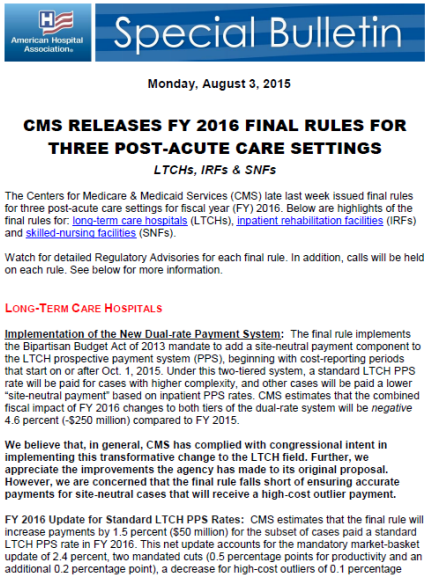
FY 2016 Update for Standard LTCH PPS Rates: CMS estimates that the final rule will increase payments by 1.5 percent ($50 million) for the subset of cases paid a standard LTCH PPS rate in FY 2016. This net update accounts for the mandatory market-basket update of 2.4 percent, two mandated cuts (0.5 percentage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

Site-Neutral Payments for HCO Cases

- **CMS: Concerned that S-Neutral high-cost-outlier payments would increase aggregate LTCH payments.**
- **CMS Solution: Applies another 5.1% BNA within the LTCH PPS.**
- **AHA: This problem unfounded since the IPPS rates are already subject to a 5.1% BNA. Therefore, the second, LTCH BNA is duplicative.**
- **RESULT: Underpayment of S-Neutral HCOs.**

Other Provisions

- **LTCH Average Length of Stay Calculation**
  - Final rule removes these cases from calculation:
    - Site-neutral cases
    - Medicare Advantage cases
  - PAMA: Only LTCHs classified by Dec. 10, 2013 can exclude these cases.
- **Discharge Ratio**
  - Penalty starts FY 2020 for LTCHs with >50% site-neutral cases.
  - Status to be reported starting in FY 2016; more guidance pending.
  - No Medicare Advantage Cases included in calculation
- **Exceptions to Moratorium on New LTCHs**
  - To qualify for an exception, only one of the three exceptions must be met by April 1, 2014.
  - Clarifies definition of “estimated cost of the project.”
  - For satellites that opened during the moratorium, its beds must come from the organization’s March 30, 2014 bed tally.



American Hospital Association

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.

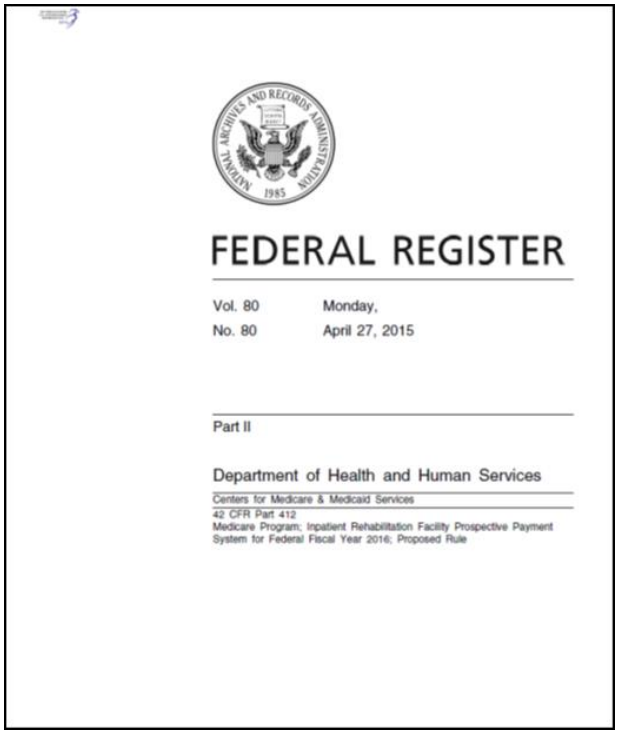
We believe that, in general, CMS has complied with congressional intent in implementing this transformative change to the LTCH field. Further, we appreciate the improvements the agency has made to its original proposal. However, we are concerned that the final rule falls short of ensuring accurate payments 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

