IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

NEW LIFECARE HOSPITALS OF CHESTER COUNTY LLC, *et al.*,

Plaintiffs,

v.

ALEX M. AZAR II, Secretary
U.S. Department of Health and Human Services,

Defendant.

Civil Action No: 19-cv-705 (EGS)

JOINT APPENDIX

/s/ *Jason M. Healy*
Jason M. Healy (D.C. Bar No. 468569)
THE LAW OFFICES OF
JASON M. HEALY PLLC
1701 Pennsylvania Ave., N.W., Ste. 300
Washington, DC 20006
(202) 706-7926
(888) 503-1585 (fax)
jhealy@healylawdc.com

Attorney for Plaintiffs

JOSEPH H. HUNT
Assistant Attorney General

JENNIFER D. RICKETTS
Director, Federal Programs Branch

JEAN LIN
Special Counsel, Federal Programs Branch

/s/ Joshua Kolsky
JOSHUA M. KOLSKY
Trial Attorney
D.C. Bar No. 993430
United States Department of Justice
Civil Division, Federal Programs Branch
1100 L Street NW Washington, DC 20005
Tel.: (202) 305-7664
Fax: (202) 616-8470
E-mail: joshua.kolsky@usdoj.gov

Attorneys for Defendant

Dated: August 14, 2019

Joint Appendix
New LifeCare Hospitals of Chester County LLC v. Azar
Case No. 1:19-cv-705

ADMINISTRATIVE RECORD	
Name of Document	**Pages (Original Numbering from Administrative Record)**
PRRB's Expedited Judicial Review (EJR) Determination, Dated January 28, 2019	2-16
Providers' Request for Expedited Judicial Review, dated January 2, 2019	22-88
Providers' Initial Group Appeal Request, Schedule of Providers & Request for Expedited Judicial Review, dated November 20, 2018	1078-1153

RULEMAKING RECORD	
Name of Document	**Pages (Original Numbering from Rulemaking Record)**
FY 2016 IPPS/LTCH PPS Proposed Rule, 80 Fed. Reg. 24324 (Apr. 30, 2015) (excerpts)	1, 325-26
American Hospital Association, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule (June 15, 2015) (excerpts)	420, 426
National Association of Long Term Hospitals, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule (June 16, 2015) (excerpts)	492, 498-99
Federation of American Hospitals, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule (June 16, 2015) (excerpts)	521, 586-87
Post Acute Medical, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule (June 16, 2015) (excerpts)	610, 630, 632-34

Kindred Healthcare, Inc. & Select Medical Holdings Corp., Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule (June 16, 2015) (excerpts)	651, 683, 687-89
FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326 (Aug. 17, 2015) (excerpts)	968, 1243-84, 1427-30, 1435-37, 1442-48
2017 IPPS/LTCH PPS Proposed Rule, 81 Fed. Reg. 24946 (Apr. 27, 2016) (excerpts)	1486, 1826-29
MedPAC, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule (May 31, 2016) (excerpts)	1864-84
LifeCare Hospitals, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule (June 15, 2016) (excerpts)	1894, 1900-04
Vibra Healthcare, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule (June 17, 2016) (excerpts)	2006, 2019-26
Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule (June 17, 2016) (excerpts)	2092, 2109-16
Federation of American Hospitals, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule (June 17, 2016) (excerpts)	2183, 2230-31
Post Acute Medical, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule (June 17, 2016) (excerpts)	2315, 2328-35
FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. 56762 (Aug. 22, 2016) (excerpts)	2362, 2670, 2886-88, 2893-95, 2901-09
Post Acute Medical, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule (June 12, 2017) (excerpts)	3424, 3427
Vibra Healthcare, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule (June 13, 2017) (excerpts)	3438, 3457-60

LifeCare Hospitals, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule (June 13, 2017) (excerpts)	3478, 3491-95
American Hospital Association, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule (June 13, 2017) (excerpts)	3566, 3569-72
Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule (June 13, 2017) (excerpts)	3585, 3589-96
Federation of American Hospitals, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule (June 13, 2017) (excerpts)	3712, 3773-74
FY 2018 IPPS/LTCH PPS Final Rule, 82 Fed. Reg. 37990 (Aug. 14, 2017) (excerpts)	4057, 4594-96, 4600-02, 4607-13
FY 2019 IPPS/LTCH PPS Proposed Rule, 83 Fed. Reg. 20164 (May 7, 2018) (excerpts)	4657, 5076, 5088-89
LifeCare Hospitals, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule (June 21, 2018) (excerpts)	5152, 5164-68
Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule (June 25, 2018) (excerpts)	5207, 5241-48
Vibra Healthcare, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule (June 25, 2018) (excerpts)	5265, 5285-89
Federation of American Hospitals, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule (June 25, 2018) (excerpts)	5311, 5352-53
American Hospital Association, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule (June 25, 2018) (excerpts)	5396, 5401-03
FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. 41144 (Aug. 17, 2018) (excerpts)	5411, 5787, 5979-80, 5984, 5990-96, 6001-05

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
410-786-2671

Electronic Mail

Jason M. Healy, Esq.
The Law Offices of Jason M. Healy PLLC
1750 Tyson Blvd.
Suite 1500
McLean, VA 22012

RE: Expedited Judicial Review Determination

19-0407GC LifeCare Health Partners FY 2019 LTCH Site Neutral Outlier Budget Neutrality Adjustment Group
19-0408GC Post Acute Medical FY 2019 LTCH Site Neutral Outlier Budget Neutrality Adjustment Group
19-0409GC Kindred Healthcare FY 2019 LTCH Site Neutral Outlier Budget Neutrality Adjustment Group
19-0410GC Vibra Healthcare FY 2019 LTCH Site Neutral Outlier Budget Neutrality Adjustment Group

Dear Mr. Healy:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' hearing request and request for expedited judicial review (EJR) that was submitted on November 20, 2018 (received November 21, 2018). When the original hearing request was received, it was noted that it was submitted as one large group appeal containing the four healthcare corporations identified above. The Board sent you a development letter on December 12, 2018, and advised that the group appeal was filed as an invalid optional group appeal that violated 42 C.F.R. § 405.1837(b), and that the Board has established four common issue related party (CIRP) groups (identified above). You were instructed to submit a Schedule of Providers with the associated jurisdictional documentation for each group, along with a copy of the EJR request and exhibits for each group. This request for additional information affected the 30-day period to respond to the EJR.[1] The requested information was submitted on January 3, 2019. The Board has subsequently reviewed the request for EJR and the Schedules of Providers and associated jurisdictional documents. The determination regarding EJR is set forth below.

[1] *See* 42 C.F.R. § 405.1842(b)(2), (e)(2)(i) and (e)(3)(ii).

Issue under Appeal

The issue under appeal in these cases is:

> Whether the Centers for Medicare & Medicaid Services ("CMS") incorrectly applied the negative 5.1 percent outlier budget neutrality adjustment twice to Long-Term Care Hospital Prospective Payment System ("LTCH PPS") site neutral case payments in violation of the Administrative Procedure Act ("APA"), the Social Security Act ("SSA"), and other federal laws.[2]

Background

The LTCH PPS was established through Section 123 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) as amended by section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554). These statutes provided for payment for both the operating and capital-related costs of hospital inpatient stays in LTCHs under Medicare Part A based on prospectively set rates. The Medicare prospective payment system (PPS) for LTCHs applies to hospitals that are described in section 42 U.S.C. § 1395ww(d)(1)(B)(iv) and is effective for cost reporting periods beginning on or after October 1, 2002. The LTCH PPS replaced the reasonable cost-based payment system that had been established under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).[3]

To be classified as a LTCH, a hospital must have an average length of stay greater than 25 days.[4] In the Federal Fiscal Year (FFY) 2008 final rule, the Secretary adopted the use of the Medicare severity long term care diagnosis related groups (MS-LTC-DRGs) which are assigned to each patient discharged from a LTCH as the basis for payment. The payment amount for each MS-LTC-DRG is intended to reflect the average cost of treating a Medicare patient assigned to an MS-LTC-DRG.[5] Weights are assigned to MS-LTC-DRGs on an annual basis that are multiplied against a Federal standardized rate[6] to arrive at a payment for the discharged patient after taking other adjustments into consideration.[7]

Site Neutral Payment

For LTCH Part A discharges for cost report periods beginning on or after October 1, 2015 (FFY 2016), Congress established a new dual-rate payment structure for LTCH PPS hospitals, with

---

[2] Providers' EJR requests at 1.
[3] 80 Fed. Reg. 49,326, 49,599 (August17, 2015).
[4] 42 C.F.R. § 412.23(e)(2).
[5] 72 Fed. Reg. 47,130, 47,278 (August 22, 2007).
[6] The standardized rate is the average standardized charge for each DRG that is calculated by summing the charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG. *See* Medicare Hospital Prospective Payment System How DRG Rates Are Calculated and Updated (Office of the Inspector General, Report OEI-09-00-00200 (Aug. 2001)) on the internet at https://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf.
[7] *See* 42 C.F.R. §§ 412.515, 412.521.

two distinct payment rates.[8] The first payment rate is the LTCH PPS standard Federal payment rate.[9] This rate only applies to discharges that meet one of two patient criteria: 3 or more days in a subsection(d) hospital[10] intensive care unit or LTCH ventilator services of at least 96 hours and a principle diagnosis that is not psychiatric or rehabilitation.[11] All other LTCH discharges are reimbursed at the site neutral payment rate which is the lesser of the IPPS comparable per diem amount (including applicable outlier payments) or 100 percent of the estimated services involved.[12]

LTCH are transitioning to the new LTCH PPS dual rate with a blended payment rate that applies to site neutral case discharges in cost reporting periods beginning on or after October 1, 2015 (FFY 2016) and on or before September 30, 2019 (FFY 2019).[13] During this transition period, the blended payment rate for site neutral cases is equal to one-half of the site neutral payment rate and one-half of the LTCH PPS standard Federal payment rate.[14] Beginning on October 1, 2019 (FFY 2020), site neutral cases will be paid at 100 percent of the site neutral payment rate.

High Cost Outlier Payments

Both the standard Federal payment rate and the site neutral payment rates include additional payments for high cost outliers (HCO) that have extraordinarily high costs relative to most discharges. For cases paid under the Federal payment rate, the HCO outlier rate is set annually by the Secretary. LTCH cases that are paid under the site neutral basis receive outlier payments that equal 80% of the estimated cost of the case above the HCO threshold which is the sum of the LTCH PPS payment for the case and the applicable fixed-loss amount for such case.[15] The calculation of the site neutral payment cases is separate from the standard LTCH Federal payment rate cases.[16] For LTCH site neutral cases, the HCO threshold is the site neutral payment rate for the case plus the IPPS fixed loss amount.

Budget Neutrality Adjustment

The site neutral payment rate for LTCH was first implemented in FFY 2016 though the IPPS[17]/LTCH PPS rulemaking. In the 2016 IPPS/LTCH PPS Final Rule, the Secretary adopted a budget neutrality factor adjustment for the site neutral portion of the LTCH site neutral blended payment rate.[18] The Secretary stated that this budget neutrality adjustment was necessary "to ensure that estimated HCO payments payable to site neutral payment rate cases in [FFY] 2016 do not result in any increase in estimated aggregate FY 2016 LTCH PPS payments."[19] The

[8] *See generally* 80 Fed. Reg. 24,323, 24,525-24,553 (April 30, 2015) and 80 Fed. Reg. 49,436, 49,599-49,623 (Aug. 17, 2017).
[9] 42 U.S.C. § 1395ww(m)(6)(A)(ii) and 42 C.F.R. § 412.522(b).
[10] 42 U.S.C. § 1395ww(d).
[11] 42 U.S.C. § 1395ww(m)(6)(A)(ii), (iii), (iv).
[12] *Id.* at § 1395ww(m)(6)(B)(ii) and 42 C.F.R. §412.522(a).
[13] *Id.* at § 1395ww(m)(6)(B)(i)(I).
[14] *Id.* at § 1395ww(m)(6)(B)(ii).
[15] 42 C.F.R. § 412.525(a)(3). *See also* 83 Fed. Reg. 41,144, 41,734 (August 17, 2018).
[16] *See e.g.* 80 Fed. Reg. at 49,804.
[17] Inpatient Prospective Payment System.
[18] 80 Fed. Reg. at 49,805.
[19] *Id.*

budget neutrality adjustment reduced the LTCH site neutral payment rate amount by 5.1 percent.[20] In the same final rule, the Secretary also finalized high cost outlier budget neutrality adjustment of 5.1 percent to the IPPS operating and capital standardized amounts.[21] The IPPS payment rate, as reduced by the IPPS outlier budget neutrality adjustment, is used to determine the IPPS comparable per diem amount under the LTCH PPS site neutral payment rate discussed above.

Providers' Position

The Providers explain that during the comment period for the FFY 2016 LTCH PPS rulemaking, the Providers and other stakeholders submitted comments objecting to the budget neutrality adjustment to both the site neutral high cost outlier payments and the operating standardized amount. The Providers believe that proposed budget neutrality adjustment (BNA) was duplicative of the outlier budget neutrality adjustment already applied to the IPPS payment rate. The American Hospital Association (AHA) explained that they believed that:

> [T]he inpatient PPS rates used as the basis for the site-neutral payment rates are already subject to a BNA for the inpatient PPS's 5.1 percent outlier pool. However, within the LTCH payment framework, CMS [the Centers for Medicare & Medicaid Services] proposes a second BNA of 2.3[22] percent for the site neutral outlier pool. CMS's rationale for this second BNA is to ensure that the site-neutral HCO payments do not increase aggregate LTCH PPS payments. However, we strongly disagree that the additional 2.3 percent BNA is necessary to achieve this goal; rather, it was already achieved when the 5.1 percent BNA was applied to the inpatient PPS rates used as the basis for the site neutral rates. We recommend that CMS calculate standard LTCH PPS and site neutral rates separately, without any co-mingling of these payments, as mentioned previously. Furthermore, the second BNA prevents LTCH site-neutral payments from aligning with inpatient PPS payments for the associated MS-DRGs and MS-LTCH-DRGs, which would counter the goals of BiBA [Bipartisan Budget Act of 2015].[23]

In response to this and other comments, in the FFY 2016 Final rule the Secretary stated that she disagreed with the commenters statements that a budget neutrality adjustment for the site neutral

---

[20] *Id.*
[21] *Id.* at 49,785.49,794-95.
[22] *See* Providers' EJR requests at 8, Ftnt. 6. *See also Id.* at 49,785.49,794-95. (The AHA's 2016 comment letter references at 2.3 percent budget neutrality adjustment. CMS initially proposed a 2.3 percent adjustment in the FY 2016 Proposed Rule because CMS planned to apply a budget neutrality adjustment to all LTCH PPS payments. FY 2016 IPPS/LTCH PPS Proposed Rule, 80 Fed. Reg. 23,324, 24,649 (Apr. 30, 2015). However, in the FY 2016 Final Rule, CMS decided that it would instead apply a 5.1 percent adjustment only to the site neutral portion of the blended rate.)
[23] Providers' EJR Request at 8.

payment rate HCO payments is unnecessarily duplicative and declined to adopt the commenters recommendations. The Secretary explained that:

> While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments, that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate. The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS. Without a budget neutrality adjustment when determining payment for a case under the LTCH PPS, any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases. Therefore, our proposed approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases.[24]

These types of comments continued in subsequent Federal Register notices through the current Federal fiscal year. The Providers had hoped that the Secretary would corrected the alleged error before the end of the LTCH site neutral transition period on September 30, 2019. In FFY 2020, the entire payment for site neutral cases will be lesser of the IPPS comparable per diem amount or 100 percent of the estimated cost of the case.[25] The Providers explain that if the Secretary continues to insist on applying the duplicative outlier budget neutrality adjustment in FFY 2020, the adjustment will apply to the entire site neutral payment. The Providers believe that LTCH's have already experienced a significant reduction in payments for site neutral cases and that applying a budget neutrality adjustment twice to site neutral payments only increases the financial pressure on these facilities.

The Providers are disputing the application of a budget neutrality adjustment to LTCH site neutral case payments that reduces the payments below what they would otherwise be in the absence of HCO payments for qualifying site neutral cases. They contend this is not budget neutrality, rather it is a payment cut that is arbitrary and unsupported. They argue that the Secretary set the target amount of the LTCH HCO payments at 5.1% of total site neutral payments, but the extra budget neutrality adjustment reduces the total LTCH site neutral payments by another 5.1%.[26] The Providers assert that this action is arbitrary and capricious, an

[24] 80 Fed. Reg. at 49,622.
[25] 42 U.S.C. § 1395ww(m)(6)(B)(i)-(ii).
[26] Providers' EJR requests at 19.

abuse of discretion and not in accordance with the Administrative Procedure Act, the Social Security Act and the laws authorizing the LTCH PPS and not supported by substantial evidence.

The Providers believe EJR is appropriate because the Board has jurisdiction over the appeals and lacks the authority to decide the legal question in these cases. There are no material facts in dispute and the challenge here is whether the budget neutrality adjustment violates the dual-rate structure of the LTCH PPS in the SSA and exceeds the Secretary's authority under the authorizing legislation for LTCH PPS.[27] The Providers believe that the duplicative budget neutrality adjustment is arbitrary and capricious and violates the APA.

Decision of the Board

Under the Medicare statute codified at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2016), the Board is required to grant a provider's EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

The Board has determined that the participants involved with the instant EJR requests which appealed from the issuance of the August 17, 2018 Federal Register[28, 29] are timely filed. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[30] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and the Providers in these appeals are entitled to a hearing before the Board;

2) Based upon the remaining Providers' assertions regarding whether the Secretary incorrectly applied the outlier budget neutrality adjustment

[27] *Id.* at 28.

[28] In accordance with the Administrator's decision in District of Columbia Hospital Association Wage Index Group Appeal, (HCFA Adm. Dec. January 15, 1993) Medicare & Medicaid Guide (CCH) ¶ 41, 025, the wage index notice published in the Federal Register is a final determination. Likewise, other rate notices published in the Federal Register can be considered final determinations.

[29] The Board notes that the participants in these group appeals have cost report periods beginning on or after January 1, 2016, which would subject their appeals to the newly-added 42 C.F.R. § 405.1873 and the related revisions to 42 C.F.R. § 413.24(j) regarding submission of cost reports. *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015). However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether any Provider's cost report included an appropriate claim for the specific item under appeal. *See* 80 Fed. Reg. at 70,556.

[30] *See* 42 C.F.R. § 405.1837.

twice to the LTCH site neutral case payments, there are no findings of fact for resolution by the Board;

3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

4) It is without the authority to decide the legal question of the Secretary incorrectly applied the outlier budget neutrality adjustment twice to the LTCH site neutral case payments for FFY 2019 as delineated in the August 17, 2018 Federal Register.

Accordingly, the Board finds that the question of whether the Secretary incorrectly applied the outlier budget neutrality adjustment twice to the LTCH site neutral case payments properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under appeal the Board hereby closes the cases.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

1/28/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Bill Tisdale, Novitas Solutions (Electronic Mail w/Schedules of Providers)
Bruce Synder, Novitas Solutions (Electronic Mail w/Schedules of Providers)
Byron Lamprecht, WPS (Electronic Mail w/Schedules of Providers)
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)

Federal Fiscal Year 2019 LTCH Site Neutral Outlier Budget Neutrality Cases
EJR Determination for Case Nos. 19-0407GC *et al.*
Page 8

Schedule of Providers

Case Number: 19-0407GC
Group Case Name: LifeCare Health Partners FY 2019 LTCH Site Neutral Outlier Budget Neutrality Adjustment Group
Group Representative: James M. Healy
Lead MAC Name/Code: Novitas Solutions (JH)
Issue Title: Whether CMS incorrectly applied a -5.1% high-cost outlier budget neutrality adjustment twice to LTCH site neutral case payments.

Date Prepared: 12/31/2018

					A	B	C	D	E	F	G
#	Provider Number	Provider Name / Provider Location (City, State)	Appealed Period (and Impacted CRPs)	MAC Name / MAC Code	Date of Final Determination	Date of Appeal Request / Add Issue	Number of Days	Audit Adjustment Number	Amount in Controversy	Price Case Number(s)	Date of Direct Add or Transfer
1	39-2005	LifeCare Hospitals of Chester County West Chester, PA	5/31/19 & 5/31/20	Novitas Solutions (JL)	8/17/2018	11/21/2018	96	n/a	$43,034		11/21/2018
2	36-2028	LifeCare Hospitals of Dayton Dayton, OH	5/31/19 & 5/31/20	WPS (05)	8/17/2018	11/21/2018	96	n/a	$27,187		11/21/2018
3	06-2012	Colorado Acute Long Term Hospital Denver, CO	5/31/19 & 5/31/20	Novitas Solutions (JH)	8/17/2018	11/21/2018	96	n/a	$97,207		11/21/2018
4	52-2007	LifeCare Hospitals of Wisconsin Pewaukee, WI	12/31/18 & 12/31/19	WPS (05)	8/17/2018	11/21/2018	96	n/a	$47,403		11/21/2018
5	34-2013	LifeCare Hospitals of North Carolina Rocky Mount, NC	2/28/19 & 2/29/20	WPS (05)	8/17/2018	11/21/2018	96	n/a	$84,337		11/21/2018
6	45-2044	LifeCare Hospitals of Dallas Dallas, TX	12/31/18 & 12/31/19	Novitas Solutions (JH)	8/17/2018	11/21/2018	96	n/a	$284,137		11/21/2018
7	39-2024	LifeCare Hospitals of Pittsburgh Pittsburgh, PA	12/31/18 & 12/31/19	Novitas Solutions (JL)	8/17/2018	11/21/2018	96	n/a	$90,977		11/21/2018
8	10-2018	Complex Care Hospital at Ridgelake Sarasota, FL	5/31/19 & 5/31/20	Palmetto (M)	8/17/2018	11/21/2018	96	n/a	$37,052		11/21/2018
9	45-2039	LifeCare Hospitals of San Antonio San Antonio, TX	5/31/19 & 5/31/20	Novitas Solutions (JH)	8/17/2018	11/21/2018	96	n/a	$72,325		11/21/2018
10	19-2011	LifeCare Hospitals of Shreveport Shreveport, LA	5/31/19 & 5/31/20	Novitas Solutions (JH)	8/17/2018	11/21/2018	96	n/a	$261,455		11/21/2018
11	29-2004	Tahoe Pacific Hospitals – Meadows Reno, NV	5/31/19 & 5/31/20	Noridian (JE)	8/17/2018	11/21/2018	96	n/a	$60,404		11/21/2018
12	35-2006	Complex Care Hospital at Tenaya Las Vegas, NV	5/31/19 & 5/31/20	Noridian (JE)	8/17/2018	11/21/2018	96	n/a	$134,320		11/21/2018
								Total:	$1,353,838		

Page 1 of 1

Federal Fiscal Year 2019 LTCH Site Neutral Outlier Budget Neutrality Cases
EJR Determination for Case Nos. 19-0407GC *et al.*
Page 9

Schedule of Providers

RECEIVED
JAN. 0 3 2019
PROVIDER REIMBURSEMENT REVIEW BOARD

Case Number: 19-0407GC
Group Case Name: Post Acute Medical FY 2019 LTCH Site Neutral Outlier Budget Neutrality Adjustment Group
Group Representative: Jason M. Plotly
Lead MAC Name/Code: Novitas Solutions (JL)
Issue Title: Whether CMS incorrectly applied a -5.1% high-cost outlier budget neutrality adjustment twice to LTCH site neutral case payments.
Date Prepared: 12/13/2018

					A	B	C	D	E	F	G
#	Provider Number	Provider Name / Provider Location (City, State)	Appealed Period (and Impacted CRPs)	MAC Name / MAC Code	Date of Final Determination	Date of Appeal Request / Add Issue	Number of Days	Audit Adjustment Number	Amount in Controversy	Prior Case Number(s)	Date of Direct Add or Transfer
1	45-2006	PAM Specialty Hospital of Corpus Christi North Corpus Christi, TX	6/21/19 & 2/21/20	Novitas Solutions (JL)	8/19/2018	11/21/2018	96	n/a	$53,356		11/21/2018
2	45-2092	PAM Specialty Hospital of Corpus Christi South Corpus Christi, TX	6/21/19 & 2/21/20	WPS (15)	8/17/2018	11/21/2018	96	n/a	$166,617		11/21/2018
3	19-2048	PAM Specialty Hospital of Covington Covington, LA	12/21/18 & 12/21/19	Novitas Solutions (JL)	8/13/2018	11/21/2018	96	n/a	$150,179		11/21/2018
4	19-2036	PAM Specialty Hospital of Hammond Hammond, LA	12/21/18 & 12/21/19	WPS (15)	8/17/2018	11/21/2018	96	n/a	$103,703		11/21/2018
5	45-2051	PAM Specialty Hospital of Lufkin Lufkin, TX	6/20/19 & 6/20/20	Novitas Solutions (JL)	8/19/2018	11/21/2018	96	n/a	$12,685		11/21/2018
6	45-2063	PAM Specialty Hospital of Lufkin Lufkin, TX	12/21/18 & 12/21/19	Novitas Solutions (JL)	8/17/2018	11/21/2018	96	n/a	$136,266		11/21/2018
7	52-2004	PAM Specialty Hospital of Milwaukee Greenfield, WI	6/21/19 & 6/21/20	WPS (M)	8/17/2018	11/21/2018	96	n/a	$39,945		11/21/2018
8	45-2106	PAM Specialty Hospital of New Braunfels New Braunfels, TX	9/30/19	Novitas Solutions (JL)	8/13/2018	11/21/2018	96	n/a	$122,322		11/21/2018
9	45-2090	PAM Specialty Hospital of San Antonio San Antonio, TX	6/21/19 & 6/21/20	Noridian (FF)	8/17/2018	11/21/2018	96	n/a	339,000		11/21/2018
10	45-2061	PAM Specialty Hospital of Texarkana North Texarkana, TX	6/21/19 & 6/21/20	Novitas Solutions (JL)	8/17/2018	11/21/2018	96	n/a	$307,886		11/21/2018
11	37-2018	PAM Specialty Hospital of Tulsa Tulsa, OK	6/21/19 & 6/21/20	Novitas Solutions (JL)	8/17/2018	11/21/2018	96	n/a	$141,459		11/21/2018
12	45-2094	PAM Specialty Hospital of Victoria North Victoria, TX	12/21/18 & 12/21/19	Novitas Solutions (JL)	8/17/2018	11/21/2018	96	n/a	$71,455		11/21/2018
13	45-2056	PAM Specialty Hospital of Victoria South Victoria, TX	6/21/19 & 6/21/20	WPS (15)	8/17/2018	11/21/2018	95	n/a	$56,586		11/21/2018
14	39-2025	PAM Specialty Hospital of Wilkes-Barre Wilkes-Barre, PA	6/21/19 & 6/21/20	Novitas Solutions (JH)	8/13/2018	11/21/2018	96	n/a	$75,086		11/21/2018
								Total:	$1,291,379		

Page 1 of 1

Federal Fiscal Year 2019 LTCH Site Neutral Outlier Budget Neutrality Cases
EJR Determination for Case Nos. 19-0407GC *et al.*
Page 10

Schedule of Providers

Case Number: 19-0407GC
Group Case Name: Vibra Healthcare FY 2019 LTCH Site Neutral Outlier Budget Neutrality Adjustment Group
Group Representative: Jamie M. Healy
Lead MAC Name/Code: Wisconsin Physicians Service (15)
Issue Title: Whether CMS incorrectly applied a -5.1% high-cost outlier budget neutrality adjustment when to LTCH site neutral cost payments.

Date Prepared: 12/13/2018
1 of 2

					A	B	C	D	E	F	G
#	Provider Number	Provider Name / Provider Location (City, State)	Appealed Period (and Impacted CRPs)	MAC Name / MAC Code	Date of Final Determination	Date of Appeal Request / Add. Issue	Number of Days	Audit Adjustment Number	Amount in Controversy	Prior Case Number(s)	Date of Direct Add-on Transfer
1	05-2043	Encinitas Hospital Encinitas, CA	6/30/19 & 6/30/20	CGS (J15)	8/17/2018	11/21/2018	96	n/a	$17,821		11/21/2018
2	22-2045	Vibra Hospital of Southeastern Massachusetts New Bedford, MA	12/31/18 & 12/31/19	CGS (J15)	8/17/2018	11/21/2018	96	n/a	$61,661		11/21/2018
3	06-3014	Vibra Hospital of Denver Thornton, CO	8/31/19 & 8/31/20	CGS (J15)	8/17/2018	11/21/2018	96	n/a	$29,096		11/21/2018
4	05-3047	Vibra Hospital of Northern California Redding, CA	12/31/18 & 12/31/19	CGS (J15)	8/17/2018	11/21/2018	96	n/a	$130,599		11/21/2018
5	45-3007	Vibra Hospital of DeSoto DeSoto, TX	7/31/19 & 7/31/20	CGS (J15)	8/17/2018	11/21/2018	96	n/a	$172,024		11/21/2018
6	38-2004	Vibra Specialty Hospital of Portland Portland, OR	1/31/19 & 1/31/20	Noridian (JF)	8/17/2018	11/21/2018	96	n/a	$33,303		11/21/2018
7	23-3015	Vibra Hospital of Southeastern Michigan Lincoln Park, MI	3/31/19 & 3/31/20	WPS (J5)	8/17/2018	11/21/2018	96	n/a	$137,634		11/21/2018
8	05-3044	Vibra Hospital of San Diego San Diego, CA	3/31/19 & 3/31/20	Novitas (JL)	8/17/2018	11/21/2018	96	n/a	$126,793		11/21/2018
9	15-3021	Vibra Hospital of Fort Wayne Fort Wayne, IN	10/31/18 & 10/31/19	WPS (J5)	8/17/2018	11/21/2018	96	n/a	$24,599		11/21/2018
10	15-3028	Vibra Hospital of Northwestern Indiana Crown Point, IN	10/31/18 & 10/31/19	WPS (J5)	8/17/2018	11/21/2018	96	n/a	$78,300		11/21/2018
11	36-3023	Vibra Hospital of Mahoning Valley Boardman, OH	10/31/18 & 10/31/19	WPS (J5)	8/17/2018	11/21/2018	96	n/a	$32,105		11/21/2018
12	13-3002	Vibra Hospital of Boise Boise, ID	8/31/19 & 8/31/20	Noridian (JF)	8/17/2018	11/21/2018	96	n/a	$93,058		11/21/2018
13	22-3046	Vibra Hospital of Western Massachusetts Springfield, MA	8/31/19 & 8/31/20	WPS (J5)	8/17/2018	11/21/2018	96	n/a	$31,179		11/21/2018
14	42-3005	Vibra Hospital of Charleston Mt. Pleasant, SC	8/31/19 & 8/31/20	WPS (J5)	8/17/2018	11/21/2018	96	n/a	$32,320		11/21/2018

Page 1 of 2

CN 19-0410GC
2057

13	14-2014	Vibra Hospital of Springfield Springfield, IL	8/31/19 & 8/31/20	MGS (35)	8/17/2018	11/21/2018	96	n/a	$37,574	11/21/2018
16	33-2305	Vibra Hospital of Central Dakotas Mandan, ND	7/31/19 & 7/31/22	WPS (35)	8/17/2018	11/21/2018	96	n/a	$33,311	11/21/2018
17	35-2304	Vibra Hospital of Fargo Fargo, ND	7/31/19 & 7/31/22	WPS (35)	8/17/2018	11/21/2018	96	n/a	39,647	11/21/2018
18	45-2060	Vibra Hospital of Amarillo Amarillo, TX	7/31/19 & 7/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$169,524	11/21/2018
19	05-2033	Vibra Hospital of Sacramento Folsom, CA	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$70,650	11/21/2018
20	49-2009	Vibra Hospital of Richmond Richmond, VA	7/31/19 & 7/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$31,855	11/21/2018
								Total:	$1,376,864	

RECEIVED
JAN. 03 2019
PROVIDER REIMBURSEMENT
REVIEW BOARD

Federal Fiscal Year 2019 LTCH Site Neutral Outlier Budget Neutrality Cases
EJR Determination for Case Nos. 19-0407GC *et al.*
Page 12

1 of 4

RECEIVED
JAN 03 2019
PROVIDER REIMBURSEMENT REVIEW BOARD

Schedule of Providers

Date Prepared: 12/13/2018

Case Number: 19-0405GC
Group Case Name: Kindred Healthcare FY 2019 LTCH Site Neutral Outlier Budget Neutrality Adjustment Group
Group Representative: James M. Healy
Lead MAC Name/Code: Wisconsin Physicians Services (05)
Issue Title: Whether CMS incorrectly applied a -5.1% high-cost outlier budget neutrality adjustment twice to LTCH site neutral case payments.

	A	B	C	D	E	F	G
#	Provider Number	Provider Name / Provider Location (City, State)	Appealed Period (and requested CRPs)	MAC Name / MAC Code	Date of Final Determination	Date of Appeal Request / Add. Issue	Number of Days	Audit Adjustment Number	Amount in Controversy	Prior Case Number(s)	Date of Direct Add or Transfer
1	05-2032	Kindred Hospital Los Angeles Los Angeles, CA	8/31/19 & 8/31/20	WPS (05)	8/17/2018	11/21/2018	96	n/a	$66,795		11/21/2018
2	05-2034	Kindred Hospital San Francisco Bay Area San Leandro, CA	8/31/19 & 8/31/20	WPS (05)	8/17/2018	11/21/2018	96	n/a	$53,227		11/21/2018
3	05-2035	Kindred Hospital Westminster Westminster, CA	8/31/19 & 8/31/20	WPS (05)	8/17/2018	11/21/2018	96	n/a	$139,670		11/21/2018
4	05-2036	Kindred Hospital San Diego San Diego, CA	8/31/19 & 8/31/20	WPS (05)	8/17/2018	11/21/2018	96	n/a	$84,068		11/21/2018
5	05-2037	Kindred Hospital Ontario Ontario, CA	8/31/19 & 8/31/20	WPS (05)	8/17/2018	11/21/2018	96	n/a	$36,237		11/21/2018
6	05-2038	Kindred Hospital La Mirada La Mirada, CA	8/31/19 & 8/31/20	WPS (05)	8/17/2018	11/21/2018	96	n/a	$370,959		11/21/2018
7	05-2039	Kindred Hospital Brea Brea, CA	8/31/19 & 8/31/20	WPS (05)	8/17/2018	11/21/2018	96	n/a	$37,532		11/21/2018
8	05-2045	Kindred Hospital Baldwin Park Baldwin Park, CA	8/31/19 & 8/31/20	Noridian (05)	8/17/2018	11/21/2018	96	n/a	$139,674		11/21/2018
9	05-2049	Kindred Hospital Rancho Rancho Cucamonga, CA	8/31/19 & 8/31/20	Noridian (05)	8/17/2018	11/21/2018	96	n/a	$23,358		11/21/2018
10	05-2050	Kindred Hospital South Bay Gardena, CA	8/31/19 & 8/31/20	Noridian (05)	8/17/2018	11/21/2018	96	n/a	$99,647		11/21/2018
11	05-2052	Kindred Hospital Riverside Perris, CA	8/31/19 & 8/31/20	Noridian (05)	8/17/2018	11/21/2018	96	n/a	$28,298		11/21/2018
12	06-2009	Kindred Hospital Denver Denver, CO	8/31/19 & 8/31/20	WPS (05)	8/17/2018	11/21/2018	96	n/a	$22,119		11/21/2018
13	06-2013	Kindred Hospital Aurora Aurora, CO	8/31/19 & 8/31/20	WPS (05)	8/17/2018	11/21/2018	96	n/a	$3,457		11/21/2018
14	06-2015	Kindred Hospital Denver South Denver, CO	8/31/19 & 8/31/20	Novitas Solutions (JL)	8/17/2018	11/21/2018	96	n/a	$19,856		11/21/2018

Page 1 of 4

CN 19-0407GC 2of4

12	10-2020	Kindred Hospital Bay Area - Tampa Tampa, FL	8/31/19 & 8/31/20	WPS (33)	8/17/2018	11/21/2018	96	n/a	$146,951	11/21/2018
16	10-2010	Kindred Hospital South Florida - Ft. Lauderdale Ft. Lauderdale, FL	8/31/19 & 8/31/20	WPS (33)	8/17/2018	11/21/2018	96	n/a	$119,833	11/21/2018
17	10-2015	Kindred Hospital Central Tampa Tampa, FL	8/31/19 & 8/31/20	WPS (33)	8/17/2018	11/21/2018	96	n/a	$162,562	11/21/2018
18	10-2215	Kindred Hospital North Florida Green Cove Springs, FL	8/31/19 & 8/31/20	WPS (33)	8/17/2018	11/21/2018	96	n/a	$110,283	11/21/2018
19	10-2025	Kindred Hospital Ocala Ocala, FL	8/31/19 & 8/31/20	WPS (33)	8/17/2018	11/21/2018	96	n/a	$45,135	11/21/2018
20	10-2225	Kindred Hospital The Palm Beaches Palm Beach, FL	8/31/19 & 8/31/20	First Coast (31)	8/17/2018	11/21/2018	96	n/a	$35,884	11/21/2018
21	10-2027	Kindred Hospital Melbourne Melbourne, FL	8/31/19 & 8/31/20	CGS (15)	8/17/2018	11/21/2018	96	n/a	$21,177	11/21/2018
22	11-2010	Kindred Hospital Rome Rome, GA	8/31/19 & 8/31/20	Palmetto (32)	8/17/2018	11/21/2018	96	n/a	$77,070	11/21/2018
23	14-2006	Kindred Hospital Sycamore Sycamore, IL	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$57,394	11/21/2018
24	14-2008	Kindred Hospital Chicago - Northlake Northlake, IL	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$149,359	11/21/2018
25	14-2009	Kindred Hospital Chicago Central - Central Chicago, IL	8/31/19 & 8/31/20	WPS (15)	8/17/2018	11/21/2018	96	n/a	$115,859	11/21/2018
26	14-2013	Kindred Hospital Peoria Peoria, IL	8/31/19 & 8/31/20	NGS (29)	8/17/2018	11/21/2018	96	n/a	$36,180	11/21/2018
27	15-2007	Kindred Hospital Indianapolis Indianapolis, IN	8/31/19 & 8/31/20	WPS (33)	8/17/2018	11/21/2018	95	n/a	$44,602	11/21/2018
28	15-2012	Kindred Hospital Northwest Indiana Hammond, IN	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$73,830	11/21/2018
29	15-2013	Kindred Hospital Indianapolis North Indianapolis, IN	8/31/19 & 8/31/20	Noridian Solutions (JL)	8/17/2018	11/21/2018	96	n/a	$40,530	11/21/2018
30	18-2007	Kindred Hospital Louisville Louisville, KY	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$58,535	11/21/2018
31	26-2010	Kindred Hospital St. Louis St. Louis, MO	8/31/19 & 8/31/20	WPS (15)	8/17/2018	11/21/2018	96	n/a	$69,036	11/21/2018
32	26-2015	Kindred Hospital Northland Kansas City, MO	8/31/19 & 8/31/20	WPS (25)	8/17/2018	11/21/2018	96	n/a	$43,062	11/21/2018
33	29-2001	Kindred Hospital Las Vegas - Sahara Las Vegas, NV	8/31/19 & 8/31/20	WPS (25)	8/17/2018	11/21/2018	96	n/a	$154,826	11/21/2018

Federal Fiscal Year 2019 LTCH Site Neutral Outlier Budget Neutrality Cases
EJR Determination for Case Nos. 19-0407GC *et al.*
Page 14

CN 19-0407GC 5 OF 4

34	31-2030	Kindred Hospital New Jersey - Morris County Dover, NJ	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$113,972	11/21/2018
35	32-2002	Kindred Hospital Albuquerque Albuquerque, NM	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$7,373	11/21/2018
36	34-2012	Kindred Hospital Greensboro Greensboro, NC	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$104,373	11/21/2018
37	36-2020	Kindred Hospital Lima Lima, OH	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$47,632	11/21/2018
38	36-2033	Kindred Hospital Dayton Dayton, OH	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$36,983	11/21/2018
39	39-2027	Kindred Hospital Philadelphia Philadelphia, PA	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$73,000	11/21/2018
40	39-2046	Kindred Hospital South Philadelphia Philadelphia, PA	8/31/19 & 8/31/20	Novitas Solutions (JL)	8/17/2018	11/21/2018	96	n/a	$36,067	11/21/2018
41	44-2007	Kindred Hospital Chattanooga Chattanooga, TN	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	95	n/a	$24,126	11/21/2018
42	45-2015	Kindred Hospital Dallas Dallas, TX	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$138,311	11/21/2018
43	45-2016	Kindred Hospital San Antonio San Antonio, TX	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$50,774	11/21/2018
44	45-2019	Kindred Hospital Mansfield Mansfield, TX	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$213,059	11/21/2018
45	45-2023	Kindred Hospital Houston Medical Center Houston, TX	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$128,792	11/21/2018
46	45-2028	Kindred Hospital Tarrant County - Arlington Arlington, TX	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$462,791	11/21/2018
47	45-2029	Kindred Hospital Houston Northwest Houston, TX	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$267,179	11/21/2018
48	45-2073	Kindred Hospital San Antonio Central San Antonio, TX	8/31/19 & 8/31/20	Novitas Solutions (JL)	8/17/2018	11/21/2018	96	n/a	$47,991	11/21/2018
49	45-2074	Kindred Hospital Tomball Tomball, TX	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$473,791	11/21/2018
50	45-2075	Kindred Hospital Clear Lake Webster, TX	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$232,265	11/21/2018
51	45-2079	Kindred Hospital El Paso El Paso, TX	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$81,372	11/21/2018
52	45-2080	Kindred Hospital Sugar Land Sugar Land, TX	8/31/19 & 8/31/20	WPS (35)	8/17/2018	11/21/2018	96	n/a	$267,503	11/21/2018

Page 3 of 4

RECEIVED
JAN 03 2019

CN 19-0407GC 4 of 4

53	45-2088	Kindred Hospital Fort Worth Fort Worth, TX	8/31/19 & 8/31/20	WPS (J5)	8/17/2018	11/21/2018	96	n/a	$103,745	11/21/2018
54	45-2108	Kindred Hospital Dallas Central Dallas, TX	8/31/19 & 8/31/20	Novitas Solutions (J5)	8/17/2018	11/21/2018	96	n/a	$129,013	11/21/2018
55	50-2002	Kindred Hospital Seattle - Northgate Seattle, WA	8/31/19 & 8/31/20	WPS (J5)	8/17/2018	11/21/2018	96	n/a	$82,598	11/21/2018
								Total:	$5,471,180	

RECEIVED
JAN 03 2019
PROVIDER REIMBURSEMENT
REVIEW BOARD

Page 4 of 4

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD

RECEIVED

JAN 03 2019

PROVIDER REIMBURSEMENT
REVIEW BOARD

LIFECARE HEALTH PARTNERS FY 2019 LTCH SITE NEUTRAL OUTLIER BUDGET NEUTRALITY ADJUSTMENT GROUP Provider Nos. Various Fiscal Year 2019 Providers, v. NOVITAS SOLUTIONS Intermediary.	PRRB Case No. 19-0407GC

POST ACUTE MEDICAL FY 2019 LTCH SITE NEUTRAL OUTLIER BUDGET NEUTRALITY ADJUSTMENT GROUP Provider Nos. Various Fiscal Year 2019 Providers, v. NOVITAS SOLUTIONS Intermediary.	PRRB Case No. 19-0408GC

RECEIVED

JAN 03 2019

PROVIDER REIMBURSEMENT
REVIEW BOARD

KINDRED HEALTHCARE FY 2019 LTCH SITE NEUTRAL OUTLIER BUDGET NEUTRALITY ADJUSTMENT GROUP Provider Nos. Various Fiscal Year 2019 Providers, v. WISCONSIN PHYSICIANS SERVICE Intermediary.	PRRB Case No. 19-0409GC
VIBRA HEALTHCARE FY 2019 LTCH SITE NEUTRAL OUTLIER BUDGET NEUTRALITY ADJUSTMENT GROUP Provider Nos. Various Fiscal Year 2019 Providers, v. WISCONSIN PHYSICIANS SERVICE Intermediary.	PRRB Case No. 19-0410GC

PROVIDERS' REQUEST FOR EXPEDITED JUDICIAL REVIEW

Jason M. Healy, Esq.
THE LAW OFFICES OF
JASON M. HEALY PLLC
1750 Tysons Boulevard
Suite 1500
McLean, VA 22012
(703) 712-4744

Attorney for the Providers

Table of Contents

Table of Authorities

Cases

Statutes

Regulations

Rules

Index of Exhibits

The 101 providers in these group appeals ("Providers") are Medicare certified long-term acute care hospitals ("LTCHs") operated by LifeCare Health Partners ("LifeCare"), Post Acute Medical ("Post Acute"), Vibra Healthcare ("Vibra"), and Kindred Healthcare ("Kindred") that submit this Request for Expedited Judicial Review ("EJR"). Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842, the Provider Reimbursement Review Board ("PRRB" or the "Board") should grant the Providers' Request for EJR for the following reasons: (1) the Providers submitted a timely request to appeal a matter in controversy exceeding the $50,000 threshold for a group appeal; (2) there are no material facts in dispute; (3) the issue in these cases requires a determination of the validity of a budget neutrality adjustment that CMS applies to the site neutral portion of the LTCH prospective payment system blended payment rate; and (4) the PRRB lacks the authority to decide this issue and grant the relief the Providers are requesting.

