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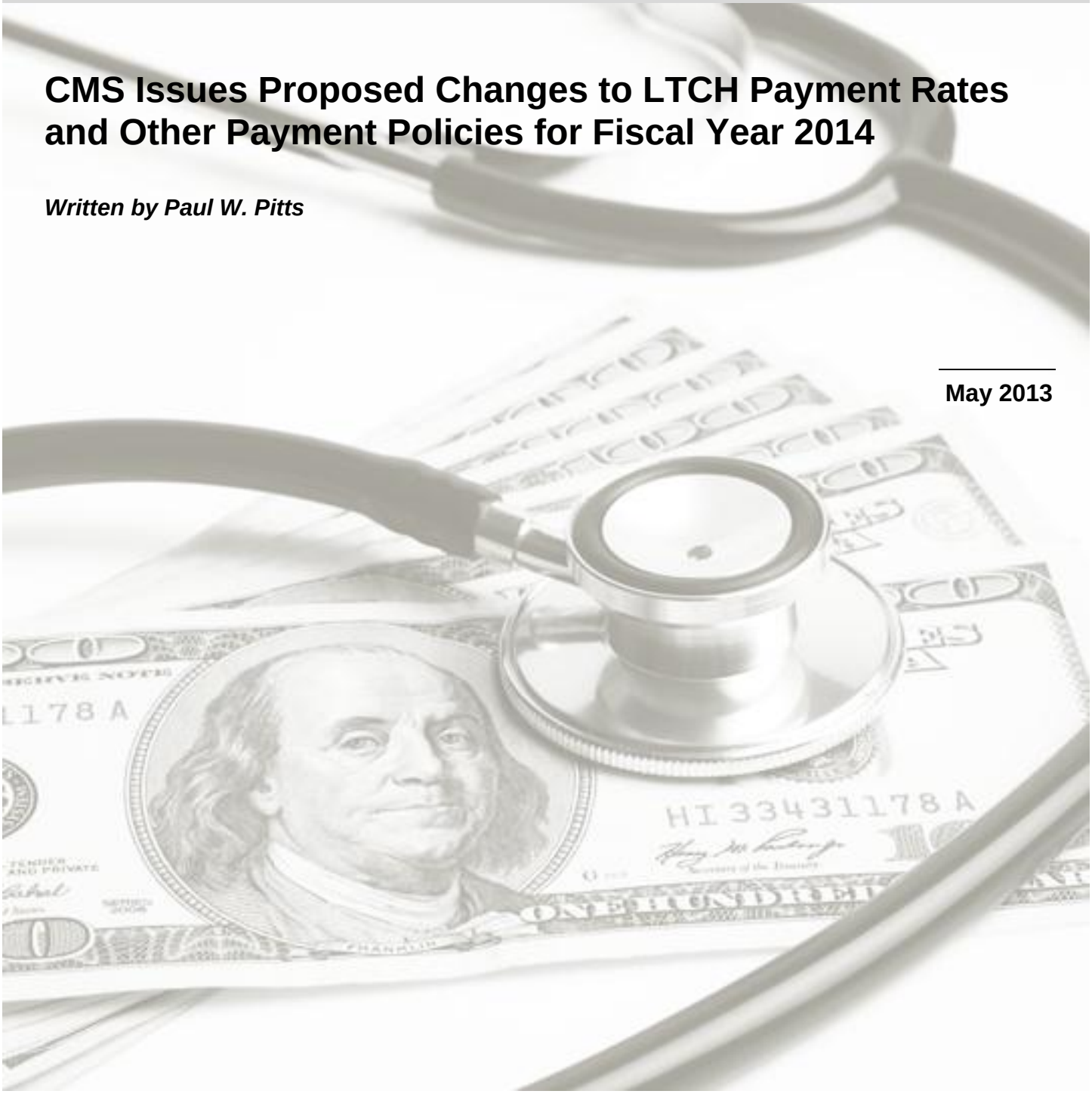
CMS Issues Proposed Changes to LTCH Payment Rates and Other Payment Policies for Fiscal Year 2014

