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Regulatory Advisory

September 19, 2022

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

The Centers for Medicare & Medicaid Services (CMS) on Aug. 1 issued its fiscal year (FY) 2023 final 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 final rule:

- Increases net LTCH payments by $71 million in FY 2023, relative to FY 2022;
- Resumes use of the most recently available claims and cost report data to calculate the annual weights and rates, with some modifications to account for the remaining impact of the COVID-19 public health emergency;
- Caps annual decreases in wage index updates;
- Caps annual relative weight decreases per MS-LTC-DRG; and
- Does not add new quality measures or other changes to the LTCH quality reporting program.

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.

AHA TAKE

We are pleased that the final rule recognized the need for a more adequate update to LTCH payments; however, the rates still fall short of what these providers need to continue to overcome the many challenges that threaten their ability to care for patients and provide essential services for their communities. We generally support the final policies related to the annual wage index and relative weight updates for individual MS-LTC-DRGs, which collectively should help maintain stability from year to year — although we preferred a non-budget neutral approach for implementing the wage index cap. 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.

Highlights from the rule follow.

LTCH PPS PAYMENT CHANGES

When considering all provisions in the rule, CMS estimates that aggregate net spending on LTCH services will increase by $71 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%. The agency finalized a payment update for this category of cases of net $61 million in FY 2023, compared to FY 2022. This increase includes a 4.1% market-basket update that is offset by a statutorily mandated 0.3 percentage-point cut for productivity, a 1.2 percentage-point cut for high-cost outlier (HCO) payments, and other adjustments. The final standard rate increases from $45,952.67 in FY 2022 to $46,432.77 in FY 2023.

Changes for the FY 2023 MS-LTC-DRG Relative Weights Methodology. The rule resumes CMS's standard methodologies used to calculate most elements of the PPS. Specifically, calculation of the FY 2023 weights and rates are based on the most recently available data — the FY 2021 MedPAR claims and FY 2020 cost report data — rather than pre-pandemic data utilized 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 makes two adjustments to its weight-setting policy. Specifically, it:

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

Averaging of Relative Weights. To account for the COVID-19 public health emergency's impact on some MS-LTC-DRGs, CMS modifies its current methodology for updating MS-LTC-DRG relative weights. Specifically, it determined that COVID-19 cases in a few MS-LTC-DRGs on average have meaningfully higher costs than the non-COVID-19 cases grouped into those MS-LTC-DRGs. 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. Therefore, it finalizes its proposal to calculate the relative MS-LTG-DRG weights both including and excluding COVID-19 cases and then average the two sets of relative weights. Because this averaging approach reduces but does not eliminate the impact of COVID-19 cases on relative weight calculations, CMS 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.

Cap on Relative Weight Decreases per MS-LTC-DRG**.** To improve the stability of the PPS, CMS finalized as proposed 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 will be implemented in a budget-neutral manner to prevent impacting aggregate payments. In addition, CMS states its expectation that the impact of a cap on relative weight reductions in a given year will be relatively small, as the cap will be applied on a per MS-LTC-DRG basis. The cap also will apply to "low-volume MS-LTC-DRGs" — those with 1-25 cases — with no application to "no-volume MS-LTC-DRGs."

Exclusion of "Site-neutral Eligible" Cases. 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 the FY 2023 LTCH weights and rates, CMS uses only FY 2021 cases that would have qualified for a standard LTCH PPS reimbursement, were the waiver not in place.

High-cost Outlier (HCO) Threshold. The proposed FY 2023 HCO threshold for standard-rate cases is $44,182, the level needed to maintain an 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 2019 MedPAR data to avoid using data from FYs 2020 and 2021, which produce unusually high HCO thresholds relative to pre-public health emergency 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.

The rule finalized a FY 2023 HCO threshold for standard-rate cases of $38,518, far lower than the proposed threshold of $44,182. To calculate this threshold, CMS modified its proposed approach to instead use FY 2021 claims; it calculated the threshold both including and excluding COVID-19 cases and averaged the two numbers. In addition, CMS states that the final threshold also reflects a newly realized anomaly that, when addressed, resulted in the lower, more accurate threshold. Specifically, the final threshold was recalculated without the cases of a particular LTCH with an extreme level of charges in FY 2021, including over 50 LTCH PPS standard rate cases with charges exceeding $9 million, and outlier payments for over 80% of its standard rate cases that year.

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% in FY 2022 to 28% in FY 2023. For this category of cases, the rule updates net payments by 2.8% (or $9 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 HCO threshold for site-neutral cases

continues to mirror that of the final inpatient PPS threshold, $38,859, which is substantially lower than initially proposed.

For FY 2023, all site-neutral cases will 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 decrease in the number of LTCHs, as reported in this rule (346) in comparison to the FY 2019 final rule (417).

Cap on LTCH Wage Index Decreases. CMS finalized as proposed 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, such as to labor market area boundaries. 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, it will implement 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 agency will apply the wage index for the area in which it is geographically located with no cap applied because the new hospital will not have a wage index to reference from the prior year. This policy will be implemented in a budget neutral manner.

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 did 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
	Catheter-associated urinary tract infection (CAUTI)

Data Source	Measure
National Healthcare Safety Network (NHSN)	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

FURTHER QUESTIONS

For questions about payment provisions, contact Joanna Hiatt Kim, AHA's vice president of policy, at jkim@aha.org; for quality-related questions, contact Caitlin Gillooley, AHA's director of policy, at cgillooley@aha.org.