I. STATEMENT OF THE ISSUE

Whether the Centers for Medicare & Medicaid Services ("CMS") incorrectly applied the negative 5.1 percent outlier budget neutrality adjustment twice to Long-Term Care Hospital Prospective Payment System ("LTCH PPS") site neutral case payments in violation of the Administrative Procedure Act ("APA"), the Social Security Act ("SSA"), and other federal laws.

II. LEGAL BACKGROUND

A. LTCH PPS

Under the Medicare program, different payment methodologies are used to reimburse different types of providers. The Medicare reimbursement system for LTCHs, the LTCH prospective payment system ("LTCH PPS"), is based on different levels of cost than the system applicable to general acute care hospitals. For general acute care hospitals, Medicare inpatient costs are reimbursed under the inpatient hospital prospective payment system ("IPPS") in which a hospital receives a fixed payment amount per discharge (adjusted for area wage differences)

using Medicare severity diagnosis related groups ("MS-DRGs").[1] The general acute care hospital MS-DRG payment rate is based on the national average cost of treating a Medicare patient's condition in that type of facility. Although the average length of stay varies for each MS-DRG, the average stay of all Medicare patients in a general acute care hospital is approximately six days. Thus, the prospective payment system for general acute care hospitals is not designed to reimburse hospitals on a regular basis for long-stay hospital care.

For a hospital to be reimbursed under the LTCH PPS, by contrast, it must have an average Medicare inpatient length of stay that is greater than twenty-five days, which reflects the medically complex cases treated in LTCHs. Each patient discharged from a LTCH is assigned to a distinct Medicare severity long-term care diagnosis related group ("MS-LTC-DRG"),[2] and the LTCH is generally paid a predetermined fixed amount applicable to the assigned MS-LTC-DRG (adjusted for area wage differences). The payment amount for each MS-LTC-DRG is intended to reflect the average cost of treating a Medicare patient assigned to that MS-LTC-DRG in a LTCH.

Weights are assigned to MS-DRGs and MS-LTC-DRGs on an annual basis that are multiplied against a Federal standard rate to arrive at the payment for the discharged patient, after taking other adjustments into consideration. See 42 C.F.R. §§ 412.515, 412.521. Most of the MS-LTC-DRGs for LTCHs are the same as the MS-DRGs for general acute care hospitals, but the weights are generally higher. In addition, the Federal standard rate has been much

---

1 The IPPS final rule for FY 2008 refined the DRG patient classification system to take into account the severity of the patient's condition for the first time. See 72 Fed. Reg. 47130 (Aug. 22, 2007). These Medicare-severity DRGs or "MS-DRGs" were created to account for complications or comorbidities. Id.

2 The IPPS final rule for FY 2008 also created Medicare-severity DRGs for LTCH PPS, referred to as "MS-LTC-DRGs". See 72 Fed. Reg. 47130 (Aug. 22, 2007).

greater for LTCHs than for general acute care hospitals: $41,558.68 under the LTCH PPS for FY 2019, see Exhibit 51, 83 Fed. Reg. 49836, 49847 (Oct. 3, 2018) (correction notice), compared to approximately $6,000 under the IPPS for FY 2019, see id. at 49844-45 (operating and capital rates combined).

B. Site Neutral Payment

For LTCH Part A discharges in cost reporting periods beginning on or after October 1, 2015, Congress established a new dual-rate payment structure under the LTCH PPS, with two distinct payment rates. Exhibit 6, 42 U.S.C. § 1395ww(m)(6) (SSA § 1886(m)(6)). The first payment rate is the LTCH PPS standard Federal payment rate. Id. at § 1395ww(m)(6)(A)(ii) (SSA § 1886(m)(6)(A)(ii)). This first payment rate only applies to discharges that meet one of the two patient criteria established by section 1206 of the Pathway for SGR Reform Act of 2013 ("PSRA"), Pub. L. No. 113-67, Div. B, 127 Stat. 1165 (2013)[3]—3 or more days in a "subsection (d) hospital"[4] intensive care unit ("ICU") or LTCH ventilator services of at least 96 hours—and a principal diagnosis that is not psychiatric or rehabilitation. Id. at §§ 1395ww(m)(6)(A)(ii),(iii),(iv) (SSA § 1886(m)(6)(A)(ii),(iii),(iv)). All other LTCH Part A discharges are reimbursed at the site neutral payment rate, which is the lesser of the IPPS comparable per diem amount (including any applicable outlier payments) or 100 percent of the

---

3 Congress has amended Section 1206 of the Pathway for SGR Reform Act of 2013 on several occasions. However, none of the amendments are at issue in these appeals. See Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 51005, 132 Stat. 64 (2018); 21st Century Cures Act, Pub. L. No. 114-255, §§ 15009(a), 15010(a), 130 Stat. 1033 (2016); Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 231, 129 Stat. 2242 (2015); Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, § 112(a), 128 Stat. 1040 (2014).

4 A reference to section 1861(d)(1)(B) of the SSA (42 U.S.C. § 1395x(d)(1)(B)). These are primarily general short-term acute care hospitals paid by Medicare under the IPPS.

estimated cost of the services involved. Id. at § 1395ww(m)(6)(B)(ii) (SSA § 1886(m)(6)(B)(ii)).

CMS implemented the site neutral payment rate through the regulation at 42 C.F.R. § 412.522. Exhibit 7. The IPPS comparable per diem amount used for determining LTCH site neutral payments is calculated by adding the adjusted standardized IPPS operating amount to the adjusted capital IPPS Federal rate, divided by the geometric average length of stay of the specific MS-DRG under the IPPS, and multiplying that amount by the covered days of the LTCH stay, but no higher than the full IPPS payment amount. Exhibit 5, FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326, 49608-09 (Aug. 17, 2015).

LTCHs are transitioning to the new LTCH PPS dual-rate structure with a blended payment rate that applies to site neutral case discharges in cost reporting periods beginning on or after October 1, 2015 and on or before September 30, 2019. Exhibit 6, 42 U.S.C. § 1395ww(m)(6)(B)(i)(I) (SSA § 1886(m)(6)(B)(i)(I)). During this transition period, the blended payment rate for site neutral cases is equal to one-half the site neutral payment rate and one-half of the LTCH PPS standard Federal payment rate. Id. at § 1395ww(m)(6)(B)(ii) (SSA § 1886(m)(6)(B)(ii)). FY 2019 is the last year of the transition period. LTCH site neutral case discharges on or after October 1, 2019 will be paid at 100 percent of the site neutral payment rate.

C. High Cost Outlier Payments

In addition to the standard Federal payment rate for a Medicare discharge, Medicare makes additional payments for high cost outlier ("HCO") cases that have extraordinarily high costs relative to the costs of most discharges. These high cost outlier payments are a feature of both the IPPS and the LTCH PPS. Exhibit 9, 42 U.S.C. § 1395ww(d)(5)(A)(ii) (SSA § 1886(d)(5)(A)(ii)); Exhibit 8, 42 C.F.R. § 412.525(a)(1). CMS sets a threshold each year at the

maximum loss that a provider can incur for a case with unusually high costs before the provider will receive an additional high cost outlier payment.

Like LTCH cases that are paid the standard Federal payment rate, site neutral cases paid at the IPPS comparable per diem amount may include a LTCH outlier payment. Exhibit 6, 42 U.S.C. § 1395ww(m)(6)(B)(ii)(I) (SSA § 1886(m)(6)(B)(ii)(I)). The HCO payment for site neutral cases is equal to 80% of the estimated cost of the case above the HCO threshold. Exhibit 8, 42 C.F.R. § 412.525(a)(3); Exhibit 2, 83 Fed. Reg. at 41734 ("[A]n LTCH receives 80 percent of the difference between the estimated cost of the case and the applicable HCO threshold, which is the sum of the LTCH PPS payment for the case and the applicable fixed-loss amount for such case."). Each fiscal year, CMS establishes a HCO threshold for site neutral payment rate cases that is separate from the HCO threshold used for standard LTCH Federal payment rate cases. See e.g., Exhibit 5, 80 Fed. Reg. at 49804 (establishing a $22,544 site neutral HCO threshold for FY 2016). For LTCH site neutral cases, the HCO threshold is the site neutral payment rate for the case plus the IPPS fixed-loss amount. Exhibit 2, 83 Fed. Reg. at 41734 ("For site neutral payment rate cases, we adopted the operating IPPS HCO target (currently 5.1 percent) and set the fixed-loss amount for site neutral payment rate cases at the value of the IPPS fixed-loss amount."). There is no additional HCO payment for site neutral payment rate cases that are paid at 100 percent of the estimated cost of the case. Exhibit 5, 80 Fed. Reg. at 49804 ("[A]ny site neutral payment rate case that is paid 100 percent of the estimated cost of the case (because that amount is lower than the IPPS comparable per diem amount) will not be eligible to receive a HCO payment because, by definition, the estimated costs of such cases would never exceed the IPPS comparable per diem amount by any threshold.").

III. MATERIAL FACTS

A. FY 2016 Rulemaking

CMS first implemented the site neutral payment rate for LTCHs during the FY 2016 IPPS/LTCH PPS rulemaking. In the FY 2016 IPPS/LTCH PPS Final Rule, CMS adopted a budget neutrality factor (adjustment) for the site neutral portion of the LTCH site neutral blended payment rate (the "BNA"). Exhibit 5, FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326, 49805 (Aug. 17, 2015). CMS claimed that this budget neutrality adjustment was necessary "to ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2016 do not result [in] any increase in estimated aggregate FY 2016 LTCH PPS payments . . . ." Id. CMS finalized this budget neutrality adjustment to reduce the LTCH site neutral payment rate amount by 5.1%. Id. In the same FY 2016 Final Rule, CMS also finalized high cost outlier budget neutrality adjustments of negative 5.1% to the IPPS operating standardized amount and approximately the same amount to the IPPS capital Federal rate.[5] Id. at 49785, 49794-95. The IPPS payment rate, as reduced by these IPPS outlier budget neutrality adjustments, is used to determine the IPPS comparable per diem amount under the LTCH PPS site neutral payment rate discussed above.

During the comment period for the FY 2016 LTCH PPS rulemaking, the Providers and other stakeholders submitted comments to CMS objecting to the BNA. The Providers explained to CMS that the proposed BNA was duplicative of the outlier budget neutrality adjustment already applied to the IPPS payment rate. For example, Kindred Healthcare, the parent company

---

5 Each year, the IPPS operating standardized amount budget neutrality adjustment is 5.1% and the IPPS capital outlier budget neutrality adjustment is approximately 5.1%. Accordingly, for the sake of clarity, this Request for Expedited Judicial Review will generally refer to both IPPS adjustments as a budget neutrality adjustment of 5.1%.

of many of the Providers in this group, and another LTCH company submitted a comment letter to CMS that stated:

> Specifically, CMS already reduced the operating standardized payment amount under the IPPS and the capital federal rate under the capital PPS for outliers. In determining these payment rates for FY 2016, CMS reduced the IPPS payment rate by a factor of 0.948999 and CMS reduced the capital PPS payment rate by a factor of 0.935731. **It would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed site neutral HCO BNA. This would be the case because the IPPS comparable per diem amount will be based on the FY 2016 IPPS payment rate, which has already been adjusted by the 5.1 percent outlier target. Since CMS has already reduced the FY 2016 IPPS payment rate by the 5.1 percent of estimated outlier payments in FY 2016, it would be inappropriate for CMS to reduce LTCH payments that are based on the IPPS rate again for site neutral cases that qualify as HCOs. Therefore, we object to CMS' proposal to apply a separate HCO BNA to LTCH site neutral payments.**

Exhibit 23, Kindred Healthcare, Inc. & Select Medical Holdings Corp., Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 39 (June 16, 2015), https://www.regulations.gov/contentStreamer?documentId=CMS-2015-0049-0222&attachmentNumber=1&contentType=pdf (footnote omitted). Post Acute and Vibra also submitted comments to CMS objecting to the duplicative budget neutrality adjustment. See Exhibit 24, Post Acute Medical, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 23-25 (June 16, 2015), https://www.regulations.gov/contentStreamer?documentId=CMS-2015-0049-0199&attachmentNumber=1&contentType=pdf; Exhibit 50, Vibra Healthcare, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 19-21 (June 15, 2015). Vibra's FY 2016 comment letter explained that Vibra objected to the BNA because the IPPS comparable per diem amount was already reduced by the same 5.1%. See Exhibit 50, Vibra Healthcare, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 21.

Leading hospital trade associations also submitted comments to CMS during the FY 2016 rulemaking opposing the erroneous BNA. The American Hospital Association ("AHA")

submitted a comment letter to CMS objecting to the "two outlier-related BNAs for site-neutral rates." Exhibit 25, American Hospital Association, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 7 (June 15, 2015), https://www.regulations.gov/contentStreamer?documentId=CMS-2015-0049-0121&attachmentNumber=1&contentType=pdf. The AHA explained:

> Specifically, the inpatient PPS rates used as the basis for site-neutral payment rates are already subject to a BNA for the inpatient PPS's 5.1 percent outlier pool. However, within the LTCH payment framework, CMS proposes a second BNA of 2.3 percent for the site-neutral outlier pool. CMS's rationale for this second BNA is to ensure that site-neutral HCO payments do not increase aggregate LTCH PPS payments. **However, we strongly disagree that the additional 2.3 percent BNA is necessary to achieve this goal; rather, it was already achieved when the 5.1 percent BNA was applied to the inpatient PPS rates used as the basis for the site-neutral rates. We recommend that CMS calculate standard LTCH PPS and site-neutral rates separately, without any co-mingling of these payments, as mentioned previously.** Furthermore, the second BNA prevents LTCH site-neutral payments from aligning with inpatient PPS payments for associated MS-DRG and MS-LTC-DRGs, which would counter the goals of BiBA.[6]

Id.

The Federation of American Hospitals ("FAH") submitted similar comments in response to the FY 2016 Proposed Rule. The FAH opposed the outlier budget neutrality adjustment for LTCH site neutral cases because "CMS has already accounted for estimated outlier payments for site neutral cases when it adjusted the IPPS payment rate for FY 2016." Exhibit 26, Federation of American Hospitals, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 67 (June

---

6 The AHA's FY 2016 comment letter references a 2.3% budget neutrality adjustment. CMS initially proposed a 2.3% adjustment in the FY 2016 Proposed Rule because CMS planned to apply a budget neutrality adjustment to all LTCH PPS payments. FY 2016 IPPS/LTCH PPS Proposed Rule, 80 Fed. Reg. 24324, 24649 (Apr. 30, 2015). However, in the FY 2016 Final Rule, CMS decided that it would instead apply a 5.1% adjustment only to the site neutral portion of the blended payment rate. See Exhibit 5, FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. at 49805.

16, 2015), https://www.regulations.gov/contentStreamer?documentId=CMS-2015-0049-0188&attachmentNumber=1&contentType=pdf. The FAH explained that because LTCH site neutral cases are already paid at the IPPS comparable rate, the additional budget neutrality adjustment is "an additional unwarranted reduction in payment." Id.

In the FY 2016 Final Rule, CMS acknowledged that it received comments objecting to the site neutral outlier budget neutrality adjustment. Exhibit 5, 80 Fed. Reg. at 49622. In response to these objections, CMS stated:

> We disagree with the commenters that a budget neutrality adjustment for site neutral payment rate HCO payments is unnecessary or duplicative. While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments, that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate. The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS. Without a budget neutrality adjustment when determining payment for a case under the LTCH PPS, any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases. Therefore, our proposed approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases. For these reasons, we are not adopting the commenters' recommendation to change the calculation of the IPPS comparable per diem amount to adjust the IPPS operating standardized amount used in that calculation to account for the application of the IPPS HCO budget neutrality adjustment.

Id. Despite admitting that the "HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS," CMS finalized the separate 5.1 percent reduction to the LTCH site neutral payment rate for the LTCH site neutral outlier budget neutrality adjustment. Id.

B. FY 2017 Rulemaking

A similar process played out during the FY 2017 LTCH PPS rulemaking. CMS proposed a 5.1% budget neutrality adjustment to the LTCH site neutral payment rate portion of the blended payment rate. FY 2017 IPPS/LTCH PPS Proposed Rule, 81 Fed. Reg. 24946, 25288-89 (Apr. 27, 2016). Commenters again responded that the proposed adjustment was flawed because CMS already reduced the IPPS comparable per diem amount to account for outlier payments. Kindred Healthcare,[7] LifeCare Hospitals,[8] Post Acute Medical,[9] and Vibra HealthCare[10] each submitted comments objecting to the proposed budget neutrality adjustment in the FY 2017 Proposed Rule. Kindred Healthcare included a table that clearly shows the duplication using the components of the site neutral payment rate. Exhibit 27 at 20-22, Table 1. Without making this change, the duplicative BNA not only "exaggerates the disparity in payment rates across provider settings," as MedPAC states, but it is also purely punitive. Id. at 22. The AHA[11] and FAH[12] also opposed the proposed site neutral budget neutrality adjustment in the FY 2017

---

7 Exhibit 27, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 18-25 (June 17, 2016), https://www.regulations.gov/contentStreamer?documentId=CMS-2016-0053-0521&attachmentNumber=1&contentType=pdf.

8 Exhibit 28, LifeCare Hospitals, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 7-11 (June 15, 2016), https://www.regulations.gov/contentStreamer?documentId=CMS-2016-0053-0315&attachmentNumber=1&contentType=pdf.

9 Exhibit 29, Post Acute Medical, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 14-21 (June 17, 2016), https://www.regulations.gov/contentStreamer?documentId=CMS-2016-0053-1262&attachmentNumber=1&contentType=pdf.

10 Exhibit 30, Vibra Healthcare, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 14-21 (June 17, 2016), https://www.regulations.gov/contentStreamer?documentId=CMS-2016-0053-0483&attachmentNumber=1&contentType=pdf.

11 Exhibit 31, American Hospital Association, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 5-8 (June 17, 2016), https://www.aha.org/system/files/advocacy-issues/letter/2016/160617-let-nickels-slavitt-ltch.pdf.

12 Exhibit 32, Federation of American Hospitals, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 48-49 (June 17, 2016),

Continued on following page

Proposed Rule. Many of these comments requested that CMS not only fix the erroneous calculation of the budget neutrality adjustment for FY 2017, but also correct the adjustment CMS applied in FY 2016 because the hospitals were systematically underpaid. See e.g., Exhibit 27, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 23 ("CMS must reverse this adjustment to all FY 2016 payments, or make an equivalent prospective increase in payments to FY 2017 site neutral rate cases to account for this underpayment.").

The Medicare Payment Advisory Commission ("MedPAC") also criticized the BNA. MedPAC's FY 2017 comment letter objected to the separate budget neutrality adjustment for LTCH site neutral high-cost outliers because, as the Providers and hospital trade associations were telling CMS, "the IPPS standard payment amount is already adjusted to account for HCO payments." Exhibit 31, MedPAC, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 16 (May 31, 2016), https://www.regulations.gov/contentStreamer?documentId=CMS-2016-0053-0123&attachmentNumber=1&contentType=pdf. MedPAC explained why it was incorrect for CMS to apply another budget neutrality adjustment to the LTCH site neutral payment rate:

> CMS proposes to use the IPPS fixed-loss amount to determine if a discharge paid under the site-neutral rate qualifies to receive an HCO payment again for FY 2017. CMS sets the IPPS fixed-loss amount each year at a level that it estimates will result in aggregate HCO payments equal 5.1 percent of total IPPS payment. **To account for the spending attributed to these outlier payments, CMS reduces the IPPS base payment rates to maintain budget neutrality in the IPPS. The IPPS-comparable rate used to pay for site-neutral cases in LTCHs includes an adjustment for budget neutrality to account for spending associated with HCOs.**

Continued from previous page
https://www.regulations.gov/contentStreamer?documentId=CMS-2016-0053-0575&attachmentNumber=1&contentType=pdf.

> With the Commission's payment principles in mind, **MedPAC urges CMS to eliminate the proposed payment adjustment for discharges paid the site-neutral rate to account for outlier payments under this payment methodology. Given that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.**

Id. at 16-17 (emphasis added).

Despite objections from even more LTCHs, and strong objections from MedPAC, in written comments to the agency, CMS again dismissed these concerns and finalized the BNA for FY 2017. See Exhibit 4, FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. 56762, 57308-09 (Aug. 22, 2016).[13] CMS said in the FY 2017 Final Rule that it continued to disagree with commenters "who assert that a HCO budget neutrality adjustment for site neutral payment rate cases is inappropriate, unnecessary, or duplicative." Id. CMS also added that it has "broad authority" to establish adjustments to the LTCH PPS standard Federal payment rate. Id. Additionally, CMS attempted to make the argument that Congress approved of CMS' implementation of the duplicative BNA because "Congress was well aware of how we had implemented our HCO policy under the LTCH PPS under § 412.525 at the time of the enactment of section 1206 of Public Law 113-67" and "Congress was also well aware of how we had implemented our 'IPPS comparable per diem amount' concept in the [short-stay outlier] context at the time of the enactment of section 1206 of Public Law 113-67." 81 Fed. Reg. at 57308.

---

13 In the FY 2017 IPPS/LTCH PPS Final Rule, CMS did make one change to the application of the BNA. CMS decided that the budget neutrality adjustment would not be applied to the HCO payment for site neutral payment rate cases. Exhibit 4, 81 Fed. Reg. at 57309.

C. FY 2018 Rulemaking

In FY 2018, CMS continued applying the BNA over the objections of the Providers and others. The FY 2018 IPPS/LTCH PPS Final Rule contained an identical budget neutrality adjustment. Exhibit 3, FY 2018 IPPS/LTCH PPS Final Rule, 82 Fed. Reg. 37990, 38544-46 (Aug. 14, 2017). During the FY 2018 comment period, Kindred Healthcare,[14] LifeCare Hospitals,[15] Post Acute Medical,[16] and Vibra HealthCare[17] each submitted comments opposing the proposed adjustment for FY 2018. The Providers also continued to request that CMS correct the duplicative adjustment that CMS already applied to FY 2016 and FY 2017 LTCH site neutral payments. See e.g., Exhibit 34, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 12 ("CMS should reverse this adjustment to all FY 2016 and FY 2017 payments, or make an equivalent prospective increase in payments to FY 2018 site neutral rate cases to account for this underpayment."). In addition to the Providers, the AHA and FAH again objected to the FY 2018 budget neutrality adjustment.[18]

---

14 Exhibit 34, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 5-12 (June 13, 2017), https://www.regulations.gov/contentStreamer?documentId=CMS-2017-0055-4033&attachmentNumber=1&contentType=pdf.

15 Exhibit 35, LifeCare Hospitals, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 14-18 (June 13, 2017), https://www.regulations.gov/contentStreamer?documentId=CMS-2017-0055-3745&attachmentNumber=1&contentType=pdf.

16 Exhibit 36, Post Acute Medical, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 4 (June 12, 2017), https://www.regulations.gov/contentStreamer?documentId=CMS-2017-0055-3620&attachmentNumber=1&contentType=pdf.

17 Exhibit 37, Vibra Healthcare, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 20-23 (June 13, 2017), https://www.regulations.gov/contentStreamer?documentId=CMS-2017-0055-3729&attachmentNumber=1&contentType=pdf.

18 Exhibit 38, American Hospital Association, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 4-7 (June 13, 2017), https://www.regulations.gov/contentStreamer?documentId=CMS-2017-0055-3995&attachmentNumber=1&contentType=pdf; Exhibit 39, Federation of American Hospitals, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 62-63 (June 13, 2017),

Continued on following page

Despite these objections for a third year, CMS again finalized the budget neutrality adjustment without any change. See Exhibit 3, FY 2018 IPPS/LTCH PPS Final Rule, 82 Fed. Reg. 37990, 38544-46 (Aug. 14, 2017). CMS reiterated its belief that it has "the authority to adopt the site neutral payment rate HCO policy in a budget neutral manner" and referred readers to its responses to comments in the two previous years. Id. at 38546.

D. FY 2019 Rulemaking

In the FY 2019 IPPS/LTCH PPS Proposed Rule, CMS again proposed a budget neutrality factor (adjustment) for all LTCH site neutral payment rate cases. CMS claimed that this adjustment is necessary so that HCO payments for such cases do not result in any change to estimated aggregate LTCH payments. Exhibit 1, FY 2019 IPPS/LTCH PPS Proposed Rule, 83 Fed. Reg. 20164, 20596 (May 7, 2018). The proposed budget neutrality adjustment would reduce the LTCH site neutral payment rate amount by 5.1% to offset the cost of LTCH site neutral HCO payments in FY 2019. Id. In addition to this budget neutrality adjustment for LTCH site neutral HCO cases, CMS again proposed adjusting the IPPS payment rate to account for projected IPPS outlier payments. Exhibit 1, 83 Fed. Reg. at 20583. Specifically, CMS proposed a budget neutrality adjustment to reduce the IPPS payment rate by 5.1%. Id. As in prior years, the IPPS rate is used to determine the IPPS comparable per diem amount for LTCH site neutral payment rate cases.

In response to the FY 2019 IPPS/LTCH PPS Proposed Rule, the Providers and other commenters again objected to the budget neutrality adjustment for LTCH site neutral HCO cases on the grounds that the adjustment is duplicative of the budget neutrality adjustment CMS

Continued from previous page
https://www.regulations.gov/contentStreamer?documentId=CMS-2017-0055-4057&attachmentNumber=1&contentType=pdf.

proposed to apply to the IPPS payment rate. CMS' calculation of the 5.1% LTCH PPS site neutral budget neutrality adjustment did not account for the budget neutrality adjustment CMS already proposed for the IPPS payment rate. Similar to prior years' comment letters, Kindred Healthcare's FY 2019 comment letter continued to object to the BNA:

> Consistent with MedPAC's and the AHA's comments, we strongly disagree with the proposed 0.949 budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. CMS already reduced the FY 2019 site neutral payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor. CMS should *not* reduce LTCH site neutral payments by *another 5.1%*.

Exhibit 40, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 42 (June 25, 2018), https://www.regulations.gov/contentStreamer?documentId=CMS-2018-0046-1349&attachmentNumber=1&contentType=pdf. LifeCare's FY 2019 comment letter also explained to CMS that the proposed LTCH site neutral adjustment was duplicative of the adjustments already included in the LTCH site neutral payment rate: "This BNA is duplicative and unwarranted because CMS has *already* applied budget neutrality adjustments to reduce the operating and capital portions of the IPPS standard Federal payment rate by the same 5.1%, before using that rate to determine the IPPS comparable per diem amount for site neutral payment cases." Exhibit 41, LifeCare Hospitals, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 14 (June 21, 2018), https://www.regulations.gov/contentStreamer?documentId=CMS-2018-0046-1055&attachmentNumber=1&contentType=pdf. Similarly, Vibra's FY 2019 comment letter contained similar comments that explained CMS' error in calculating the budget neutrality adjustment. Exhibit 42, Vibra Healthcare, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 21-25 (June 25, 2018),

https://www.regulations.gov/contentStreamer?documentId=CMS-2018-0046-1360&attachmentNumber=1&contentType=pdf. As in prior years, the AHA and FAH also objected to the FY 2019 site neutral outlier budget neutrality adjustment. See Exhibit 43, American Hospital Association, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 6-8 (June 25, 2018), https://www.regulations.gov/contentStreamer?documentId=CMS-2018-0046-1495&attachmentNumber=1&contentType=pdf; Exhibit 44, Federation of American Hospitals, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 42-43 (June 25, 2018), https://www.regulations.gov/contentStreamer?documentId=CMS-2018-0046-1468&attachmentNumber=1&contentType=pdf.

The FY 2019 comment letters specifically asked CMS to take a fresh look at this issue and consider the detrimental effect the duplicative adjustment would have on LTCHs in FY 2019, but also the harm that already occurred by applying the adjustment in FYs 2016 through 2018. See Exhibit 41, LifeCare Hospitals, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 15 ("Because CMS has been unwilling to address these issues directly the past two years, we are forced to raise them again for consideration this year."); Exhibit 40, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 36 ("We request that CMS take a fresh look at this issue to avoid a continuation of this erroneous policy."); id. at 42 ("CMS' unwillingness to address these issues directly the past two years requires that we raise them again for further consideration this year. We ask that CMS take our concerns more seriously, now that the agency has had additional time to consider the matter and the analysis and table we provided.").

The Providers' comment letters explained that after taking a fresh look at this issue and correcting the erroneous adjustment for FY 2019, CMS also needed to fix the duplicative

adjustments already applied in FYs 2016 through 2018. See e.g., Exhibit 40, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 42 ("For the same reason, it was incorrect for CMS to apply the 5.1% site neutral HCO BNA to FY 2016, FY 2017 and FY 2018 payments for site neutral rate cases. CMS should reverse this adjustment to all FY 2016, FY 2017 and FY 2018 payments, or make an equivalent prospective increase in payments to FY 2019 site neutral rate cases to account for this underpayment.").

Despite these comments, CMS finalized the duplicative budget neutrality adjustment for all LTCH site neutral payment rate cases in the FY 2019 IPPS/LTCH PPS Final Rule. Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. 41144, 41737-38 (Aug. 17, 2018). At the same time, CMS finalized the 5.1% budget neutrality adjustment to the IPPS payment rate. Id. at 41723, 41728. In the FY 2019 Final Rule, CMS offered only a brief response to the Providers' comments objecting to the budget neutrality adjustment, essentially repeating what it had said in the FY 2018 Final Rule:

> We continue to disagree with the commenters that a budget neutrality adjustment for site neutral payment rate HCO payments is inappropriate, unnecessary, or duplicative. As we discussed in response to similar comments (82 FR 38545 through 38546, 81 FR 57308 through 57309, and 80 FR 49621 through 49622), we have the authority to adopt the site neutral payment rate HCO policy in a budget neutral manner. More importantly, we continue to believe this budget neutrality adjustment is appropriate for reasons outlined in our response to the nearly identical comments in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57308 through 57309) and our response to similar comments in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49621 through 49622).

Id. at 41738. Accordingly, CMS is applying a budget neutrality factor of 0.949 to reduce the site neutral payment rate portion of the LTCH PPS blended payment rate for all site neutral cases, despite the fact that the IPPS comparable amount has already been reduced to offset IPPS outlier

payments. This BNA reduces site neutral case payments by an *additional* 5.1% for all LTCHs, including the Providers in these group appeals.

The Providers have given CMS ample opportunity to correct the flawed methodology for determining the LTCH site neutral payment outlier budget neutrality adjustment. The Providers clearly spelled out the duplication in their comments, and MedPAC agreed that a separate budget neutrality adjustment should not be applied for this reason. However, CMS has been dismissive of the Providers' concerns.

The Providers had hoped that CMS would correct the error before the end of the LTCH site neutral transition period because when the transition period ends on September 30, 2019, the monetary consequences of CMS' error will double. See Exhibit 6, 42 U.S.C. § 1395ww(m)(6)(B)(i)(I) (SSA § 1886(m)(6)(B)(i)(I)). Starting in FY 2020, the entire payment for site neutral cases will be the lesser of the IPPS comparable per diem amount or 100% of the estimated costs of the case. Id. at §§ 1395ww(m)(6)(B)(i)-(ii). If CMS continues to insist on applying the duplicative outlier budget neutrality adjustment in FY 2020, the adjustment will apply to the entire site neutral payment. The Providers' LTCHs are already experiencing significantly reduced Medicare payments for site neutral cases. Applying a budget neutrality adjustment twice to site neutral payments only increases the financial pressure on these hospitals and unnecessarily deters care for Medicare patients in LTCHs. The Providers have no choice but to seek relief from the courts.

IV. ARGUMENT

The Providers do not dispute that CMS can apply a budget neutrality adjustment to LTCH site neutral case payments so that overall LTCH payments do not increase due to high cost outlier payments for qualifying site neutral cases. What the Providers dispute is the

application of a budget neutrality adjustment to LTCH site neutral case payments that *reduces* overall LTCH payments *below* what they would otherwise be in the absence of high cost outlier payments for qualifying site neutral cases. This is not budget neutrality. It is a payment cut that is completely arbitrary and unsupported, and results in a windfall to the Medicare program.

CMS set the target amount of LTCH HCO payments at 5.1% of total LTCH site neutral payments. The simple math is clear that CMS can only reduce total LTCH site neutral payments by 5.1% to maintain budget neutrality. Yet, the extra BNA at issue here reduces total LTCH site neutral payments by *another* 5.1% in the name of budget neutrality.

The Providers, hospital trade associations and MedPAC have repeatedly told CMS not to apply the extra budget neutrality adjustment. CMS has stubbornly refused, with unconvincing attempts to recast the IPPS outlier budget neutrality adjustments as "inputs" that only relate to the IPPS. But this form over function argument does not change the math. CMS has continued setting the LTCH site neutral payment rate based upon an erroneous calculation that includes *double* the budget neutrality adjustment for HCO payments.

CMS has committed a clear error of judgment by refusing to correct this error in the FY 2016, FY 2017, FY 2018 and FY 2019 IPPS/LTCH PPS Final Rules. It is arbitrary and capricious, an abuse of discretion, not in accordance with the APA, the SSA and the laws authorizing the LTCH PPS, and it is not supported by substantial evidence. Because the PRRB lacks the authority to reverse the agency's budget neutrality adjustment, we request that the PRRB certify these appeals for expedited judicial review.

A. Requirements for EJR

In order to be eligible for EJR, the providers in a group appeal must satisfy three requirements. First, the providers must be eligible for a PRRB hearing (*i.e.*, the Board must have jurisdiction over the appeal because the providers meet the amount-in-controversy requirement

of 42 C.F.R. § 405.1837(a)(3) and the 180-day window for requesting an appeal as set forth in § 405.1835(a)(3)). Second, there must be no factual issues in dispute. Third, the case must turn on a legal question that the PRRB lacks authority to decide. See 42 C.F.R. § 405.1842.

Because the PRRB is bound by the Social Security Act as well as the implementing regulations and CMS rulings (see 42 C.F.R. § 405.1867), the Board lacks authority to decide an issue when the appeal involves a challenge to the constitutionality of a statute, or the substantive or procedural validity of a regulation or CMS ruling. Specifically, the regulation on EJR states that:

> The Board's decision must grant EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines the following conditions are satisfied:
>
> (i) The Board has jurisdiction to conduct a hearing on the specific matter at issue in accordance with §405.1840 of this subpart.
>
> (ii) The Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.

42 C.F.R. § 405.1842(f)(1) (emphasis added).

The Board has stated that it has "no authority to dictate or fashion CMS policy or to retroactively apply policy changes," and has granted EJR where "the remedies that the Providers are seeking are not provided for, nor are they addressed in the [applicable] statute or regulations." See Hunterdon/Somerset 2001 Wage Index Grp. v. Riverbend Gov't Benefits Adm'r, PRRB Hearing Dec. No. 2004-D13, Case No. 01-0881GE at 6 (Apr. 14, 2004). In addition, if there is a statute, regulation, or CMS ruling that would specifically preclude granting the remedy sought by the provider, EJR would be appropriate. See Oakwood Hosp. and Med. Ctr. v. Blue Cross Blue Shield Ass'n, PRRB Hearing Dec. No. 02-1686 (Nov. 16, 2005).

B. The Providers Meet the Jurisdictional Requirements for a PRRB Hearing

The first requirement for EJR is met because the PRRB has jurisdiction over these group appeals since (1) the PRRB has jurisdiction to hear the Providers' direct appeals of a budget neutrality adjustment published in the *Federal Register*; (2) the Providers filed a request for a hearing with the PRRB within 180 days of the publication of the budget neutrality adjustment in the *Federal Register*; and (3) the amount in controversy for each group is over $50,000. These elements are based in section 1878(a) and (b) of the Social Security Act, which provides that:

> (a) . . . [A]ny hospital which receives payments in the amounts computed under subsection (b) and (d) of section 1886 and which has submitted such reports within such time frame as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—
> (1) such provider
> . . .
> (A)(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1886,
> . . .
> (2) the amount in controversy is $10,000 or more, and
> (3) such provider files a request for a hearing . . . , with respect to appeals under paragraph (1)(A)(ii), 180 days after the notice of the Secretary's final determination.
>
> (b) The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

42 U.S.C. § 1395oo (SSA § 1878); see also 42 C.F.R. § 405.1837(a) ("A provider . . . has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, only if—(1) The provider satisfies individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement . . . and (3) The

amount in controversy is, in the aggregate, $50,000 or more, as determined in accordance with §405.1839 of this subpart.").