Written by Paul W. Pitts



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CMS Issues Proposed Changes to LTCH Payment Rates and Other Payment Policies for Fiscal Year 2014

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On April 26, 2013, the Centers for Medicare & Medicaid Services ("CMS") released the proposed update to the Medicare long-term acute care hospital prospective payment system ("LTCH PPS") policies and payment rates for fiscal year ("FY") 2014. The proposed changes would apply to discharges occurring on or after October 1, 2013 through September 30, 2014. CMS will accept comments on the proposed rule until June 25, 2013, and will respond to comments in a final rule to be issued by August 1, 2013. The proposed rule will appear in the May 10, 2013 Federal Register.

This Client Alert provides a summary of the most significant proposed changes to the LTCH PPS in the proposed rule, including the following:

- **Standard Federal Rate**. The proposed standard federal rate for FY 2014 is $40,622.06, which would apply to LTCH PPS discharges occurring on or after October 1, 2013 through September 30, 2014. The proposed rule would result in an increase from the FY 2013 standard federal rate of $40,397.96 in effect during the last nine months of fiscal year 2013.

- **Market Basket Update.** CMS proposes a 1.8% annual update for LTCHs. The proposed change to the LTCH PPS standard federal rate for FY 2014 would be based on a market basket increase estimate of 2.5% less a productivity adjustment of 0.4% and less an additional reduction of 0.3% mandated by the Affordable Care Act. The market basket increase is further reduced by a portion of the one-time budget neutrality adjustment, as discussed below. For those LTCHs that fail to submit quality reporting data, the standard federal rate is further reduced by 2%.

- **Adjustment to Reflect Budget Neutrality**. CMS proposes to implement the second year of a three year phase-in of the one-time budget neutrality adjustment that is intended to permanently reduce the LTCH base rate by 3.75 percent. CMS is proposing to implement the adjustment in FY 2014 by applying a factor of 0.98734 to the standard federal rate.

- **Fixed-Loss Amount**. The fixed loss amount for high cost outlier cases would be set at $14,139. This is a decrease from the fixed loss amount in the 2013 fiscal year of $15,408.

- **Labor-Related Share**. CMS proposes to decrease the labor-related share from 63.096 percent to 62.717 percent under the LTCH PPS for FY 2014, based on data on the relative importance of the labor-related share of operating and capital costs. CMS also proposes to apply an area wage level budget neutrality factor of 1.000433, which increases the proposed standard Federal rate by approximately 0.04 percent. Therefore, the proposed changes to the wage data and labor-related share do not result in a change in estimated aggregate LTCH PPS payments.

- **Full Implementation of the 25% Rule**. CMS proposes to allow the regulatory moratorium on the full application of the 25% Rule to lapse. If the proposal is adopted, full implementation of the 25% Rule would go into effect for cost reporting periods beginning on or after October 1, 2013. All LTCHs, whether freestanding or co-located with another hospital, would become subject to the 25% Rule for its Medicare patients during its first cost reporting period beginning on or after October 1, 2013 (except rural LTCHs,

LTCHs co-located with an urban single hospital, or LTCHs co-located with an MSA-dominant hospital where the percentage is no more than 50%, nor less than 25%). CMS estimates that the expiration of the moratorium will result in a payment reduction of approximately $190 million to LTCHs.

CMS requests public comment on whether adoption of a new payment adjustment based on whether a patient qualifies as chronically critically ill/medically complex, as discussed below, obviates the need for the 25% Rule in the future. CMS is interested in public comment on whether it should discontinue the 25% Rule if a payment adjustment is adopted based on patient criteria or whether to continue both rules simultaneously.

