

April 19, 2022

CMS Releases FY 2023 Long-term Care Hospital PPS Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) yesterday issued the fiscal year (FY) 2023 [proposed rule](#) for the inpatient and long-term care hospital (LTCH) prospective payment systems (PPS). This Special Bulletin reviews highlights of the LTCH provisions in this rule, while the inpatient PPS provisions are covered in a separate Special Bulletin.

Key Highlights

The proposed rule would:

- Increase net LTCH payments \$25 million in FY 2023, relative to prior levels.
- When calculating the annual payment update, resume the use of the most recently available claims and cost report data, with some modifications to account for the remaining impact of the COVID-19 public health emergency (PHE).
- Cap annual decreases in wage index updates.
- Cap annual relative weight decreases per MS-LTC-DRG.
- Not add new quality measures or adaptations to the LTCH quality reporting program (QRP).
- Ask stakeholders for information regarding a possible future *C. difficile* infection outcome measure and strategies to better measure equity and quality disparities.

AHA TAKE

The proposed rule contains no major changes to the LTCH payment system. However, the proposed high-cost outlier offset of 1.7 percentage point is significant; the AHA will be carefully evaluating it in the weeks ahead, as we prepare our official comments on the proposed rule. Also, CMS's proposed safeguards to the agency's methodologies for annual wage index updates and relative weight updates for individual MS-LTC-DRGs should help maintain stability in payments, although AHA plans to urge the agency to implement these changes in a non-budget-neutral manner. We remain concerned that implementation of the full site-neutral payment policy continues to challenge some LTCHs — especially as site-neutral payments, on average, do not cover the cost of care. In addition, AHA is very supportive of the agency's outreach to stakeholders to improve efforts to address health equity and quality disparities.

Highlights from the rule follow.

PROPOSED LTCH PPS PAYMENT CHANGES

Overall Proposed FY 2023 Payment Update

When considering all proposed LTCH provisions in the rule, CMS estimates that aggregate net spending on LTCH services would increase by \$25 million in FY 2023 compared to the current FY. CMS estimates that in FY 2023, Medicare payments for standard-rate cases would account for 89% of aggregate payments to LTCHs, with the remaining 11% spent on site-neutral cases.

The rule proposes to resume CMS' standard methodologies used to calculate certain elements of the PPS. Specifically, calculation of the proposed FY 2023 weights and rates for both the inpatient and LTCH PPSs would be based on the most recently available data — the FY 2021 MedPAR claims and FY 2020 cost report data, rather than pre-pandemic data — as occurred for the agency's rate-setting process for FY 2022. This modification is based on the agency's expectation that the volume of COVID-19 hospitalizations will continue to drop in FY 2023.

Update for Standard LTCH PPS Rate Cases. CMS estimates that 72% of all LTCH discharges will be paid a LTCH PPS standard rate in FY 2022 — a reduction from the prior FY's level of 75%. CMS proposes to update payments for this category of cases by a net 0.7% (or \$18 million) in FY 2023 compared to FY 2022. This update includes a 3.1% market-basket update that would be offset by a statutorily mandated cut of 0.4 percentage point for productivity, a 1.7 percentage point cut for high-cost outlier (HCO) payments, and other adjustments. The proposed FY 2023 standard rate would increase to \$45,952.67.

High-cost Outlier (HCO) Threshold. The proposed FY 2023 HCO threshold for standard-rate cases would increase to \$44,182 — the level needed to maintain a HCO pool of 7.975% of aggregate payments to LTCHs, as required by law. CMS again proposes to calculate the proposed inpatient and LTCH PPS HCO thresholds using MedPAR charge data from FYs 2018 and 2019. By using this approach, CMS stated that it can avoid using the PHE data from FYs 2020 and 2021, which produce unusually high HCO thresholds relative to pre-PHE levels. CMS's view is that these abnormalities are partially due to the high number of COVID-19 cases with higher charges in inpatient PPS hospitals and LTCHs in FY 2021. Since CMS projects fewer COVID-19 hospitalizations in FY 2023 than in FY 2021, it proposes to update the HCO thresholds using pre-PHE charge data from FYs 2018 and 2019. CMS also would apply an inflation adjustment factor to the older charges data to reconcile the impact of mixed data periods, using a methodology that we will outline in AHA's upcoming LTCH PPS regulatory advisory.