The Secretary previously interpreted this statute to grant the PRRB jurisdiction over a hospital's appeal "only after an NPR has been issued for the hospital's first cost reporting period under the prospective payment system." Medicare Program; Provider Reimbursement Review Board Jurisdiction Over Appeals From Estimation of and Modifications to Base Year Costs Under the Prospective Payment System, 49 Fed. Reg. 22413, 22415 (May 29, 1984). However, the United States Court of Appeal for the District of Columbia Circuit later determined that, contrary to the Secretary's interpretation, "a year-end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal." Exhibit 16, Washington Hosp. Ctr. v. Bowen, 795 F.2d 139, 145 (D.C. Cir. 1986).

Since Washington Hosp. Ctr., the PRRB and the CMS Administrator have recognized that the PRRB has jurisdiction in cases involving provider challenges to CMS prospective payment system policies published in the *Federal Register*. See e.g., Crozer-Keystone Hosp. v. BlueCross BlueShield Ass'n/Highmark Medicare Servs., CMS Admin. Dec. (December 21, 2009) (finding that the PRRB had jurisdiction over a challenge to the FY 2007 IPPS wage index published in the *Federal Register*); King & Spalding FFY 2014 0.2% IPPS Reduction Group, PRRB Jurisdictional Dec., Case No. 14-2154G (Mar. 12, 2014) (finding that the PRRB has jurisdiction over a challenge to the -0.2% reduction to the IPPS standardized amount and capital standard Federal payment rate, to offset the impact of the "two-midnight" rule, that was published in the *Federal Register*); Youngstown-Warren 02 MSA Wage Index Grp. v. BlueCross

Ass'n/Nat'l Gov't Servs., Inc., PRRB Hearing Dec. No. 2012-D5, Case No. 02-0531G (July 26, 2011) (finding that the PRRB has jurisdiction over a challenge to the FY 2002 hospital wage index published in the *Federal Register*); Hall Render FFY 2018 ATRA/MACRA 0.7% D&C Adjustment Groups, PRRB Jurisdictional Dec., Case Nos. various (Jul. 24, 2018) (finding that the PRRB has jurisdiction over a challenge to the documentation and coding adjustment for FY 2018 published by CMS in a *Federal Register* notice).

A provider's direct challenge to payment policies published in the *Federal Register* is appropriate for EJR, even though the PRRB is sometimes reluctant to reach this conclusion. See Exhibit 17, Cape Cod Hosp. v. Sebelius, 677 F. Supp. 2d 18, 25 (D.D.C. 2009), rev'd on different grounds. In Cape Cod, plaintiffs brought challenges to both the FY 2007 and 2008 Final Rules before the Board, contending that CMS erred in applying the annual budget neutrality adjustment factor to the wage index rather than the standardized amount. Id. at 24. Although the Board initially determined that the Medicare regulations precluded judicial review, the United States District Court for the District of Columbia vacated the Board's decision and remanded to the Secretary for reconsideration of the hospitals' appeals. Id. After the Secretary remanded to the PRRB, the Board determined that expedited judicial review was appropriate. Similarly here, the PRRB has jurisdiction over the Providers' direct appeals of the FY 2019 LTCH PPS site neutral outlier budget neutrality adjustment.

Relying on a prior version of 42 C.F.R. § 405.1804(a), the PRRB previously believed it did not have jurisdiction in appeals challenging budget neutrality adjustments published in the *Federal Register*. See e.g., St. Rose Hospital, PRRB Jurisdictional Dec., Case. No. 14-0483 at 5 (Dec. 19, 2013) ("The Board concludes that it lacks jurisdiction over the appeal because review of budget neutrality adjustments is expressly prohibited by the statute and regulations."). This

interpretation was based on language in section 405.1804(a), since revised, that said administrative review was not available for the "determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates." Exhibit 18, 42 C.F.R. § 405.1804(a) (2013).

In 2013, CMS revised this regulation because it was inconsistent with the text of section 1878(d)(7) of the SSA. Section 1878(d)(7) only precludes review of the budget neutrality adjustment authorized by section 1886(e)(1) of the SSA. Section 1886(e)(1) only required a budget neutrality adjustment so that FY 1984 and FY 1985 IPPS payments would be budget neutral. The regulatory text of section 405.1804(a) was therefore inconsistent with the statutory text of SSA section 1878(d)(7) with respect to the Board's jurisdiction over challenges to budget neutrality adjustments. Now, the regulation only precludes administrative review of "the budget neutrality adjustment in the prospective payment rates required **under section 1886(e)(1) of the Social Security Act**." Exhibit 19, 42 C.F.R. § 405.1804(a) (2017) (emphasis added). When revising the regulation, CMS stated that this "technical conforming change clarifies that there is no administrative or judicial review with respect to the budget neutrality adjustments enumerated in section 1886(e)(1) of the Act, and this preclusion of review does not apply to other budget neutrality adjustments under the IPPS." Medicare and Medicaid Programs: Provider Reimbursement Determinations and Appeals, 78 Fed. Reg. 74826, 75162 (Dec. 10, 2013). The Providers here are not challenging the budget neutrality adjustment authorized by section 1886(e)(1) of the SSA. Accordingly, 42 C.F.R. § 405.1804(a) does not preclude the Board from accepting jurisdiction over the Providers' challenge to the BNA.

With the exception of the budget neutrality adjustment required under section 1886(e)(1) of the SSA, the PRRB now recognizes that it has jurisdiction over challenges to all other budget

neutrality adjustments. See e.g., Exhibit 20, Toyon 2009 Rural Floor Budget Neutrality Group, PRRB Jurisdictional Dec., PRRB Case No. 09-1313G (Apr. 6, 2017) (finding that the PRRB has jurisdiction over challenge to application of statewide rural floor budget neutrality adjustment factor); HCA 2010 Sole Community Re-basing Group, PRRB Jurisdictional Dec., PRRB Case No. 09-1864GC at 2 (Dec. 31, 2015) (finding that the PRRB has jurisdiction over a challenge to the application of budget neutrality adjustments to the hospital-specific rate for sole community hospitals because 42 C.F.R. § 405.1804 "has been revised, permitting the Board to review budget neutrality adjustments of the type under appeal in this case."); Exhibit 22, Toyon 2009-2010 SCH Hospital Specific Rate Rebasing Group, PRRB Jurisdictional Dec., PRRB Case No. 10-0351G (Dec. 31, 2015) (finding that the PRRB has jurisdiction over a challenge to budget neutrality adjustments to sole community hospitals' hospital specific rates).

No other statute or regulation precludes administrative review of a budget neutrality adjustment under the LTCH PPS. See 42 C.F.R. §§ 405.1804, 405.1840(b) and 405.1842(f)(2)(i). The Social Security Act and implementing regulations only prohibit administrative and judicial review of the following matters:

> (1) A finding in a contractor determination that expenses incurred for certain items or services furnished by a provider to an individual are not payable under title XVIII of the Act because those items or services are excluded from coverage under section 1862 of the Act and Part 411 of the regulations. Review of these findings is limited to the applicable provisions of sections 1155, 1869, and 1879(d) of the Act and of Subpart I of Part 405 and Subpart B of Part 478 of the regulations, as applicable.

42 C.F.R. § 405.1840(b)(1).

> (a) The determination of the requirement, or the proportional amount, of the budget neutrality adjustment in the prospective payment rates required under section 1886(e)(1) of the Social Security Act.
>
> (b) The establishment of—
> (1) Diagnosis related groups (DRGs);

> (2) The methodology for the classification of inpatient discharges within the DRGs; or
> (3) Appropriate weighting facts that reflect the relative hospital resources used with respect to discharge within each DRG.

42 C.F.R. § 405.1804 (implementing 42 U.S.C. § 1395ww(d)(7) (SSA § 1886(d)(7)) and 42 U.S.C. § 1395oo(g) (SSA § 1878(g))).

Moreover, the Providers timely submitted a PRRB Group Appeal Request on November 20, 2018, see LTCH 2019 Site Neutral Outlier Budget Neutrality Adjustment Group Appeal Request at 1, less than 180 days after the site neutral budget neutrality adjustment for FY 2019 was published in the *Federal Register* on August 17, 2018, see Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. 41144 (Aug. 17, 2018).[19]

Finally, the amount in controversy in each group appeal exceeds the $50,000 statutory requirement for a group appeal, see 42 U.S.C. § 1395oo(b) (SSA § 1878(b)); 42 C.F.R. § 405.1837(a)(3). The amount in controversy in the LifeCare group appeal (Case No. 19-0407GC) is approximately $1,252,030. See LifeCare Health Partners FY 2019 LTCH Site Neutral Outlier Budget Neutrality Adjustment Group Schedule of Providers. The amount in controversy in the Post Acute group appeal (Case No. 19-0408GC) is approximately $1,291,270. See Post Acute Medical FY 2019 LTCH Site Neutral Outlier Budget Neutrality Adjustment Group Schedule of Providers. The amount in controversy in the Kindred group appeal (Case No. 19-0409GC) is approximately $5,471,180. See Kindred Healthcare FY 2019 LTCH Site Neutral Outlier Budget Neutrality Adjustment Group Schedule of Providers. The amount in controversy in the Vibra

[19] On November 20, 2018, the Providers submitted a single Group Appeal Request to form an optional group that included all 101 Providers. The Board received this request on November 21, 2018. On December 12, 2018, the Board issued a letter explaining that the single group appeal with all 101 Providers was being converted into four Common Issue Related Party ("CIRP") group appeals (one CIRP group for each of the four distinct healthcare corporations). Accordingly, the Providers' Group Appeal Request applies to all four CIRP Groups.

group appeal (Case No. 19-0410GC) is approximately $1,374,064. See Vibra Healthcare FY 2019 LTCH Site Neutral Outlier Budget Neutrality Adjustment Group Schedule of Providers. The combined amount in controversy for the four group appeals is approximately $9,388,544.

Because neither the statute nor the implementing regulations prohibit the PRRB from reviewing the Providers' direct appeals of a budget neutrality adjustment published in the *Federal Register*, and the statutory requirements for PRRB review are satisfied, the PRRB has jurisdiction over these group appeals. Therefore, the Providers satisfy the first requirement for EJR.

C. There Are No Disputed Facts Material to the Resolution of the Providers' Appeals

The second requirement for EJR is met because there are no facts material to the Providers' appeals that are in dispute. The Providers are directly challenging the FY 2019 LTCH PPS site neutral HCO budget neutrality adjustment in the final rule. This budget neutrality adjustment reduces the amount of the site neutral payment rate in FY 2019 for all LTCHs, including the Providers. This payment reduction is documented in the *Federal Register*. See Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. 41144, 41738 (Aug. 17, 2018) ("[I]t is necessary to reduce the site neutral payment rate portion of the blended rate payment by 5.1% to account for the estimated additional HCO payments payment to those cases in FY 2019."). Moreover, the comment letters to CMS and the agency's responses in the FY 2019 Final Rule (with references to the earlier rules) confirm that there is no dispute about the fact that CMS does not remove the outlier budget neutrality adjustment to the IPPS payment rate when calculating LTCH site neutral payments. Exhibit 5, FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326, 49622 (Aug. 17, 2015) ("While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment

for IPPS HCO payments, . . ."). It is irrefutable that the Providers are and will continue to experience reduced Medicare payments as a result of the HCO budget neutrality adjustment to the site neutral payment rate. Thus, the Providers have satisfied the second requirement for EJR.

D. The Issue to Be Resolved Through These Appeals Is Beyond the Scope of the Board's Authority

The third requirement for EJR is met because the legal question in these appeals is a challenge to the substantive and procedural validity of a regulation—the BNA in the FY 2019 Final Rule. See 42 C.F.R. § 405.1842(f)(1)(ii). Since the Board has jurisdiction over these appeals, it "must consider whether it lacks the authority to decide a legal question relevant to the matter at issue." 42 C.F.R. § 405.1842(e)(1). The Board lacks the authority to decide a question if "the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling." 42 C.F.R. § 405.1842(f)(1)(ii) (emphasis added); see also Allina Health Servs. v. Burwell, 141 F. Supp. 3d 17, 19 (D.D.C. 2015) ("The PRRB . . . is bound by agency regulation and rulings, [42 C.F.R. § 405.1867,] and cannot decide 'question[s] of law or regulations.'") (citing 42 U.S.C. § 1395oo(f)(1)).

These appeals turn on the pure legal issue of whether the BNA is legally valid and enforceable. However, the Board lacks the authority to decide whether this adjustment is contrary to the APA, the Medicare statute, and other federal laws. Since the PRRB is bound by agency regulations and rulings, and cannot decide questions of law or regulations, a decision concerning the legal validity of this budget neutrality adjustment in the FY 2019 IPPS/LTCH PPS Final Rule is beyond the scope of the Board's authority. See 42 C.F.R. § 405.1869. As discussed more fully below, the Providers have ample legal support for their position that the

BNA in the FY 2019 Final Rule is invalid as a matter of law and that CMS's enforcement of this budget neutrality adjustment is thus without legal basis.

1. The Board Lacks Authority to Decide the Legal Issue Concerning this Budget Neutrality Adjustment, Making the Issue Appropriate for EJR

The Board lacks authority to decide whether the BNA is arbitrary and capricious, an abuse of discretion, not in accordance with law, or unsupported by substantial evidence under the APA, and whether CMS met the APA's procedural requirements for responding to major policy issues identified in comments. The Board also lacks authority to decide whether this budget neutrality adjustment violates the dual-rate structure of the LTCH PPS in the SSA and exceeds CMS's authority under the authorizing legislation for the LTCH PPS.

In Toyon 2009 Rural Floor Budget Neutrality Group, PRRB Jurisdictional Dec., PRRB Case No. 09-1313G (Apr. 6, 2017), the Board on its motion decided that it did not have the authority to decide the legal question of the validity of CMS' application of the statewide rural floor budget neutrality adjustment factor used to determine IPPS payments. Exhibit 20, PRRB Jurisdictional Dec., PRRB Case No. 09-1313G at 1. The providers argued that the budget neutrality adjustment was arbitrary and capricious, did not comply with the APA's procedural requirements, and was contrary to the statute. Id. at 7. In response to the providers' challenge to this budget neutrality adjustment, the Board stated:

> Pursuant to 42 C.F.R. § 405.1867, the Board must comply with Title XVIII of the Act and its supporting regulations. The Providers contend that the application of the within-state (or statewide) rural floor budget neutrality adjustment for FFY 2009 and 2010 is contrary to the Medicare statute and that CMS promulgated that regulation in violation of the Administrative Procedure[] Act. The Board finds it lacks the authority to examine this legal question as it pertains to the issue in these group appeals.

Id. at 9. The Board therefore granted EJR, allowing the providers to challenge the validity of this budget neutrality adjustment in Federal District Court. Id. at 9-10. Here, the Providers are also

challenging a budget neutrality adjustment that violates the APA. This is a legal question that the PRRB does not have the authority to resolve.

The PRRB also granted EJR in response to a provider group challenge to budget neutrality adjustments that CMS directed the intermediaries to apply to sole community hospitals' Hospital Specific Rates ("HSRs"). Exhibit 22, Toyon 2009-2010 SCH Hospital Specific Rate Rebasing Group, PRRB Jurisdictional Dec., PRRB Case No. 10-0351G (Dec. 31, 2015). In Toyon 2009-2010 SCH Hospital Specific Rate Rebasing Group, the Board on its own motion granted EJR after finding that CMS established a cumulative budget neutrality adjustment in an August 2005 Final Rule. Id. at 2. The providers objected to this adjustment on grounds that it resulted in HSRs that were contrary to the statutory requirements for HSRs. See id. The Board determined that EJR was appropriate because the Board had jurisdiction, no findings of fact were needed, and the Board was "bound by [the] regulation and the publication of [the] notices in the Federal Register." Id. The Board further noted that it "lacks the authority to decide the legal question of whether the application of the cumulative budget neutrality adjustment to the Providers' reimbursement rates is proper." Id. The same analysis applies to the Providers' challenge of the BNA published in the FY 2019 IPPS/LTCH PPS Final Rule. The Board has jurisdiction over the Providers' appeals and no findings of fact are required, but the Board does not have the authority to consider the validity of a budget neutrality adjustment published in the *Federal Register*.

Because the Board does not have the authority to decide this legal issue challenging the substantive and procedural validity of the BNA, expedited judicial review is appropriate.

2. The BNA Is Arbitrary and Capricious Because CMS Did Not Account For the Budget Neutrality Adjustments Already Included in the IPPS Comparable Amount

CMS' promulgation of the duplicative BNA is a textbook violation of the Administrative Procedure Act's arbitrary and capricious standard. For several reasons, it is very clearly "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law." 5 U.S.C. § 706(2)(A). First, the duplicative budget neutrality adjustment is arbitrary and capricious because it is unreasonable. See Exhibit 45, U.S. Postal Serv. v. Postal Regulatory Comm'n, 785 F.3d 740, 750 (D.C. Cir. 2015) (recognizing that agency action must be reasonable to survive arbitrary and capricious review under the APA). Second, the duplicative budget neutrality adjustment is arbitrary and capricious because "the agency . . . entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." Exhibit 12, Motor Vehicle Mfrs. Ass'n of the U.S., Inc. v. State Farm Mut. Auto. Ins., 463 U.S. 29, 43 (1983); see also Summer Hill Nursing Home LLC v. Johnson, 603 F. Supp. 2d 35, 39 (D.D.C. 2009) (concluding that "the Secretary entirely failed to consider an important aspect of the problem" and "the Secretary's decision provide[d] no basis upon which [the Court] could conclude that it was the product of reasoned decisionmaking" because CMS did not explain why Summer Hill's subsequent receipt of remittance advices was insufficient to establish that the bad debts were actually uncollectible when claimed) (internal quotation marks omitted). Third, the duplicative budget neutrality adjustment is arbitrary and capricious because CMS' reasoning is "internally inconsistent." See Exhibit 46, District Hosp. Partners v. Burwell, 786 F.3d 46, 59 (D.C. Cir. 2015) (finding agency action arbitrary and capricious when it is "internally inconsistent and inadequately explained"). Finally, the duplicative budget neutrality adjustment is arbitrary and capricious because it

reflects a clear error of judgment. See Exhibit 11, Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 416 (1971) (noting that agency action is arbitrary and capricious when "there has been a clear error of judgment" by the agency). Each of these reasons is discussed more fully below.

a. CMS' Unwarranted BNA is Arbitrary and Capricious Because it is Unreasonable

To survive arbitrary and capricious review under the APA, an agency's "exercise of its authority must be 'reasonable and reasonably explained.'" Exhibit 45, U.S. Postal Serv. v. Postal Regulatory Comm'n, 785 F.3d 740, 750 (D.C. Cir. 2015) (quoting Mfrs. Ry. Co. v. Surface Transp. Bd., 676 F.3d 1094, 1096 (D.C .Cir. 2012)). Agency action must be set aside if "the agency has failed to provide a reasoned explanation, or where the record belies the agency's conclusion . . . ." Exhibit 13, Cty. of L.A. v. Shalala, 192 F.3d 1005, 1021 (D.C. Cir. 1999); see also FiberTower Spectrum Holdings, LLC v. F.C.C., 782 F.3d 692, 699 (D.C. Cir. 2015) (stating that if an agency's "interpretation is 'plainly erroneous or inconsistent with the regulation[s]' or there is any other 'reason to suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter in question,'" courts will not "defer to an agency's interpretation of its regulations").

CMS' unreasonable decision to apply a second outlier budget neutrality adjustment to the LTCH site neutral payment rate is a textbook violation of the APA's arbitrary and capricious standard. It is not reasonable for CMS to apply a 5.1% budget neutrality adjustment to the LTCH site neutral payment rate to offset the cost of high cost outlier payments *after* CMS already applied the same 5.1% budget neutrality adjustment to the IPPS payment rate. CMS uses the IPPS payment rate, as reduced by the budget neutrality adjustments of 5.1%, to determine the LTCH site neutral payment rate. It was not reasonable for CMS to ignore the budget neutrality

adjustment already included in the IPPS comparable per diem amount (which is the basis for the LTCH site neutral payment rate in most cases) when adopting the additional BNA. Under a reasonable approach, CMS would have *either* applied the negative 5.1% budget neutrality adjustments to the IPPS rate when calculating the LTCH site neutral payment rate, *or* applied the separate negative 5.1% BNA to that calculation, *but not both*. Instead of adopting either of these approaches, CMS used both, resulting in a negative 10.2% adjustment to the LTCH site neutral payment rate—*double* the amount needed to maintain budget neutrality. See Exhibit 40, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 37 ("CMS needs to consider the adjustments that it has *already* made to the proposed IPPS and capital PPS payment rates to account for outlier payments."); Exhibit 41, LifeCare Hospitals, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 15 ("[B]ecause CMS is using the adjusted IPPS base rates for LTCH site neutral payments, the rates are already reduced 5.1% for outlier budget neutrality. The separate 5.1% budget neutrality adjustment for LTCH site neutral HCOs reduced such payments by *another* 5.1% for a total BNA of 10.2%.").

CMS has trivialized the comments and evidence submitted during the comment period about this duplication, and insisted on applying a second adjustment to the LTCH site neutral payment rate. As a result, Medicare has arbitrarily cut aggregate payment to all LTCHs by tens of millions of dollars each year.[20] This is clearly unreasonable. Accordingly, the duplicative BNA must be set aside as arbitrary and capricious under the APA.

---

20 The AHA's analysis of FY 2016 MedPAR data found that the duplicative budget neutrality adjustment reduces aggregate payments by approximately $28 million per year. Exhibit 43, American Hospital Association, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 6.

b. CMS Did Not Engage in a Reasoned Analysis When It Implemented the Duplicative BNA without Accounting for the Adjustments Already Applied to the IPPS Comparable Per Diem Amount

An agency violates the APA's reasoned analysis requirement if it fails to consider an important aspect of the problem. See Wood v. Betlach, 922 F. Supp. 2d 836 (D. Ariz. 2013) (finding that HHS failed to address an important aspect of the problem because the record contains no evidence that HHS considered or responded to plaintiffs' expert opinion that none of the demonstration project's hypotheses test anything new); St. James Hosp. v. Heckler, 760 F.2d 1460 (7th Cir. 1985), accord, Walter O. Boswell Mem'l Hosp. v Heckler, 628 F. Supp. 1121 (D.D.C. 1985) (holding that malpractice rule was arbitrary and capricious because HHS entirely failed to consider an important aspect of the problem by making no attempt to examine the relationship between actual malpractice loss experience and premium costs, and its rule was not adequately supported by the study it relied on); see also Shays v. Fed. Election Comm'n, 337 F. Supp. 2d 28, 72 (D.D.C. 2004) (concluding that the FEC's regulation implementing the Bipartisan Campaign Reform Act ("BCRA") was arbitrary and capricious because the FEC "did not adequately explain its decision to exclude 'apparent authority' from the scope of its definition of 'agent'" and provided "no indication that [it] considered how [its] decision might facilitate circumvention or perpetuate the appearance of corruption, two policies Congress definitely sought to advance in passing BCRA," demonstrating that the FEC "'entirely failed to consider an important aspect of the problem'") (quoting State Farm Mut. Auto. Ins., 463 U.S. at 43). Although courts typically exercise restraint in reviewing agency action, the courts will intervene if "the agency has not really taken a 'hard look' at the salient problems, and has not genuinely engaged in reasoned decision-making." Exhibit 14, Greater Boston Television Corp. v. F.C.C., 444 F.2d 841, 851 (D.C. Cir. 1970).

The Providers do not dispute that CMS has the authority to apply a budget neutrality adjustment to reduce LTCH site neutral payments to account for HCO payments for LTCH site neutral payment rate cases. However, the Providers do object to a budget neutrality adjustment on top of budget neutrality adjustments of the same size. See Exhibit 40, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 37 ("Consistent with MedPAC's recommendation, CMS should only adjust LTCH site neutral payments *once* for outlier budget neutrality."); Exhibit 41, LifeCare Hospitals, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 16 ("To ensure that LTCHs are only paying for high cost outliers at LTCHs once, not twice, CMS must not apply the separate 5.1% budget neutrality adjustment for LTCH site neutral cases."). The BNA is duplicative of the adjustments CMS borrows from the IPPS payment rates. CMS' refusal to seriously consider whether the adjustment is duplicative shows that the agency has not taken a "hard look" to ensure that the math behind the calculation of the budget neutrality adjustment is valid. See Exhibit 14, Greater Boston Television Corp., 444 F.2d at 851. A serious examination of the way the IPPS comparable per diem amount is calculated for LTCH site neutral payments would reveal the fact that this extra LTCH budget neutrality adjustment results in underpayments to LTCHs and a savings for the Medicare program. Accordingly, CMS has "entirely failed to consider an important aspect of the problem" because the agency refuses to recognize that it is applying a duplicative budget neutrality adjustment. See Exhibit 12, State Farm Mut. Auto. Ins., 463 U.S. at 43.

CMS believes that a separate budget neutrality adjustment for LTCH site neutral HCO cases will "reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems."

Exhibit 2, 83 Fed. Reg. at 41737. However, by aligning this policy with the IPPS payment system—and making the IPPS comparable per diem amount and the IPPS fixed-loss amount the primary components—CMS did not adequately consider the adjustment that it *already* made to the IPPS payment rate to account for outlier payments. Specifically, CMS already reduced the IPPS payment rate for outlier budget neutrality. For FY 2019, CMS reduced the operating portion of the IPPS payment rate by a factor of 0.948999 and the capital portion of the IPPS payment rate by a factor of 0.949431. Id. at 41723. As CMS explains, these budget neutrality factors result in a 5.1% outlier adjustment that already reduces the IPPS payment rate. Id. at 41723-24. CMS has therefore not taken a "hard look" at the salient problem and is not engaging in reasoned decisionmaking because CMS is unwilling to consider the duplicative effect of the extra BNA. See Exhibit 14, Greater Boston Television Corp., 444 F.2d at 851. Moreover, this extra 5.1% adjustment to LTCH site neutral payments in the name of budget neutrality does not "reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS"—it exacerbates differences—and it does not "promote fairness between the two systems"—it is patently unfair to LTCHs.

Accordingly, CMS' decision to adopt the BNA for FY 2019 is arbitrary and capricious because CMS did not engage in reasoned decisionmaking when the agency's adoption of the BNA failed to account for the budget neutrality adjustment to the IPPS standard Federal payment rate that is used in the calculation of the LTCH site neutral payment rate. Therefore, the LTCH site neutral budget outlier neutrality adjustment in the FY 2019 IPPS/LTCH PPS Final Rule must be set aside.

c. CMS' Decision to Apply a Duplicative Budget Neutrality Adjustment is Arbitrary and Capricious Because CMS' Reasoning is Internally Inconsistent

An agency's decision is also arbitrary and capricious if it is "internally inconsistent and inadequately explained." Exhibit 46, District Hosp. Partners v. Burwell, 786 F.3d 46, 59 (D.C. Cir. 2015) (citing General Chem. Corp. v. United States, 817 F.2d 844, 846 (D.C. Cir. 1987). In Banner Health v. Price, 867 F.3d 1323 (D.C. Cir. 2017) (Exhibit 47), hospitals brought a challenge to CMS' implementation of certain changes to the IPPS outlier policies aimed at addressing "turbo-charging" by hospitals. Turbo-charging hospitals were accused of manipulating the IPPS outlier system so that they could obtain greater outlier payments. Id. at 1328. The D.C. Circuit held that one of CMS' changes was arbitrary and capricious because the agency failed to adequately explain why it was not making adjustments to projection cost-to-charge ratios for the turbo-charging hospitals. Id. The court said CMS' "approach was 'internally inconsistent and inadequately explained.'" Id. at 1349 (citing District Hosp. Partners, 786 F.3d at 59). Specifically, the D.C. Circuit faulted CMS for not accounting for other changes CMS made to the outlier policies when setting the projection cost-to-charge ratios. Id. The court explained CMS' internally inconsistent policy as follows:

> When HHS set the FY 2004 threshold in August 2003, it knew it would end up using updated cost-to-charge ratios to make outlier payments as tentatively settled cost reports came in for each hospital. Yet it did not account for the fact that those updated cost-to-charge ratios were likely to be considerably lower than its projection cost-to-charge ratios, thereby leading many hospitals to be underpaid for outlier cases.

Id.

CMS' rationale for the duplicative BNA suffers from similar "internal inconsistency" for several reasons. First, the BNA is "internally inconsistent" because CMS chose to make the LTCH site neutral outlier policy identical to the IPPS outlier policy, but add an extra budget

neutrality adjustment to LTCH site neutral payments. CMS uses the same outlier policy as the IPPS for LTCH site neutral cases because CMS actuaries "projected that the costs and resource use for cases paid at the site neutral payment rate . . . would likely mirror the costs and resource use for IPPS cases assigned to the same MS-DRG" and "site neutral payment rate cases would generally be paid based on an IPPS comparable per diem amount," rather than 100% of the estimated costs of the case. Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. at 41737. CMS therefore uses the same IPPS fixed-loss amount for LTCH site neutral outlier cases. Id. ("[W]e continue to believe that the most appropriate fixed-loss amount for site neutral payment rate cases for FY 2019 is the IPPS fixed-loss amount for FY 2019."). CMS also uses the same target amount of 5.1% of total payments for outlier cases. Id. To be internally consistent, the LTCH site neutral payment rate would be considered budget neutral after applying the negative 5.1% IPPS outlier budget neutrality adjustment. See id. at 41723, 41728 (establishing a 0.948999 outlier adjustment factor to the IPPS operating standardized amount and a 0.949431 outlier adjustment factor to the IPPS capital federal rate). But CMS did not stop there. The agency applied an additional BNA of 5.1%, thereby doubling the reduction to LTCH site neutral payments. Id. at 41737. This approach is very clearly "internally inconsistent."

Second, CMS' LTCH PPS outlier policies are "internally inconsistent" because LTCH PPS standard rate payments are subject to a single outlier budget neutrality adjustment, yet CMS applies two budget neutrality adjustments to the site neutral payment rate. The AHA explained this issue in their comments to CMS on the FY 2017 and FY 2018 LTCH PPS rulemakings. The AHA's FY 2017 comment letter states:

> When calculating any of the LTCH PPS standard rate payments[], only one BNA applies. Similarly, when pricing out the LTCH PPS short-stay outliers . . . that are paid either an IPPS comparable amount or cost (similar to what site-neutral cases

> are being paid), only one BNA applies. However, by contrast, when calculating rates for site-neutral cases paid the IPPS comparable amount, two BNAs apply.

Exhibit 31, American Hospital Association, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 6 (footnote omitted). The AHA's comment letter included a chart that diagrams the budget neutrality adjustment CMS applies to other LTCH PPS payment rates and the two budget neutrality adjustments CMS applies to the LTCH site neutral payment rate. Id. at 7. CMS' deviation from its standard practice of applying only one outlier budget neutrality adjustment indicates that CMS' outlier policies are "internally inconsistent."

Finally, the BNA is "internally inconsistent" because it is contrary to the intent of budget neutrality. The intent of budget neutrality is to ensure that a particular payment policy does not raise *or lower* the aggregate payments to providers. In fact, CMS states in the FY 2019 Final Rule that the LTCH site neutral HCO policy should be budget neutral, "meaning that estimated site neutral payment rate HCO payments should not result in *any change* in estimated aggregate LTCH PPS payments." Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. at 41737 (emphasis added). However, CMS' implementation of the BNA reduces aggregate site neutral payments to LTCHs to a level that is *below* the budget neutral baseline. In other words, the additional budget neutrality adjustment the Providers are challenging in these appeals is not an adjustment that achieves budget neutrality at all—it is purely a payment cut. This unwarranted reduction is therefore "internally inconsistent" with the goals of budget neutrality.

Each of these examples of "internal inconsistency" on their own renders CMS' duplicative BNA arbitrary and capricious. Exhibit 47, Banner Health v. Price, 867 F.3d 1323 (D.C. Cir. 2017); Exhibit 46, District Hosp. Partners v. Burwell, 786 F.3d 46, 59 (D.C. Cir. 2015). CMS' rationale for the duplicative budget neutrality adjustment is fatally defective. The duplicative budget neutrality adjustment must therefore be set aside.

d. CMS' Decision to Apply a Duplicative Budget Neutrality Adjustment is Arbitrary and Capricious Because it Reflects a Clear Error of Judgment

Review of agency action under the arbitrary and capricious standard requires consideration of "whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." Exhibit 11, Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 416 (1971). A "clear error of judgment" is evaluated by looking at the substance of the agency's decision, not just the agency's procedures for promulgating the rule. Exhibit 48, James Madison Ltd. by Hecht v. Ludwig, 82 F.3d 1085, 1098 (D.C. Cir. 1996).

In James Madison Ltd., the D.C. Circuit stated that "judicial review of agency action under the APA must go beyond the agency's procedures to include the substantive reasonableness of its decision." Id. Relying on the Supreme Court's decision in Overton Park, the D.C. Circuit stated: "Although the reasonableness of the agency's procedures is relevant to the court's inquiry, reasonable procedures alone cannot absolve a court from making a 'thorough, probing, in-depth review' to determine if the agency has considered the relevant factors or committed a clear error of judgment." Id. (citing Overton Park, 401 U.S. at 415-16). According to the D.C. Circuit, the agency's action would amount to a substantive violation of the APA if the agency ignored salient facts or offered "patently implausible justifications." Id. In other circuits, there is a "clear error of judgment" that is "sufficient to constitute arbitrary and capricious agency action . . . when 'the agency offer[s] an explanation that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." Sierra Club v. E.P.A., 346 F.3d 955, 961 (9th Cir. 2003) (alteration in original) (quoting Motor Vehicle Mfrs. Ass'n of the U.S., Inc. v. State Farm Mut. Auto. Ins., 463 U.S. 29, 43 (1983)).

The "clear error of judgment" standard requires reversing the agency action "if the error is so clear as to deprive the agency's decision of a rational basis." Ethyl Corp. v. Envtl. Prot. Agency, 541 F.2d 1, 34-35 n. 74 (D.C. Cir. 1976), cert. denied, 426 U.S. 941, (1976). In the context of an agency's informal rulemaking, compared to agency decisions made after an evidentiary hearing, it is even more important that the record contain a rational basis for the agency's decision because it is easier for the agency to abuse informal rulemaking proceedings. Almay, Inc. v. Califano, 569 F.2d 674, 681 (D.C. Cir. 1977).

Here, CMS' decision to apply the duplicative budget neutrality adjustment is arbitrary and capricious because the agency committed a "clear error of judgment" when it ignored evidence that the IPPS comparable per diem amount for LTCH site neutral payment cases already includes a 5.1% budget neutrality adjustment to offset the cost of LTCH outlier cases. CMS first adopted the LTCH site neutral HCO budget neutrality adjustment in the FY 2016 IPPS/LTCH PPS Final Rule. See Exhibit 5, FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326, 49617-23 (Aug. 17, 2015). Prior to issuing the FY 2016 Final Rule, the Providers submitted comments to CMS explaining why the proposed BNA was unnecessary and duplicative because the IPPS comparable per diem amount already includes a budget neutrality adjustment. See e.g., Exhibit 24, Post Acute Medical, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 25 ("It would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed site neutral HCO BNA. This would be the case because the IPPS comparable per diem amount will be based on the FY 2016 IPPS payment rate, which has already been adjusted by the 5.1 percent outlier target."). The Providers, and other stakeholders, submitted additional comments to CMS during the FY 2017, FY 2018, and FY 2019 LTCH PPS rulemakings making the same point. See supra Parts III.B.-D. Even

MedPAC submitted a comment letter objecting to the budget neutrality adjustment because it is "duplicative and exaggerates the disparity in payment rates across provider settings." Exhibit 33, MedPAC, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 16-17.

Based on these comments, CMS had more than enough information to know that the BNA was erroneous and unnecessary as early as FY 2016. In every rulemaking since FY 2016, commenters including the Providers explained to CMS that it erred when it failed to account for the outlier budget neutrality adjustment already applied to the IPPS comparable per diem amount when calculating the LTCH PPS site neutral outlier budget neutrality adjustment. See e.g., Exhibit 28, LifeCare Hospitals, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 10 ("CMS already reduced the FY 2017 site neutral payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor. CMS should *not* reduce LTCH site neutral payments by *another 5.1%*."); Exhibit 37, Vibra Healthcare, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 23 ("Since CMS has already made these adjustments for budget neutrality, it would be inappropriate for CMS to reduce LTCH site neutral payments that are based on the IPPS and capital PPS rates by *another 5.1%* for HCOs."); Exhibit 40, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 42 ("CMS already reduced the FY 2019 site neutral payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor.").

The D.C. Circuit has stated that CMS cannot continue using payment rates based on computational errors. See Exhibit 49, Cape Cod Hosp. v. Sebelius, 630 F.3d 203, 214-15 (D.C. Cir. 2011) ("[W]e never suggested that even after the error in the data on which the Secretary had relied was brought to her attention, she could have chosen to continue using the inaccurate

wage index in calculating future payments."). Here, CMS has continued setting the LTCH site neutral payment rate based upon an erroneous calculation that includes double the budget neutrality adjustment for HCO payments, even after MedPAC, the Providers, and others repeatedly brought the error to CMS' attention. Accordingly, CMS has committed a "clear error of judgment" by refusing to correct this error in the FY 2016, FY 2017, FY 2018 and FY 2019 IPPS/LTCH PPS Final Rules.

3. CMS' Decision to Apply a Second Outlier Budget Neutrality Adjustment to the LTCH Site Neutral Payment Rate is Not Supported by Substantial Evidence

CMS' duplicative budget neutrality adjustment should also be set aside because CMS' determination that a second adjustment is necessary to offset the cost of site neutral high cost outlier payments is not supported by substantial evidence. Pursuant to 5 U.S.C. § 706(2)(E) of the APA, a reviewing court is required to "hold unlawful and set aside agency action, findings, and conclusions found to be . . . unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of any agency hearing provided by statute." Exhibit 10, 5 U.S.C. § 706(2)(E). According to the Supreme Court, this substantial evidence test applies "when the agency action is taken pursuant to a rulemaking provision of the Administrative Procedure Act itself, 5 U.S.C. § 553 . . . ." Exhibit 11, Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 414 (1971), abrogated on other grounds by Califano v. Sanders, 430 U.S. 99 (1977). CMS' duplicative budget neutrality adjustment at issue here was adopted through the APA's notice and comment rulemaking procedures. See Exhibit 15, 5 U.S.C. § 553.

Substantial evidence supports the agency's action when there is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Banner Health v. Sebelius, 715 F. Supp. 2d 142, 153 (D.D.C. 2010). No such evidence exists here to support

CMS' decision to apply a second outlier budget neutrality adjustment to the LTCH site neutral payment rate. CMS claims that this second budget neutrality adjustment is necessary "to ensure estimated HCO payments payable for site neutral payment rate cases in FY 2019 would not result in any increase in estimated aggregate FY 2019 LTCH PPS payments . . . ." Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. at 41737. However, CMS offers no evidence in support of its claim that this second budget neutrality adjustment is *not* duplicative of the adjustment already applied to the IPPS payment rate used to determine the IPPS comparable per diem amount for LTCH site neutral cases. Instead, the evidence in the rulemaking record confirms that CMS is applying multiple outlier budget neutrality adjustments to the LTCH site neutral payment rate.

Specifically, the rulemaking record shows that CMS included the 5.1% budget neutrality adjustment to reduce the IPPS payment rate amount used for the IPPS comparable per diem amount before applying the separate negative 5.1% BNA. Id. at 41723, 41728. The site neutral payment rate for most LTCH site neutral cases is based on the IPPS comparable per diem amount. Exhibit 6, 42 U.S.C. § 1395ww(m)(6)(B)(ii)(I); Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. at 41737 ("[S]ite neutral payment rate cases would generally be paid based on an IPPS comparable per diem amount . . . ."). Because there is no evidence to contradict that this second budget neutrality adjustment is duplicative, it must be set aside.

4. CMS Did Not Provide a Sufficient Response to Comments Raising Major Issues Regarding the Duplicative BNA in the FY 2019 IPPS/LTCH PPS Final Rule

In addition to the substantive deficiencies with CMS' adoption of the site neutral budget neutrality adjustment, CMS' nominal response to comments in the FY 2019 IPPS/LTCH PPS Final Rule also violates the procedural requirements for notice and comment rulemaking at section 553(c) of the APA. The APA requires that the agency's response to comments, the basis

and purpose statement, "must identify 'what major issues of policy were ventilated by the informal proceedings and why the agency reacted to them as it did.'" Exhibit 21, St. James Hosp. v. Heckler, 760 F.2d 1460, 1469 (7th Cir. 1985) (citing Automotive Parts & Accessories Ass'n v. Boyd, 407 F.2d 330, 338 (D.C. Cir. 1968).

