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Regulatory Advisory

May 20, 2022

Long-term Care Hospital Prospective Payment System Proposed Rule for FY 2023

The Centers for Medicare & Medicaid Services (CMS) on April 18 issued its fiscal year (FY) 2023 proposed rule for the inpatient and long-term care hospital (LTCH) prospective payment system (PPS). The LTCH elements of the rule are covered in this regulatory advisory, while the inpatient PPS content has been summarized in a separate advisory.

KEY HIGHLIGHTS

The proposed rule would:

- Increase net LTCH payments by $25 million in FY 2023, relative to FY 2022
- Resume use of the most recently available claims- and cost-report data to calculate the annual weights and payment rates , with some modifications to account for the remaining impact of the COVID-19 public health emergency
- Cap annual decreases in wage index updates
- Cap annual relative weight decreases per MS-LTC-DRG
- Forgo adding new quality measures or adaptations to the LTCH quality reporting program
- Ask stakeholders for information regarding a possible, future *C. difficile* infection outcome measure, along with strategies to better measure disparities in equity and quality

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WHAT YOU CAN DO

- **Share** the attached summary with your senior management team to examine the impact these payment changes would have on your organization in FY 2023.
- **Listen** to a replay of a May 17 members-only conference call, during which staff and AHA members discussed the rule's key elements; find a link to the webinar in the LTCH section of aha.org/postacute.
- **Submit** a comment letter on the proposed rule to CMS not later than June 17 explaining the rule's impact on your patients, staff and facility, and local healthcare partners.

AHA TAKE

The rule does not propose major changes to the LTCH payment system. However, the proposed 1.7 percentage-point decrease of the high-cost outlier is significant; the AHA

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is carefully evaluating this change as we prepare our official comments on the proposed rule.

Also, CMS's proposed safeguards to the agency's methodologies for annual wage-index 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. In addition, 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.

Finally, AHA is very supportive of the agency's outreach to stakeholders to improve efforts to address health equity and quality disparities.

PROPOSED LTCH PPS PAYMENT CHANGES

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 fiscal year. CMS estimates that Medicare payments for standard-rate cases in FY 2023 will account for 89% of aggregate payments to LTCHs, with the remaining 11% spent on site-neutral cases.

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 fiscal year'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 0.4 percentage-point cut 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.

Proposed Changes for the FY 2023 MS-LTC-DRG Relative Weights Methodology. The rule proposes to CMS resume its standard methodologies used to calculate certain elements of the PPS. Specifically, calculation of the proposed FY 2023 weights and rates 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 utulized for the agency's FY 2022 rate-setting process. This modification is based on the agency's expectation that the volume of COVID-19 hospitalizations will continue to drop in FY 2023.

In addition, CMS proposes two adjustments to its weight-setting policy. Specifically, it would:

- average two versions of the relative weights (those with and without COVID-19 cases); and
- impose a 10% cap on reductions to relative weights.

Proposed Averaging of Relative Weights. To account for public health emergency's impact of the on some MS-LTC-DRGs, CMS would modify its current methodology for updating MS-LTC-DRG relative weights. CMS has specifically determined that COVID-19 cases in a few MS-LTC-DRGs on average have meaningfully higher costs. Thus, the relative weights calculated using all cases will be meaningfully different than the relative weights calculated excluding COVID-19 cases. CMS also believes there will be fewer COVID-19 hospitalizations in FY 2023, compared to FY 2021. As such, CMS proposes to calculate the relative MS-LTG-DRG weights both including and excluding COVID-19 cases and then average the two sets of relative weights.

While the agency recognizes that this averaging approach would reduce, but not eliminate, the impact of COVID-19 cases on relative weight calculations, it believes the result is a reasonable estimation of the mix of cases for FY 2023, and a more accurate estimate of the relative resource use for FY 2023 cases.

Proposed Cap on Relative Weight Decreases per MS-LTC-DRG**.** To improve the stability of this PPS, CMS is proposing a 10% cap on year-to-year relative weight decreases. The agency notes that in recent years, some MS-LTC-DRG weight fluctuations have been quite significant; some stakeholders have asked the agency to mitigate these negative effects. This cap would be implemented in a budget-neutral manner to prevent any impact on aggregate payments. In addition, CMS states an 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," i.e. those with 1-25 cases, with no application to "no-volume MS-LTC-DRGs."

Proposed Exclusion of "Site-neutral Eligible" Cases. The rule notes that in FY 2021, because of the COVID-19 public health emergency waiver on the LTCH site-neutral payment policy, all LTCH cases were paid an LTCH PPS standard rate, regardless of compliance with standard-rate payment criteria. However, for the purpose of establishing FY 2023 LTCH weights and rates, CMS would solely use FY 2021 cases that would have qualified for a standard LTCH PPS reimbursement, were the waiver not in place. Consistent with its current weighting methodology, CMS proposes to remove LTCH cases with a length of stay of seven days or less.

High-cost Outlier (HCO) Threshold. The proposed FY 2023 HCO threshold for standard-rate cases is $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 FY 2018 and 2018 MedPAR data to avoid using 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, which is not expected to continue in FY 2023.

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 LTCH Wage Index Decreases

CMS also proposes a permanent approach to smooth year-to-year changes in the LTCH PPS wage index. The agency 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. LTCHs that were operational during the prior federal fiscal year would be subject to the LTCH PPS wage index cap. For any 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.