AHA Impact Estimate

- **AHA-members received impact estimate on proposed rule. Estimates on final rule in process.**
- **In FY 2016, due to rolling basis implementation of site-neutral payment, 23% of cases (from 2014) would actually be paid a site-neutral blend.**
  - Average rate for Standard LTCH PPS: **$46,565**
  - Average rates for Site-neutral cases:
    - S-N paid standard rate: **$36,264**
    - S-N paid blend: **$9,950**
- **Substantial variation in response to 2-tiered system**
  - Cost-reporting periods distributed across all 12 months
  - Wide range of prevalence of site-neutral cases
  - Local marketplaces differ
  - LTCH strategies differ

LTCH
Quality Reporting Program



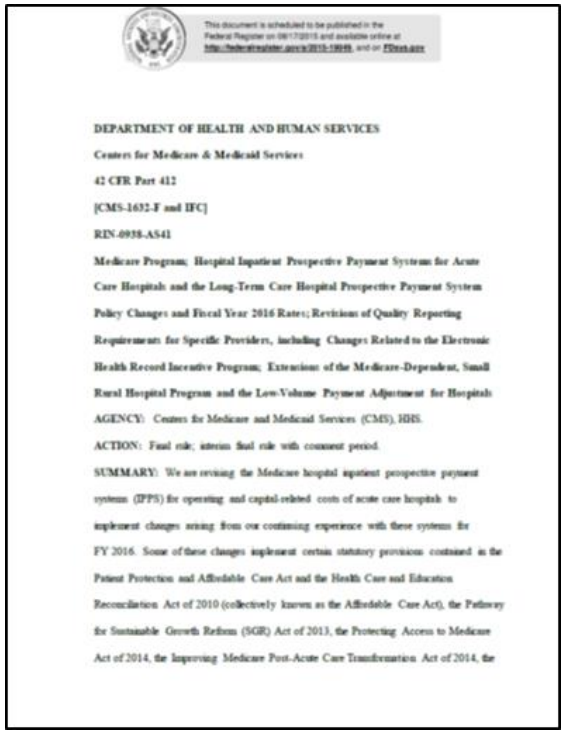
FEDERAL REGISTER

Vol. 80 Monday,
No. 80 April 27, 2015

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services
42 CFR Part 412
Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016; Proposed Rule



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS-1632-F and IFC]

RIN-0938-AS41

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, including Changes Related to the Electronic Health Record Incentive Program; Extensions of the Medicare-Dependent, Small Rural Hospital Program and the Low-Volume Payment Adjustment for Hospitals

AGENCY: Centers for Medicare and Medicaid Services (CMS), HHS.

ACTION: Final rule; interim final rule with comment period.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from our continuing experience with these systems for FY 2016. Some of these changes implement certain statutory provisions contained in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively known as the Affordable Care Act), the Pathway for Sustainable Growth Reform (SGR) Act of 2013, the Protecting Access to Medicare Act of 2014, the Improving Medicare Post-Acute Care Transformation Act of 2014, the

American Hospital Association

Long-Term Care Hospital Quality Reporting (LTCH QRP)

- LTCHs submit quality measures to avoid 2.0 percentage point reduction to annual update

Measure	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Central-Line Associated Blood Stream Infection (CLABSI)	X	X	X	X	X
Catheter-Associated Urinary Tract Infection (CAUTI)	X	X	X	X	X
Percent of patients with pressure ulcers that are new or worsened	**X**	**X**	**X**	**X**	**X^F**
Percent of patients who were assessed and appropriately given the seasonal influenza vaccine	--	--	X	X	X
Influenza vaccination coverage among healthcare personnel	--	--	X	X	X
Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia				X	X
Clostridium difficile (C Diff)				X	X
Unplanned all-cause, all condition readmissions within 30 days following LTCH discharge				X	X
Percent of residents experiencing one or more falls with major injury (Long stay)					**X^F**
Functional Status: Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function					**X^F**
Functional Status: Change in mobility among LTCH patients requiring ventilator support					X
Ventilator-Associated Event Outcome Measure					X