In St. James Hospital, the court held that a new Medicare regulation setting the formula for Medicare reimbursement of providers' malpractice insurance premiums violated APA section 553(c) because "the Secretary's basis and purpose statement did not adequately respond to the criticisms raised in the many adverse comments submitted on the Malpractice Rule in several respects." Id. at 1469. The court found that the Secretary did not even attempt to respond to comments asserting that the agency relied on a statistically unreliable study to support its rule. Id. Other comments criticized the regulation because "the Malpractice Rule's formula for reimbursing premium costs bears no relation to the actual premium costs incurred by hospitals on behalf of Medicare recipients." Id. at 1469-70. In the final rule, the Secretary issued only a two sentence response to these commenters' concerns. Id. at 1470. The court characterized the Secretary's response as "nonresponsive" and noted that the response ignored a key fact central to this issue. See id. As a result, the court determined that the Secretary violated APA section 553(c). Id. The court concluded:

> We agree with the district courts' conclusion that the Secretary's basis and purpose statement failed to respond to many significant points made by the public in opposition to the Malpractice Rule. **The Secretary's statement of basis and purpose provided no indication of why criticisms of the Westat study were deemed to be invalid, and failed to give a reasoned response to other criticisms of the Rule**. We therefore conclude that the Secretary failed to comply with section 553(c) of the APA.

Id. (emphasis added). In addition to finding that the malpractice rule violated APA section 553(c), the court also held that the rule must be set aside because the rule was arbitrary and

capricious and an abuse of discretion, it violated the Medicare Act's cost-shifting prohibition, and it violated the Medicare Act's mandate to reimburse hospitals for the "reasonable cost" of services provided to Medicare beneficiaries. See id. at 1469, 1472-73.

Here, CMS' three sentence response to commenters in the FY 2019 IPPS/LTCH PPS Final Rule shows that the agency is disregarding major issues with the budget neutrality adjustment raised by commenters. Just as the Secretary's response to comments in St. James Hospital made no effort to respond to comments regarding a statistically unreliable study, CMS' response here did not attempt to explain why the BNA is not duplicative. CMS only responded that it "continue[s] to disagree with the commenters that a budget neutrality adjustment for site neutral payment rate HCO payments is inappropriate, unnecessary, or duplicative" and referred readers to CMS' responses in prior years. Exhibit 2, 83 Fed. Reg. at 41738. There was no effort by CMS to develop a substantive response to the commenters and explain why the BNA is *not* duplicative of the adjustment already applied to the IPPS payment rate used to determine the IPPS comparable per diem amount for LTCH site neutral cases. In sum, CMS did not even attempt to explain why commenters' criticisms of the budget neutrality adjustment were invalid. See St. James Hosp., 760 F.2d at 1470. CMS' lack of a reasoned response to comments regarding the duplicative nature of the BNA therefore violates the procedural requirements for notice and comment rulemaking at section 553(c) of the APA.

The agency does not need to respond to every individual issue raised by commenters. See Auto. Parts & Accessories Ass'n v. Boyd, 407 F.2d 330, 338 (D.C. Cir. 1968) ("We do not expect the agency to discuss every item of fact or opinion included in the submissions . . . ."). However, the agency "must respond in a reasoned manner to those [comments] that raise significant problems." Reytblatt v. U.S. Nuclear Regulatory Comm'n, 105 F.3d 715, 722 (D.C.

Cir. 1997). Here, the Providers submitted comment letters to CMS identifying a "significant problem." That is, CMS is underpaying LTCH site neutral cases due to a duplicative outlier budget neutrality adjustment. The significance of this problem is only confirmed by the fact that many LTCH organizations, MedPAC, the AHA, and the FAH submitted comment letters to CMS objecting to the duplicative budget neutrality adjustment. Although CMS can disagree with comments, it cannot simply dismiss comments from MedPAC and others as insignificant. Accordingly, the unwarranted reduction to the LTCH site neutral payment rate that resulted from the duplicative BNA was a "significant problem" that required a substantive response from CMS. Unfortunately, CMS' response in the FY 2019 Final Rule and the referenced prior rules cannot be considered a substantive response. CMS has not shown that the challenged budget neutrality adjustment is the only 5.1% outlier budget neutrality adjustment to the LTCH site neutral payment rate.

5. There was no Congressional Approval or Ratification of the Duplicative BNA

As discussed above, CMS provides only a nominal response in the FY 2019 IPPS/LTCH PPS Final Rule to the comments submitted by the Providers and others. See Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. at 41737-38. Instead of taking a fresh look at the duplicative BNA, as requested by commenters, CMS' response in the FY 2019 Final Rule relies on citations to CMS' responses in prior years. Id. at 41738. One such citation was to CMS' response to comments on this issue in the FY 2017 IPPS/LTCH PPS Final Rule. See id. ("As we discussed in response to similar comments (82 FR 38545 through 38546, 81 FR 57308 through

57309, and 80 FR 49621 through 49622), we have the authority to adopt the site neutral payment rate HCO policy in a budget neutral manner.").[21]

In the FY 2017 Final Rule, cited by CMS in the FY 2019 Final Rule, CMS attempts to argue that Congress approved or otherwise ratified CMS' decision to apply the extra 5.1% budget neutrality adjustment to the LTCH site neutral payment rate. See Exhibit 4, FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. at 57308. Specifically, CMS defended the extra budget neutrality adjustment by arguing that "Congress was well aware of how we had implemented our HCO policy under the LTCH PPS under § 412.525 at the time of enactment of section 1206 of Public Law 113-67." Id. CMS also claimed that "Congress was also well aware of how we had implemented our 'IPPS comparable per diem amount' concept in the SSO context at the time of the enactment of section 1206 of Public Law 113-67" because CMS had "budget neutralized" estimated HCO payments for short stay outlier cases since 2006. Id. CMS asserted that "Congress left us the discretion to continue to treat the 'IPPS comparable per diem amount' in the site neutral payment rate context as we have historically done with respect to LTCH PPS HCO payments made to discharges paid using the 'IPPS comparable per diem amount.'" Id. However, the regulation CMS refers to in this FY 2017 rulemaking (42 C.F.R. § 412.529(d)(4)) does not specify a separate budget neutrality adjustment for high cost outlier or short stay outlier payments based upon the IPPS comparable per diem amount, and CMS does not state any other authority for this assertion. Therefore, it is difficult to see how Congress was "well aware" of this policy when it established the LTCH patient criteria and site neutral payment rate in the

21 As discussed above, the Providers are not challenging CMS' authority to apply an appropriate budget neutrality adjustment to account for the cost of LTCH site neutral outlier payments. Rather, the Providers are challenging CMS' decision to apply a second budget neutrality adjustment to the LTCH site neutral payment rate that effectively doubles the budget neutrality adjustment.

PSRA. CMS needs far greater evidence to conclude that Congress specifically authorized or ratified CMS' decision to apply a second outlier budget neutrality adjustment to the LTCH site neutral payment rate.

Congress did not specifically require a budget neutrality adjustment in the PSRA. Congress did include a reference to the short stay outlier policy at 42 C.F.R. § 412.529(d)(4) for calculating the IPPS comparable per diem amount. Exhibit 6, 42 U.S.C. § 1395ww(m)(6)(B)(ii)(I) (SSA § 1886(m)(6)(B)(ii)(I)). Congress also specified that the site neutral payment rate based on the IPPS comparable per diem amount must include high cost outlier payments under 42 C.F.R. § 412.525. Id. However, neither the statute itself, nor the referenced short stay outlier regulation (42 C.F.R. § 412.529(d)(4)), specifically requires a budget neutrality adjustment. Accordingly, the text of the PSRA does not suggest that Congress was "well aware" of CMS' budget neutrality adjustments to authorize the BNA at issue in these appeals.

Not only is there no Congressional authorization of the BNA in the statute, but there is no subsequent action from Congress ratifying the duplicative BNA. In Cape Cod Hosp. v. Sebelius, 630 F.3d 203 (D.C. Cir. 2011), Exhibit 49, the Secretary of the Department of Health and Human Services ("HHS") argued that Congress ratified her decision to "ignore mistakes made in calculating rural-floor budget neutrality adjustments for prior years." Id. at 214. The D.C. Circuit acknowledged that the "Supreme Court has stated that 'Congress is presumed to be aware of an administrative or judicial interpretation when it re-enacts a statute without change.'" Id. (quoting Merrill Lynch, Pierce, Fenner & Smith, Inc. v. Curran, 456 U.S. 353, 382 n.66 (1982)). However, the D.C. Circuit rejected the Secretary's contention that Congress ratified her interpretation because there was no Congressional reenactment of the statutory section at issue.

Id. The same is true here. There have been some "isolated amendments" to the LTCH site neutral statutory provisions of the SSA, but there has been no re-enactment by Congress of the LTCH site neutral payment provisions to argue that Congress ratified CMS' duplicative BNA. See Alexander v. Sandoval, 532 U.S. 275, 292 (2001) ("[W]hen Congress has not comprehensively revised a statutory scheme but has made only isolated amendments, . . . [i]t is impossible to assert with any degree of assurance that congressional failure to act represents affirmative congressional approval of the Court's statutory interpretation.") (internal quotation marks omitted).

Moreover, Congress has not "implicitly ratified" CMS' duplicative BNA. The D.C. Circuit in Cape Cod rejected the contention that Congress "implicitly ratified" the Secretary's position by failing to enact legislation overturning the Secretary's interpretation. Exhibit 49, Cape Cod Hosp., 630 F.3d at 214. The D.C. Circuit stated that "[p]resuming ratification based on congressional inaction is inappropriate 'absent some evidence of (or reason to assume) congressional familiarity with the administrative interpretation at issue.'" Id. (quoting Pub. Citizen, Inc. v. HHS, 332 F.3d 654, 669 (D.C. Cir. 2003)). The D.C. Circuit's 2011 decision in Cape Cod also explained that the agency's error, identified in 2006, was "simply of too recent vintage to presume that Congress has tacitly ratified CMS's interpretation by failing to overturn it." Id. Here, there is no evidence that Congress is familiar with CMS' duplicative BNA. None of the isolated amendments to the SSA's site neutral provisions have addressed outlier payments or budget neutrality. See Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 51005, 132 Stat. 64 (2018); 21st Century Cures Act, Pub. L. No. 114-255, §§ 15009(a), 15010(a), 130 Stat. 1033 (2016); Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 231, 129 Stat. 2242 (2015); Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, § 112(a), 128 Stat. 1040

(2014). Moreover, the erroneous BNA is even more recent than the error at issue in Cape Cod where the D.C. Circuit rejected implicit Congressional ratification because the error was "of too recent vintage." Cape Cod Hosp., 630 F.3d at 214. Thus, CMS cannot rely on any Congressional authorization or ratification to support the duplicative BNA.

6. CMS' Duplicative BNA Violates the Social Security Act and Other Federal Laws

CMS' decision to apply a second outlier budget neutrality adjustment to the LTCH site neutral payment rate violates several provisions of the SSA and other pieces of legislation. First, the duplicative budget neutrality adjustment violates the Federal statutes authorizing the LTCH PPS because it is not an "appropriate adjustment." Second, the adjustment is contrary to the SSA's authorization of only two payment rates for LTCH cases, the standard federal payment rate and the site neutral payment rate. Finally, the unwarranted budget neutrality adjustment violates the SSA's prohibition on cost-shifting.

a. The Extra BNA is Not an "Appropriate Adjustment"

In prior rulemakings, CMS has asserted that it has "ongoing authority to make annual HCO budget neutrality adjustments for payments under the LTCH PPS . . . using the broad authority provided by section 123 of Public Law 106-113 and section 307 of Public Law 106-554." Exhibit 4, FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. at 57308. However, CMS' exercise of this authority in applying the duplicative BNA is contrary to the statutory text.

Section 123 of the Balanced Budget Refinement Act of 1999 ("BBRA"), Pub. L. No. 106-113, 113 Stat. 1501 (1999), required CMS to develop and implement an LTCH PPS that "shall include an adequate patient classification system that is based on diagnosis-related groups (DRGs) and that reflects the differences in patient resource use and costs, and shall maintain

budget neutrality."[22] BBRA § 123(a)(1). Section 307 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"), Pub. L. No. 106-554, 114 Stat. 2763 (2000), states that the Secretary "may provide for appropriate adjustment to the long-term hospital payment system." BIPA § 307(b)(1). The duplicative budget neutrality adjustment that CMS applies to the LTCH site neutral payment rate is not an "appropriate adjustment."

CMS claims that it has the authority to implement the additional BNA and that the BNA is necessary because "estimated site neutral payment rate HCO payments should not result in any change in estimated aggregate LTCH PPS payments." Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. at 41737. We do not dispute that CMS generally possesses the authority under BBRA section 123 and BIPA section 307 to apply a budget neutrality adjustment to prevent LTCH high cost outlier payments from increasing aggregate LTCH payments. CMS applies such a budget neutrality adjustment to account for outlier payments for LTCH standard rate cases. Similarly, CMS applies a budget neutrality adjustment to the IPPS payment rate to account for IPPS outlier payments. However, CMS exceeded its statutory authority, in violation of BIPA section 307(b)(1), when it applied a duplicative BNA to the LTCH site neutral payment rate because this extra adjustment is not an "appropriate adjustment."

An "appropriate adjustment" to maintain budget neutrality for site neutral outlier payments would have achieved actual budget neutrality and ensured that LTCH site neutral outlier payments did not increase *or decrease* aggregate LTCH payments. This was already accomplished by the 5.1% outlier budget neutrality adjustment from IPPS rate setting that CMS

---

22 CMS interprets BBRA's "budget neutrality" requirement as applying only to the first year of the LTCH PPS. See FY 2013 IPPS/LTCH PPS Final Rule, 77 Fed. Reg. 53258, 53494 (Aug. 31, 2012) ("[I]t has been our consistent interpretation that the statutory requirement for budget neutrality applies exclusively to FY 2003 when the LTCH PPS was implemented.").

uses to calculate the IPPS comparable per diem amount for LTCH site neutral payments. This adjustment achieved the 5.1% offset (reduction) to LTCH site neutral payments equal to the target amount of LTCH site neutral outlier payments. The budget neutrality adjustment from the IPPS is arguably an "appropriate adjustment" to the LTCH site neutral payment rate. Any additional adjustment to LTCH site neutral payments to maintain budget neutrality due to LTCH site neutral outlier payments cannot be considered an "appropriate adjustment" under BIPA section 307(b)(1). Therefore, the extra 5.1% BNA at issue here violates BIPA section 307(b)(1). It is budget neutral in name only. Instead of ensuring that site neutral outlier payments do not cause any change in aggregate Medicare payments to LTCHs, this adjustment actually saves the Medicare program tens of millions of dollars every year. When Congress authorized CMS to make "appropriate adjustments" to the LTCH PPS, it could not have envisioned that CMS would apply a duplicative adjustment like the BNA at issue here. Accordingly, the adjustment must be set aside because it violates CMS' authority under BIPA section 307(b)(1) to apply "appropriate adjustments" to LTCH PPS payments.

b. CMS' Duplicative BNA Violates the Social Security Act's Dual-Rate Structure for the LTCH PPS

As discussed above, Congress established a new dual-rate payment structure under the LTCH PPS in section 1206 of the Pathway for SGR Reform Act of 2013. As of cost reporting periods beginning on or after October 1, 2015, this new dual-rate structure, at SSA section 1886(m)(6) requires, that CMS pay LTCHs one of two possible rates for Medicare Part A cases, either the standard Federal payment rate or the new site neutral payment rate.[23] CMS'

23 During the site neutral transition period, LTCH cases are paid either the standard Federal payment rate if the LTCH patient criteria are met or at the transitional blended payment rate if the
Continued on following page

implementation of the new dual-rate structure violates SSA section 1886(m)(6) because CMS has decided to pay LTCH site neutral cases a rate that is contrary to the statute.

Section 1886(m)(6)(B)(ii) of the SSA defines the "site neutral payment rate" as the lower of: (1) "the IPPS comparable per diem amount determined under paragraph (d)(4) of section 412.529 of title 42, Code of Federal Regulations, including any applicable outlier payments under section 412.525 of such title;" or (2) "100 percent of the estimated cost of the services involved." Exhibit 6, 42 U.S.C. § 1395ww(m)(6)(B)(ii) (SSA § 1886(m)(6)(B)(ii)). CMS is violating this provision of the SSA because CMS is paying LTCH site neutral cases a rate that is not contemplated by the statute. CMS' payment rate for LTCH site neutral cases includes the 5.1% reduction to the IPPS payment rate to account for the targeted 5.1% of LTCH site neutral cases that will be paid a HCO payment. CMS then reduces the LTCH site neutral payment rate by *another 5.1%* to account for the same 5.1% target amount of LTCH site neutral outlier payments. The Social Security Act, at section 1886(m)(6), does not authorize CMS' payment rate with this extra budget neutrality adjustment. Furthermore, the regulation cited in the statute, 42 C.F.R. § 412.529(d)(4), does not specify a separate budget neutrality adjustment for LTCH payments based upon the IPPS comparable per diem amount.

CMS has stated with regard to the dual rate LTCH PPS that it does "not have the authority to pay LTCH discharges that fail to meet the patient-level criteria for payment at the LTCH PPS standard Federal payment rate at a rate other than the site neutral payment rate . . . ." FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. at 57070. However, CMS is doing just that by applying the duplicative BNA. CMS is acting in direct contradiction of its own position on

---

Continued from previous page

LTCH patient criteria are not met. See Exhibit 6, 42 U.S.C. § 1395ww(m)(6)(B)(iii) (SSA § 1886(m)(6)(B)(iii)).

the dual rate LTCH PPS by paying LTCH site neutral cases a rate other than the site neutral payment rate contemplated by the statute. Furthermore, because CMS applies multiple budget neutrality adjustments to the site neutral payment rate, LTCHs may receive a lower Medicare payment for these cases than a short term acute care hospital would receive for the case under the IPPS. Therefore, the duplicative budget neutrality adjustment must be set aside because it is contrary to the SSA.

c. The Extra BNA Violates the Medicare Prohibition on Cost-Shifting

The Social Security Act prohibits CMS from shifting Medicare costs to non-beneficiaries (*i.e.*, "cost-shifting"). 42 U.S.C. § 1395x(v)(1)(A) (SSA § 1861(v)(1)(A)) ("[T]he necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered . . . ."). Courts have regularly recognized Medicare's cost-shifting prohibition (sometimes referred to as "anti-cross-subsidization provisions"). E.g., Abington Crest Nursing and Rehab. Ctr. v. Leavitt, 541 F. Supp. 2d 99, 106 (D.D.C. 2008); Foothill Hosp.-Morris L. Johnston Mem'l v. Leavitt, 558 F. Supp. 2d 1, 3 (D.D.C. 2008). In Howard Univ. v. Bowen, No. 85-3342, 1988 WL 33508 (D.D.C. Mar. 29, 1988), the D.C. District Court found that the cost-shifting prohibition superseded a contrary Medicare regulation, stating ". . . the Secretary failed to note that the prohibition against cost-shifting is not merely a general regulation, but, as noted above, is an integral part of the Medicare statute itself and has been so found by numerous courts." Id. at *2.

Here, CMS' decision to apply a second outlier budget neutrality adjustment to the LTCH site neutral payment rate violates the statutory prohibition on cost-shifting under 42 U.S.C. § 1395x(v)(1)(A)(i) because it results in Medicare costs being shifted to non-Medicare beneficiaries. Applying this duplicative budget neutrality adjustment reduces aggregate LTCH

payments by approximately $28 million per year. See Exhibit 43, American Hospital Association, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 6. This is a windfall for the Medicare program that violates the Social Security Act's cost-shifting prohibition.

For the reasons discussed above, the duplicative outlier budget neutrality adjustment should be set aside because it violates the Social Security Act and other federal laws (*i.e.*, BIPA § 307(b)(1)). As a result of these statutory violations, the budget neutrality adjustment also must be set aside under the APA because the adjustment is "not in accordance with the law." Exhibit 10, 5 U.S.C. § 706(2)(A).

V. CONCLUSION

In order to grant the relief the Providers are requesting in these appeals, the PRRB would have to set aside the duplicative BNA. Such action is beyond the scope of the PRRB's authority. The Board is not authorized to create new Medicare regulations or policies or extend, limit, or modify the application of existing regulations or policies to address the legal challenge the Providers raise. Therefore, expedited judicial review is appropriate for the resolution of this matter. Because the Providers meet all of the requirements for EJR, the Board should grant the Providers' Request for EJR without delay.

Respectfully Submitted,

Jason M. Healy, Esq.
THE LAW OFFICES OF
JASON M. HEALY PLLC
1750 Tysons Boulevard
Suite 1500
McLean, VA 22012
(703) 712-4744

Attorney for the Providers

January 2, 2019

CERTIFICATE OF SERVICE

We hereby certify that on this 2nd day of January, 2019, the attached Providers' Request for Expedited Judicial Review was served by email to:

Bill Lange, WPS (by email to appealsprrb@wpsic.com)

Christopher R. Smith, Novitas (by email to CostReportAppeals@novitas-solutions.com)

Wilson C. Leong, Esq., FSS (by email to board@fssappeals.com)

Jason M. Healy

Jason M. Healy, Esq.

19-0407GC
MBS
11/28/18

The Law Offices of
Jason M. Healy PLLC

1750 Tysons Boulevard
Suite 1500
McLean, VA 22102
703-712-4744
Fax 888-503-1585
jhealy@healylawdc.com

RECEIVED

NOV 21 2018

PROVIDER REIMBURSEMENT
REVIEW BOARD

November 20, 2018

BY FEDERAL EXPRESS OVERNIGHT

Chairman
Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207

Re: INITIAL GROUP APPEAL REQUEST, SCHEDULE OF PROVIDERS & REQUEST FOR EXPEDITED JUDICIAL REVIEW

Group Case Name: LTCH 2019 Site Neutral Outlier Budget Neutrality Adjustment Group
FY: 2019
Lead MAC: Wisconsin Physicians Service

Dear Chairman:

Enclosed please find an initial group appeal request for the LTCH 2019 Site Neutral Outlier Budget Neutrality Adjustment Group. The Providers in this group are challenging a budget neutrality adjustment published in the August 17, 2018 FY2019 IPPS/LTCH PPS Final Rule. This request is timely filed within 180 days using the enclosed "Model Form B" for requesting a group appeal, as set forth by the Board. Also enclosed is the Schedule of Providers for this group with the supporting jurisdictional documentation for each Provider. The total amount in controversy is approximately $9,388,544.

Pursuant to PRRB Rule 19.1, we are also notifying the Board that this optional group is now fully formed. Per PRRB Rule 19.4, Wisconsin Physicians Service is the Lead MAC because it services the greatest number of Providers in this group.

Additionally, enclosed is the Providers' **Request for Expedited Judicial Review** and exhibits.

Because the Office of Hearings Case and Document Management System ("OH CDMS") cannot accommodate the Schedule of Providers with jurisdictional documents, we are submitting this letter, Model Form B, the Schedule of Providers and the Request for Expedited Judicial Review in hard copy by overnight mail to the PRRB and Wisconsin Physicians Service. Copies of the same documents have been sent to the MAC appeal representative, Federal Specialized Services, except the Schedule of Providers does not include jurisdictional documents per PRRB Rule 20.1.

The Law Offices of
Jason M. Healy PLLC

Please direct all correspondence to me at the above address. If you have any questions or need any additional information, please contact me directly at 703-712-4744.

Sincerely,

Jason M. Healy

Jason M. Healy

Enclosures

cc: Byron Lamprecht
Wisconsin Physicians Service
Cost Report Appeals
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

Wilson C. Leong, Esq.
Federal Specialized Services
1701 S. Racine Avenue
Chicago, IL 60608-4058

RECEIVED
NOV 21 2018
PROVIDER REIMBURSEMENT REVIEW BOARD

Appendix B: Model Form B – Group Appeal Request

All appeal requests and subsequent correspondence may be filed through the Office of Hearings Case and Document Management System. *See* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing.html. The Board strongly encourages the use of OH CDMS, but model forms are available for reference purposes.

General Information

Select the type of group.

☑ **Optional Group**

☐ **Common Issue Related Party ("CIRP") Group**

Electronic forms for both group types are accessible from the PRRB Home page in OH CDMS.

Parent Information

(Applicable to CIRP groups only)

Parent Organization: _____

Street Address: _____

City, State and ZIP: _____

Representative Information

Name: Jason M. Healy, Esq.

Title: Principal

Organization: The Law Offices of Jason M. Healy PLLC

Address: 1750 Tysons Boulevard, Suite 1500

City, State and ZIP: McLean, VA 22102

Telephone Number: 703-712-4744

E-mail Address: jhealy@healylawdc.com

Issue Information

Issue Title: LTCH 2019 Site Neutral Outlier Budget Neutrality Adjustment Group

Attach Issue Statement.

Is this appeal based on a Federal Register Notice? Yes

If yes, enter **Federal Fiscal Year:** 2019

If no, enter **Calendar Year:** _____

Lead MAC Information

MAC Code: J8

MAC Name: Wisconsin Physicians Service

For additional information regarding the MACs, please see Medicare Administrative Contractors from CMS.gov. For information regarding Lead MAC selection, *see* Rule 19.

Group Participants

For each participant being transferred into this group, complete a transfer request (see Model Form D).

For each participant being directly added into this group from its final determination, complete a direct add request (see Model Form E).

Attach Representation Letters for each provider.

Please see the enclosed Schedule of Providers with all required jurisdictional documents for the providers in this group.

Certifications

Check each box to accept the following certification statements.

☑ I certify that the group issue filed in this appeal is not pending in any other appeal for the same period for the same providers, nor has it been adjudicated, withdrawn, or dismissed from any other PRRB appeal.

☑ APPLICABLE TO OPTIONAL GROUPS ONLY
I certify to the best of my knowledge that there are no other providers to which these participating providers are related by common ownership or control that have a pending request for a Board hearing on the same issue for a cost reporting period that ends in the same calendar year covered in this request. *See* 42 C.F.R. § 405.1837(b)(1)(i).

☑ I certify that I have read and am familiar with Board statutes, regulations, and rules and, to the best of my knowledge, the appeal is filed in full compliance with such statutes, regulations, and rules.

☑ I certify that I am authorized to submit an appeal on behalf of the listed providers.

Signature: Jason M. Healy

Printed Name: Jason M. Healy

Date: November 20, 2018

STATEMENT OF THE ISSUE

LTCH 2019 Site Neutral Outlier Budget Neutrality Adjustment Group

Group Appeal Issue:

Whether the Centers for Medicare & Medicaid Services ("CMS") incorrectly applied the negative 5.1 percent outlier budget neutrality adjustment twice to Long-Term Care Hospital Prospective Payment System ("LTCH PPS") site neutral case payments in violation of the Administrative Procedure Act ("APA"), the Social Security Act ("SSA"), and other Federal laws.

Date of Determination:

The final agency determination is the FY 2019 IPPS/LTCH PPS Final Rule published in the Federal Register on August 17, 2018. See FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. 41144 (Aug. 17, 2018).

Amount in Controversy:

The amount in controversy in this appeal is approximately $9,388,544.

Statement Identifying Legal Basis for the Appeal:

The Providers assert that CMS violated sections 553 and 706 of the APA, sections 1886(m)(6) and 1861(v)(1)(A) of Title XVIII of the SSA (the Medicare Act), section 123 of the Balanced Budget Refinement Act of 1999 ("BBRA"), Pub. L. No. 106-113, and section 307 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"), Pub. L. No. 106-554, when the agency adopted a duplicative budget neutrality adjustment ("BNA") for LTCH site neutral cases in the FY 2019 IPPS/LTCH PPS Final Rule. This BNA is unwarranted because CMS *already* applied an equivalent budget neutrality adjustment to reduce the IPPS payment rate by the same 5.1%, before using that rate to determine the IPPS comparable per diem amount for LTCH site neutral cases. Comments submitted to CMS in response to the FY 2019 IPPS/LTCH PPS Proposed Rule explained this error to CMS in detail. Despite receiving these comments, CMS adopted the duplicative BNA in the Final Rule. CMS' dismissive response to comments in the Final Rule shows that the agency has not taken a "hard look" at this issue and has failed to meaningfully consider this problem. This is a textbook violation of the arbitrary and capricious standard under the APA. Accordingly, this duplicative BNA finalized in the FY 2019 IPPS/LTCH PPS Final Rule must be set aside, and the agency must be ordered to remove the duplicative BNA from past and future payment years.

The Board has jurisdiction over this appeal pursuant to 42 C.F.R. §§ 405.1837 and 405.1840. The Board has jurisdiction to hear a direct appeal from a Final Rule promulgated through the rulemaking process. See Cape Code Hospital, et. al. v.

Sebelius, 677 F.Supp. 2d 18, 25 (D.D.C. 2009), rev'd on different grounds; see also Washington Hospital Center v. Bowen, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year end cost report is not a report necessary in order for the Secretary to make PPS payments, and the appeals provisions applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal"). Here, the Providers are challenging the separate budget neutrality adjustment for site neutral high cost outlier payments that CMS promulgated in the FY 2019 IPPS/LTCH PPS Final Rule.

For LTCH Part A discharges in cost reporting periods beginning on or after October 1, 2015, Medicare began to reimburse LTCHs using a dual-rate LTCH PPS structure, with two distinct payment rates. The first payment rate is the LTCH PPS standard Federal payment rate. This first payment rate only applies to discharges that meet one of the two patient criteria established by the Pathway for SGR Reform Act of 2013 (Pub. Law 113-67, Div. B)—3 or more days in a "subsection (d) hospital" intensive care unit (ICU) immediately preceding the LTCH admission, or LTCH ventilator services of at least 96 hours directly following a "subsection (d) hospital" stay. All other LTCH Part A discharges are reimbursed at a site neutral payment rate, which is the lesser of the IPPS comparable per diem amount (including any applicable outlier payments) or 100 percent of the estimated cost of the case. The IPPS comparable per diem amount is calculated by adding the adjusted standardized IPPS operating amount to the adjusted capital IPPS Federal rate, divided by the geometric average length of stay of the specific MS-DRG under the IPPS, and multiplying that amount by the covered days of the LTCH stay, but no higher than the full IPPS payment amount. See FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49,326, 49,608-09 (Aug. 17, 2015). LTCHs are transitioning to the site neutral payment rate with a blended payment rate for site neutral discharges in cost reporting periods beginning on or after October 1, 2015 and on or before September 30, 2019. During this transition period, the blended payment rate for site neutral cases is an amount equal to one-half the site neutral payment rate and one-half the standard LTCH PPS standard Federal payment rate. FY 2019 is the last year of the transition period. LTCH site neutral case discharges on or after October 1, 2019 will be paid at 100 percent of the site neutral payment rate.

Like LTCH cases that are paid the standard Federal payment rate, site neutral cases paid at the IPPS comparable per diem amount may include a LTCH outlier payment. Specifically, LTCH site neutral payment rate cases may receive an additional high cost outlier ("HCO") payment in an amount equal to 80% of the estimated cost of the case above the HCO threshold. Each fiscal year since the new dual-rate payment structure went into effect, CMS implemented a HCO threshold for LTCH site neutral payment rate cases that is separate and distinct from the HCO threshold used for LTCH standard Federal payment rate cases. The HCO threshold is equal to the LTCH payment for the case plus a fixed-loss amount. For LTCH site neutral cases, CMS uses the IPPS fixed-loss amount because the agency believes that LTCH site neutral cases are substantially the same as IPPS cases. There is no additional HCO payment for site neutral payment rate cases that are paid at 100 percent of the estimated cost of the case.

In the FY 2019 IPPS/LTCH PPS Final Rule, CMS finalized a budget neutrality factor (adjustment) for all site neutral payment rate cases so that HCO payments for such cases do not result in any change in estimated aggregate LTCH payments. FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. 41144, 41737-38 (Aug. 17, 2018). In FY 2019, CMS will apply a budget neutrality factor of 0.949 to reduce the site neutral payment rate portion of the LTCH PPS blended payment rate (not including any outlier payment). This results in a 5.1% reduction to the site neutral portion of the blended payment rate. An identical budget neutrality adjustment was applied to site neutral case payments in FYs 2016 through 2018. See FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49,326, 49,617-22 (Aug. 17, 2015); FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. 56,762, 57,306-09 (Aug. 22, 2016); FY 2018 IPPS/LTCH PPS Final Rule, 82 Fed. Reg. 37,990, 38,544-46 (Aug. 14, 2017).

CMS believes that a separate budget neutrality adjustment for LTCH site neutral HCO cases will "reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems." 83 Fed. Reg. at 41737. However, by aligning this policy with the IPPS payment system—and making the IPPS comparable per diem amount and the IPPS fixed-loss amount the primary components—CMS failed to account for the adjustments that it has *already* made to the operating and capital cost components of the IPPS payment rate for outlier payments. Specifically, CMS *already reduced* the operating standardized payment amount under the IPPS by a factor of 0.948999 and the capital federal rate under the capital PPS by a factor of 0.949431 for outliers. 83 Fed. Reg. at 41723. These outlier adjustment factors already reduce the IPPS comparable per diem amount for LTCH site neutral case payments by 5.1%. 83 Fed. Reg. at 41723-24. The challenged BNA then reduces LTCH site neutral case payments by *another* 5.1% for outlier budget neutrality.

As noted above, CMS first adopted the duplicative BNA during the FY 2016 rulemaking. 80 Fed. Reg. at 49617-22 (Aug. 17, 2015). In the FY 2016 IPPS/LTCH PPS Final Rule, CMS acknowledged that it received comments, including comments from the Medicare Payment Advisory Commission (MedPAC), objecting to this BNA because the BNA was duplicative and would result in savings for the Medicare program. Id. at 49622. However, CMS finalized the BNA for FY 2016 despite receiving these comments. The same process played out in FYs 2017 and 2018—CMS proposed a duplicative BNA, commenters objected, and CMS finalized the adjustment despite commenters' explanations of CMS' error.

Commenters again objected to the BNA in the FY 2019 IPPS/LTCH PPS Proposed Rule. Commenters said that the BNA improperly reduces LTCH site neutral payments because the IPPS comparable per diem amount is calculated using the adjusted IPPS payment rate that already includes a 5.1% outlier budget neutrality adjustment. CMS' response to the concerns raised by commenters consists of three sentences in the Final Rule. See 83 Fed. Reg. 41738. CMS says it disagrees with commenters, it has the authority to implement the HCO policy in a budget neutral manner, and the BNA is appropriate. CMS' response does not indicate that it took a "fresh look" at this issue, as requested by commenters. Instead, CMS' response in the FY 2019 Final Rule relies on references back to CMS'

responses in the FY 2016, FY 2017, and FY 2018 IPPS/LTCH PPS Final Rules. See id. ("As we discussed in response to similar comments (82 FR 38545 through 38546, 81 FR 57308 through 57309, and 80 FR 49621 through 49622), we have the authority . . . .").

CMS' decision to apply a duplicative BNA in FY 2019 must be set aside because it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" (5 U.S.C. § 706(2)(A)), "without observance of procedure required by law" (5 U.S.C. § 706(2)(D)), and "unsupported by substantial evidence" (5 U.S.C. § 706(2)(E)).

The Administrative Procedure Act's arbitrary and capricious standard under section 706(A) requires that, at a minimum, the "agency must examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.'" Motor Vehicle Mfrs. Ass'n of the U.S., Inc. v. State Farm Mut. Auto. Ins., 463 U.S. 29, 43 (1983) (quoting Burlington Truck Lines v. United States, 371 U.S. 156, 168 (1962)). An agency's rule is arbitrary and capricious if it "entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." Id.

To survive arbitrary and capricious review under the APA, an agency's "exercise of its authority must be 'reasonable and reasonably explained.'" U.S. Postal Serv. v. Postal Regulatory Comm'n, 785 F.3d 740, 750 (D.C. Cir. 2015) (quoting Mfrs. Ry. Co. v. Surface Transp. Bd., 676 F.3d 1094, 1096 (D.C.Cir.2012)). An agency acts arbitrarily and capriciously under the APA if "the agency has not really taken a 'hard look' at the salient problems, and has not genuinely engaged in reasoned decision-making." Greater Boston Television Corp. v. F.C.C., 444 F.2d 841, 851 (D.C. Cir. 1970).

In addition, an agency's decision is arbitrary and capricious if it is "internally inconsistent and inadequately explained." District Hosp. Partners v. Burwell, 786 F.3d 46, 59 (D.C. Cir. 2015) (citing General Chem. Corp. v. United States, 817 F.2d 844, 846 (D.C. Cir. 1987). Agency action is also arbitrary and capricious if the agency's decision reflects "a clear error of judgement." Citizens to Preserve Pres. Overton Park, Inc. v. Volpe, 401 U.S. 402, 416 (1971).

CMS' decision to apply the duplicative BNA for FY 2019 LTCH site neutral outlier cases is a textbook violation of the APA's arbitrary and capricious standard. The agency fails to acknowledge that this BNA is duplicative because the IPPS comparable per diem amount for LTCH site neutral payments already includes outlier adjustment factors that reduce site neutral payments by 5.1% for outlier payments. As a result, the agency has disregarded almost universal criticism, including by MedPAC, that a separate 5.1% LTCH BNA is erroneous. It improperly doubles the payment reduction, resulting in underpayments to LTCHs and a windfall for the Medicare program. CMS has thus "entirely failed to consider an important aspect of the problem" because the agency refuses to recognize the duplicative BNA, see State Farm Mut. Auto. Ins., 463 U.S. at 43, and CMS has committed a "clear error of judgment" by refusing to correct this error in

the FY 2019 IPPS/LTCH PPS Final Rule, see Citizens to Preserve Pres. Overton Park, Inc. v. Volpe, 401 U.S. 402, 416 (1971). Therefore, this unreasonable BNA must be invalidated and set aside as arbitrary and capricious.

CMS' duplicative BNA should also be set aside because CMS' determination that a second adjustment is necessary to offset the cost of site neutral high cost outlier payments is not supported by substantial evidence. The APA requires agency actions, findings, and conclusions to be set aside if they are unsupported by substantial evidence. 5 U.S.C. § 706(2)(E). Substantial evidence supports the agency's action when there is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Banner Health v. Sebelius, F. Supp. 2d 142, 153 (D.D.C. 2010). No such evidence exists here to support CMS' decision to apply a second BNA. CMS claims that this second BNA is necessary "to ensure estimated HCO payments payable for site neutral payment rate cases in FY 2019 would not result in any increase in estimated aggregate FY 2019 LTCH PPS payments . . . ." FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. at 41737. However, CMS offers no evidence in support of its claim that this second BNA is *not* duplicative of the adjustment already applied to the IPPS payment rate used to determine the IPPS comparable per diem amount for LTCH site neutral cases. Instead, the evidence in the rulemaking record only confirms that CMS is applying multiple BNAs to the LTCH site neutral payment rate.

CMS' response to comments in the FY 2019 IPPS/LTCH PPS Final Rule does not comply with the APA's procedural requirements for notice and comment rulemaking at section 553(c). The APA requires that the agency's response to comments (the basis and purpose statement) identify "what major issues of policy were ventilated by the informal proceedings and why the agency reacted to them as it did." St. James Hospital v. Heckler, 760 F.2d 1460, 1469 (7th Cir. 1985) (citing Automotive Parts & Accessories Ass'n v. Boyd, 407 F.2d 330, 338 (D.C. Cir. 1968). Here, CMS' three sentence response to commenters shows that the agency is disregarding the basic duplication inherent in a separate HCO budget neutrality adjustment for LTCH site neutral cases. The response is so brief, that it is impossible to discern "why the agency reacted to [the major issues] as it did." See id. However, even if the agency were to cure these procedural defects, it would not remedy the injury to the Providers. The Providers would still be unfairly subject to the duplicative BNA. The only remedy is to invalidate and set aside the extra 5.1% budget neutrality adjustment.

CMS' decision to apply a second BNA also violates the SSA and other federal laws. First, the duplicative BNA violates the BBRA section 123 and BIPA section 307 because the BNA is not an "appropriate adjustment." Second, the adjustment is contrary to the dual rate structure for LTCHs provided for at section 1886(m)(6) of the SSA. CMS' implementation of the new dual-rate structure violates SSA section 1886(m)(6) because CMS has decided to apply the duplicative BNA and therefore pay LTCH site neutral cases a rate that is contrary to the statute. Finally, the unwarranted budget neutrality adjustment violates the SSA's prohibition on cost-shifting at section 1861(v)(1)(A) because the BNA results in Medicare costs being shifted to non-Medicare beneficiaries.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD

LTCH 2019 SITE NEUTRAL OUTLIER BUDGET NEUTRALITY ADJUSTMENT GROUP Provider Nos. Various Fiscal Year 2019 Providers, v. WISCONSIN PHYSICIANS SERVICE Intermediary.	RECEIVED NOV 21 2018 PROVIDER REIMBURSEMENT REVIEW BOARD PRRB Case No. [to be assigned]

PROVIDERS' REQUEST FOR EXPEDITED JUDICIAL REVIEW

Jason M. Healy, Esq.
THE LAW OFFICES OF
JASON M. HEALY PLLC
1750 Tysons Boulevard
Suite 1500
McLean, VA 22012
(703) 712-4744

Attorney for the Providers

Table of Contents

Table of Authorities

Cases

Statutes

Regulations

Rules

Index of Exhibits

The 101 providers in this group appeal ("Providers") are Medicare certified long-term acute care hospitals ("LTCHs") operated by LifeCare Health Partners ("LifeCare"), Post Acute Medical ("Post Acute"), Vibra Healthcare ("Vibra"), and Kindred Healthcare ("Kindred") that submit this Request for Expedited Judicial Review ("EJR"). Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842, the Provider Reimbursement Review Board ("PRRB" or the "Board") should grant the Providers' Request for EJR for the following reasons: (1) the Providers submitted a timely request to appeal a matter in controversy exceeding the $50,000 threshold for a group appeal; (2) there are no material facts in dispute; (3) the issue in this case requires a determination of the validity of a budget neutrality adjustment that CMS applies to the site neutral portion of the LTCH prospective payment system blended payment rate; and (4) the PRRB lacks the authority to decide this issue and grant the relief the Providers are requesting.