- **Patient Criteria-Based Payment Adjustments**. In comments to the FY 2013 update, CMS indicated that "within the near future" it may recommend revisions to the payment policies addressing MedPAC's recommendations for the development of patient-level and facility-level criteria. CMS now indicates that it is not proposing a new payment policy at this time. Instead, CMS has published the findings of its research study and requested public comments on adoption of a payment adjustment based on whether a particular case qualifies as chronically critically ill/medically complex ("CCI/MC"). CMS also seeks public comment on the potential impact these changes could have on hospital markets with the expectation of proposing changes to the LTCH PPS in FY 2015.

  CMS is considering a system that would limit full LTCH PPS payment to patients meeting the definition of CCI/MC while they were in an IPPS hospital inpatient setting and subsequently directly admitted to a LTCH. Payment for non-CCI/MC patients would be made at an "IPPS comparable amount," that is, an amount comparable to what would have been paid under the IPPS calculated as a per diem rate with total payments capped at the full IPPS MS-DRG payment rate.

  CMS suggests that a patient would be identified as a CCI/MC patient in the IPPS setting based on having one or more of the five clinical factors combined with a stay of 8 or more days in an ICU/CCU at an IPPS hospital. The five clinical factors proposed are:

  1. Prolonged Mechanical Ventilation
  2. Tracheotomy
  3. Multiple Organ Failure/Stroke/Intercerebral Hemorrhage/TBI
  4. Sepsis and Other Severe Infections
  5. Severe Wounds

  While CMS appears disposed to adopting a system that is based on payment adjustments for patients who do not meet the definition of CCI/MC during their IPPS stay, other potential policy changes remain on the table. In particular, CMS noted that MedPAC recently discussed three "policy options" for payment of chronically critically ill cases that are also based in part on the use of ICU services as a defining characteristic. Of MedPAC's policy options, the first option would remove the LTCH designation and pay for cases under a modified IPPS, which would include changes to the current IPPS high-cost outlier policy. A second option breaks out CCI patients into separate MS-DRGs with higher payment relative weights. The third option would bundle expected post-acute care costs into the new CCI MS-DRGs so that the IPPS hospital would be responsible for associated LTCH or SNF care for CCI/MC patients. CMS intends to continue to review MedPAC's recommendations and any additional research presented by MedPAC in the coming months.

- **Quality Measures**. For FY 2014 and subsequent fiscal years CMS is proposing to reduce the standard federal rate by 2 percentage points for any LTCH that does not submit quality reporting data in the form, manner and time required. The reduction would apply only to the fiscal year involved and would not be taken into account in computing the annual update to the standard federal rate in the subsequent year.

  CMS also is proposing five new LTCH quality measures that would affect the FY 2017 and FY 2018 payment updates. For the FY 2017 payment determination, the proposal includes: (1) an all-cause unplanned readmission measure for 30 days post- discharge from long-term care hospitals, (2) the CDC's National Healthcare Safety Network (NHSN) facility-wide inpatient hospital-onset MRSA bacteremia outcome measure, and (3) the NHSN facility-wide inpatient hospital-onset clostridium difficile infection (CDI) outcome measure. CMS is also proposing to apply the NQF measure of the percent of residents experiencing one or more falls with major injury (long stay) for the FY 2018 payment determination. CMS is seeking comment regarding the addition of these measures.

- **Hospital Readmissions Reduction Program**. Although LTCHs, skilled nursing facilities, and inpatient rehabilitation facilities are not subject to a reduction in Medicare payment under the Hospital Readmissions Reduction Program, certain patient transfers from post-acute providers may result in a decrease in Medicare payments to a general acute care hospital. CMS is proposing to expand its policy of reducing payments to general acute care hospitals paid under IPPS when an LTCH, skilled nursing facility, inpatient rehabilitation facility or other post-acute care provider transfers a patient back to a IPPS-hospital within 30 days for additional services. For FY 2014 the maximum reduction in payments under the Hospital Readmissions Reduction Program will increase from 1% to 2%. CMS also proposes to add two new readmission measures which could be used to calculate readmission penalties for FY 2015: (1) patients admitted for an acute exacerbation of chronic obstructive pulmonary disease; and (2) patients admitted for elective total hip arthroplasty and total knee arthroplasty.

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