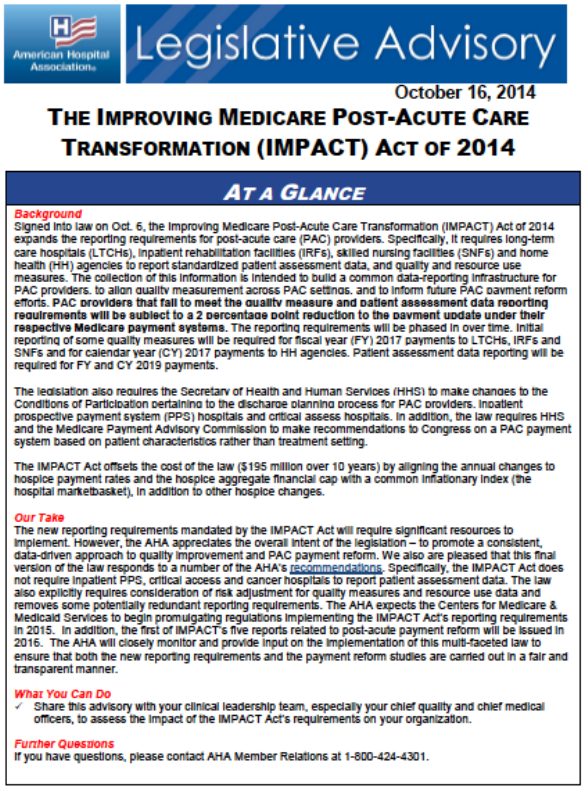
X = Previously Finalized

X^F = Previously finalized, re-finalized in FY 2016 rule

can Hospital sociation

Post-Acute Reporting Changes: IMPACT Act

- Signed into law Oct. 6, 2014
- Framed as creating "building blocks" of post-acute care reform through collection and reporting of "**standardized and interoperable**":
  - Patient assessment data
  - Quality measures
- Expands data collection and reporting requirements for LTCHs, IRFs, SNFs and HHAs
  - Payment penalties for non-reporting
- Significant regulatory activity in 2015



American Hospital Association Legislative Advisory

October 16, 2014

THE IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION (IMPACT) ACT OF 2014

AT A GLANCE

Background

Signed into law on Oct. 6, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 expands the reporting requirements for post-acute care (PAC) providers. Specifically, it requires long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs) and home health (HH) agencies to report standardized patient assessment data, and quality and resource use measures. The collection of this information is intended to build a common data-reporting infrastructure for PAC providers, to allow quality measurement across PAC settings, and to inform future PAC payment reform efforts. **PAC providers that fail to meet the quality measure and patient assessment data reporting requirements will be subject to a 2 percentage point reduction to the payment update under their respective Medicare payment systems.** The reporting requirements will be phased in over time. Initial reporting of some quality measures will be required for fiscal year (FY) 2017 payments to LTCHs, IRFs and SNFs and for calendar year (CY) 2017 payments to HH agencies. Patient assessment data reporting will be required for FY and CY 2019 payments.

The legislation also requires the Secretary of Health and Human Services (HHS) to make changes to the Conditions of Participation pertaining to the discharge planning process for PAC providers. Inpatient prospective payment system (PPS) hospitals and critical assess hospitals. In addition, the law requires HHS and the Medicare Payment Advisory Commission to make recommendations to Congress on a PAC payment system based on patient characteristics rather than treatment setting.

The IMPACT Act offsets the cost of the law ($195 million over 10 years) by aligning the annual changes to hospice payment rates and the hospice aggregate financial cap with a common inflationary index (the hospital marketbasket), in addition to other hospice changes.