I. STATEMENT OF THE ISSUE

Whether the Centers for Medicare & Medicaid Services ("CMS") incorrectly applied the negative 5.1 percent outlier budget neutrality adjustment twice to Long-Term Care Hospital Prospective Payment System ("LTCH PPS") site neutral case payments in violation of the Administrative Procedure Act ("APA"), the Social Security Act ("SSA"), and other federal laws.

II. LEGAL BACKGROUND

A. LTCH PPS

Under the Medicare program, different payment methodologies are used to reimburse different types of providers. The Medicare reimbursement system for LTCHs, the LTCH prospective payment system ("LTCH PPS"), is based on different levels of cost than the system applicable to general acute care hospitals. For general acute care hospitals, Medicare inpatient costs are reimbursed under the inpatient hospital prospective payment system ("IPPS") in which a hospital receives a fixed payment amount per discharge (adjusted for area wage differences)

using Medicare severity diagnosis related groups ("MS-DRGs").[1] The general acute care hospital MS-DRG payment rate is based on the national average cost of treating a Medicare patient's condition in that type of facility. Although the average length of stay varies for each MS-DRG, the average stay of all Medicare patients in a general acute care hospital is approximately six days. Thus, the prospective payment system for general acute care hospitals is not designed to reimburse hospitals on a regular basis for long-stay hospital care.

For a hospital to be reimbursed under the LTCH PPS, by contrast, it must have an average Medicare inpatient length of stay that is greater than twenty-five days, which reflects the medically complex cases treated in LTCHs. Each patient discharged from a LTCH is assigned to a distinct Medicare severity long-term care diagnosis related group ("MS-LTC-DRG"),[2] and the LTCH is generally paid a predetermined fixed amount applicable to the assigned MS-LTC-DRG (adjusted for area wage differences). The payment amount for each MS-LTC-DRG is intended to reflect the average cost of treating a Medicare patient assigned to that MS-LTC-DRG in a LTCH.

Weights are assigned to MS-DRGs and MS-LTC-DRGs on an annual basis that are multiplied against a Federal standard rate to arrive at the payment for the discharged patient, after taking other adjustments into consideration. See 42 C.F.R. §§ 412.515, 412.521. Most of the MS-LTC-DRGs for LTCHs are the same as the MS-DRGs for general acute care hospitals, but the weights are generally higher. In addition, the Federal standard rate has been much

---

1 The IPPS final rule for FY 2008 refined the DRG patient classification system to take into account the severity of the patient's condition for the first time. See 72 Fed. Reg. 47130 (Aug. 22, 2007). These Medicare-severity DRGs or "MS-DRGs" were created to account for complications or comorbidities. Id.

2 The IPPS final rule for FY 2008 also created Medicare-severity DRGs for LTCH PPS, referred to as "MS-LTC-DRGs". See 72 Fed. Reg. 47130 (Aug. 22, 2007).

greater for LTCHs than for general acute care hospitals: $41,558.68 under the LTCH PPS for FY 2019, see Exhibit 51, 83 Fed. Reg. 49836, 49847 (Oct. 3, 2018) (correction notice), compared to approximately $6,000 under the IPPS for FY 2019, see id. at 49844-45 (operating and capital rates combined).

B. Site Neutral Payment

For LTCH Part A discharges in cost reporting periods beginning on or after October 1, 2015, Congress established a new dual-rate payment structure under the LTCH PPS, with two distinct payment rates. Exhibit 6, 42 U.S.C. § 1395ww(m)(6) (SSA § 1886(m)(6)). The first payment rate is the LTCH PPS standard Federal payment rate. Id. at § 1395ww(m)(6)(A)(ii) (SSA § 1886(m)(6)(A)(ii)). This first payment rate only applies to discharges that meet one of the two patient criteria established by section 1206 of the Pathway for SGR Reform Act of 2013 ("PSRA"), Pub. L. No. 113-67, Div. B, 127 Stat. 1165 (2013)[3]—3 or more days in a "subsection (d) hospital"[4] intensive care unit ("ICU") or LTCH ventilator services of at least 96 hours—and a principal diagnosis that is not psychiatric or rehabilitation. Id. at §§ 1395ww(m)(6)(A)(ii),(iii),(iv) (SSA § 1886(m)(6)(A)(ii),(iii),(iv)). All other LTCH Part A discharges are reimbursed at the site neutral payment rate, which is the lesser of the IPPS comparable per diem amount (including any applicable outlier payments) or 100 percent of the

3 Congress has amended Section 1206 of the Pathway for SGR Reform Act of 2013 on several occasions. However, none of the amendments are at issue in this appeal. See Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 51005, 132 Stat. 64 (2018); 21st Century Cures Act, Pub. L. No. 114-255, §§ 15009(a), 15010(a), 130 Stat. 1033 (2016); Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 231, 129 Stat. 2242 (2015); Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, § 112(a), 128 Stat. 1040 (2014).

4 A reference to section 1861(d)(1)(B) of the SSA (42 U.S.C. § 1395x(d)(1)(B)). These are primarily general short-term acute care hospitals paid by Medicare under the IPPS.

estimated cost of the services involved. Id. at § 1395ww(m)(6)(B)(ii) (SSA § 1886(m)(6)(B)(ii)).

CMS implemented the site neutral payment rate through the regulation at 42 C.F.R. § 412.522. Exhibit 7. The IPPS comparable per diem amount used for determining LTCH site neutral payments is calculated by adding the adjusted standardized IPPS operating amount to the adjusted capital IPPS Federal rate, divided by the geometric average length of stay of the specific MS-DRG under the IPPS, and multiplying that amount by the covered days of the LTCH stay, but no higher than the full IPPS payment amount. Exhibit 5, FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326, 49608-09 (Aug. 17, 2015).

LTCHs are transitioning to the new LTCH PPS dual-rate structure with a blended payment rate that applies to site neutral case discharges in cost reporting periods beginning on or after October 1, 2015 and on or before September 30, 2019. Exhibit 6, 42 U.S.C. § 1395ww(m)(6)(B)(i)(I) (SSA § 1886(m)(6)(B)(i)(I)). During this transition period, the blended payment rate for site neutral cases is equal to one-half the site neutral payment rate and one-half of the LTCH PPS standard Federal payment rate. Id. at § 1395ww(m)(6)(B)(ii) (SSA § 1886(m)(6)(B)(ii)). FY 2019 is the last year of the transition period. LTCH site neutral case discharges on or after October 1, 2019 will be paid at 100 percent of the site neutral payment rate.

C. High Cost Outlier Payments

In addition to the standard Federal payment rate for a Medicare discharge, Medicare makes additional payments for high cost outlier ("HCO") cases that have extraordinarily high costs relative to the costs of most discharges. These high cost outlier payments are a feature of both the IPPS and the LTCH PPS. Exhibit 9, 42 U.S.C. § 1395ww(d)(5)(A)(ii) (SSA § 1886(d)(5)(A)(ii)); Exhibit 8, 42 C.F.R. § 412.525(a)(1). CMS sets a threshold each year at the

maximum loss that a provider can incur for a case with unusually high costs before the provider will receive an additional high cost outlier payment.

Like LTCH cases that are paid the standard Federal payment rate, site neutral cases paid at the IPPS comparable per diem amount may include a LTCH outlier payment. Exhibit 6, 42 U.S.C. § 1395ww(m)(6)(B)(ii)(I) (SSA § 1886(m)(6)(B)(ii)(I)). The HCO payment for site neutral cases is equal to 80% of the estimated cost of the case above the HCO threshold. Exhibit 8, 42 C.F.R. § 412.525(a)(3); Exhibit 2, 83 Fed. Reg. at 41734 ("[A]n LTCH receives 80 percent of the difference between the estimated cost of the case and the applicable HCO threshold, which is the sum of the LTCH PPS payment for the case and the applicable fixed-loss amount for such case."). Each fiscal year, CMS establishes a HCO threshold for site neutral payment rate cases that is separate from the HCO threshold used for standard LTCH Federal payment rate cases. See e.g., Exhibit 5, 80 Fed. Reg. at 49804 (establishing a $22,544 site neutral HCO threshold for FY 2016). For LTCH site neutral cases, the HCO threshold is the site neutral payment rate for the case plus the IPPS fixed-loss amount. Exhibit 2, 83 Fed. Reg. at 41734 ("For site neutral payment rate cases, we adopted the operating IPPS HCO target (currently 5.1 percent) and set the fixed-loss amount for site neutral payment rate cases at the value of the IPPS fixed-loss amount."). There is no additional HCO payment for site neutral payment rate cases that are paid at 100 percent of the estimated cost of the case. Exhibit 5, 80 Fed. Reg. at 49804 ("[A]ny site neutral payment rate case that is paid 100 percent of the estimated cost of the case (because that amount is lower than the IPPS comparable per diem amount) will not be eligible to receive a HCO payment because, by definition, the estimated costs of such cases would never exceed the IPPS comparable per diem amount by any threshold.").

III. MATERIAL FACTS

A. FY 2016 Rulemaking

CMS first implemented the site neutral payment rate for LTCHs during the FY 2016 IPPS/LTCH PPS rulemaking. In the FY 2016 IPPS/LTCH PPS Final Rule, CMS adopted a budget neutrality factor (adjustment) for the site neutral portion of the LTCH site neutral blended payment rate (the "BNA"). Exhibit 5, FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326, 49805 (Aug. 17, 2015). CMS claimed that this budget neutrality adjustment was necessary "to ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2016 do not result [in] any increase in estimated aggregate FY 2016 LTCH PPS payments . . . ." Id. CMS finalized this budget neutrality adjustment to reduce the LTCH site neutral payment rate amount by 5.1%. Id. In the same FY 2016 Final Rule, CMS also finalized high cost outlier budget neutrality adjustments of negative 5.1% to the IPPS operating standardized amount and approximately the same amount to the IPPS capital Federal rate.[5] Id. at 49785, 49794-95. The IPPS payment rate, as reduced by these IPPS outlier budget neutrality adjustments, is used to determine the IPPS comparable per diem amount under the LTCH PPS site neutral payment rate discussed above.

During the comment period for the FY 2016 LTCH PPS rulemaking, the Providers and other stakeholders submitted comments to CMS objecting to the BNA. The Providers explained to CMS that the proposed BNA was duplicative of the outlier budget neutrality adjustment already applied to the IPPS payment rate. For example, Kindred Healthcare, the parent company

5 Each year, the IPPS operating standardized amount budget neutrality adjustment is 5.1% and the IPPS capital outlier budget neutrality adjustment is approximately 5.1%. Accordingly, for the sake of clarity, this Request for Expedited Judicial Review will generally refer to both IPPS adjustments as a budget neutrality adjustment of 5.1%.

of many of the Providers in this group, and another LTCH company submitted a comment letter to CMS that stated:

> Specifically, CMS already reduced the operating standardized payment amount under the IPPS and the capital federal rate under the capital PPS for outliers. In determining these payment rates for FY 2016, CMS reduced the IPPS payment rate by a factor of 0.948999 and CMS reduced the capital PPS payment rate by a factor of 0.935731. **It would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed site neutral HCO BNA. This would be the case because the IPPS comparable per diem amount will be based on the FY 2016 IPPS payment rate, which has already been adjusted by the 5.1 percent outlier target. Since CMS has already reduced the FY 2016 IPPS payment rate by the 5.1 percent of estimated outlier payments in FY 2016, it would be inappropriate for CMS to reduce LTCH payments that are based on the IPPS rate again for site neutral cases that qualify as HCOs. Therefore, we object to CMS' proposal to apply a separate HCO BNA to LTCH site neutral payments.**

Exhibit 23, Kindred Healthcare, Inc. & Select Medical Holdings Corp., Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 39 (June 16, 2015), https://www.regulations.gov/contentStreamer?documentId=CMS-2015-0049-0222&attachmentNumber=1&contentType=pdf (footnote omitted). Post Acute and Vibra also submitted comments to CMS objecting to the duplicative budget neutrality adjustment. See Exhibit 24, Post Acute Medical, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 23-25 (June 16, 2015), https://www.regulations.gov/contentStreamer?documentId=CMS-2015-0049-0199&attachmentNumber=1&contentType=pdf; Exhibit 50, Vibra Healthcare, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 19-21 (June 15, 2015). Vibra's FY 2016 comment letter explained that Vibra objected to the BNA because the IPPS comparable per diem amount was already reduced by the same 5.1%. See Exhibit 50, Vibra Healthcare, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 21.

Leading hospital trade associations also submitted comments to CMS during the FY 2016 rulemaking opposing the erroneous BNA. The American Hospital Association ("AHA")

submitted a comment letter to CMS objecting to the "two outlier-related BNAs for site-neutral rates." Exhibit 25, American Hospital Association, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 7 (June 15, 2015), https://www.regulations.gov/contentStreamer?documentId=CMS-2015-0049-0121&attachmentNumber=1&contentType=pdf. The AHA explained:

> Specifically, the inpatient PPS rates used as the basis for site-neutral payment rates are already subject to a BNA for the inpatient PPS's 5.1 percent outlier pool. However, within the LTCH payment framework, CMS proposes a second BNA of 2.3 percent for the site-neutral outlier pool. CMS's rationale for this second BNA is to ensure that site-neutral HCO payments do not increase aggregate LTCH PPS payments. **However, we strongly disagree that the additional 2.3 percent BNA is necessary to achieve this goal; rather, it was already achieved when the 5.1 percent BNA was applied to the inpatient PPS rates used as the basis for the site-neutral rates. We recommend that CMS calculate standard LTCH PPS and site-neutral rates separately, without any co-mingling of these payments, as mentioned previously.** Furthermore, the second BNA prevents LTCH site-neutral payments from aligning with inpatient PPS payments for associated MS-DRG and MS-LTC-DRGs, which would counter the goals of BiBA.[6]

Id.

The Federation of American Hospitals ("FAH") submitted similar comments in response to the FY 2016 Proposed Rule. The FAH opposed the outlier budget neutrality adjustment for LTCH site neutral cases because "CMS has already accounted for estimated outlier payments for site neutral cases when it adjusted the IPPS payment rate for FY 2016." Exhibit 26, Federation of American Hospitals, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 67 (June

---

6 The AHA's FY 2016 comment letter references a 2.3% budget neutrality adjustment. CMS initially proposed a 2.3% adjustment in the FY 2016 Proposed Rule because CMS planned to apply a budget neutrality adjustment to all LTCH PPS payments. FY 2016 IPPS/LTCH PPS Proposed Rule, 80 Fed. Reg. 24324, 24649 (Apr. 30, 2015). However, in the FY 2016 Final Rule, CMS decided that it would instead apply a 5.1% adjustment only to the site neutral portion of the blended payment rate. See Exhibit 5, FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. at 49805.

16, 2015), https://www.regulations.gov/contentStreamer?documentId=CMS-2015-0049-0188&attachmentNumber=1&contentType=pdf. The FAH explained that because LTCH site neutral cases are already paid at the IPPS comparable rate, the additional budget neutrality adjustment is "an additional unwarranted reduction in payment." Id.

In the FY 2016 Final Rule, CMS acknowledged that it received comments objecting to the site neutral outlier budget neutrality adjustment. Exhibit 5, 80 Fed. Reg. at 49622. In response to these objections, CMS stated:

> We disagree with the commenters that a budget neutrality adjustment for site neutral payment rate HCO payments is unnecessary or duplicative. While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments, that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate. The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS. Without a budget neutrality adjustment when determining payment for a case under the LTCH PPS, any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases. Therefore, our proposed approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases. For these reasons, we are not adopting the commenters' recommendation to change the calculation of the IPPS comparable per diem amount to adjust the IPPS operating standardized amount used in that calculation to account for the application of the IPPS HCO budget neutrality adjustment.

Id. Despite admitting that the "HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS," CMS finalized the separate 5.1 percent reduction to the LTCH site neutral payment rate for the LTCH site neutral outlier budget neutrality adjustment. Id.

B. FY 2017 Rulemaking

A similar process played out during the FY 2017 LTCH PPS rulemaking. CMS proposed a 5.1% budget neutrality adjustment to the LTCH site neutral payment rate portion of the blended payment rate. FY 2017 IPPS/LTCH PPS Proposed Rule, 81 Fed. Reg. 24946, 25288-89 (Apr. 27, 2016). Commenters again responded that the proposed adjustment was flawed because CMS already reduced the IPPS comparable per diem amount to account for outlier payments. Kindred Healthcare,[7] LifeCare Hospitals,[8] Post Acute Medical,[9] and Vibra HealthCare[10] each submitted comments objecting to the proposed budget neutrality adjustment in the FY 2017 Proposed Rule. Kindred Healthcare included a table that clearly shows the duplication using the components of the site neutral payment rate. Exhibit 27 at 20-22, Table 1. Without making this change, the duplicative BNA not only "exaggerates the disparity in payment rates across provider settings," as MedPAC states, but it is also purely punitive. Id. at 22. The AHA[11] and FAH[12] also opposed the proposed site neutral budget neutrality adjustment in the FY 2017

---

7 Exhibit 27, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 18-25 (June 17, 2016), https://www.regulations.gov/contentStreamer?documentId=CMS-2016-0053-0521&attachmentNumber=1&contentType=pdf.

8 Exhibit 28, LifeCare Hospitals, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 7-11 (June 15, 2016), https://www.regulations.gov/contentStreamer?documentId=CMS-2016-0053-0315&attachmentNumber=1&contentType=pdf.

9 Exhibit 29, Post Acute Medical, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 14-21 (June 17, 2016), https://www.regulations.gov/contentStreamer?documentId=CMS-2016-0053-1262&attachmentNumber=1&contentType=pdf.

10 Exhibit 30, Vibra Healthcare, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 14-21 (June 17, 2016), https://www.regulations.gov/contentStreamer?documentId=CMS-2016-0053-0483&attachmentNumber=1&contentType=pdf.

11 Exhibit 31, American Hospital Association, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 5-8 (June 17, 2016), https://www.aha.org/system/files/advocacy-issues/letter/2016/160617-let-nickels-slavitt-ltch.pdf.

12 Exhibit 32, Federation of American Hospitals, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 48-49 (June 17, 2016),

Continued on following page

Proposed Rule. Many of these comments requested that CMS not only fix the erroneous calculation of the budget neutrality adjustment for FY 2017, but also correct the adjustment CMS applied in FY 2016 because the hospitals were systematically underpaid. See e.g., Exhibit 27, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 23 ("CMS must reverse this adjustment to all FY 2016 payments, or make an equivalent prospective increase in payments to FY 2017 site neutral rate cases to account for this underpayment.").

The Medicare Payment Advisory Commission ("MedPAC") also criticized the BNA. MedPAC's FY 2017 comment letter objected to the separate budget neutrality adjustment for LTCH site neutral high-cost outliers because, as the Providers and hospital trade associations were telling CMS, "the IPPS standard payment amount is already adjusted to account for HCO payments." Exhibit 31, MedPAC, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 16 (May 31, 2016), https://www.regulations.gov/contentStreamer?documentId=CMS-2016-0053-0123&attachmentNumber=1&contentType=pdf. MedPAC explained why it was incorrect for CMS to apply another budget neutrality adjustment to the LTCH site neutral payment rate:

> CMS proposes to use the IPPS fixed-loss amount to determine if a discharge paid under the site-neutral rate qualifies to receive an HCO payment again for FY 2017. CMS sets the IPPS fixed-loss amount each year at a level that it estimates will result in aggregate HCO payments equal 5.1 percent of total IPPS payment. **To account for the spending attributed to these outlier payments, CMS reduces the IPPS base payment rates to maintain budget neutrality in the IPPS. The IPPS-comparable rate used to pay for site-neutral cases in LTCHs includes an adjustment for budget neutrality to account for spending associated with HCOs.**

Continued from previous page
https://www.regulations.gov/contentStreamer?documentId=CMS-2016-0053-0575&attachmentNumber=1&contentType=pdf.

> With the Commission's payment principles in mind, **MedPAC urges CMS to eliminate the proposed payment adjustment for discharges paid the site-neutral rate to account for outlier payments under this payment methodology. Given that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.**

Id. at 16-17 (emphasis added).

Despite objections from even more LTCHs, and strong objections from MedPAC, in written comments to the agency, CMS again dismissed these concerns and finalized the BNA for FY 2017. See Exhibit 4, FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. 56762, 57308-09 (Aug. 22, 2016).[13] CMS said in the FY 2017 Final Rule that it continued to disagree with commenters "who assert that a HCO budget neutrality adjustment for site neutral payment rate cases is inappropriate, unnecessary, or duplicative." Id. CMS also added that it has "broad authority" to establish adjustments to the LTCH PPS standard Federal payment rate. Id. Additionally, CMS attempted to make the argument that Congress approved of CMS' implementation of the duplicative BNA because "Congress was well aware of how we had implemented our HCO policy under the LTCH PPS under § 412.525 at the time of the enactment of section 1206 of Public Law 113-67" and "Congress was also well aware of how we had implemented our 'IPPS comparable per diem amount' concept in the [short-stay outlier] context at the time of the enactment of section 1206 of Public Law 113-67." 81 Fed. Reg. at 57308.

---

13 In the FY 2017 IPPS/LTCH PPS Final Rule, CMS did make one change to the application of the BNA. CMS decided that the budget neutrality adjustment would not be applied to the HCO payment for site neutral payment rate cases. Exhibit 4, 81 Fed. Reg. at 57309.

C. FY 2018 Rulemaking

In FY 2018, CMS continued applying the BNA over the objections of the Providers and others. The FY 2018 IPPS/LTCH PPS Final Rule contained an identical budget neutrality adjustment. Exhibit 3, FY 2018 IPPS/LTCH PPS Final Rule, 82 Fed. Reg. 37990, 38544-46 (Aug. 14, 2017). During the FY 2018 comment period, Kindred Healthcare,[14] LifeCare Hospitals,[15] Post Acute Medical,[16] and Vibra HealthCare[17] each submitted comments opposing the proposed adjustment for FY 2018. The Providers also continued to request that CMS correct the duplicative adjustment that CMS already applied to FY 2016 and FY 2017 LTCH site neutral payments. See e.g., Exhibit 34, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 12 ("CMS should reverse this adjustment to all FY 2016 and FY 2017 payments, or make an equivalent prospective increase in payments to FY 2018 site neutral rate cases to account for this underpayment."). In addition to the Providers, the AHA and FAH again objected to the FY 2018 budget neutrality adjustment.[18]

---

14 Exhibit 34, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 5-12 (June 13, 2017), https://www.regulations.gov/contentStreamer?documentId=CMS-2017-0055-4033&attachmentNumber=1&contentType=pdf.

15 Exhibit 35, LifeCare Hospitals, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 14-18 (June 13, 2017), https://www.regulations.gov/contentStreamer?documentId=CMS-2017-0055-3745&attachmentNumber=1&contentType=pdf.

16 Exhibit 36, Post Acute Medical, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 4 (June 12, 2017), https://www.regulations.gov/contentStreamer?documentId=CMS-2017-0055-3620&attachmentNumber=1&contentType=pdf.

17 Exhibit 37, Vibra Healthcare, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 20-23 (June 13, 2017), https://www.regulations.gov/contentStreamer?documentId=CMS-2017-0055-3729&attachmentNumber=1&contentType=pdf.

18 Exhibit 38, American Hospital Association, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 4-7 (June 13, 2017), https://www.regulations.gov/contentStreamer?documentId=CMS-2017-0055-3995&attachmentNumber=1&contentType=pdf; Exhibit 39, Federation of American Hospitals, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 62-63 (June 13, 2017),

Continued on following page

Despite these objections for a third year, CMS again finalized the budget neutrality adjustment without any change. See Exhibit 3, FY 2018 IPPS/LTCH PPS Final Rule, 82 Fed. Reg. 37990, 38544-46 (Aug. 14, 2017). CMS reiterated its belief that it has "the authority to adopt the site neutral payment rate HCO policy in a budget neutral manner" and referred readers to its responses to comments in the two previous years. Id. at 38546.

D. FY 2019 Rulemaking

In the FY 2019 IPPS/LTCH PPS Proposed Rule, CMS again proposed a budget neutrality factor (adjustment) for all LTCH site neutral payment rate cases. CMS claimed that this adjustment is necessary so that HCO payments for such cases do not result in any change to estimated aggregate LTCH payments. Exhibit 1, FY 2019 IPPS/LTCH PPS Proposed Rule, 83 Fed. Reg. 20164, 20596 (May 7, 2018). The proposed budget neutrality adjustment would reduce the LTCH site neutral payment rate amount by 5.1% to offset the cost of LTCH site neutral HCO payments in FY 2019. Id. In addition to this budget neutrality adjustment for LTCH site neutral HCO cases, CMS again proposed adjusting the IPPS payment rate to account for projected IPPS outlier payments. Exhibit 1, 83 Fed. Reg. at 20583. Specifically, CMS proposed a budget neutrality adjustment to reduce the IPPS payment rate by 5.1%. Id. As in prior years, the IPPS rate is used to determine the IPPS comparable per diem amount for LTCH site neutral payment rate cases.

In response to the FY 2019 IPPS/LTCH PPS Proposed Rule, the Providers and other commenters again objected to the budget neutrality adjustment for LTCH site neutral HCO cases on the grounds that the adjustment is duplicative of the budget neutrality adjustment CMS

Continued from previous page
https://www.regulations.gov/contentStreamer?documentId=CMS-2017-0055-4057&attachmentNumber=1&contentType=pdf.

proposed to apply to the IPPS payment rate. CMS' calculation of the 5.1% LTCH PPS site neutral budget neutrality adjustment did not account for the budget neutrality adjustment CMS already proposed for the IPPS payment rate. Similar to prior years' comment letters, Kindred Healthcare's FY 2019 comment letter continued to object to the BNA:

> Consistent with MedPAC's and the AHA's comments, we strongly disagree with the proposed 0.949 budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. CMS already reduced the FY 2019 site neutral payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor. CMS should *not* reduce LTCH site neutral payments by *another 5.1%*.

Exhibit 40, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 42 (June 25, 2018), https://www.regulations.gov/contentStreamer?documentId=CMS-2018-0046-1349&attachmentNumber=1&contentType=pdf. LifeCare's FY 2019 comment letter also explained to CMS that the proposed LTCH site neutral adjustment was duplicative of the adjustments already included in the LTCH site neutral payment rate: "This BNA is duplicative and unwarranted because CMS has *already* applied budget neutrality adjustments to reduce the operating and capital portions of the IPPS standard Federal payment rate by the same 5.1%, before using that rate to determine the IPPS comparable per diem amount for site neutral payment cases." Exhibit 41, LifeCare Hospitals, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 14 (June 21, 2018), https://www.regulations.gov/contentStreamer?documentId=CMS-2018-0046-1055&attachmentNumber=1&contentType=pdf. Similarly, Vibra's FY 2019 comment letter contained similar comments that explained CMS' error in calculating the budget neutrality adjustment. Exhibit 42, Vibra Healthcare, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 21-25 (June 25, 2018),

https://www.regulations.gov/contentStreamer?documentId=CMS-2018-0046-1360&attachmentNumber=1&contentType=pdf. As in prior years, the AHA and FAH also objected to the FY 2019 site neutral outlier budget neutrality adjustment. See Exhibit 43, American Hospital Association, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 6-8 (June 25, 2018), https://www.regulations.gov/contentStreamer?documentId=CMS-2018-0046-1495&attachmentNumber=1&contentType=pdf; Exhibit 44, Federation of American Hospitals, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 42-43 (June 25, 2018), https://www.regulations.gov/contentStreamer?documentId=CMS-2018-0046-1468&attachmentNumber=1&contentType=pdf.

The FY 2019 comment letters specifically asked CMS to take a fresh look at this issue and consider the detrimental effect the duplicative adjustment would have on LTCHs in FY 2019, but also the harm that already occurred by applying the adjustment in FYs 2016 through 2018. See Exhibit 41, LifeCare Hospitals, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 15 ("Because CMS has been unwilling to address these issues directly the past two years, we are forced to raise them again for consideration this year."); Exhibit 40, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 36 ("We request that CMS take a fresh look at this issue to avoid a continuation of this erroneous policy."); id. at 42 ("CMS' unwillingness to address these issues directly the past two years requires that we raise them again for further consideration this year. We ask that CMS take our concerns more seriously, now that the agency has had additional time to consider the matter and the analysis and table we provided.").

The Providers' comment letters explained that after taking a fresh look at this issue and correcting the erroneous adjustment for FY 2019, CMS also needed to fix the duplicative

adjustments already applied in FYs 2016 through 2018. See e.g., Exhibit 40, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 42 ("For the same reason, it was incorrect for CMS to apply the 5.1% site neutral HCO BNA to FY 2016, FY 2017 and FY 2018 payments for site neutral rate cases. CMS should reverse this adjustment to all FY 2016, FY 2017 and FY 2018 payments, or make an equivalent prospective increase in payments to FY 2019 site neutral rate cases to account for this underpayment.").

Despite these comments, CMS finalized the duplicative budget neutrality adjustment for all LTCH site neutral payment rate cases in the FY 2019 IPPS/LTCH PPS Final Rule. Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. 41144, 41737-38 (Aug. 17, 2018). At the same time, CMS finalized the 5.1% budget neutrality adjustment to the IPPS payment rate. Id. at 41723, 41728. In the FY 2019 Final Rule, CMS offered only a brief response to the Providers' comments objecting to the budget neutrality adjustment, essentially repeating what it had said in the FY 2018 Final Rule:

> We continue to disagree with the commenters that a budget neutrality adjustment for site neutral payment rate HCO payments is inappropriate, unnecessary, or duplicative. As we discussed in response to similar comments (82 FR 38545 through 38546, 81 FR 57308 through 57309, and 80 FR 49621 through 49622), we have the authority to adopt the site neutral payment rate HCO policy in a budget neutral manner. More importantly, we continue to believe this budget neutrality adjustment is appropriate for reasons outlined in our response to the nearly identical comments in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57308 through 57309) and our response to similar comments in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49621 through 49622).

Id. at 41738. Accordingly, CMS is applying a budget neutrality factor of 0.949 to reduce the site neutral payment rate portion of the LTCH PPS blended payment rate for all site neutral cases, despite the fact that the IPPS comparable amount has already been reduced to offset IPPS outlier

payments. This BNA reduces site neutral case payments by an *additional* 5.1% for all LTCHs, including the Providers in this Group Appeal.

The Providers have given CMS ample opportunity to correct the flawed methodology for determining the LTCH site neutral payment outlier budget neutrality adjustment. The Providers clearly spelled out the duplication in their comments, and MedPAC agreed that a separate budget neutrality adjustment should not be applied for this reason. However, CMS has been dismissive of the Providers' concerns.

The Providers had hoped that CMS would correct the error before the end of the LTCH site neutral transition period because when the transition period ends on September 30, 2019, the monetary consequences of CMS' error will double. See Exhibit 6, 42 U.S.C. § 1395ww(m)(6)(B)(i)(I) (SSA § 1886(m)(6)(B)(i)(I)). Starting in FY 2020, the entire payment for site neutral cases will be the lesser of the IPPS comparable per diem amount or 100% of the estimated costs of the case. Id. at §§ 1395ww(m)(6)(B)(i)-(ii). If CMS continues to insist on applying the duplicative outlier budget neutrality adjustment in FY 2020, the adjustment will apply to the entire site neutral payment. The Provider's LTCHs are already experiencing significantly reduced Medicare payments for site neutral cases. Applying a budget neutrality adjustment twice to site neutral payments only increases the financial pressure on these hospitals and unnecessarily deters care for Medicare patients in LTCHs. The Providers have no choice but to seek relief from the courts.

IV. ARGUMENT

The Providers do not dispute that CMS can apply a budget neutrality adjustment to LTCH site neutral case payments so that overall LTCH payments do not increase due to high cost outlier payments for qualifying site neutral cases. What the Providers dispute is the

application of a budget neutrality adjustment to LTCH site neutral case payments that *reduces* overall LTCH payments *below* what they would otherwise be in the absence of high cost outlier payments for qualifying site neutral cases. This is not budget neutrality. It is a payment cut that is completely arbitrary and unsupported, and results in a windfall to the Medicare program.

CMS set the target amount of LTCH HCO payments at 5.1% of total LTCH site neutral payments. The simple math is clear that CMS can only reduce total LTCH site neutral payments by 5.1% to maintain budget neutrality. Yet, the extra BNA at issue here reduces total LTCH site neutral payments by *another* 5.1% in the name of budget neutrality.

The Providers, hospital trade associations and MedPAC have repeatedly told CMS not to apply the extra budget neutrality adjustment. CMS has stubbornly refused, with unconvincing attempts to recast the IPPS outlier budget neutrality adjustments as "inputs" that only relate to the IPPS. But this form over function argument does not change the math. CMS has continued setting the LTCH site neutral payment rate based upon an erroneous calculation that includes *double* the budget neutrality adjustment for HCO payments.

CMS has committed a clear error of judgment by refusing to correct this error in the FY 2016, FY 2017, FY 2018 and FY 2019 IPPS/LTCH PPS Final Rules. It is arbitrary and capricious, an abuse of discretion, not in accordance with the APA, the SSA and the laws authorizing the LTCH PPS, and it is not supported by substantial evidence. Because the PRRB lacks the authority to reverse the agency's budget neutrality adjustment, we request that the PRRB certify this appeal for expedited judicial review.

A. Requirements for EJR

In order to be eligible for EJR, the providers in a group appeal must satisfy three requirements. First, the providers must be eligible for a PRRB hearing (*i.e.*, the Board must have jurisdiction over the appeal because the providers meet the amount-in-controversy requirement

of 42 C.F.R. § 405.1837(a)(3) and the 180-day window for requesting an appeal as set forth in § 405.1835(a)(3)). Second, there must be no factual issues in dispute. Third, the case must turn on a legal question that the PRRB lacks authority to decide. See 42 C.F.R. § 405.1842.

Because the PRRB is bound by the Social Security Act as well as the implementing regulations and CMS rulings (see 42 C.F.R. § 405.1867), the Board lacks authority to decide an issue when the appeal involves a challenge to the constitutionality of a statute, or the substantive or procedural validity of a regulation or CMS ruling. Specifically, the regulation on EJR states that:

> The Board's decision must grant EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines the following conditions are satisfied:
>
> (i) The Board has jurisdiction to conduct a hearing on the specific matter at issue in accordance with §405.1840 of this subpart.
>
> (ii) The Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.

42 C.F.R. § 405.1842(f)(1) (emphasis added).

The Board has stated that it has "no authority to dictate or fashion CMS policy or to retroactively apply policy changes," and has granted EJR where "the remedies that the Providers are seeking are not provided for, nor are they addressed in the [applicable] statute or regulations." See Hunterdon/Somerset 2001 Wage Index Grp. v. Riverbend Gov't Benefits Adm'r, PRRB Hearing Dec. No. 2004-D13, Case No. 01-0881GE at 6 (Apr. 14, 2004). In addition, if there is a statute, regulation, or CMS ruling that would specifically preclude granting the remedy sought by the provider, EJR would be appropriate. See Oakwood Hosp. and Med. Ctr. v. Blue Cross Blue Shield Ass'n, PRRB Hearing Dec. No. 02-1686 (Nov. 16, 2005).

B. The Providers Meet the Jurisdictional Requirements for a PRRB Hearing

The first requirement for EJR is met because the PRRB has jurisdiction over this group appeal since (1) the PRRB has jurisdiction to hear the Providers' direct appeal of a budget neutrality adjustment published in the *Federal Register*; (2) the Providers filed a request for a hearing with the PRRB within 180 days of the publication of the budget neutrality adjustment in the *Federal Register*; and (3) the amount in controversy for the group is over $50,000. These elements are based in section 1878(a) and (b) of the Social Security Act, which provides that:

> (a) . . . [A]ny hospital which receives payments in the amounts computed under subsection (b) and (d) of section 1886 and which has submitted such reports within such time frame as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—
> (1) such provider
> . . .
> (A)(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1886,
> . . .
> (2) the amount in controversy is $10,000 or more, and
> (3) such provider files a request for a hearing . . . , with respect to appeals under paragraph (1)(A)(ii), 180 days after the notice of the Secretary's final determination.
>
> (b) The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

42 U.S.C. § 1395oo (SSA § 1878); see also 42 C.F.R. § 405.1837(a) ("A provider . . . has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, only if—(1) The provider satisfies individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement . . . and (3) The

amount in controversy is, in the aggregate, $50,000 or more, as determined in accordance with §405.1839 of this subpart.").

The Secretary previously interpreted this statute to grant the PRRB jurisdiction over a hospital's appeal "only after an NPR has been issued for the hospital's first cost reporting period under the prospective payment system." Medicare Program; Provider Reimbursement Review Board Jurisdiction Over Appeals From Estimation of and Modifications to Base Year Costs Under the Prospective Payment System, 49 Fed. Reg. 22413, 22415 (May 29, 1984). However, the United States Court of Appeal for the District of Columbia Circuit later determined that, contrary to the Secretary's interpretation, "a year-end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal." Exhibit 16, Washington Hosp. Ctr. v. Bowen, 795 F.2d 139, 145 (D.C. Cir. 1986).

Since Washington Hosp. Ctr., the PRRB and the CMS Administrator have recognized that the PRRB has jurisdiction in cases involving provider challenges to CMS prospective payment system policies published in the *Federal Register*. See e.g., Crozer-Keystone Hosp. v. BlueCross BlueShield Ass'n/Highmark Medicare Servs., CMS Admin. Dec. (December 21, 2009) (finding that the PRRB had jurisdiction over a challenge to the FY 2007 IPPS wage index published in the *Federal Register*); King & Spalding FFY 2014 0.2% IPPS Reduction Group, PRRB Jurisdictional Dec., Case No. 14-2154G (Mar. 12, 2014) (finding that the PRRB has jurisdiction over a challenge to the -0.2% reduction to the IPPS standardized amount and capital standard Federal payment rate, to offset the impact of the "two-midnight" rule, that was published in the *Federal Register*); Youngstown-Warren 02 MSA Wage Index Grp. v. BlueCross

Ass'n/Nat'l Gov't Servs., Inc., PRRB Hearing Dec. No. 2012-D5, Case No. 02-0531G (July 26, 2011) (finding that the PRRB has jurisdiction over a challenge to the FY 2002 hospital wage index published in the *Federal Register*); Hall Render FFY 2018 ATRA/MACRA 0.7% D&C Adjustment Groups, PRRB Jurisdictional Dec., Case Nos. various (Jul. 24, 2018) (finding that the PRRB has jurisdiction over a challenge to the documentation and coding adjustment for FY 2018 published by CMS in a *Federal Register* notice).

A provider's direct challenge to payment policies published in the *Federal Register* is appropriate for EJR, even though the PRRB is sometimes reluctant to reach this conclusion. See Exhibit 17, Cape Cod Hosp. v. Sebelius, 677 F. Supp. 2d 18, 25 (D.D.C. 2009), rev'd on different grounds. In Cape Cod, plaintiffs brought challenges to both the FY 2007 and 2008 Final Rules before the Board, contending that CMS erred in applying the annual budget neutrality adjustment factor to the wage index rather than the standardized amount. Id. at 24. Although the Board initially determined that the Medicare regulations precluded judicial review, the United States District Court for the District of Columbia vacated the Board's decision and remanded to the Secretary for reconsideration of the hospitals' appeals. Id. After the Secretary remanded to the PRRB, the Board determined that expedited judicial review was appropriate. Similarly here, the PRRB has jurisdiction over the Providers' direct appeal of the FY 2019 LTCH PPS site neutral outlier budget neutrality adjustment.

Relying on a prior version of 42 C.F.R. § 405.1804(a), the PRRB previously believed it did not have jurisdiction in appeals challenging budget neutrality adjustments published in the *Federal Register*. See e.g., St. Rose Hospital, PRRB Jurisdictional Dec., Case. No. 14-0483 at 5 (Dec. 19, 2013) ("The Board concludes that it lacks jurisdiction over the appeal because review of budget neutrality adjustments is expressly prohibited by the statute and regulations."). This

interpretation was based on language in section 405.1804(a), since revised, that said administrative review was not available for the "determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates." Exhibit 18, 42 C.F.R. § 405.1804(a) (2013).