LTCH QUALITY REPORTING PROGRAM (QRP)

As mandated by the Affordable Care Act, LTCHs receiving Medicare payments have been required to participate in the LTCH QRP since 2014. The Improving Medicare Post-Acute Care Transformation Act requires that, starting FY 2019, providers must report standardized patient assessment data elements as part of the LTCH QRP. Failure to comply with these requirements results in a two-percentage point reduction to the LTCH's annual market-basket update. CMS does not propose to adopt or remove

any measures from the QRP in this rule. The LTCH QRP currently consists of 18 measures for FY 2023-FY 2025, as described in Table 1.

Table 1: Finalized Measures for the LTCH QRP, FY 2022 – FY 2025

Data Source	Measure
National Healthcare Safety Network (NHSN)	Catheter-associated urinary tract infection (CAUTI)
	Central Line-associated Blood Stream Infection (CLABSI)
	Clostridium difficile (CDI) infection
	Influenza vaccination coverage among health care personnel
	COVID-19 Vaccination Coverage among Healthcare Personnel
LTCH CARE Data Set (LCDS)	Application of Percent of residents experiencing one or more falls with major injury (Long stay)
	Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function
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	Change in Mobility among LTCH Patients Requiring Ventilator Support
	Drug regimen review conducted with follow-up for identified issues
	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
	Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of LTCH Stay
	Ventilator Liberation Rate
	Transfer of Health Information to Provider
	Transfer of Health Information to Patient
Claims	Medicare spending per beneficiary
	Discharge to community
	Potentially preventable 30-day post-discharge readmission

Requests for Information (RFIs)
CMS seeks feedback on various concepts for quality measurement across quality reporting programs as well as particular issues for the LTCH QRP.

Digital Healthcare-associated Infection Measure. CMS introduces the potential future inclusion of a measure informed by data in an electronic health record (EHR) that would assess rates of LTCH-onset *Clostridioides difficile* infection (CDI). LTCHs have reported rates of CDI through the NHSN platform since 2015. This new measure, which is still under review by the National Quality Forum (NQF), would use EHR-derived data via a Fast Healthcare Interoperability Resource (FHIR) interface, meaning that with this measure, LTCHs would not have to manually enter data as they do with the current CDI measure. In addition, incidence of CDI would be demonstrated by both a lab value indicating infection and evidence of antimicrobial treatment (instead of solely the lab

test, as in the current measure). CMS believes using both factors would improve the accuracy of the measure.

The agency also argues that the digital measure would reduce burden associated with manual entry; it estimates that an LTCH experiencing the average of 72 CDI events in a year would save up to 2.5 hours per LTCH per month and $1,598 per year if the measure were automatically informed by the EHR rather than entered manually. However, CMS acknowledges that not all LTCHs use EHRs, and there would be "initial implementation and training costs" to install one.

In addition, the measure as currently specified would use a specific version of the FHIR standard (HL7), which is not yet uniformly used. To bridge this gap, CMS explains that it would use existing clinical document architecture "and potentially other formats" to allow for data transfer. Finally, CMS notes that if the new measure were adopted, the agency would simultaneously continue the traditional NHSN reporting of the CDI measure in order to maintain surveillance of CDI while establishing a baseline for the new measure.

CMS seeks stakeholder input on these issues; specifically, the agency asks whether:

- stakeholders would support using LTCH EHRs for quality measure data collection;
- current LTCH EHRs would support data transfer via HL7 FHIR;
- a transition period between the current method of data submission for the NHSN measure and an electronic submission method would be necessary; and
- LTCHs anticipate challenges in adopting the new CDI measure, other than the adoption of an EHR.

Health Equity. Continuing its efforts to determine how the agency can leverage its data collection and quality reporting capabilities to address disparities in health outcomes, CMS proffers an RFI on topics similar to those addressed in last year's proposed rules.

First, CMS discusses a general framework that could be used across the agency's quality programs to assess disparities through data reporting. Specifically, CMS reviews various options for stratified data reporting, which analyzes differences in performance on quality measures by certain patient characteristics. In this section, CMS asks for feedback on how it should select and prioritize particular measures for disparity reporting, as well as which types of data sources would be most helpful to use for this purpose.

Next, CMS describes options to assess drivers of health care quality disparities within the LTCH QRP specifically. One option to do this would be to employ performance disparity decomposition, which allows one to estimate the extent to which differences in measure performance between subgroups of patient populations are due to specific factors. Another way to determine disparities within the LTCH QRP could be to adopt measures related to health equity. Here CMS describes the Health Equity Summary Score, a measure developed for Medicare Advantage plans that computes disparities in performance on measures across different subgroups as well as between different

plans. CMS also describes a structural measure recently reviewed by the NQF Measure Applications Partnership that uses survey questions to assess hospital leadership's commitment to implementing processes and procedures related to equity.

CMS invites general comments on the principles and approaches described in the RFI, as well as additional thoughts about disparity measurement.

Future Measure Topics. CMS seeks input on the importance, relevance, and applicability of certain concepts under consideration for quality measures to potentially be included in future years of the LTCH QRP. Specifically, the agency requests feedback on:

- A cross-setting functional measure assessing domains of self-care and mobility
- Measures addressing health equity, as described in the previous section
- A measure assessing whether LTCH patients are up-to-date on their COVID-19 vaccination

NEXT STEPS

The AHA urges all LTCHs to submit comments to CMS by June 17. Comments may be submitted electronically at www.regulations.gov.

FURTHER QUESTIONS

For questions about payment provisions, contact Rochelle Archuleta, AHA's director of policy, at rarchuleta@aha.org; for quality-related questions, contact Caitlin Gillooley, AHA's director of policy, at cgillooley@aha.org.