Our Take

The new reporting requirements mandated by the IMPACT Act will require significant resources to implement. However, the AHA appreciates the overall intent of the legislation -- to promote a consistent, data-driven approach to quality improvement and PAC payment reform. We also are pleased that this final version of the law responds to a number of the AHA's recommendations. Specifically, the IMPACT Act does not require inpatient PPS, critical access and cancer hospitals to report patient assessment data. The law also explicitly requires consideration of risk adjustment for quality measures and resource use data and removes some potentially redundant reporting requirements. The AHA expects the Centers for Medicare & Medicaid Services to begin promulgating regulations implementing the IMPACT Act's reporting requirements in 2015. In addition, the first of IMPACT's five reports related to post-acute payment reform will be issued in 2016. The AHA will closely monitor and provide input on the implementation of this multi-faceted law to ensure that both the new reporting requirements and the payment reform studies are carried out in a fair and transparent manner.

What You Can Do

✓ Share this advisory with your clinical leadership team, especially your chief quality and chief medical officers, to assess the impact of the IMPACT Act's requirements on your organization.

Further Questions

If you have questions, please contact AHA Member Relations at 1-800-424-4301.

American Hospital Association

IMPACT Act – Patient Assessment Data Domains

To be addressed in future rulemaking

- **Functional status** (e.g., mobility, self care)
- **Cognitive function and mental status** (e.g., depression, ability to understand)
- **Special services, treatments, and interventions** (e.g., ventilator use, dialysis, chemotherapy, central line placement, TPN)
- **Medical condition** (e.g., diabetes, CHF, comorbidities such as severe pressure ulcers)
- **Impairments** (e.g., incontinence, impaired and an impaired ability to hear, see, or swallow.
- Other categories deemed necessary and appropriate by the Secretary of HHS

American Hospital Association

IMPACT Act: Quality Measures

Measures must address following topics:

- **Functional Status**
- **Skin integrity**
- **Major falls**

Addressed in FY 2016 LTCH PPS Final Rule

- Medication reconciliation
- Patients preferences
- Resource use, including at a minimum:
  - Medicare spending per beneficiary
  - Discharges to community
  - Potentially preventable admissions and readmissions

American Hospital Association

FY 2018 LTCH QRP NEW Measures: Falls and Pressure Ulcers

- **Pressure Ulcers:** Assesses percentage of patients with one or more pressure ulcers new or worsened
  - Already in LTCH QRP
  - Collected using LTCH CARE Data Set

- **Falls:** Assesses percentage of patients experiencing one or more falls with major injury during IRF stay
  - Also already in the LTCH QRP
  - Collected using LTCH QRP data set
  - **Not NQF-endorsed for LTCH setting**

American Hospital Association

FY 2018 LTCH QRP NEW Measure: Functional Status

- Assesses the percentage of LTCH patients who have functional status assessments completed on admission and discharge and that have care plan assessing function
  - **Does not measure functional status change, just completion of assessments**

- LTCH CARE data set includes appropriate items to collect assessments
  - Clinicians score level of independence on self-care, mobility, cognition, communication and continence items
  - To demonstrate a care plan assesses function, at least one assessment item needs a numerical “goal”

- **Not yet NQF-endorsed**

American Hospital Association

FY 2018 Revision to LTCH QRP Data Submission Deadlines

FY 2018 Data Collection	FY 2018 Deadline	Subsequent Fiscal Year Data Collection	Subsequent Fiscal Year Deadlines
Jan. 1 – Mar. 31, 2016 Apr. 1 – Jun. 30, 2016 Jul. 1 – Sep. 30, 2016 Oct. 1 – Dec. 31, 2016	Aug. 15, 2016 Nov. 15, 2016 Feb. 15, 2017 May. 15, 2017	Q1: Jan. 1 – Mar. 31 Q2: Apr. 1 – Jun. 30 Q3: Jul. 1 – Sep. 30 Q4: Oct. 1 – Dec. 31	Quarterly, approximately 135 days after the end of each calendar quarter

- LTCHs would have approximately 4.5 months (or 135) after the close of a CY quarter to submit data
- Applies to LTCH QRP measures submitted using LTCH CARE Data Set and NHSN measures
  - Except influenza vaccination

American Hospital Association

Questions
&
Discussion

American Hospital Association