In 2013, CMS revised this regulation because it was inconsistent with the text of section 1878(d)(7) of the SSA. Section 1878(d)(7) only precludes review of the budget neutrality adjustment authorized by section 1886(e)(1) of the SSA. Section 1886(e)(1) only required a budget neutrality adjustment so that FY 1984 and FY 1985 IPPS payments would be budget neutral. The regulatory text of section 405.1804(a) was therefore inconsistent with the statutory text of SSA section 1878(d)(7) with respect to the Board's jurisdiction over challenges to budget neutrality adjustments. Now, the regulation only precludes administrative review of "the budget neutrality adjustment in the prospective payment rates required **under section 1886(e)(1) of the Social Security Act**." Exhibit 19, 42 C.F.R. § 405.1804(a) (2017) (emphasis added). When revising the regulation, CMS stated that this "technical conforming change clarifies that there is no administrative or judicial review with respect to the budget neutrality adjustments enumerated in section 1886(e)(1) of the Act, and this preclusion of review does not apply to other budget neutrality adjustments under the IPPS." Medicare and Medicaid Programs: Provider Reimbursement Determinations and Appeals, 78 Fed. Reg. 74826, 75162 (Dec. 10, 2013). The Providers here are not challenging the budget neutrality adjustment authorized by section 1886(e)(1) of the SSA. Accordingly, 42 C.F.R. § 405.1804(a) does not preclude the Board from accepting jurisdiction over the Providers' challenge to the BNA.

With the exception of the budget neutrality adjustment required under section 1886(e)(1) of the SSA, the PRRB now recognizes that it has jurisdiction over challenges to all other budget

neutrality adjustments. See e.g., Exhibit 20, Toyon 2009 Rural Floor Budget Neutrality Group, PRRB Jurisdictional Dec., PRRB Case No. 09-1313G (Apr. 6, 2017) (finding that the PRRB has jurisdiction over challenge to application of statewide rural floor budget neutrality adjustment factor); HCA 2010 Sole Community Re-basing Group, PRRB Jurisdictional Dec., PRRB Case No. 09-1864GC at 2 (Dec. 31, 2015) (finding that the PRRB has jurisdiction over a challenge to the application of budget neutrality adjustments to the hospital-specific rate for sole community hospitals because 42 C.F.R. § 405.1804 "has been revised, permitting the Board to review budget neutrality adjustments of the type under appeal in this case."); Exhibit 22, Toyon 2009-2010 SCH Hospital Specific Rate Rebasing Group, PRRB Jurisdictional Dec., PRRB Case No. 10-0351G (Dec. 31, 2015) (finding that the PRRB has jurisdiction over a challenge to budget neutrality adjustments to sole community hospitals' hospital specific rates).

No other statute or regulation precludes administrative review of a budget neutrality adjustment under the LTCH PPS. See 42 C.F.R. §§ 405.1804, 405.1840(b) and 405.1842(f)(2)(i). The Social Security Act and implementing regulations only prohibit administrative and judicial review of the following matters:

> (1) A finding in a contractor determination that expenses incurred for certain items or services furnished by a provider to an individual are not payable under title XVIII of the Act because those items or services are excluded from coverage under section 1862 of the Act and Part 411 of the regulations. Review of these findings is limited to the applicable provisions of sections 1155, 1869, and 1879(d) of the Act and of Subpart I of Part 405 and Subpart B of Part 478 of the regulations, as applicable.

42 C.F.R. § 405.1840(b)(1).

> (a) The determination of the requirement, or the proportional amount, of the budget neutrality adjustment in the prospective payment rates required under section 1886(e)(1) of the Social Security Act.
>
> (b) The establishment of—
> (1) Diagnosis related groups (DRGs);

> (2) The methodology for the classification of inpatient discharges within the DRGs; or
> (3) Appropriate weighting facts that reflect the relative hospital resources used with respect to discharge within each DRG.

42 C.F.R. § 405.1804 (implementing 42 U.S.C. § 1395ww(d)(7) (SSA § 1886(d)(7)) and 42 U.S.C. § 1395oo(g) (SSA § 1878(g))).

Moreover, the Providers timely submitted a PRRB Group Appeal Request simultaneously with this Request for EJR, see LTCH 2019 Site Neutral Outlier Budget Neutrality Adjustment Group Appeal Request at 1, less than 180 days after the site neutral budget neutrality adjustment for FY 2019 was published in the *Federal Register* on August 17, 2018, see Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. 41144 (Aug. 17, 2018).

Finally, the amount in controversy in this appeal is approximately $9,388,544, see LTCH 2019 Site Neutral Outlier Budget Neutrality Adjustment Group Appeal Request Statement of the Issue at 1, which exceeds the $50,000 statutory requirement for a group appeal, see 42 U.S.C. § 1395oo(b) (SSA § 1878(b)); 42 C.F.R. § 405.1837(a)(3).

Because neither the statute nor the implementing regulations prohibit the PRRB from reviewing the Providers' direct appeal of a budget neutrality adjustment published in the *Federal Register*, and the statutory requirements for PRRB review are satisfied, the PRRB has jurisdiction over this group appeal. Therefore, the Providers satisfy the first requirement for EJR.

C. There Are No Disputed Facts Material to the Resolution of the Providers' Appeal

The second requirement for EJR is met because there are no facts material to the Providers' appeal that are in dispute. The Providers are directly challenging the FY 2019 LTCH PPS site neutral HCO budget neutrality adjustment in the final rule. This budget neutrality adjustment reduces the amount of the site neutral payment rate in FY 2019 for all LTCHs,

including the Providers. This payment reduction is documented in the *Federal Register*. See Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. 41144, 41738 (Aug. 17, 2018) ("[I]t is necessary to reduce the site neutral payment rate portion of the blended rate payment by 5.1% to account for the estimated additional HCO payments payment to those cases in FY 2019."). Moreover, the comment letters to CMS and the agency's responses in the FY 2019 Final Rule (with references to the earlier rules) confirm that there is no dispute about the fact that CMS does not remove the outlier budget neutrality adjustment to the IPPS payment rate when calculating LTCH site neutral payments. Exhibit 5, FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326, 49622 (Aug. 17, 2015) ("While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments, . . ."). It is irrefutable that the Providers are and will continue to experience reduced Medicare payments as a result of the HCO budget neutrality adjustment to the site neutral payment rate. Thus, the Providers have satisfied the second requirement for EJR.

D. The Issue to Be Resolved Through This Appeal Is Beyond the Scope of the Board's Authority

The third requirement for EJR is met because the legal question in this appeal is a challenge to the substantive and procedural validity of a regulation—the BNA in the FY 2019 Final Rule. See 42 C.F.R. § 405.1842(f)(1)(ii). Since the Board has jurisdiction over this appeal, it "must consider whether it lacks the authority to decide a legal question relevant to the matter at issue." 42 C.F.R. § 405.1842(e)(1). The Board lacks the authority to decide a question if "the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling." 42 C.F.R. § 405.1842(f)(1)(ii) (emphasis added); see also Allina Health Servs. v. Burwell, 141 F. Supp. 3d 17, 19 (D.D.C. 2015) ("The PRRB . . . is bound by agency regulation and rulings, [42 C.F.R. §

405.1867,] and cannot decide 'question[s] of law or regulations.'") (citing 42 U.S.C. § 1395oo(f)(1)).

This appeal turns on the pure legal issue of whether the BNA is legally valid and enforceable. However, the Board lacks the authority to decide whether this adjustment is contrary to the APA, the Medicare statute, and other federal laws. Since the PRRB is bound by agency regulations and rulings, and cannot decide questions of law or regulations, a decision concerning the legal validity of this budget neutrality adjustment in the FY 2019 IPPS/LTCH PPS Final Rule is beyond the scope of the Board's authority. See 42 C.F.R. § 405.1869. As discussed more fully below, the Providers have ample legal support for their position that the BNA in the FY 2019 Final Rule is invalid as a matter of law and that CMS's enforcement of this budget neutrality adjustment is thus without legal basis.

1. The Board Lacks Authority to Decide the Legal Issue Concerning this Budget Neutrality Adjustment, Making the Issue Appropriate for EJR

The Board lacks authority to decide whether the BNA is arbitrary and capricious, an abuse of discretion, not in accordance with law, or unsupported by substantial evidence under the APA, and whether CMS met the APA's procedural requirements for responding to major policy issues identified in comments. The Board also lacks authority to decide whether this budget neutrality adjustment violates the dual-rate structure of the LTCH PPS in the SSA and exceeds CMS's authority under the authorizing legislation for the LTCH PPS.

In Toyon 2009 Rural Floor Budget Neutrality Group, PRRB Jurisdictional Dec., PRRB Case No. 09-1313G (Apr. 6, 2017), the Board on its motion decided that it did not have the authority to decide the legal question of the validity of CMS' application of the statewide rural floor budget neutrality adjustment factor used to determine IPPS payments. Exhibit 20, PRRB Jurisdictional Dec., PRRB Case No. 09-1313G at 1. The providers argued that the budget

neutrality adjustment was arbitrary and capricious, did not comply with the APA's procedural requirements, and was contrary to the statute. Id. at 7. In response to the providers' challenge to this budget neutrality adjustment, the Board stated:

> Pursuant to 42 C.F.R. § 405.1867, the Board must comply with Title XVIII of the Act and its supporting regulations. The Providers contend that the application of the within-state (or statewide) rural floor budget neutrality adjustment for FFY 2009 and 2010 is contrary to the Medicare statute and that CMS promulgated that regulation in violation of the Administrative Procedure[] Act. The Board finds it lacks the authority to examine this legal question as it pertains to the issue in these group appeals.

Id. at 9. The Board therefore granted EJR, allowing the providers to challenge the validity of this budget neutrality adjustment in Federal District Court. Id. at 9-10. Here, the Providers are also challenging a budget neutrality adjustment that violates the APA. This is a legal question that the PRRB does not have the authority to resolve.

The PRRB also granted EJR in response to a provider group challenge to budget neutrality adjustments that CMS directed the intermediaries to apply to sole community hospitals' Hospital Specific Rates ("HSRs"). Exhibit 22, Toyon 2009-2010 SCH Hospital Specific Rate Rebasing Group, PRRB Jurisdictional Dec., PRRB Case No. 10-0351G (Dec. 31, 2015). In Toyon 2009-2010 SCH Hospital Specific Rate Rebasing Group, the Board on its own motion granted EJR after finding that CMS established a cumulative budget neutrality adjustment in an August 2005 Final Rule. Id. at 2. The providers objected to this adjustment on grounds that it resulted in HSRs that were contrary to the statutory requirements for HSRs. See id. The Board determined that EJR was appropriate because the Board had jurisdiction, no findings of fact were needed, and the Board was "bound by [the] regulation and the publication of [the] notices in the Federal Register." Id. The Board further noted that it "lacks the authority to decide the legal question of whether the application of the cumulative budget neutrality

adjustment to the Providers' reimbursement rates is proper." Id. The same analysis applies to the Providers' challenge of the BNA published in the FY 2019 IPPS/LTCH PPS Final Rule. The Board has jurisdiction over the Providers' appeal and no findings of fact are required, but the Board does not have the authority to consider the validity of a budget neutrality adjustment published in the *Federal Register*.

Because the Board does not have the authority to decide this legal issue challenging the substantive and procedural validity of the BNA, expedited judicial review is appropriate.

2. The BNA Is Arbitrary and Capricious Because CMS Did Not Account For the Budget Neutrality Adjustments Already Included in the IPPS Comparable Amount

CMS' promulgation of the duplicative BNA is a textbook violation of the Administrative Procedure Act's arbitrary and capricious standard. For several reasons, it is very clearly "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law." 5 U.S.C. § 706(2)(A). First, the duplicative budget neutrality adjustment is arbitrary and capricious because it is unreasonable. See Exhibit 45, U.S. Postal Serv. v. Postal Regulatory Comm'n, 785 F.3d 740, 750 (D.C. Cir. 2015) (recognizing that agency action must be reasonable to survive arbitrary and capricious review under the APA). Second, the duplicative budget neutrality adjustment is arbitrary and capricious because "the agency . . . entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." Exhibit 12, Motor Vehicle Mfrs. Ass'n of the U.S., Inc. v. State Farm Mut. Auto. Ins., 463 U.S. 29, 43 (1983); see also Summer Hill Nursing Home LLC v. Johnson, 603 F. Supp. 2d 35, 39 (D.D.C. 2009) (concluding that "the Secretary entirely failed to consider an important aspect of the problem" and "the Secretary's decision provide[d] no basis upon which [the Court] could conclude that it was the product of

reasoned decisionmaking" because CMS did not explain why Summer Hill's subsequent receipt of remittance advices was insufficient to establish that the bad debts were actually uncollectible when claimed) (internal quotation marks omitted). Third, the duplicative budget neutrality adjustment is arbitrary and capricious because CMS' reasoning is "internally inconsistent." See Exhibit 46, District Hosp. Partners v. Burwell, 786 F.3d 46, 59 (D.C. Cir. 2015) (finding agency action arbitrary and capricious when it is "internally inconsistent and inadequately explained"). Finally, the duplicative budget neutrality adjustment is arbitrary and capricious because it reflects a clear error of judgment. See Exhibit 11, Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 416 (1971) (noting that agency action is arbitrary and capricious when "there has been a clear error of judgment" by the agency). Each of these reasons is discussed more fully below.

a. CMS' Unwarranted BNA is Arbitrary and Capricious Because it is Unreasonable

To survive arbitrary and capricious review under the APA, an agency's "exercise of its authority must be 'reasonable and reasonably explained.'" Exhibit 45, U.S. Postal Serv. v. Postal Regulatory Comm'n, 785 F.3d 740, 750 (D.C. Cir. 2015) (quoting Mfrs. Ry. Co. v. Surface Transp. Bd., 676 F.3d 1094, 1096 (D.C .Cir. 2012)). Agency action must be set aside if "the agency has failed to provide a reasoned explanation, or where the record belies the agency's conclusion . . . ." Exhibit 13, Cty. of L.A. v. Shalala, 192 F.3d 1005, 1021 (D.C. Cir. 1999); see also FiberTower Spectrum Holdings, LLC v. F.C.C., 782 F.3d 692, 699 (D.C. Cir. 2015) (stating that if an agency's "interpretation is 'plainly erroneous or inconsistent with the regulation[s]' or there is any other 'reason to suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter in question,'" courts will not "defer to an agency's interpretation of its regulations").

CMS' unreasonable decision to apply a second outlier budget neutrality adjustment to the LTCH site neutral payment rate is a textbook violation of the APA's arbitrary and capricious standard. It is not reasonable for CMS to apply a 5.1% budget neutrality adjustment to the LTCH site neutral payment rate to offset the cost of high cost outlier payments *after* CMS already applied the same 5.1% budget neutrality adjustment to the IPPS payment rate. CMS uses the IPPS payment rate, as reduced by the budget neutrality adjustments of 5.1%, to determine the LTCH site neutral payment rate. It was not reasonable for CMS to ignore the budget neutrality adjustment already included in the IPPS comparable per diem amount (which is the basis for the LTCH site neutral payment rate in most cases) when adopting the additional BNA. Under a reasonable approach, CMS would have *either* applied the negative 5.1% budget neutrality adjustments to the IPPS rate when calculating the LTCH site neutral payment rate, *or* applied the separate negative 5.1% BNA to that calculation, *but not both*. Instead of adopting either of these approaches, CMS used both, resulting in a negative 10.2% adjustment to the LTCH site neutral payment rate—*double* the amount needed to maintain budget neutrality. See Exhibit 40, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 37 ("CMS needs to consider the adjustments that it has *already* made to the proposed IPPS and capital PPS payment rates to account for outlier payments."); Exhibit 41, LifeCare Hospitals, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 15 ("[B]ecause CMS is using the adjusted IPPS base rates for LTCH site neutral payments, the rates are already reduced 5.1% for outlier budget neutrality. The separate 5.1% budget neutrality adjustment for LTCH site neutral HCOs reduced such payments by *another* 5.1% for a total BNA of 10.2%.").

CMS has trivialized the comments and evidence submitted during the comment period about this duplication, and insisted on applying a second adjustment to the LTCH site neutral payment rate. As a result, Medicare has arbitrarily cut aggregate payment to all LTCHs by tens of millions of dollars each year.[19] This is clearly unreasonable. Accordingly, the duplicative BNA must be set aside as arbitrary and capricious under the APA.

b. CMS Did Not Engage in a Reasoned Analysis When It Implemented the Duplicative BNA without Accounting for the Adjustments Already Applied to the IPPS Comparable Per Diem Amount

An agency violates the APA's reasoned analysis requirement if it fails to consider an important aspect of the problem. See Wood v. Betlach, 922 F. Supp. 2d 836 (D. Ariz. 2013) (finding that HHS failed to address an important aspect of the problem because the record contains no evidence that HHS considered or responded to plaintiffs' expert opinion that none of the demonstration project's hypotheses test anything new); St. James Hosp. v. Heckler, 760 F.2d 1460 (7th Cir. 1985), accord, Walter O. Boswell Mem'l Hosp. v Heckler, 628 F. Supp. 1121 (D.D.C. 1985) (holding that malpractice rule was arbitrary and capricious because HHS entirely failed to consider an important aspect of the problem by making no attempt to examine the relationship between actual malpractice loss experience and premium costs, and its rule was not adequately supported by the study it relied on); see also Shays v. Fed. Election Comm'n, 337 F. Supp. 2d 28, 72 (D.D.C. 2004) (concluding that the FEC's regulation implementing the Bipartisan Campaign Reform Act ("BCRA") was arbitrary and capricious because the FEC "did not adequately explain its decision to exclude 'apparent authority' from the scope of its

19 The AHA's analysis of FY 2016 MedPAR data found that the duplicative budget neutrality adjustment reduces aggregate payments by approximately $28 million per year. Exhibit 43, American Hospital Association, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 6.

definition of 'agent'" and provided "no indication that [it] considered how [its] decision might facilitate circumvention or perpetuate the appearance of corruption, two policies Congress definitely sought to advance in passing BCRA," demonstrating that the FEC "'entirely failed to consider an important aspect of the problem'") (quoting State Farm Mut. Auto. Ins., 463 U.S. at 43). Although courts typically exercise restraint in reviewing agency action, the courts will intervene if "the agency has not really taken a 'hard look' at the salient problems, and has not genuinely engaged in reasoned decision-making." Exhibit 14, Greater Boston Television Corp. v. F.C.C., 444 F.2d 841, 851 (D.C. Cir. 1970).

The Providers do not dispute that CMS has the authority to apply a budget neutrality adjustment to reduce LTCH site neutral payments to account for HCO payments for LTCH site neutral payment rate cases. However, the Providers do object to a budget neutrality adjustment on top of budget neutrality adjustments of the same size. See Exhibit 40, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 37 ("Consistent with MedPAC's recommendation, CMS should only adjust LTCH site neutral payments *once* for outlier budget neutrality."); Exhibit 41, LifeCare Hospitals, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 16 ("To ensure that LTCHs are only paying for high cost outliers at LTCHs once, not twice, CMS must not apply the separate 5.1% budget neutrality adjustment for LTCH site neutral cases."). The BNA is duplicative of the adjustments CMS borrows from the IPPS payment rates. CMS' refusal to seriously consider whether the adjustment is duplicative shows that the agency has not taken a "hard look" to ensure that the math behind the calculation of the budget neutrality adjustment is valid. See Exhibit 14, Greater Boston Television Corp., 444 F.2d at 851. A serious examination of the way the IPPS comparable per diem amount is calculated for LTCH site neutral payments would

reveal the fact that this extra LTCH budget neutrality adjustment results in underpayments to LTCHs and a savings for the Medicare program. Accordingly, CMS has "entirely failed to consider an important aspect of the problem" because the agency refuses to recognize that it is applying a duplicative budget neutrality adjustment. See Exhibit 12, State Farm Mut. Auto. Ins., 463 U.S. at 43.

CMS believes that a separate budget neutrality adjustment for LTCH site neutral HCO cases will "reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems." Exhibit 2, 83 Fed. Reg. at 41737. However, by aligning this policy with the IPPS payment system—and making the IPPS comparable per diem amount and the IPPS fixed-loss amount the primary components—CMS did not adequately consider the adjustment that it *already* made to the IPPS payment rate to account for outlier payments. Specifically, CMS already reduced the IPPS payment rate for outlier budget neutrality. For FY 2019, CMS reduced the operating portion of the IPPS payment rate by a factor of 0.948999 and the capital portion of the IPPS payment rate by a factor of 0.949431. Id. at 41723. As CMS explains, these budget neutrality factors result in a 5.1% outlier adjustment that already reduces the IPPS payment rate. Id. at 41723-24. CMS has therefore not taken a "hard look" at the salient problem and is not engaging in reasoned decisionmaking because CMS is unwilling to consider the duplicative effect of the extra BNA. See Exhibit 14, Greater Boston Television Corp., 444 F.2d at 851. Moreover, this extra 5.1% adjustment to LTCH site neutral payments in the name of budget neutrality does not "reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS"—it exacerbates differences—and it does not "promote fairness between the two systems"—it is patently unfair to LTCHs.

Accordingly, CMS' decision to adopt the BNA for FY 2019 is arbitrary and capricious because CMS did not engage in reasoned decisionmaking when the agency's adoption of the BNA failed to account for the budget neutrality adjustment to the IPPS standard Federal payment rate that is used in the calculation of the LTCH site neutral payment rate. Therefore, the LTCH site neutral budget outlier neutrality adjustment in the FY 2019 IPPS/LTCH PPS Final Rule must be set aside.

c. CMS' Decision to Apply a Duplicative Budget Neutrality Adjustment is Arbitrary and Capricious Because CMS' Reasoning is Internally Inconsistent

An agency's decision is also arbitrary and capricious if it is "internally inconsistent and inadequately explained." Exhibit 46, District Hosp. Partners v. Burwell, 786 F.3d 46, 59 (D.C. Cir. 2015) (citing General Chem. Corp. v. United States, 817 F.2d 844, 846 (D.C. Cir. 1987). In Banner Health v. Price, 867 F.3d 1323 (D.C. Cir. 2017) (Exhibit 47), hospitals brought a challenge to CMS' implementation of certain changes to the IPPS outlier policies aimed at addressing "turbo-charging" by hospitals. Turbo-charging hospitals were accused of manipulating the IPPS outlier system so that they could obtain greater outlier payments. Id. at 1328. The D.C. Circuit held that one of CMS' changes was arbitrary and capricious because the agency failed to adequately explain why it was not making adjustments to projection cost-to-charge ratios for the turbo-charging hospitals. Id. The court said CMS' "approach was 'internally inconsistent and inadequately explained.'" Id. at 1349 (citing District Hosp. Partners, 786 F.3d at 59). Specifically, the D.C. Circuit faulted CMS for not accounting for other changes CMS made to the outlier policies when setting the projection cost-to-charge ratios. Id. The court explained CMS' internally inconsistent policy as follows:

> When HHS set the FY 2004 threshold in August 2003, it knew it would end up using updated cost-to-charge ratios to make outlier payments as tentatively settled cost reports came in for each hospital. Yet it did not account for the fact that

> those updated cost-to-charge ratios were likely to be considerably lower than its projection cost-to-charge ratios, thereby leading many hospitals to be underpaid for outlier cases.

Id.

CMS' rationale for the duplicative BNA suffers from similar "internal inconsistency" for several reasons. First, the BNA is "internally inconsistent" because CMS chose to make the LTCH site neutral outlier policy identical to the IPPS outlier policy, but add an extra budget neutrality adjustment to LTCH site neutral payments. CMS uses the same outlier policy as the IPPS for LTCH site neutral cases because CMS actuaries "projected that the costs and resource use for cases paid at the site neutral payment rate . . . would likely mirror the costs and resource use for IPPS cases assigned to the same MS-DRG" and "site neutral payment rate cases would generally be paid based on an IPPS comparable per diem amount," rather than 100% of the estimated costs of the case. Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. at 41737. CMS therefore uses the same IPPS fixed-loss amount for LTCH site neutral outlier cases. Id. ("[W]e continue to believe that the most appropriate fixed-loss amount for site neutral payment rate cases for FY 2019 is the IPPS fixed-loss amount for FY 2019."). CMS also uses the same target amount of 5.1% of total payments for outlier cases. Id. To be internally consistent, the LTCH site neutral payment rate would be considered budget neutral after applying the negative 5.1% IPPS outlier budget neutrality adjustment. See id. at 41723, 41728 (establishing a 0.948999 outlier adjustment factor to the IPPS operating standardized amount and a 0.949431 outlier adjustment factor to the IPPS capital federal rate). But CMS did not stop there. The agency applied an additional BNA of 5.1%, thereby doubling the reduction to LTCH site neutral payments. Id. at 41737. This approach is very clearly "internally inconsistent."

Second, CMS' LTCH PPS outlier policies are "internally inconsistent" because LTCH PPS standard rate payments are subject to a single outlier budget neutrality adjustment, yet CMS applies two budget neutrality adjustments to the site neutral payment rate. The AHA explained this issue in their comments to CMS on the FY 2017 and FY 2018 LTCH PPS rulemakings. The AHA's FY 2017 comment letter states:

> When calculating any of the LTCH PPS standard rate payments[], only one BNA applies. Similarly, when pricing out the LTCH PPS short-stay outliers . . . that are paid either an IPPS comparable amount or cost (similar to what site-neutral cases are being paid), only one BNA applies. However, by contrast, when calculating rates for site-neutral cases paid the IPPS comparable amount, two BNAs apply.

Exhibit 31, American Hospital Association, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 6 (footnote omitted). The AHA's comment letter included a chart that diagrams the budget neutrality adjustment CMS applies to other LTCH PPS payment rates and the two budget neutrality adjustments CMS applies to the LTCH site neutral payment rate. Id. at 7. CMS' deviation from its standard practice of applying only one outlier budget neutrality adjustment indicates that CMS' outlier policies are "internally inconsistent."

Finally, the BNA is "internally inconsistent" because it is contrary to the intent of budget neutrality. The intent of budget neutrality is to ensure that a particular payment policy does not raise *or lower* the aggregate payments to providers. In fact, CMS states in the FY 2019 Final Rule that the LTCH site neutral HCO policy should be budget neutral, "meaning that estimated site neutral payment rate HCO payments should not result in *any change* in estimated aggregate LTCH PPS payments." Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. at 41737 (emphasis added). However, CMS' implementation of the BNA reduces aggregate site neutral payments to LTCHs to a level that is *below* the budget neutral baseline. In other words, the additional budget neutrality adjustment the Providers are challenging in this appeal is not an

adjustment that achieves budget neutrality at all—it is purely a payment cut. This unwarranted reduction is therefore "internally inconsistent" with the goals of budget neutrality.

Each of these examples of "internal inconsistency" on their own renders CMS' duplicative BNA arbitrary and capricious. Exhibit 47, Banner Health v. Price, 867 F.3d 1323 (D.C. Cir. 2017); Exhibit 46, District Hosp. Partners v. Burwell, 786 F.3d 46, 59 (D.C. Cir. 2015). CMS' rationale for the duplicative budget neutrality adjustment is fatally defective. The duplicative budget neutrality adjustment must therefore be set aside.

d. CMS' Decision to Apply a Duplicative Budget Neutrality Adjustment is Arbitrary and Capricious Because it Reflects a Clear Error of Judgment

Review of agency action under the arbitrary and capricious standard requires consideration of "whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." Exhibit 11, Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 416 (1971). A "clear error of judgment" is evaluated by looking at the substance of the agency's decision, not just the agency's procedures for promulgating the rule. Exhibit 48, James Madison Ltd. by Hecht v. Ludwig, 82 F.3d 1085, 1098 (D.C. Cir. 1996).

In James Madison Ltd., the D.C. Circuit stated that "judicial review of agency action under the APA must go beyond the agency's procedures to include the substantive reasonableness of its decision." Id. Relying on the Supreme Court's decision in Overton Park, the D.C. Circuit stated: "Although the reasonableness of the agency's procedures is relevant to the court's inquiry, reasonable procedures alone cannot absolve a court from making a 'thorough, probing, in-depth review' to determine if the agency has considered the relevant factors or committed a clear error of judgment." Id. (citing Overton Park, 401 U.S. at 415-16). According to the D.C. Circuit, the agency's action would amount to a substantive violation of the APA if

the agency ignored salient facts or offered "patently implausible justifications." Id. In other circuits, there is a "clear error of judgment" that is "sufficient to constitute arbitrary and capricious agency action . . . when 'the agency offer[s] an explanation that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." Sierra Club v. E.P.A., 346 F.3d 955, 961 (9th Cir. 2003) (alteration in original) (quoting Motor Vehicle Mfrs. Ass'n of the U.S., Inc. v. State Farm Mut. Auto. Ins., 463 U.S. 29, 43 (1983)).

The "clear error of judgment" standard requires reversing the agency action "if the error is so clear as to deprive the agency's decision of a rational basis." Ethyl Corp. v. Envtl. Prot. Agency, 541 F.2d 1, 34-35 n. 74 (D.C. Cir. 1976), cert. denied, 426 U.S. 941, (1976). In the context of an agency's informal rulemaking, compared to agency decisions made after an evidentiary hearing, it is even more important that the record contain a rational basis for the agency's decision because it is easier for the agency to abuse informal rulemaking proceedings. Almay, Inc. v. Califano, 569 F.2d 674, 681 (D.C. Cir. 1977).

Here, CMS' decision to apply the duplicative budget neutrality adjustment is arbitrary and capricious because the agency committed a "clear error of judgment" when it ignored evidence that the IPPS comparable per diem amount for LTCH site neutral payment cases already includes a 5.1% budget neutrality adjustment to offset the cost of LTCH outlier cases. CMS first adopted the LTCH site neutral HCO budget neutrality adjustment in the FY 2016 IPPS/LTCH PPS Final Rule. See Exhibit 5, FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326, 49617-23 (Aug. 17, 2015). Prior to issuing the FY 2016 Final Rule, the Providers submitted comments to CMS explaining why the proposed BNA was unnecessary and duplicative because the IPPS comparable per diem amount already includes a budget neutrality

adjustment. See e.g., Exhibit 24, Post Acute Medical, Comment Letter on FY 2016 IPPS/LTCH PPS Proposed Rule at 25 ("It would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed site neutral HCO BNA. This would be the case because the IPPS comparable per diem amount will be based on the FY 2016 IPPS payment rate, which has already been adjusted by the 5.1 percent outlier target."). The Providers, and other stakeholders, submitted additional comments to CMS during the FY 2017, FY 2018, and FY 2019 LTCH PPS rulemakings making the same point. See supra Parts III.B.-D. Even MedPAC submitted a comment letter objecting to the budget neutrality adjustment because it is "duplicative and exaggerates the disparity in payment rates across provider settings." Exhibit 33, MedPAC, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 16-17.

Based on these comments, CMS had more than enough information to know that the BNA was erroneous and unnecessary as early as FY 2016. In every rulemaking since FY 2016, commenters including the Providers explained to CMS that it erred when it failed to account for the outlier budget neutrality adjustment already applied to the IPPS comparable per diem amount when calculating the LTCH PPS site neutral outlier budget neutrality adjustment. See e.g., Exhibit 28, LifeCare Hospitals, Comment Letter on FY 2017 IPPS/LTCH PPS Proposed Rule at 10 ("CMS already reduced the FY 2017 site neutral payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor. CMS should *not* reduce LTCH site neutral payments by *another 5.1%*."); Exhibit 37, Vibra Healthcare, Comment Letter on FY 2018 IPPS/LTCH PPS Proposed Rule at 23 ("Since CMS has already made these adjustments for budget neutrality, it would be inappropriate for CMS to reduce LTCH site neutral payments that are based on the IPPS and capital PPS rates by *another 5.1%* for HCOs."); Exhibit 40, Kindred Healthcare & Select Medical Holdings Corporation, Comment Letter on FY

2019 IPPS/LTCH PPS Proposed Rule at 42 ("CMS already reduced the FY 2019 site neutral payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor.").

The D.C. Circuit has stated that CMS cannot continue using payment rates based on computational errors. See Exhibit 49, Cape Cod Hosp. v. Sebelius, 630 F.3d 203, 214-15 (D.C. Cir. 2011) ("[W]e never suggested that even after the error in the data on which the Secretary had relied was brought to her attention, she could have chosen to continue using the inaccurate wage index in calculating future payments."). Here, CMS has continued setting the LTCH site neutral payment rate based upon an erroneous calculation that includes double the budget neutrality adjustment for HCO payments, even after MedPAC, the Providers, and others repeatedly brought the error to CMS' attention. Accordingly, CMS has committed a "clear error of judgment" by refusing to correct this error in the FY 2016, FY 2017, FY 2018 and FY 2019 IPPS/LTCH PPS Final Rules.

3. CMS' Decision to Apply a Second Outlier Budget Neutrality Adjustment to the LTCH Site Neutral Payment Rate is Not Supported by Substantial Evidence

CMS' duplicative budget neutrality adjustment should also be set aside because CMS' determination that a second adjustment is necessary to offset the cost of site neutral high cost outlier payments is not supported by substantial evidence. Pursuant to 5 U.S.C. § 706(2)(E) of the APA, a reviewing court is required to "hold unlawful and set aside agency action, findings, and conclusions found to be . . . unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of any agency hearing provided by statute." Exhibit 10, 5 U.S.C. § 706(2)(E). According to the Supreme Court, this substantial evidence test applies "when the agency action is taken pursuant to a rulemaking provision of the Administrative Procedure Act itself, 5 U.S.C. § 553 . . . ." Exhibit 11, Citizens to Preserve

Overton Park, Inc. v. Volpe, 401 U.S. 402, 414 (1971), abrogated on other grounds by Califano v. Sanders, 430 U.S. 99 (1977). CMS' duplicative budget neutrality adjustment at issue here was adopted through the APA's notice and comment rulemaking procedures. See Exhibit 15, 5 U.S.C. § 553.

Substantial evidence supports the agency's action when there is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Banner Health v. Sebelius, 715 F. Supp. 2d 142, 153 (D.D.C. 2010). No such evidence exists here to support CMS' decision to apply a second outlier budget neutrality adjustment to the LTCH site neutral payment rate. CMS claims that this second budget neutrality adjustment is necessary "to ensure estimated HCO payments payable for site neutral payment rate cases in FY 2019 would not result in any increase in estimated aggregate FY 2019 LTCH PPS payments . . . ." Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. at 41737. However, CMS offers no evidence in support of its claim that this second budget neutrality adjustment is *not* duplicative of the adjustment already applied to the IPPS payment rate used to determine the IPPS comparable per diem amount for LTCH site neutral cases. Instead, the evidence in the rulemaking record confirms that CMS is applying multiple outlier budget neutrality adjustments to the LTCH site neutral payment rate.

Specifically, the rulemaking record shows that CMS included the 5.1% budget neutrality adjustment to reduce the IPPS payment rate amount used for the IPPS comparable per diem amount before applying the separate negative 5.1% BNA. Id. at 41723, 41728. The site neutral payment rate for most LTCH site neutral cases is based on the IPPS comparable per diem amount. Exhibit 6, 42 U.S.C. § 1395ww(m)(6)(B)(ii)(I); Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. at 41737 ("[S]ite neutral payment rate cases would generally be paid

based on an IPPS comparable per diem amount . . . ."). Because there is no evidence to contradict that this second budget neutrality adjustment is duplicative, it must be set aside.

4. CMS Did Not Provide a Sufficient Response to Comments Raising Major Issues Regarding the Duplicative BNA in the FY 2019 IPPS/LTCH PPS Final Rule

In addition to the substantive deficiencies with CMS' adoption of the site neutral budget neutrality adjustment, CMS' nominal response to comments in the FY 2019 IPPS/LTCH PPS Final Rule also violates the procedural requirements for notice and comment rulemaking at section 553(c) of the APA. The APA requires that the agency's response to comments, the basis and purpose statement, "must identify 'what major issues of policy were ventilated by the informal proceedings and why the agency reacted to them as it did.'" Exhibit 21, St. James Hosp. v. Heckler, 760 F.2d 1460, 1469 (7th Cir. 1985) (citing Automotive Parts & Accessories Ass'n v. Boyd, 407 F.2d 330, 338 (D.C. Cir. 1968).

In St. James Hospital, the court held that a new Medicare regulation setting the formula for Medicare reimbursement of providers' malpractice insurance premiums violated APA section 553(c) because "the Secretary's basis and purpose statement did not adequately respond to the criticisms raised in the many adverse comments submitted on the Malpractice Rule in several respects." Id. at 1469. The court found that the Secretary did not even attempt to respond to comments asserting that the agency relied on a statistically unreliable study to support its rule. Id. Other comments criticized the regulation because "the Malpractice Rule's formula for reimbursing premium costs bears no relation to the actual premium costs incurred by hospitals on behalf of Medicare recipients." Id. at 1469-70. In the final rule, the Secretary issued only a two sentence response to these commenters' concerns. Id. at 1470. The court characterized the Secretary's response as "nonresponsive" and noted that the response ignored a key fact central to

this issue. See id. As a result, the court determined that the Secretary violated APA section 553(c). Id. The court concluded:

> We agree with the district courts' conclusion that the Secretary's basis and purpose statement failed to respond to many significant points made by the public in opposition to the Malpractice Rule. **The Secretary's statement of basis and purpose provided no indication of why criticisms of the Westat study were deemed to be invalid, and failed to give a reasoned response to other criticisms of the Rule.** We therefore conclude that the Secretary failed to comply with section 553(c) of the APA.

Id. (emphasis added). In addition to finding that the malpractice rule violated APA section 553(c), the court also held that the rule must be set aside because the rule was arbitrary and capricious and an abuse of discretion, it violated the Medicare Act's cost-shifting prohibition, and it violated the Medicare Act's mandate to reimburse hospitals for the "reasonable cost" of services provided to Medicare beneficiaries. See id. at 1469, 1472-73.

Here, CMS' three sentence response to commenters in the FY 2019 IPPS/LTCH PPS Final Rule shows that the agency is disregarding major issues with the budget neutrality adjustment raised by commenters. Just as the Secretary's response to comments in St. James Hospital made no effort to respond to comments regarding a statistically unreliable study, CMS' response here did not attempt to explain why the BNA is not duplicative. CMS only responded that it "continue[s] to disagree with the commenters that a budget neutrality adjustment for site neutral payment rate HCO payments is inappropriate, unnecessary, or duplicative" and referred readers to CMS' responses in prior years. Exhibit 2, 83 Fed. Reg. at 41738. There was no effort by CMS to develop a substantive response to the commenters and explain why the BNA is *not* duplicative of the adjustment already applied to the IPPS payment rate used to determine the IPPS comparable per diem amount for LTCH site neutral cases. In sum, CMS did not even attempt to explain why commenters' criticisms of the budget neutrality adjustment were invalid.

See St. James Hosp., 760 F.2d at 1470. CMS' lack of a reasoned response to comments regarding the duplicative nature of the BNA therefore violates the procedural requirements for notice and comment rulemaking at section 553(c) of the APA.

The agency does not need to respond to every individual issue raised by commenters. See Auto. Parts & Accessories Ass'n v. Boyd, 407 F.2d 330, 338 (D.C. Cir. 1968) ("We do not expect the agency to discuss every item of fact or opinion included in the submissions . . . ."). However, the agency "must respond in a reasoned manner to those [comments] that raise significant problems." Reytblatt v. U.S. Nuclear Regulatory Comm'n, 105 F.3d 715, 722 (D.C. Cir. 1997). Here, the Providers submitted comment letters to CMS identifying a "significant problem." That is, CMS is underpaying LTCH site neutral cases due to a duplicative outlier budget neutrality adjustment. The significance of this problem is only confirmed by the fact that many LTCH organizations, MedPAC, the AHA, and the FAH submitted comment letters to CMS objecting to the duplicative budget neutrality adjustment. Although CMS can disagree with comments, it cannot simply dismiss comments from MedPAC and others as insignificant. Accordingly, the unwarranted reduction to the LTCH site neutral payment rate that resulted from the duplicative BNA was a "significant problem" that required a substantive response from CMS. Unfortunately, CMS' response in the FY 2019 Final Rule and the referenced prior rules cannot be considered a substantive response. CMS has not shown that the challenged budget neutrality adjustment is the only 5.1% outlier budget neutrality adjustment to the LTCH site neutral payment rate.