Update for Site-neutral Rate Cases. CMS finds that the proportion of all LTCH discharges that are paid an LTCH site-neutral rate increased from 25% to 28% in FY 2022. For this category of cases, the rule would update net payments by 2.3% (or \$8 million) compared to FY 2022. Site-neutral payment rates are paid the lower of the

inpatient PPS-comparable per-diem amount, including any outlier payments, or 100% of the estimated cost of the case. For FY 2023, the proposed HCO threshold for site-neutral cases would continue to mirror that of the proposed inpatient PPS threshold, \$43,214.

For FY 2023, all site-neutral cases would continue to receive the full site-neutral payment rate, instead of the prior 50/50 blend of LTCH PPS and site-neutral rates. We note that, as required by statute, the cost of the last two years of the blended-rate (cost reporting periods starting in FYs 2018 and 2019) is offset by a 4.6% payment cut to site-neutral payments in FYs 2018 through 2026. This offset is explained in CMS [Transmittal 4046](#).

AHA analyses have found that site-neutral cases are underpaid by CMS, both under the prior blended rate and the current full site-neutral rate. This finding contrasts with CMS' ongoing position that the costs and resource use for FY 2021 cases paid at the site neutral payment rate will likely mirror the costs and resource use for IPPS cases assigned to the same MS-DRG. As such, we recognize that some LTCHs are facing challenges due to site-neutral payments not covering the cost of providing care, as indicated by the drop in the number of LTCHs reported in this rule (346) in comparison to those in the FY 2019 final rule (417).

Proposed Cap on Relative Weight Decreases per MS-LTC-DRG

To improve the stability of this PPS, CMS is proposing a 10% cap on relative weight decreases to mitigate fluctuations in MS-LTC-DRG relative weight changes from year to year. The agency notes that in recent years, some MS-LTC-DRGs weight fluctuations have been quite significant and some stakeholders have asked the agency to mitigate these negative effects. This cap would be implemented in a budget-neutral manner to prevent impacting aggregation payments. In addition, CMS states its expectation that the impact of a cap on relative weight reductions in a given year would be relatively small, as the cap would be applied on a per MS-LTC-DRG basis. The cap also would apply to “low-volume MS-LTC-DRGs” — those with 1-25 cases, with no application to “no-volume MS-LTC-DRGs.”

Proposed Cap on LTCH Wage Index Decreases

CMS also proposes a permanent approach to smooth year-to-year changes in the LTCH PPS wage index. In the past, to mitigate stability, CMS phased in significant changes to labor market areas. CMS notes that, while relatively rare, year-to-year fluctuations in an area's wage index can occur due to external factors beyond a provider's control, such as the COVID-19 pandemic. To mitigate this type of occasional instability, CMS proposes a permanent 5.0% cap on any decrease to a provider's wage index, relative to the prior year, regardless of the circumstances causing the decline. For a new LTCH, the rule would apply the wage index for the area in which it is geographically located with no cap applied because the new hospital would not have a wage index to reference from the prior year.

REQUESTS FOR INFORMATION

CMS seeks stakeholder feedback on a number of topics, which the agency reports will influence the direction of the LTCH QRP in the future.

C. *difficile* Infection Outcome Measure. CMS requests input on the potential inclusion of an updated healthcare-associated infection measure in the LTCH Quality Reporting Program (QRP). The measure, National Healthcare Safety Network (NHSN) Healthcare-associated *Clostridioides difficile* Infection (HA-CDI) Outcome Measure, improves upon the CDI measure currently used in the LTCH QRP by using data from electronic health records. CMS purports that this method both increases the accuracy of the measure and reduces reporting burden, as it would negate manual entry of information into the NHSN reporting platform. In the RFI, CMS would like to assess the feasibility of this “digital” measure in LTCHs.

Measuring Equity and Quality Disparities. Separately, CMS seeks feedback on its strategies to improve measurement of disparities in health care outcomes. In this RFI, the agency requests input on its framework to collect, stratify and report quality performance data across CMS programs as well as specific methods the agency could deploy within the LTCH QRP specifically. The latter might include quality measures assessing a facility’s commitment to addressing health equity by taking on certain practices.

FURTHER QUESTIONS

CMS will accept comments on the LTCH proposed rule through June 17. LTCH members will receive an invitation for a call to discuss the rule and inform AHA’s comments. Please contact Rochelle Archuleta, AHA director of policy, at rarchuleta@aha.org with any questions related to payment, and Caitlin Gillooley, AHA director of policy, at cgillooley@aha.org, regarding any quality-related questions.