5. There was no Congressional Approval or Ratification of the Duplicative BNA

As discussed above, CMS provides only a nominal response in the FY 2019 IPPS/LTCH PPS Final Rule to the comments submitted by the Providers and others. See Exhibit 2, FY 2019

IPPS/LTCH PPS Final Rule, 83 Fed. Reg. at 41737-38. Instead of taking a fresh look at the duplicative BNA, as requested by commenters, CMS' response in the FY 2019 Final Rule relies on citations to CMS' responses in prior years. Id. at 41738. One such citation was to CMS' response to comments on this issue in the FY 2017 IPPS/LTCH PPS Final Rule. See id. ("As we discussed in response to similar comments (82 FR 38545 through 38546, 81 FR 57308 through 57309, and 80 FR 49621 through 49622), we have the authority to adopt the site neutral payment rate HCO policy in a budget neutral manner.").[20]

In the FY 2017 Final Rule, cited by CMS in the FY 2019 Final Rule, CMS attempts to argue that Congress approved or otherwise ratified CMS' decision to apply the extra 5.1% budget neutrality adjustment to the LTCH site neutral payment rate. See Exhibit 4, FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. at 57308. Specifically, CMS defended the extra budget neutrality adjustment by arguing that "Congress was well aware of how we had implemented our HCO policy under the LTCH PPS under § 412.525 at the time of enactment of section 1206 of Public Law 113-67." Id. CMS also claimed that "Congress was also well aware of how we had implemented our 'IPPS comparable per diem amount' concept in the SSO context at the time of the enactment of section 1206 of Public Law 113-67" because CMS had "budget neutralized" estimated HCO payments for short stay outlier cases since 2006. Id. CMS asserted that "Congress left us the discretion to continue to treat the 'IPPS comparable per diem amount' in the site neutral payment rate context as we have historically done with respect to LTCH PPS HCO payments made to discharges paid using the 'IPPS comparable per diem amount.'" Id.

20 As discussed above, the Providers are not challenging CMS' authority to apply an appropriate budget neutrality adjustment to account for the cost of LTCH site neutral outlier payments. Rather, the Providers are challenging CMS' decision to apply a second budget neutrality adjustment to the LTCH site neutral payment rate that effectively doubles the budget neutrality adjustment.

However, the regulation CMS refers to in this FY 2017 rulemaking (42 C.F.R. § 412.529(d)(4)) does not specify a separate budget neutrality adjustment for high cost outlier or short stay outlier payments based upon the IPPS comparable per diem amount, and CMS does not state any other authority for this assertion. Therefore, it is difficult to see how Congress was "well aware" of this policy when it established the LTCH patient criteria and site neutral payment rate in the PSRA. CMS needs far greater evidence to conclude that Congress specifically authorized or ratified CMS' decision to apply a second outlier budget neutrality adjustment to the LTCH site neutral payment rate.

Congress did not specifically require a budget neutrality adjustment in the PSRA. Congress did include a reference to the short stay outlier policy at 42 C.F.R. § 412.529(d)(4) for calculating the IPPS comparable per diem amount. Exhibit 6, 42 U.S.C. § 1395ww(m)(6)(B)(ii)(I) (SSA § 1886(m)(6)(B)(ii)(I)). Congress also specified that the site neutral payment rate based on the IPPS comparable per diem amount must include high cost outlier payments under 42 C.F.R. § 412.525. Id. However, neither the statute itself, nor the referenced short stay outlier regulation (42 C.F.R. § 412.529(d)(4)), specifically requires a budget neutrality adjustment. Accordingly, the text of the PSRA does not suggest that Congress was "well aware" of CMS' budget neutrality adjustments to authorize the BNA at issue in this appeal.

Not only is there no Congressional authorization of the BNA in the statute, but there is no subsequent action from Congress ratifying the duplicative BNA. In Cape Cod Hosp. v. Sebelius, 630 F.3d 203 (D.C. Cir. 2011), Exhibit 49, the Secretary of the Department of Health and Human Services ("HHS") argued that Congress ratified her decision to "ignore mistakes made in calculating rural-floor budget neutrality adjustments for prior years." Id. at 214. The D.C.

Circuit acknowledged that the "Supreme Court has stated that 'Congress is presumed to be aware of an administrative or judicial interpretation when it re-enacts a statute without change.'" Id. (quoting Merrill Lynch, Pierce, Fenner & Smith, Inc. v. Curran, 456 U.S. 353, 382 n.66 (1982)). However, the D.C. Circuit rejected the Secretary's contention that Congress ratified her interpretation because there was no Congressional reenactment of the statutory section at issue. Id. The same is true here. There have been some "isolated amendments" to the LTCH site neutral statutory provisions of the SSA, but there has been no re-enactment by Congress of the LTCH site neutral payment provisions to argue that Congress ratified CMS' duplicative BNA. See Alexander v. Sandoval, 532 U.S. 275, 292 (2001) ("[W]hen Congress has not comprehensively revised a statutory scheme but has made only isolated amendments, . . . [i]t is impossible to assert with any degree of assurance that congressional failure to act represents affirmative congressional approval of the Court's statutory interpretation.") (internal quotation marks omitted).

Moreover, Congress has not "implicitly ratified" CMS' duplicative BNA. The D.C. Circuit in Cape Cod rejected the contention that Congress "implicitly ratified" the Secretary's position by failing to enact legislation overturning the Secretary's interpretation. Exhibit 49, Cape Cod Hosp., 630 F.3d at 214. The D.C. Circuit stated that "[p]resuming ratification based on congressional inaction is inappropriate 'absent some evidence of (or reason to assume) congressional familiarity with the administrative interpretation at issue.'" Id. (quoting Pub. Citizen, Inc. v. HHS, 332 F.3d 654, 669 (D.C. Cir. 2003)). The D.C. Circuit's 2011 decision in Cape Cod also explained that the agency's error, identified in 2006, was "simply of too recent vintage to presume that Congress has tacitly ratified CMS's interpretation by failing to overturn it." Id. Here, there is no evidence that Congress is familiar with CMS' duplicative BNA. None

of the isolated amendments to the SSA's site neutral provisions have addressed outlier payments or budget neutrality. See Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 51005, 132 Stat. 64 (2018); 21st Century Cures Act, Pub. L. No. 114-255, §§ 15009(a), 15010(a), 130 Stat. 1033 (2016); Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 231, 129 Stat. 2242 (2015); Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, § 112(a), 128 Stat. 1040 (2014). Moreover, the erroneous BNA is even more recent than the error at issue in Cape Cod where the D.C. Circuit rejected implicit Congressional ratification because the error was "of too recent vintage." Cape Cod Hosp., 630 F.3d at 214. Thus, CMS cannot rely on any Congressional authorization or ratification to support the duplicative BNA.

6. CMS' Duplicative BNA Violates the Social Security Act and Other Federal Laws

CMS' decision to apply a second outlier budget neutrality adjustment to the LTCH site neutral payment rate violates several provisions of the SSA and other pieces of legislation. First, the duplicative budget neutrality adjustment violates the Federal statutes authorizing the LTCH PPS because it is not an "appropriate adjustment." Second, the adjustment is contrary to the SSA's authorization of only two payment rates for LTCH cases, the standard federal payment rate and the site neutral payment rate. Finally, the unwarranted budget neutrality adjustment violates the SSA's prohibition on cost-shifting.

a. The Extra BNA is Not an "Appropriate Adjustment"

In prior rulemakings, CMS has asserted that it has "ongoing authority to make annual HCO budget neutrality adjustments for payments under the LTCH PPS . . . using the broad authority provided by section 123 of Public Law 106-113 and section 307 of Public Law 106-554." Exhibit 4, FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. at 57308. However, CMS' exercise of this authority in applying the duplicative BNA is contrary to the statutory text.

Section 123 of the Balanced Budget Refinement Act of 1999 ("BBRA"), Pub. L. No. 106-113, 113 Stat. 1501 (1999), required CMS to develop and implement an LTCH PPS that "shall include an adequate patient classification system that is based on diagnosis-related groups (DRGs) and that reflects the differences in patient resource use and costs, and shall maintain budget neutrality."[21] BBRA § 123(a)(1). Section 307 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"), Pub. L. No. 106-554, 114 Stat. 2763 (2000), states that the Secretary "may provide for appropriate adjustment to the long-term hospital payment system." BIPA § 307(b)(1). The duplicative budget neutrality adjustment that CMS applies to the LTCH site neutral payment rate is not an "appropriate adjustment."

CMS claims that it has the authority to implement the additional BNA and that the BNA is necessary because "estimated site neutral payment rate HCO payments should not result in any change in estimated aggregate LTCH PPS payments." Exhibit 2, FY 2019 IPPS/LTCH PPS Final Rule, 83 Fed. Reg. at 41737. We do not dispute that CMS generally possesses the authority under BBRA section 123 and BIPA section 307 to apply a budget neutrality adjustment to prevent LTCH high cost outlier payments from increasing aggregate LTCH payments. CMS applies such a budget neutrality adjustment to account for outlier payments for LTCH standard rate cases. Similarly, CMS applies a budget neutrality adjustment to the IPPS payment rate to account for IPPS outlier payments. However, CMS exceeded its statutory authority, in violation of BIPA section 307(b)(1), when it applied a duplicative BNA to the LTCH site neutral payment rate because this extra adjustment is not an "appropriate adjustment."

---

21 CMS interprets BBRA's "budget neutrality" requirement as applying only to the first year of the LTCH PPS. See FY 2013 IPPS/LTCH PPS Final Rule, 77 Fed. Reg. 53258, 53494 (Aug. 31, 2012) ("[I]t has been our consistent interpretation that the statutory requirement for budget neutrality applies exclusively to FY 2003 when the LTCH PPS was implemented.").

An "appropriate adjustment" to maintain budget neutrality for site neutral outlier payments would have achieved actual budget neutrality and ensured that LTCH site neutral outlier payments did not increase *or decrease* aggregate LTCH payments. This was already accomplished by the 5.1% outlier budget neutrality adjustment from IPPS rate setting that CMS uses to calculate the IPPS comparable per diem amount for LTCH site neutral payments. This adjustment achieved the 5.1% offset (reduction) to LTCH site neutral payments equal to the target amount of LTCH site neutral outlier payments. The budget neutrality adjustment from the IPPS is arguably an "appropriate adjustment" to the LTCH site neutral payment rate. Any additional adjustment to LTCH site neutral payments to maintain budget neutrality due to LTCH site neutral outlier payments cannot be considered an "appropriate adjustment" under BIPA section 307(b)(1). Therefore, the extra 5.1% BNA at issue here violates BIPA section 307(b)(1). It is budget neutral in name only. Instead of ensuring that site neutral outlier payments do not cause any change in aggregate Medicare payments to LTCHs, this adjustment actually saves the Medicare program tens of millions of dollars every year. When Congress authorized CMS to make "appropriate adjustments" to the LTCH PPS, it could not have envisioned that CMS would apply a duplicative adjustment like the BNA at issue here. Accordingly, the adjustment must be set aside because it violates CMS' authority under BIPA section 307(b)(1) to apply "appropriate adjustments" to LTCH PPS payments.

b. CMS' Duplicative BNA Violates the Social Security Act's Dual-Rate Structure for the LTCH PPS

As discussed above, Congress established a new dual-rate payment structure under the LTCH PPS in section 1206 of the Pathway for SGR Reform Act of 2013. As of cost reporting periods beginning on or after October 1, 2015, this new dual-rate structure, at SSA section 1886(m)(6) requires. that CMS pay LTCHs one of two possible rates for Medicare Part A cases,

either the standard Federal payment rate or the new site neutral payment rate.[22] CMS' implementation of the new dual-rate structure violates SSA section 1886(m)(6) because CMS has decided to pay LTCH site neutral cases a rate that is contrary to the statute.

Section 1886(m)(6)(B)(ii) of the SSA defines the "site neutral payment rate" as the lower of: (1) "the IPPS comparable per diem amount determined under paragraph (d)(4) of section 412.529 of title 42, Code of Federal Regulations, including any applicable outlier payments under section 412.525 of such title;" or (2) "100 percent of the estimated cost of the services involved." Exhibit 6, 42 U.S.C. § 1395ww(m)(6)(B)(ii) (SSA § 1886(m)(6)(B)(ii)). CMS is violating this provision of the SSA because CMS is paying LTCH site neutral cases a rate that is not contemplated by the statute. CMS' payment rate for LTCH site neutral cases includes the 5.1% reduction to the IPPS payment rate to account for the targeted 5.1% of LTCH site neutral cases that will be paid a HCO payment. CMS then reduces the LTCH site neutral payment rate by *another 5.1%* to account for the same 5.1% target amount of LTCH site neutral outlier payments. The Social Security Act, at section 1886(m)(6), does not authorize CMS' payment rate with this extra budget neutrality adjustment. Furthermore, the regulation cited in the statute, 42 C.F.R. § 412.529(d)(4), does not specify a separate budget neutrality adjustment for LTCH payments based upon the IPPS comparable per diem amount.

CMS has stated with regard to the dual rate LTCH PPS that it does "not have the authority to pay LTCH discharges that fail to meet the patient-level criteria for payment at the LTCH PPS standard Federal payment rate at a rate other than the site neutral payment rate . . . ."

---

22 During the site neutral transition period, LTCH cases are paid either the standard Federal payment rate if the LTCH patient criteria are met or at the transitional blended payment rate if the LTCH patient criteria are not met. See Exhibit 6, 42 U.S.C. § 1395ww(m)(6)(B)(iii) (SSA § 1886(m)(6)(B)(iii)).

FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. at 57070. However, CMS is doing just that by applying the duplicative BNA. CMS is acting in direct contradiction of its own position on the dual rate LTCH PPS by paying LTCH site neutral cases a rate other than the site neutral payment rate contemplated by the statute. Furthermore, because CMS applies multiple budget neutrality adjustments to the site neutral payment rate, LTCHs may receive a lower Medicare payment for these cases than a short term acute care hospital would receive for the case under the IPPS. Therefore, the duplicative budget neutrality adjustment must be set aside because it is contrary to the SSA.

c. The Extra BNA Violates the Medicare Prohibition on Cost-Shifting

The Social Security Act prohibits CMS from shifting Medicare costs to non-beneficiaries (*i.e.*, "cost-shifting"). 42 U.S.C. § 1395x(v)(1)(A) (SSA § 1861(v)(1)(A)) ("[T]he necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered . . . ."). Courts have regularly recognized Medicare's cost-shifting prohibition (sometimes referred to as "anti-cross-subsidization provisions"). E.g., Abington Crest Nursing and Rehab. Ctr. v. Leavitt, 541 F. Supp. 2d 99, 106 (D.D.C. 2008); Foothill Hosp.-Morris L. Johnston Mem'l v. Leavitt, 558 F. Supp. 2d 1, 3 (D.D.C. 2008). In Howard Univ. v. Bowen, No. 85-3342, 1988 WL 33508 (D.D.C. Mar. 29, 1988), the D.C. District Court found that the cost-shifting prohibition superseded a contrary Medicare regulation, stating ". . . the Secretary failed to note that the prohibition against cost-shifting is not merely a general regulation, but, as noted above, is an integral part of the Medicare statute itself and has been so found by numerous courts." Id. at *2.

Here, CMS' decision to apply a second outlier budget neutrality adjustment to the LTCH site neutral payment rate violates the statutory prohibition on cost-shifting under 42 U.S.C.

§ 1395x(v)(1)(A)(i) because it results in Medicare costs being shifted to non-Medicare beneficiaries. Applying this duplicative budget neutrality adjustment reduces aggregate LTCH payments by approximately $28 million per year. See Exhibit 43, American Hospital Association, Comment Letter on FY 2019 IPPS/LTCH PPS Proposed Rule at 6. This is a windfall for the Medicare program that violates the Social Security Act's cost-shifting prohibition.

For the reasons discussed above, the duplicative outlier budget neutrality adjustment should be set aside because it violates the Social Security Act and other federal laws (*i.e.*, BIPA § 307(b)(1)). As a result of these statutory violations, the budget neutrality adjustment also must be set aside under the APA because the adjustment is "not in accordance with the law." Exhibit 10, 5 U.S.C. § 706(2)(A).

V. CONCLUSION

In order to grant the relief the Providers are requesting in this appeal, the PRRB would have to set aside the duplicative BNA. Such action is beyond the scope of the PRRB's authority. The Board is not authorized to create new Medicare regulations or policies or extend, limit, or modify the application of existing regulations or policies to address the legal challenge the Providers raise. Therefore, expedited judicial review is appropriate for the resolution of this matter. Because the Providers meet all of the requirements for EJR, the Board should grant the Providers' Request for EJR without delay.

Respectfully Submitted,

Jason M. Healy

Jason M. Healy, Esq.
THE LAW OFFICES OF
JASON M. HEALY PLLC
1750 Tysons Boulevard
Suite 1500
McLean, VA 22012
(703) 712-4744

Attorney for the Providers

November 20, 2018

CERTIFICATE OF SERVICE

We hereby certify that on this 20th day of November, 2018, the attached Providers' Request for Expedited Judicial Review was served by overnight mail to:

Byron Lamprecht
Wisconsin Physicians Service
Cost Report Appeals
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

Wilson C. Leong, Esq.
Federal Specialized Services
1701 S. Racine Avenue
Chicago, IL 60608-4058

Jason M. Healy

Jason M. Healy, Esq.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

Office of the Secretary

45 CFR Part 170

[CMS–1632–P]

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

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

ACTION: Proposed rule.

SUMMARY: We are proposing to revise 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, and other legislation. We also are addressing the update of the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits for FY 2016.

We also are proposing to update the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for FY 2016 and implement certain statutory changes to the LTCH PPS under the Affordable Care Act and the Pathway for Sustainable Growth Rate (SGR) Reform Act of 2013 and the Protecting Access to Medicare Act of 2014.

In addition, we are proposing to establish new requirements or to revise existing requirements for quality reporting by specific providers (acute care hospitals, PPS-exempt cancer hospitals, and LTCHs) that are participating in Medicare, including related proposals for eligible hospitals and critical access hospitals participating in the Medicare Electronic Health Record (EHR) Incentive Program. We also are proposing to update policies relating to the Hospital Value-Based Purchasing (VBP) Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition (HAC) Reduction Program.

DATES: *Comment Period:* To be assured consideration, comments on all sections of this proposed rule must be received at one of the addresses provided in the **ADDRESSES** section no later than 5 p.m. EST on June 29, 2015.

ADDRESSES: In commenting, please refer to file code CMS–1632–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may (and we encourage you to) submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the instructions under the ''submit a comment'' tab.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1632–P, P.O. Box 8013, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments via express or overnight mail to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1632–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call the telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, we refer readers to the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Ing-Jye Cheng, (410) 786–4548 and Donald Thompson, (410) 786–4487, Operating Prospective Payment, MS–DRGs, Deficit Reduction Act Hospital-Acquired Acquired Conditions—Present on Admission (DRA HAC–POA) Program, Hospital-Acquired Conditions Reduction Program, Hospital Readmission Reductions Program, Wage Index, New Medical Service and Technology Add-On Payments, Hospital Geographic Reclassifications, Graduate Medical Education, Capital Prospective Payment, Excluded Hospitals, and Medicare Disproportionate Share Hospital (DSH) Issues.

Michele Hudson, (410) 786–4487, Long-Term Care Hospital Prospective Payment System and MS–LTC–DRG Relative Weights Issues.

Siddhartha Mazumdar, (410) 786–6673, Rural Community Hospital Demonstration Program Issues.

Cindy Tourison, (410) 786–1093, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing—Program Administration, Validation, and Reconsideration Issues.

Pierre Yong, (410) 786–8896, Hospital Inpatient Quality Reporting—Measures Issues Except Hospital Consumer Assessment of Healthcare Providers and Systems Issues.

Elizabeth Goldstein, (410) 786–6665, Hospital Inpatient Quality Reporting—Hospital Consumer Assessment of Healthcare Providers and Systems Measures Issues.

Mary Pratt, (410) 786–6867, LTCH Quality Data Reporting Issues.

Kim Spalding Bush, (410) 786–3232, Hospital Value-Based Purchasing Efficiency Measures Issues.

James Poyer, (410) 786–2261, PPS-Exempt Cancer Hospital Quality Reporting Issues.

for LTCH PPS standard Federal payment rate cases would be budget neutral. Below we present our proposed calculation of the proposed LTCH PPS fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2016, which is consistent with the methodology used to establish the FY 2015 LTCH PPS fixed-loss amount. (Additional discussion of our HCO payment policy proposals for site neutral payment rate cases is discussed subsequently in section V.D.4. of this Addendum.)

In the FY 2015 IPPS/LTCH PPS final rule (79 FR 50399 through 50400), we presented our policies regarding the methodology and data we used to establish a fixed-loss amount of $14,972 for FY 2015, which was calculated using our existing methodology (based on the data and the rates and policies presented in that final rule) in order to maintain estimated HCO payments at the projected 8 percent of total estimated LTCH PPS payments. Consistent with our historical practice of using the best data available, in determining the fixed-loss amount for FY 2015, we used the most recent available LTCH claims data and CCR data, that is, LTCH claims data from the March 2014 update of the FY 2013 MedPAR file and CCRs from the March 2014 update of the PSF, as these data were the most recent complete LTCH data available at that time.

In this proposed rule, we are proposing to continue to use our existing methodology to calculate a fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2016 using the best available data that would maintain estimated HCO payments at the projected 8 percent of total estimated LTCH PPS payments for LTCH PPS standard Federal payment rate cases (based on the proposed rates and policies for these cases presented in this proposed rule). Specifically, based on the most recent complete LTCH data available (that is, LTCH claims data from the December 2014 update of the FY 2014 MedPAR file and CCRs from the December 2014 update of the PSF), we are proposing to determine a fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2016 that would result in estimated outlier payments projected to be equal to 8 percent of total estimated payments for these cases in FY 2016. Under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of the BIPA, we are proposing a fixed-loss amount of $18,768 for LTCH PPS standard Federal payment rate cases for FY 2016, and also to continue to make an additional HCO payment for the cost of an LTCH PPS standard Federal payment rate case that exceeds the HCO threshold amount that is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted LTCH PPS standard Federal payment rate payment and the proposed fixed-loss amount for LTCH PPS standard Federal payment rate cases of $18,768).

We note that the proposed fixed-loss amount of $18,768 for LTCH PPS standard Federal payment rate cases for FY 2016 is higher than the FY 2015 fixed-loss amount of $14,792. This increase is largely attributable to the implementation of the new statutory dual-rate LTCH PPS payment structure, under which we have proposed to have separate HCO target amounts for LTCH PPS standard Federal payment rate cases and site neutral payment rate cases. The FY 2015 fixed-loss amount was determined based data from all LTCH cases—both those that would have been paid as site neutral payment rate cases and those that would have been paid as LTCH PPS standard Federal payment rate cases if the statutory changes had been in effect at that time. However, under our proposal, the proposed fixed-loss amount of $18,768 for FY 2016 would only be used to determine HCO payments made for LTCH PPS standard Federal payment rate cases. We currently estimate that the FY 2015 fixed-loss amount of $14,972 results in estimated HCO payments for LTCH PPS standard Federal payment rate cases of approximately 8.6 percent of total estimated FY 2015 LTCH PPS payments to those cases, which exceeds the 8 percent target. Therefore, we believe that it is necessary and appropriate to increase the fixed-loss amount to maintain that, for LTCH PPS standard Federal payment rate cases, estimated HCO payments would equal 8 percent of estimated total LTCH PPS payments for those cases as required under the proposed revisions to § 412.525(a). (For further information on the existing 8 percent HCO ''target'' requirement, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 56022 through 56024).) Maintaining the fixed-loss amount at the current level would result in HCO payments that are more than the current regulatory 8-percent target that we are proposing would apply to total payments for LTCH PPS standard Federal payment rate cases because a lower fixed-loss amount would result in more cases qualifying as outlier cases, as well as higher outlier payments for qualifying HCO cases because the maximum loss that an LTCH must incur before receiving an HCO payment (that is, the fixed-loss amount) would be smaller. Consistent with our historical practice, we are proposing that if more recent data is available, we would use such data to calculate the FY 2016 fixed-loss amount for LTCH PPS standard Federal payment rate cases in the final rule.

b. Application of the High-Cost Outlier Policy to SSO Cases

Under our proposals to implement the dual-rate LTCH PPS payment structure required by statute, we are proposing that LTCH PPS standard Federal payment rate cases (that is, LTCH discharges that meet the criteria for exclusion from the site neutral payment rate) would continue to be paid based on the LTCH PPS standard Federal payment rate, and would include all of the existing payment adjustments under § 412.525(d), such as the adjustments for SSO cases under § 412.529. (For additional information on our proposed payments for LTCH standard payment rate cases, we refer readers to section VII.B.4.c. of the preamble of this proposed rule.) Under some rare circumstances, an LTCH discharge can qualify as an SSO case (as defined in the regulations at § 412.529 in conjunction with § 412.503) and also as an HCO case, as discussed in the August 30, 2002 final rule (67 FR 56026). In this scenario, a patient could be hospitalized for less than five-sixths of the geometric average length of stay for the specific MS–LTC–DRG, and yet incur extraordinarily high treatment costs. If the estimated costs exceeded the HCO threshold (that is, the SSO payment plus the fixed-loss amount), the discharge is eligible for payment as an HCO. Therefore, for an SSO case in FY 2016, the HCO payment would be 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the proposed fixed-loss amount of $18,768 and the amount paid under the SSO policy as specified in § 412.529).

4. Proposed High-Cost Outlier Payments for Site Neutral Payment Rate Cases

Under the new dual-rate LTCH PPS payment structure, the statute establishes two distinct payment rates for LTCH discharges beginning in FY 2016. Under this statutory change, as discussed in section VII.B. of the preamble of this proposed rule, we are proposing to pay for LTCH discharges that meet the criteria for exclusion from the site neutral payment rate (that is, LTCH PPS standard Federal payment rate cases) based on the LTCH PPS standard Federal payment rate. In addition, consistent with the statute, we are proposing that the site neutral payment rate is the lower of the IPPS comparable per diem amount as determined under § 412.529(d)(4), including any applicable outlier payments as specified in § 412.525(a); or 100 percent of the estimated cost of the case as determined under existing § 412.529(d)(2). Furthermore, we are proposing have two separate HCO targets-one for LTCH PPS standard Federal payment rate cases and one for site neutral payment rate cases.

For site neutral payment rate cases, we are proposing that such cases would receive an additional HCO payment for costs that exceed the HCO threshold that would be equal to 80 percent of the difference between the estimated cost of the case and the HCO threshold. We are proposing that the HCO threshold for site neutral payment rate cases would be the sum of the site neutral payment rate for the case and the IPPS fixed-loss amount. (We note that, as discussed in section VII.B.7.b. of the preamble of this proposed rule, in light of our HCO proposals in accordance with our implementation of the new statutory dual-rate LTCH PPS payment structure, any site neutral payment rate case that is paid 100 percent of the estimated cost of the case (because that amount is lower than the IPPS comparable per diem amount) would not be eligible to receive a HCO payment because, by definition, the estimated costs of such cases would never exceed the IPPS comparable amount by any threshold.) Under this proposal, we are proposing that HCO payments for site neutral payment rate cases would be budget neutral, such that the proposed site neutral payment rate HCO payments would not result in any change in estimated aggregate LTCH PPS payments. In order to achieve this, under proposed new § 412.522(c)(2)(i), we are proposing to apply a budget neutrality factor to the payments for all site neutral payment rate cases, which would be established on an estimated basis. (For additional details on our HCO policy

proposals for site neutral payment rate cases, we refer readers to section VII.B.7.b. of the preamble of this proposed rule.)

As we discussed in section VII.B.7.b. of the preamble of this proposed rule, in order to estimate the magnitude a proposed budget neutrality adjustment for HCO payments for site neutral payment rate cases, we relied on the assumption by our actuaries that site neutral payment rate cases would have lengths of stay and costs comparable to IPPS cases assigned to the same MS–DRG. Because site neutral payment rate cases are expected to have lengths of stay and costs comparable to IPPS cases assigned to the same MS DRG, we project that our proposal to use the IPPS fixed-loss threshold for the site neutral payment rate cases would result in HCO payments for site neutral payment rate cases that are similar in proportion as is seen in IPPS cases assigned to the same MS–DRG; that is, 5.1 percent. Therefore, under proposed new § 412.522(c)(2)(i), we are proposing to adjust all payments for site neutral payment rate cases by a budget neutrality factor so that the estimated HCO payments payable for site neutral payment rate cases do not result in any increase in aggregate LTCH PPS payments.

The statutory LTCH PPS payment changes required by section 1886(m)(6) of the Act (that is, the application of the site neutral payment rate) are effective for LTCH PPS discharges occurring in cost reporting periods beginning on or after October 1, 2015. In this proposed rule, to estimate total LTCH PPS site neutral payment rate payments in Federal FY 2016, we are proposing an adjustment to account for the varying effective dates of the statutory dual-rate LTCH PPS payment structure. In order to estimate FY 2016 LTCH PPS payments based on site neutral payment rate cases, it is necessary to account for the fact that LTCHs whose cost reporting periods begin after October 1, 2015, will receive the LTCH PPS standard Federal payment rates for all of their LTCH PPS cases, including their cases that would be site neutral payment rate cases, until the start of their next cost reporting period. For purposes of estimating site neutral payment rate payments in FY 2016, we examined LTCHs whose cost reporting periods begin in the first quarter of FY 2016 (that is, October through December 2015). We modeled that all of the FY 2016 site neutral payment rate cases associated with these LTCHs would be paid at the proposed transitional blended payment rate (that is, 50 percent of the applicable site neutral payment rate amount for the discharge as determined under proposed new § 412.522(c)(1) and 50 percent of the applicable LTCH PPS standard Federal payment rate determined under § 412.523). All of the first quarter FY 2016 site neutral payment rate cases for LTCHs whose cost reporting periods begin after the start of the first quarter of FY 2016 were modeled as being paid at the LTCH PPS standard Federal payment rate for all discharges in that quarter. We then examined LTCHs whose cost reporting periods begin in the second quarter of FY 2016 (that is, January through March 2016). We modeled that all of the second, third, and fourth quarter FY 2016 site neutral payment rate cases associated with these LTCHs would be paid at the transitional blended payment rate. All of the second quarter FY 2016 site neutral payment rate cases for LTCHs whose cost reporting periods begin after the start of the second quarter of FY 2016 were modeled as being paid at the LTCH PPS standard Federal payment rate for all discharges in that quarter. Similarly, we examined LTCHs whose cost reporting periods begin in the third quarter of FY 2016 (that is, April through June 2016). We modeled that all of the third and fourth quarter FY 2016 site neutral payment rate cases associated with these LTCHs would be paid at the transitional blended payment rate. For all of the third quarter FY 2016 site neutral payment rate cases for LTCHs whose cost reporting periods begin after the start of the third quarter of FY 2016, we modeled as being paid at the LTCH PPS standard Federal payment rate. Finally, we examined LTCHs whose cost reporting periods begin in the fourth quarter of FY 2016 (that is, July through September of 2016). We modeled all of the fourth quarter FY 2016 site neutral payment rate cases associated with these LTCHs as being paid at the transitional blended payment rate. We believe that this approach is reasonable for the purpose of taking into account in our FY 2016 payment estimates given the fact that LTCHs whose cost reporting periods begin after October 1, 2015 will receive the LTCH PPS standard Federal payment rate as payment for all of their LTCH PPS cases, including their cases that would be categorized as site neutral payment rate cases, until the start of their next cost reporting period. Based on the fiscal year start dates recorded in the December update of the Provider Specific File, of the 418 LTCHs in our database of LTCH claims from the December 2014 update of the FY 2014 MedPAR files used for this proposed rule, the following percentages apply in the approach described above: 10.85 percent of site neutral payment rate cases are from LTCHs whose cost reporting periods begin in the first quarter of FY 2016; 31.41 percent of site neutral payment rate cases are from LTCHs whose cost reporting periods begin in the second quarter of FY 2016; 10.83 percent of site neutral payment rate cases are from LTCHs whose cost reporting periods begin in the third quarter of FY 2016; and 46.91 percent of site neutral payment rate cases are from LTCHs whose cost reporting periods begin in the fourth quarter of FY 2016.

Using the approach described above to account for when LTCHs' first cost reporting period begins on or after October 1, 2015, and based on the applicable LTCH claims in our database from the December 2014 update of the FY 2014 MedPAR files, we estimate that site neutral payment rate HCO payments would be approximately 2.3 percent of total LTCH PPS payments for site neutral payment rate cases in FY 2016. Therefore, we are proposing to apply a budget neutrality factor of 0.976996 to all payments for site neutral payment rate cases in FY 2016 so that the estimated HCO payments payable to those cases do not result any increase in aggregate LTCH PPS payments, in accordance with proposed new § 412.522(c)(2)(i).

E. Proposed Update to the IPPS Comparable/Equivalent Amounts To Reflect the Statutory Changes to the IPPS DSH Payment Adjustment Methodology

In the FY 2014 IPPS/LTCH PPS final rule, we established a policy for reflecting the changes to the Medicare IPPS DSH payment adjustment methodology provided for by section 3133 of the Affordable Care Act in the calculation of the ''IPPS comparable amount'' under the SSO policy at § 412.529 and the ''IPPS equivalent amount'' under the 25-percent threshold payment adjustment policy at § 412.534 and § 412.536. Historically, the determination of both the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' includes an amount for inpatient operating costs ''for the costs of serving a disproportionate share of low-income patients.'' Under the statutory changes to the Medicare DSH payment adjustment methodology that began in FY 2014, in general, eligible IPPS hospitals receive an empirically justified Medicare DSH payment equal to 25 percent of the amount they otherwise would have received under the statutory formula for Medicare DSH payments prior to the amendments made by the Affordable Care Act. The remaining amount, equal to an estimate of 75 percent of the amount that otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under the age of 65 who are uninsured, is made available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. The additional uncompensated care payments are based on the hospital's amount of uncompensated care for a given time period relative to the total amount of uncompensated care for that same time period reported by all IPPS hospitals that receive Medicare DSH payments.

To reflect the statutory changes to the Medicare DSH payment adjustment methodology in the calculation of the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' under the LTCH PPS, we stated that we will include a reduced Medicare DSH payment amount that reflects the projected percentage of the payment amount calculated based on the statutory Medicare DSH payment formula prior to the amendments made by the Affordable Care Act that will be paid to eligible IPPS hospitals as empirically justified Medicare DSH payments and uncompensated care payments in that year (that is, a percentage of the operating DSH payment amount that has historically been reflected in the LTCH PPS payments that is based on IPPS rates). We also stated that the projected percentage will be updated annually, consistent with the annual determination of the amount of uncompensated care payments that will be made to eligible IPPS hospitals. As explained in the FY 2014 IPPS/LTCH PPS final rule (79 FR 50766 through 50767), we believe that this approach results in appropriate payments under the LTCH PPS and is consistent with our intention that the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' under the LTCH PPS closely resemble what an IPPS payment would have been for the same episode of

American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

June 15, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1632-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS 1632-P, 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, April 30, 2015.

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 286 long-term care hospitals (LTCHs), the American Hospital Association (AHA) appreciates the opportunity to comment on the LTCH provisions in the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2016 proposed rule for the inpatient and LTCH prospective payment systems (PPS). This letter addresses the proposed criteria for the standard LTCH PPS rate, the proposed implementation of LTCH site-neutral payment and the proposed additions to the LTCH quality reporting program (QRP). We will submit comments separately on the agency's inpatient PPS proposals.

In addition to other changes, this rule proposes implementation of the Bipartisan Budget Act of 2013 (BiBA) requirement to add a site-neutral payment component to the LTCH PPS for cost reporting periods beginning on or after Oct. 1, 2015. This change represents a major transformation of the LTCH PPS. **We support many of CMS's proposals, such as how the agency would identify psychiatric and rehabilitation cases and intensive care unit (ICU) or coronary care unit (CCU) days, which align with congressional intent. However, we have serious concerns about others, especially the proposal to use the patient discharge status code from prior hospital stays, to, in part, distinguish cases that would be eligible for a**

We speculate that this inconsistency has arisen due to the complexity of applying the blended rates to FY 2016 payments. CMS's proposed methodology for doing so utilizes discordant concepts related to the 2.3 percent and 5.1 percent targets, which is one of the major hindrances to us understanding the calculations leading to its proposed HCO outlier pool for site-neutral cases. **Therefore, when applying blended payments in FYs 2016 and 2017, we urge CMS to calculate the site-neutral and the standard rate portions separately. That is, we urge CMS to allow the site-neutral portion to be governed solely by the inpatient PPS rates (which have already been adjusted for outlier budget neutrality) and inpatient PPS fixed-loss amount, and allow the standard rate portion to be governed solely by the standard LTCH PPS rates (which also have been adjusted for outlier budget neutrality) and the LTCH PPS fixed-loss amount.** By removing elements of the site-neutral HCO calculation that inappropriately co-mingle site-neutral and standard rate elements, CMS would streamline the policy in a way that will help set accurate payments for both the site-neutral and standard rate portions.

Duplicate BNAs Are Unwarranted and Result in Inappropriately Low-payment Rates. CMS is proposing two outlier-related BNAs for the standard LTCH PPS rates that are used to calculate the blended rate paid to site-neutral cases. The first BNA, which CMS applies to the standard rate, is 8 percent and allocates funds for an 8-percent outlier pool for all standard LTCH PPS cases. The second BNA, which CMS applies to both the site-neutral and standard portion of the blended rate, is 2.3 percent. Thus, for cases paid under the site-neutral blended rate, the standard rate portion of that payment will have two BNAs applied. **Consequently, the standard rate portion of the blended payment is lower than the standard rate used to pay standard LTCH PPS cases. This is inappropriate.**

CMS also proposes two outlier-related BNAs for site-neutral rates. Specifically, the inpatient PPS rates used as the basis for site-neutral payment rates are already subject to a BNA for the inpatient PPS's 5.1 percent outlier pool. However, within the LTCH payment framework, CMS proposes a second BNA of 2.3 percent for the site-neutral outlier pool. CMS's rationale for this second BNA is to ensure that site-neutral HCO payments do not increase aggregate LTCH PPS payments. **However, we strongly disagree that the additional 2.3 percent BNA is necessary to achieve this goal; rather, it was already achieved when the 5.1 percent BNA was applied to the inpatient PPS rates used as the basis for the site-neutral rates. We recommend that CMS calculate standard LTCH PPS and site-neutral rates separately, without any co-mingling of these payments, as mentioned previously.** Furthermore, the second BNA prevents LTCH site-neutral payments from aligning with inpatient PPS payments for associated MS-DRG and MS-LTC-DRGs, which would counter the goals of BiBA.

Duplicative BNA Based on Overstated Costs and Lengths of Stay for Site-neutral Cases. **While we urge CMS to eliminate application of the duplicative 2.3 percent BNA, if it does not, it must at the very least correct its calculation of the figure, which is based on overstated costs and lengths of stay.** Specifically, when calculating the site-neutral rates for FY 2016, CMS used the historical cost and length-of-stay data from the FY 2014 LTCH MedPAR file. However, this approach does not align with the generally held expectation that site-neutral cases will have, on average, lower levels of medical severity and shorter lengths of stay than standard

NATIONAL ASSOCIATION OF LONG TERM HOSPITALS
NALTH

Administration: 342 North Main St, Suite 301 • West Hartford, CT 06117
Phone: 860 586-7579 • info@NALTH.org • nalth.org

June 16, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Submitted electronically

RE: CMS-1632-P, 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; Proposed Rule (Vol. 80, No. 83), April 30, 2015

Dear Mr. Slavitt:

The National Association of Long Term Hospitals (NALTH) is pleased to submit comments on the inpatient prospective payment system (IPPS) and long-term care hospital payment system proposed rule for fiscal year (FY) 2016. NALTH is the only hospital trade association in the nation that is devoted exclusively to the needs of patients who require services provided by long term care hospitals (LTCHs). NALTH is committed to research, education and public policy development that further the interests of the very ill and often debilitated patient populations that receive services in LTCHs throughout the nation. NALTH's membership is composed of the nation's leading LTCHs, which serve approximately one-third of the Medicare beneficiaries who are admitted to LTCHs in the United States. On behalf of our member hospitals, we wish to express our gratitude for the opportunity to share our comments on this proposed rule.

These comments place special attention on issues that uniquely affect LTCHs. Our comments are structured as follows:

1. Proposed payment policies affecting long-term care hospitals in FY 2016. This section includes comments related to implementation to the new LTCH patient criteria and the short-stay outlier policy.

2. Quality measures. We provide comments on future measures and measure concepts under consideration by CMS.

3. The Bundled Payment for Care Improvement (BPCI) Initiative. We provide comments on the future of the BPCI initiative.

Calculation of the High-Cost Outlier Fixed-Loss Threshold: Separate Outlier Thresholds

- **NALTH Position: We concur with CMS's proposed establishment of separate outlier thresholds for site neutral and non-site neutral cases. We also concur with CMS's proposed use of the IPPS fixed loss outlier threshold for site-neutral cases.**

The high-cost outlier (HCO) fixed-loss threshold is set at a value such that the outlier pool will be equal to 8% of total payments. This is estimated using historical Medicare claims data. In NALTH comments to the FY 2015 proposed rule, we recommend that CMS exclude non-qualifying cases from the calculation of the fixed-loss threshold. We appreciate CMS's acceptance of this approach and support the establishment of a separate outlier threshold for site-neutral cases at the IPPS HCO fixed-loss threshold.

Calculation of the High-Cost Outlier Fixed-Loss Threshold: Budget Neutrality

- **NALTH Position: We object to the application of a budget neutrality adjustment to site-neutral cases.**

CMS is proposing to make a budget neutrality adjustment to make sure the use of the IPPS outlier threshold for site-neutral cases does not result in an increase in LTCH payments for these cases. CMS states on page 24540-24541: "*For site neutral payment rate cases, we are proposing to use the fixed loss amount determined annually under the IPPS HCO policy, and we estimate that this would result in an estimated proportion of HCO payments to total LTCH PPS payments for site neutral payment rate cases of 5.1 percent*."

While this would seem to indicate that CMS believes that the application of the IPPS HCO threshold would result in total payments for site-neutral cases that are equal to what the cases would have been paid in total had they been cared for at a subsection(d) hospital, CMS goes on to state: "*We are proposing that HCO payments to site neutral payment rate cases would be budget neutral, consistent with the current LTCH PPS HCO policy. To maintain budget neutrality, we are proposing to apply a budget neutrality factor to the LTCH PPS payments for site neutral payment rate cases.*"

CMS proposes to apply a budget neutrality factor of 0.976996 to all site-neutral payment rate cases to ensure budget neutrality.

NALTH objects to the application of a budget neutrality adjustment to site-neutral cases. First, the application of budget neutrality adjustment to payment rates for site-neutral cases is inconsistent with the concept of site-neutral payment. Under this policy, "site-neutral" payments in the LTCH PPS are distorted by two factors: (1) the use of the lesser of cost to the LTCH or the IPPS comparable amount; and (2) the application of budget neutrality adjustment.

Thus, even the IPPS comparable amount is not truly comparable to the IPPS payments. **Second, the LTCHs payment for site-neutral cases is already reduced because rates are determined using the IPPS standardized amount, which has been reduced to fund high-cost outliers.** If CMS continues with the application of a budget neutrality adjustment for site-neutral cases, it should estimate payments for these cases using an IPPS standardized amount prior to the application of reductions to pay for outliers and set the budget neutrality adjustment such that total estimated payments to site-neutral cases equal total estimated payment with this unreduced standardized amount.

Calculation of MS-LTC-DRG Weights

- **NALTH Position: For FY 2016, calculation of MS-LTC-DRG weights should be based on all LTCH cases. In subsequent years, the MS-LTC-DRG weights should be based exclusively on cases meeting the LTCH criteria. CMS should explore options for improving the year-to-year stability of the MS-LTC-DRG weights.**

Relative weights in the LTCH PPS are calculated based on average resource-use and MS-LTC-DRGs. Under the Pathway for SGR Reform Act, only cases meeting the LTCH criteria will be paid using these rates. In comments to the FY 2015 proposed rule, NALTH recommended that payment weights calculated for the LTCH-PPS should be based exclusively on cases that will be paid using these weights (i.e., the non-site neutral cases). We argued that including non-qualifying cases in the relative weight calculation will introduce statistical noise that will degrade payment accuracy, because site neutral cases are likely to have different costs than cases that meet the new criteria.

While NALTH continues to believe that the costs of site neutral and non-site neutral cases will be very different once LTCH behavior responds to the incentives under the new policies, these behavioral changes are not observable in the 2014 MEDPAR data as the new policies were not in effect. In addition, LTCHs will be subject to the new policies based on their cost reporting periods, so LTCHs will be responding to the incentives under the new policies at different times between October 1, 2015 and October 1, 2016. Further, NALTH is concerned that the reduced sample sizes that result from including only qualifying cases in the calculation of the MS-LTC-DRG weights creates greater instability in the weights and may result in greater year-to-year variations. These year-to-year variations make it harder for LTCHs to plan and conduct regular business operations.

We are aware that CMS reported that the weights overall are similar when using all LTCH cases or only those that meet criteria. However, we believe that there can be significant variation for specific LTC-MS-DRGs. **Therefore, we request CMS to base FY 2016 weights on all cases and**

Charles N. Kahn III
President and CEO

June 16, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

SUBJECT: CMS-1632-P. Medicare Program; Hospital Inpatient Prospective Payment System 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 Records Incentive Program; Proposed Rule, April 30, 2015

Dear Administrator Slavitt:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay, rehabilitation, and long-term care hospitals in urban and rural America, and provide a wide range of acute, post-acute and ambulatory services. The FAH appreciates the opportunity to comment to the Centers for Medicare & Medicaid Services ("CMS") about the referenced Notice of Proposed Rulemaking on the 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 Records Incentive Program; Proposed Rule, April 30, 2015 ("Proposed Rule").

- **Short-Stay Outlier Adjustment**

The FAH agrees with CMS that it should not apply the short stay outlier ("SSO") payment adjustment at 42 C.F.R. § 412.529, or any other SSO payment adjustment, to payments for LTCH cases paid at the site neutral rates.

VII.B.6. Proposals Relating to the LTCH Discharge Payment Percentage

The FAH urges CMS to develop a process to notify LTCHs of their discharge payment percentage through regulations and a formal rulemaking process. This issue is too important and the consequences of not meeting the 50 percent threshold are too severe to relegate to subregulatory guidance the process through which CMS will inform LTCHs. It requires the transparency and public input that notice and comment rulemaking would ensure.

For LTCHs that do not maintain a discharge payment percentage of at least 50 percent in a cost reporting period beginning on or after October 1, 2020, CMS should establish a "cure period" similar to the one that is used to confirm compliance with the ALOS requirement. The FAH also suggests that CMS establish a reinstatement process that allows a hospital to regain its LTCH payment classification after demonstrating over a period of time (perhaps the 5 to 6 month period that is used to establish that an LTCH meets the ALOS requirement) to establish that it satisfies the 50 percent discharge payment percentage requirement. The FAH believes CMS should propose regulations to implement this cure period and reinstatement process well in advance of FY 2021 to allow sufficient time for notice, comment and industry dialogue.

VII.B.7.b. High Cost Outlier Fixed Loss Thresholds Target Amounts and Budget Neutrality Adjustment

CMS has made a number of proposals relative to high-cost outlier ("HCO") cases. First, CMS is proposing to establish separate fixed-loss amounts for cases paid at the site neutral payment rate ($24,485, the same as the proposed FY 2016 IPPS fixed-loss amount) and for cases paid the LTCH PPS standard Federal payment rate ($18,768 based only upon cases that meet the new patient criteria). CMS is proposing to establish two separate HCO targets, one for LTCH PPS standard Federal payment rate cases and one for cases paid at the site neutral payment rate. CMS is also proposing to continue to use an 8 percent target for HCO payments for LTCH standard Federal payment rate cases and to use the IPPS HCO payment target of 5.1 for HCO payments for site neutral payment rate cases. Lastly, CMS is proposing to apply a new budget neutrality adjustment ("BNA") factor of .976996 to cases paid at the site neutral rate.

The FAH agrees with CMS's proposal to revise the LTCH HCO policy to establish a separate HCO outlier pool (target) and fixed-loss threshold for site neutral payment cases and to use a target amount of 8 percent for HCOs paid using the LTCH PPS standard Federal payment rate. We believe CMS should recalculate and reduce the proposed fixed-loss amount for HCO cases paid under the LTCH PPS standard Federal payment rate to incorporate the cases that were improperly excluded from CMS's calculation, as explained in greater detail in commentary from the comment letter submitted by Kindred Healthcare. The FAH supports CMS's proposals to

use the FY 2016 IPPS fixed-loss amount of $24,485 for site neutral payment rate cases, and the same 5.1 percent target as the IPPS for HCO payments to these cases, which are paid based largely on the IPPS for short stay acute care hospitals. The FAH does not believe, however, that CMS should automatically use the IPPS fixed-loss amount and target for site neutral HCO cases every year. Instead, the FAH suggests that once data becomes available following the transition to the new two-tiered LTCH payment system, CMS should calculate the fixed-loss amount and target amount for site neutral HCO cases.

The FAH does not believe CMS should apply a budget neutrality factor to LTCH site neutral cases that qualify for HCO payments. CMS has already accounted for estimated outlier payments for site neutral cases when it adjusted the IPPS payment rate for FY 2016. So to apply an additional budget neutrality factor for these LTCH cases, which are paid at an IPPS comparable rate, amounts to an additional unwarranted reduction in payment, and there is otherwise no precedent for such an adjustment to the annual payment rate determination for the LTCH PPS. The FAH does not think that CMS should, under any circumstances, apply a budget neutrality factor to payments for all LTCH PPS cases to adjust for site neutral high-cost outliers.

VII.C.2.g. Steps for Determining the Proposed FY 2016 MS-LTC-DRG Relative Weights

Each year CMS updates and adjusts the MS-LTC-DRG classifications and relative weights.

CMS established the LTCH cases for FY 2016 rate setting by identifying LTCH cases that would have met the new patient criteria and excluding claims from all-inclusive rate LTCHs, claims from demonstration project LTCHs, and certain Medicare advantage claims. The remaining claims data were used to calculate the proposed relative weights for the LTCH PPS standard Federal payment rate payments for FY 2016.

Based on a review performed by Watson Policy Analysis noted in Kindred's comment letter, the FAH is informed that there were a number of errors in the methodology employed by CMS in calculating the proposed payment weights, which impacted the LTC-DRG weights, geometric mean length of stay, SSO thresholds, and the HCO fixed-loss thresholds. The FAH urges CMS to review its methodology and the findings of Watson Policy Analysis carefully and to ensure that any methodological errors are corrected when calculating the final weights.

In order to determine the proposed transitional blended payment for site neutral payment rate cases grouped to one of the psychiatric or rehabilitation MS-LTC-DRGs in FY 2016, CMS must assign a relative weight to each of these MS-LTC-DRGs. CMS is proposing to use the FY 2015 relative weights for these 15 psychiatric and rehabilitation MS-LTC-DRGs, since there will be no LTCH cases exempt from the site neutral payments to use in calculating a new proposed relative weight for these proposed MS-LTC-DRGs. The proposed FY 2016 MS-LTC-DRG relative weights are listed in Table 11 of the Proposed Rule.

The FAH agrees with this approach. However, Table 11 to the Proposed Rule shows different weights for these 15 MS-LTC-DRGs than the weights listed in the FY 2015 LTCH PPS Final Rule. The FAH recommends that CMS correct Table 11 in the Final Rule so the

POST ACUTE MEDICAL™

June 16, 2015

Filed Electronically

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-1632-P
P.O. Box 8013
Baltimore, MD 21244-1850

***Re: 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*; 80 Federal Register 24,324 (April 30, 2015).**

Dear Mr. Slavitt:

This letter presents the comments and recommendations of Post Acute Medical on the above-referenced Proposed Rule. Post Acute Medical operates a network of 11 long-term acute care hospitals ("LTCHs") that care for medically-complex patients who require acute care hospital services for an extended period of time. We appreciate the opportunity to express our concerns with the proposed changes to the fiscal year ("FY") 2016 LTCH prospective payment system ("LTCH PPS") and related policies, and we trust that CMS will carefully consider each of the issues raised in this letter.

NEW LTCH PATIENT CRITERIA & SITE-NEUTRAL PAYMENT

1. Proposed Implementation of the ICU Criterion

Issue. Section 1886(m)(6)(A)(iii)(I) of the Social Security Act specifies that in order to qualify for the ICU criterion, the LTCH admission must be immediately preceded by a discharge from a subsection (d) hospital that included at least 3 days in an intensive care unit ("ICU"), as determined by the Secretary. Section 1886(m)(6)(A)(iii)(II) of the Social Security Act states that, in determining ICU days, the Secretary shall use data from revenue center codes 020X or 021X (or such successor codes as the Secretary may establish). Both of these revenue code descriptions are further divided into subcategories that form a revenue center code series. For billing purposes, the "X" in the revenue code descriptions for revenue center codes 020X and 021X refers to one of

Second, CMS is proposing to establish two separate HCO targets—one for LTCH PPS standard Federal payment rate cases and one for site neutral payment rate cases. CMS is proposing to continue to use an 8 percent target for HCO payments for LTCH standard Federal payment rate cases. This target should result in estimated HCO payments projected to be equal to 8 percent of total estimated payments for these cases in FY 2016. CMS also is proposing to use the target that is used for IPPS HCO payment of 5.1 percent for HCO payments to site neutral payment rate cases. CMS projects that using this target "would result in HCO payments for site neutral payment rate cases that are similar in proportion as is seen in IPPS cases assigned to the same MS-DRG; that is, 5.1 percent."[31]

Third, CMS is proposing to apply a new budget neutrality adjustment ("BNA") factor of 0.976996 under proposed new regulation § 412.522(c)(2)(i) to all site neutral payment rate cases to offset the 5.1 percent target, so that HCO payments for site neutral cases would not result in any change in estimated aggregate LTCH PPS payments. CMS explains that it calculated this BNA based upon when LTCHs' first cost reporting period begins on or after October 1, 2015, and based on the applicable LTCH claims in their database from the December 2014 update of the FY 2014 MedPAR files, which resulted in an estimate that site neutral payment rate HCO payments would be approximately 2.3 percent of total LTCH PPS payments for site neutral payment rate cases in FY 2016. However, CMS is asking for comments on this approach and whether to apply a single budget neutrality factor to all LTCH PPS cases, irrespective of the site neutral payment rate.[32]

Comment. Section 1206 of the PSRA states that discharges which do not qualify for a standard LTCH PPS payment amount based on a MS-LTC-DRG will receive a "site neutral" payment rate. When the "IPPS comparable per diem amount" is used for this site neutral payment, the legislation states that any applicable high cost outlier payment under the LTCH PPS is included. The PSRA specifically refers to the LTCH HCO regulation at 42 C.F.R. § 412.525 for this purpose. However, the legislation does not state whether or not the HCO payment is made out of the LTCH PPS 8 percent HCO "pool," which is the targeted 8 percent of total LTCH payments each year that CMS uses to pay for LTCH HCO cases. CMS specifically asked for comments on this issue in the FY 2015 LTCH PPS Proposed Rule.[33] CMS stated that they have the authority to make appropriate modifications to payments determinations under the LTCH PPS. CMS said that they "will need to decide whether to maintain a single high-cost outlier 'target' for all LTCH PPS cases (including 'site neutral' payment cases) or whether it may be more appropriate to establish separate high-cost outlier 'targets' for each of the two payment groups under the revised LTCH PPS."[34]

As commenters recommended last year, CMS should revise the LTCH HCO policy to establish a separate HCO outlier pool (target) and fixed-loss threshold for site neutral payment cases. A target of 8 percent should be maintained for cases that meet the new

[31] Id. at 24649.
[32] Id. at 24540.
[33] 79 Fed. Reg. 27978, 28205-06 (May 15, 2014).
[34] Id. at 28,206.

we do not believe that CMS should automatically use the IPPS fixed-loss amount and target for site neutral HCO cases every year. As claims data become available from the transition to the new dual-rate LTCH PPS, we expect that CMS will need to calculate a different fixed-loss amount and target amount for site neutral HCO cases. Until that time, using the IPPS fixed-loss amount and target amount is a reasonable place to start.

We do *not* agree with the proposed budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. CMS says that "a budget neutrality factor will *continue* to be applied to LTCH PPS *standard Federal payment rate* cases to offset that 8 percent [target] so that HCO payments for LTCH PPS standard Federal payment rate cases would be budget neutral."[37] CMS points to this budget neutrality factor as precedent for a BNA factor to offset LTCH *site neutral* payments by the 5.1 percent target for site neutral HCO cases.[38] As CMS explains in the preamble:

> The current LTCH PPS HCO policy has a budget neutrality requirement in which the LTCH PPS standard Federal payment rate is reduced by an adjustment factor to account for the estimated proportion of HCO payments to total estimated LTCH PPS payments, that is, 8 percent. (We refer readers to § 412.523(d)(1) of the regulations.) This budget neutrality requirement is intended to ensure that the HCO policy would not result in any change in estimated aggregate LTCH PPS payments. Under our proposal to continue to apply the current HCO methodology as it relates to LTCH PPS standard Federal payment rate cases (other than determining a fixed-loss amount using only data from LTCH PPS standard Federal payment rate cases), we also would continue to apply the current budget neutrality requirement (described above). In accordance with the current LTCH PPS HCO policy budget neutrality requirement, we believe that the HCO policy for site neutral payment rate cases should also be budget neutral, meaning that the proposed site neutral payment rate HCO payments should not result in any change in estimated aggregate LTCH PPS payments. In order to achieve this, under proposed new § 412.522(c)(2)(i), we are proposing to apply a budget neutrality factor to the payment for all site neutral payment rate cases described under proposed new § 412.522(a)(1), which would also be established on an estimated basis. This approach is consistent with the HCO policy proposed for LTCH PPS standard Federal payment rate cases, which is budget neutral within the universe of LTCH PPS standard Federal payment rate cases. We are inviting public comments on this proposed approach and the alternative approach of applying a single budget neutrality factor to all LTCH PPS cases, irrespective of the site neutral payment rate.[39]

[37] 80 Fed. Reg. at 24647-48 (emphasis added).
[38] See 80 Fed. Reg. at 24539-40, 24647-48.
[39] Id. at 24539-40.

However, CMS does not state in the Proposed Rule what the budget neutrality factor is for HCO payments to LTCH PPS *standard Federal payment rate* cases. In addition, the regulation at § 412.523(d)(1) only says that "CMS adjusts the standard Federal rate by a reduction factor of 8 percent, the estimated proportion of outlier payments under the long-term care hospital prospective payment system, as described in § 412.525(a)." The regulation at § 412.525(a) does *not* address budget neutrality—it determines the amount of the HCO payment, when an HCO payment is made, the cost-to-charge ratio that is used and reconciliation of outlier payments. Moreover, in the same parts of the preamble to the LTCH PPS rate update in previous years, CMS does *not* mention a budget neutrality adjustment for LTCH HCO cases.

Based upon our review of the rulemaking record, there does *not* appear to be an existing budget neutrality adjustment for LTCH HCO payments that is applied during the update to the LTCH PPS standard Federal payment rate each fiscal year. Rather, it appears that CMS may have considered the HCO target and its effect on overall LTCH HCO payments when setting the payment rate *in the first year of the LTCH PPS only*. This was done to comply with the statutory requirement that the LTCH PPS be budget neutral *in the first year only*, compared to the previous TEFRA payment system—not each year as CMS implies in the Proposed Rule.[40] Therefore, the BNA factor that CMS is proposing to apply to offset FY 2016 site neutral payments by the 5.1 percent target for site neutral HCO cases—and would no doubt apply in each subsequent fiscal year—has *no precedent* in the LTCH PPS and is *not required* by the PSRA, the PAMA, or the Social Security Act.

Having established that there is no precedent in the LTCH PPS for a budget neutrality adjustment to FY 2016 site neutral payments, we also found that CMS already accounted for site neutral HCO payments when setting the IPPS payment rate. As discussed above, HCO payments for LTCH site neutral cases will be 80% of the difference between the estimated cost of the case and the proposed IPPS HCO threshold, which is $24,485 for FY 2016. The proposed IPPS HCO threshold for site neutral payment rate cases would be the sum of the site neutral payment and the proposed IPPS fixed-loss amount of $24,485. Because site neutral payment rate cases that are paid 100% of the estimated cost of the case would never be eligible for a HCO payments, all site neutral HCO payments will be based on the IPPS comparable per diem amount. CMS believes that this methodology will "reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems."[41] However, by aligning this proposed policy with the IPPS payment system—and making the IPPS comparable per diem amount and the IPPS fixed-loss amount the primary components—CMS needs to consider the adjustments that it has already made to the

[40] See Section 123(a)(1) of Public Law 106-113; 42 C.F.R. § 412.523(d)(2) ("*Budget neutrality.* CMS adjusts the Federal prospective payment rates for FY 2003 so that aggregate payments under the prospective payment system are estimated to equal the amount that would have been made to long-term care hospitals under Part 413 of this subchapter without regard to the prospective payment system implemented under this subpart.").

[41] 80 Fed. Reg. at 24539.

proposed IPPS payment rates to account for outlier payments. We do not believe CMS had done this in the Proposed Rule.

Specifically, CMS already reduced the operating standardized payment amount under the IPPS and the capital federal rate under the capital PPS for outliers.[42] In determining these payment rates for FY 2016, CMS reduced the IPPS payment rate by a factor of 0.948999 and CMS reduced the capital PPS payment rate by a factor of 0.935731. **It would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed site neutral HCO BNA. This would be the case because the IPPS comparable per diem amount will be based on the FY 2016 IPPS payment rate, which has already been adjusted by the 5.1 percent outlier target. Since CMS has already reduced the FY 2016 IPPS payment rate by the 5.1 percent of estimated outlier payments in FY 2016, it would be inappropriate for CMS to reduce LTCH payments that are based on the IPPS rate again for site neutral cases that qualify as HCOs. Therefore, we object to CMS' proposal to apply a separate HCO BNA to LTCH site neutral payments.**

Recommendations. CMS should continue to use a target amount of 8 percent for HCOs paid using the LTCH PPS standard Federal payment rate. CMS should recalculate and reduce the proposed fixed-loss amount for HCO cases paid under the LTCH PPS standard Federal payment rate after adding the 30,000 to 60,000 cases that were incorrectly excluded from CMS' calculation. For FY 2016 only, we agree with CMS' proposals to use the FY 2016 IPPS fixed-loss amount of $24,485 for site neutral payment rate cases, and the same 5.1 percent target as the IPPS for HCO payments to these cases. CMS should *not* apply a budget neutrality factor to LTCH site neutral payments for high-cost outliers. In no event should CMS apply a budget neutrality factor to payments for all LTCH PPS cases to adjust for site neutral high-cost outliers.

MORATORIUM ON NEW LTCHS AND LTCH SATELLITE FACILITIES

Issue. CMS states that, while the expired moratorium specifically included an exception to the moratorium on the increase in the number of beds in existing LTCHs and LTCH satellite facilities, the new moratorium under section 1206(b)(2)(B) of Public Law 113–67 expressly noted that the exceptions to the expired moratoria would not apply under the "new" moratoria. Further amendments made by section 112(b) of Public Law 113–93, which create the exceptions to the current moratoria, did not change that express omission (79 FR 50189 through 50193). Given the lack of any exception to the new moratorium on increasing the number of beds in an existing LTCH or LTCH satellite facility, an LTCH may not increase the total number of Medicare certified beds beyond the number that existed prior to April 1, 2014, *including when an existing LTCH meets one of the exceptions to the moratorium on the establishment of a new LTCH satellite facility*. An LTCH satellite facility's beds historically have been, and continue to be, counted as the LTCH's beds. Therefore, under CMS' existing regulation at § 412.23(e)(7)(iii), an existing LTCH cannot, through meeting the criteria for an exception to the new moratorium on the establishment of a new LTCH satellite facility, increase its

[42] Id. at 24634-35.

June 16, 2015

Filed Electronically

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-1632-P
P.O. Box 8013
Baltimore, MD 21244-1850

***Re: 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*; 80 Federal Register 24,324 (April 30, 2015).**

Dear Mr. Slavitt:

This letter presents the comments and recommendations of Kindred Healthcare, Inc. ("Kindred") and Select Medical Holdings Corp. ("Select Medical") on the above-referenced Proposed Rule. Kindred and Select Medical collectively operate 209 hospitals that are certified by Medicare as long-term acute care hospitals ("LTCHs")—almost half of the LTCHs operating across the United States. These hospitals care for medically-complex patients who require acute care hospital services for an extended period of time. We appreciate the opportunity to express our concerns with the proposed changes to the fiscal year ("FY") 2016 LTCH prospective payment system ("LTCH PPS") and related policies, and we trust that CMS will carefully consider each of the issues raised in this letter.

EXECUTIVE SUMMARY

We agree with the 13 ICD-10 MS-LTC-DRGs relating to psychiatric diagnoses and the 2 ICD-10 MS-LTC-DRGs relating to rehabilitation diagnoses that CMS listed in the Proposed Rule for excluding LTCH cases from the LTCH PPS standard Federal payment rate. We also agree that the Social Security Act, as amended by the Pathway

Third, CMS is proposing to apply a new budget neutrality adjustment ("BNA") factor of 0.976996 under proposed new regulation § 412.522(c)(2)(i) to all cases paid at the site neutral payment rate to offset the HCO payments, so that HCO payments for site neutral cases would not result in any change in estimated aggregate LTCH PPS payments. CMS explains that it calculated this BNA based upon when LTCHs' first cost reporting period begins on or after October 1, 2015, and based on the applicable LTCH claims in their database from the December 2014 update of the FY 2014 MedPAR files, which resulted in an estimate that site neutral payment rate HCO payments would be approximately 2.3 percent of total LTCH PPS payments for cases paid at the site neutral payment rate in FY 2016. However, CMS is asking for comments on this approach and whether to apply a single budget neutrality factor to all LTCH PPS cases, irrespective of the site neutral payment rate.[49]

Comment. Section 1206 of the PSRA states that discharges which do not qualify for a standard LTCH PPS payment amount based on a MS-LTC-DRG will receive a "site neutral" payment rate. When the "IPPS comparable per diem amount" is used for this site neutral payment, the legislation states that any applicable high cost outlier payment under the LTCH PPS is included. The PSRA specifically refers to the LTCH HCO regulation at 42 C.F.R. § 412.525 for this purpose. However, the legislation does not state whether or not the HCO payment is made out of the LTCH PPS 8 percent HCO "pool," which is the targeted 8 percent of total LTCH payments each year that CMS uses to pay for LTCH HCO cases. CMS specifically asked for comments on this issue in the FY 2015 LTCH PPS Proposed Rule.[50] CMS stated that they have the authority to make appropriate modifications to payments determinations under the LTCH PPS. CMS said that they "will need to decide whether to maintain a single high-cost outlier 'target' for all LTCH PPS cases (including 'site neutral' payment cases) or whether it may be more appropriate to establish separate high-cost outlier 'targets' for each of the two payment groups under the revised LTCH PPS."[51]

In the current Proposed Rule, CMS discusses the comments that it received last year. CMS says that some of the commenters recommended initially applying the existing HCO policy separately to both LTCH PPS standard Federal payment rate cases and cases paid at the site neutral payment rate (*i.e.*, determining separate HCO fixed-loss amounts so that estimated HCO payments would be equal to 8 percent of estimated total payments for each of the two LTCH PPS payment types, the LTCH PPS standard Federal payment rate cases and cases paid at the site neutral payment rate), and then adjusting the HCO targets as more data under the statutory revisions to the LTCH PPS become available. In other words, commenters suggested that it may be more appropriate to have different HCO targets for the two LTCH PPS payment types rather than two HCO targets of 8 percent. When making recommendations regarding the HCO policy under the statutory LTCH PPS changes, several commenters urged CMS to focus on maintaining LTCH PPS payments for LTCH PPS standard Federal payment

[49] Id. at 24540.
[50] 79 Fed. Reg. 27978, 28205-06 (May 15, 2014).
[51] Id. at 28,206.

that HCO payments to standard LTCH cases and site neutral LTCH cases are appropriate. It means that Congress intended that CMS evaluate LTCH site neutral HCO payments against standard LTCH HCO payments, not against IPPS HCO payments. When compared in this way, on a per case basis, any fixed-loss amount for LTCH site neutral cases that is higher than the fixed-loss amount for standard LTCH cases cannot be considered an overpayment because it will result in a smaller HCO payment or no HCO payment. Because the site neutral payment rate will already be a much reduced rate of payment for the case, a higher fixed-loss amount further reduces the LTCH's payment when the case qualifies as an HCO. These payment reductions would be compounded further if CMS applies a budget neutrality adjustment to site neutral payments.

We do *not* agree with the proposed budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. CMS says that "a budget neutrality factor will *continue* to be applied to LTCH PPS *standard Federal payment rate* cases to offset that 8 percent [target] so that HCO payments for LTCH PPS standard Federal payment rate cases would be budget neutral."[60] CMS points to this budget neutrality factor as precedent for a BNA factor to offset LTCH *site neutral* payments by the 5.1 percent target for site neutral HCO cases.[61] As CMS explains in the preamble:

> The current LTCH PPS HCO policy has a budget neutrality requirement in which the LTCH PPS standard Federal payment rate is reduced by an adjustment factor to account for the estimated proportion of HCO payments to total estimated LTCH PPS payments, that is, 8 percent. (We refer readers to § 412.523(d)(1) of the regulations.) This budget neutrality requirement is intended to ensure that the HCO policy would not result in any change in estimated aggregate LTCH PPS payments. Under our proposal to continue to apply the current HCO methodology as it relates to LTCH PPS standard Federal payment rate cases (other than determining a fixed-loss amount using only data from LTCH PPS standard Federal payment rate cases), we also would continue to apply the current budget neutrality requirement (described above). In accordance with the current LTCH PPS HCO policy budget neutrality requirement, we believe that the HCO policy for site neutral payment rate cases should also be budget neutral, meaning that the proposed site neutral payment rate HCO payments should not result in any change in estimated aggregate LTCH PPS payments. In order to achieve this, under proposed new § 412.522(c)(2)(i), we are proposing to apply a budget neutrality factor to the payment for all site neutral payment rate cases described under proposed new § 412.522(a)(1), which would also be established on an estimated basis. This approach is consistent with the HCO policy proposed for LTCH PPS standard Federal payment rate cases, which is budget neutral within the universe of LTCH PPS standard Federal payment rate cases. We are

[60] 80 Fed. Reg. at 24647-48 (emphasis added).
[61] See 80 Fed. Reg. at 24539-40, 24647-48.

> inviting public comments on this proposed approach and the alternative approach of applying a single budget neutrality factor to all LTCH PPS cases, irrespective of the site neutral payment rate.[62]

However, CMS does not state in the Proposed Rule what the budget neutrality factor is for HCO payments to LTCH PPS *standard Federal payment rate* cases. In addition, the regulation at § 412.523(d)(1) only says that "CMS adjusts the standard Federal rate by a reduction factor of 8 percent, the estimated proportion of outlier payments under the long-term care hospital prospective payment system, as described in § 412.525(a)." The regulation at § 412.525(a) does *not* address budget neutrality—it determines the amount of the HCO payment, when an HCO payment is made, the cost-to-charge ratio that is used and reconciliation of outlier payments. Moreover, in the same parts of the preamble to the LTCH PPS rate update in previous years, CMS does *not* mention a budget neutrality adjustment for LTCH HCO cases.

Based upon our review of the rulemaking record, there does *not* appear to be an existing budget neutrality adjustment for LTCH HCO payments that is applied during the update to the LTCH PPS standard Federal payment rate each fiscal year. Rather, it appears that CMS may have considered the HCO target and its effect on overall LTCH HCO payments when setting the payment rate *in the first year of the LTCH PPS only*. This was done to comply with the statutory requirement that the LTCH PPS be budget neutral *in the first year only*, compared to the previous TEFRA payment system—not each year as CMS implies in the Proposed Rule.[63] Therefore, the BNA factor that CMS is proposing to apply to offset FY 2016 site neutral payments by the 5.1 percent target for site neutral HCO cases—and would no doubt apply in each subsequent fiscal year—has *no precedent* in the LTCH PPS and is *not required* by the PSRA, the PAMA, or the Social Security Act.

Having established that there is no precedent in the LTCH PPS for a budget neutrality adjustment to FY 2016 site neutral payments, we also found that CMS already accounted for site neutral HCO payments when setting the IPPS payment rate. As discussed above, HCO payments for LTCH site neutral cases will be 80% of the difference between the estimated cost of the case and the proposed IPPS HCO threshold, which is $24,485 for FY 2016. The proposed IPPS HCO threshold for cases paid at the site neutral payment rate would be the sum of the site neutral payment and the proposed IPPS fixed-loss amount of $24,485. Because cases paid at the site neutral payment rate that are paid 100% of the estimated cost of the case would never be eligible for a HCO payments, all site neutral HCO payments will be based on the IPPS comparable per diem amount. CMS believes that this methodology will "reduce

[62] Id. at 24539-40.
[63] See Section 123(a)(1) of Public Law 106-113; 42 C.F.R. § 412.523(d)(2) ("*Budget neutrality.* CMS adjusts the Federal prospective payment rates for FY 2003 so that aggregate payments under the prospective payment system are estimated to equal the amount that would have been made to long-term care hospitals under Part 413 of this subchapter without regard to the prospective payment system implemented under this subpart.").

differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems."[64] However, by aligning this proposed policy with the IPPS payment system—and making the IPPS comparable per diem amount and the IPPS fixed-loss amount the primary components—CMS needs to consider the adjustments that it has already made to the proposed IPPS payment rates to account for outlier payments. We do not believe CMS had done this in the Proposed Rule.

Specifically, CMS already reduced the operating standardized payment amount under the IPPS and the capital federal rate under the capital PPS for outliers.[65] In determining these payment rates for FY 2016, CMS reduced the IPPS payment rate by a factor of 0.948999 and CMS reduced the capital PPS payment rate by a factor of 0.935731. **It would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed site neutral HCO BNA. This would be the case because the IPPS comparable per diem amount will be based on the FY 2016 IPPS payment rate, which has already been adjusted by the 5.1 percent outlier target. Since CMS has already reduced the FY 2016 IPPS payment rate by the 5.1 percent of estimated outlier payments in FY 2016, it would be inappropriate for CMS to reduce LTCH payments that are based on the IPPS rate again for site neutral cases that qualify as HCOs. Therefore, we object to CMS' proposal to apply a separate HCO BNA to LTCH site neutral payments.**

Recommendations. CMS should continue to use a target amount of 8 percent for HCOs paid using the LTCH PPS standard Federal payment rate. However, CMS should recalculate and reduce the proposed fixed-loss amount to approximately $13,783 for FY 2016 HCO cases paid under the LTCH PPS standard Federal payment rate, after adding the estimated 60,000 cases that we determined were incorrectly excluded from CMS' calculation. For FY 2016 only, we agree with CMS' proposals to use the FY 2016 IPPS fixed-loss amount of $24,485 for cases paid at the site neutral payment rate, and the same 5.1 percent target as the IPPS for HCO payments to these cases. CMS should *not* apply a budget neutrality factor to LTCH site neutral payments for high-cost outliers. There is no precedent for such an adjustment to the annual payment rate determination for the LTCH PPS. Moreover, CMS already accounted for estimated outlier payments for site neutral cases when adjusting the IPPS payment rate for FY 2016. In no event should CMS apply a budget neutrality factor to payments for all LTCH PPS cases to adjust for site neutral high-cost outliers.

PROPOSED REWEIGHTING OF MS-LTC-DRGS

***Issue*.** Pursuant to the regulation at 42 C.F.R. § 412.517(a), CMS is required to annually update the MS-LTC-DRG classifications and relative weights. CMS has historically used the same patient classification system under the LTCH PPS that is used under the IPPS. In addition, CMS annually adjusts the MS-LTC-DRG weights so

[64] 80 Fed. Reg. at 24539.
[65] Id. at 24634-35.

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 Medicare Access and CHIP Reauthorization Act of 2015, and other legislation. We also are addressing the update of the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits for FY 2016. As an interim final rule with comment period, we are implementing the statutory extensions of the Medicare-dependent, small rural hospital (MDH) Program and changes to the payment adjustment for low-volume hospitals under the IPPS.

We also are updating the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for FY 2016 and implementing certain statutory changes to the LTCH PPS under the Affordable Care Act and the Pathway for Sustainable Growth Rate (SGR) Reform Act of 2013 and the Protecting Access to Medicare Act of 2014.

In addition, we are establishing new requirements or revising existing requirements for quality reporting by specific providers (acute care hospitals, PPS-exempt cancer hospitals, and LTCHs) that are participating in Medicare, including related provisions for eligible hospitals and critical access hospitals participating in the Medicare Electronic Health Record (EHR) Incentive Program. We also are updating policies relating to the Hospital Value-Based Purchasing (VBP) Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition (HAC) Reduction Program.

DATES: *Effective Date:* This final rule is effective on October 1, 2015.

Applicability Date: The provisions of the interim final rule with comment period portion of this rule (presented in section IV.L. of the preamble) are applicable for discharges on or after April 1, 2015 and on or before September 30, 2017.

Comment Period: To be assured consideration, comments on the interim final rule with comment period presented in section IV.L. of this document must be received at one of the addresses provided in the **ADDRESSES** section no later than 5 p.m. EST on September 29, 2015.

ADDRESSES: In commenting, please refer to file code CMS–1632–IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may (and we encourage you to) submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the instructions under the ''submit a comment'' tab.

2. *By regular mail.* You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1632–IFC, P.O. Box 8013, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments via express or overnight mail to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1632–IFC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call the telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, we refer readers to the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Ing-Jye Cheng, (410) 786–4548 and Donald Thompson, (410) 786–4487, Operating Prospective Payment, MS–DRGs, Deficit Reduction Act Hospital-Acquired Acquired Conditions—Present on Admission (DRA HAC–POA) Program, Hospital-Acquired Conditions Reduction Program, Hospital Readmission Reductions Program, Wage Index, New Medical Service and Technology Add-On Payments, Hospital Geographic Reclassifications, Graduate Medical Education, Capital Prospective Payment, Excluded Hospitals, Medicare Disproportionate Share Hospital (DSH), Medicare-dependent, small rural hospital (MDH), and Low Volume Hospital Payment Adjustment Issues.

Michele Hudson, (410) 786–4487, Long-Term Care Hospital Prospective

specific types of cases and may also waive such denial in such unusual cases as the Secretary finds appropriate (68 FR 48805). Section 3 of the ASCA operates in the context of the HIPAA regulations, which include, among other provisions, the transactions and code sets standards requirements codified under 45 CFR parts 160 and 162 (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered health care providers, to conduct certain electronic health care transactions according to the applicable transactions and code sets standards.

The Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and support the adoption of health information technology and promote nationwide health information exchange to improve health care. The Office of the National Coordinator for Health Information Technology (ONC) leads these efforts in collaboration with other agencies, including CMS and the Office of the Assistant Secretary for Planning and Evaluation (ASPE). Through a number of activities, including several open government initiatives, HHS is promoting the adoption of electronic health record (EHR) technology certified under the ONC Health Information Technology (HIT) Certification Program developed to support secure, interoperable, health information exchange. The HIT Policy Committee (a Federal Advisory Committee) has recommended areas in which HIT certification under the ONC HIT Certification Program would help support providers that are eligible for the Medicare and Medicaid EHR Incentive Programs, such as long-term care and postacute care hospitals and behavioral health care providers. We believe that the use of certified EHRs by LTCHs (and other types of providers that are ineligible for the Medicare and Medicaid EHR Incentive Programs) can effectively and efficiently help providers improve internal care delivery practices, support the exchange of important information across care partners and during transitions of care, and could enable the reporting of electronically specified clinical quality measures (eCQMs) (as described elsewhere in this rule). More information on the ONC HIT Certification Program and efforts to develop standards applicable to LTCHs can be found by accessing the following Web sites and resources:

- *http://www.healthit.gov/sites/default/files/generalcertexchangeguidance_final_9-9-13.pdf*;
- *http://www.healthit.gov/facas/FACAS/health-it-policy-committee/hitpc-workgroups/certificationadoption*;
- *http://wiki.siframework.org/LCC+LTPAC+Care+Transition+SWG*; and
- *http://wiki.siframework.org/Longitudinal+Coordination+of+Care*.

B. Application of the Site Neutral Payment Rate (New § 412.522)

1. Overview

Section 1206 of Public Law 113–67 mandates significant changes to the payment system for LTCHs beginning with LTCH discharges occurring in cost reporting periods beginning on or after October 1, 2015. Under the current LTCH PPS, all discharges are paid under the LTCH PPS standard Federal payment rate (that is, payments calculated under the existing regulations, including adjustments, in Subpart O of 42 CFR part 412). Section 1206 requires the establishment of an alternate ''site neutral'' payment rate for Medicare inpatient discharges from an LTCH that fail to meet certain statutorily defined criteria. Discharges that meet the criteria will continue to be paid the LTCH PPS standard Federal payment rate. Discharges that do not meet the statutory criteria will be paid at a new site neutral payment rate, as described below. We note that, for the remainder of this section, the phrase ''LTCH PPS standard Federal payment rate case'' refers to an LTCH PPS case that meets the criteria for exclusion from the site neutral payment rate under section 1886(m)(6)(A)(ii) of the Act as discussed in section VII.B.3. of the preamble of this final rule, and the phrase ''site neutral payment rate case'' refers to an LTCH PPS case that does *not* meet the statutory patient-level criteria and, therefore, is paid the applicable site neutral payment rate in accordance with section 1886(m)(6)(A)(i) of the Act, as discussed in section VII.B.4. of the preamble of this final rule.

Under section 1886(m)(6)(A) of the Act as added by section 1206(a) of Public Law 113–67, beginning in cost reporting periods starting on or after October 1, 2015, all LTCH discharges are paid according to the site neutral payment rate unless certain criteria are met. For LTCH cases that meet the criteria for exclusion, the site neutral payment rate does not apply and payment is made without regard to the provisions of section 1886(m)(6) of the Act. For cases that meet the criteria for exclusion from the site neutral payment rate, payment will continue to be based on the LTCH PPS standard Federal payment rate as determined in § 412.523. As discussed in section VII.B.3. of the preamble of this final rule, under section 1886(m)(6)(A)(ii) of the Act, the criteria for exclusion from the site neutral payment rate are: (1) The discharge from the LTCH does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation; (2) admission to the LTCH was immediately preceded by discharge from a subsection (d) hospital; and (3) the immediately preceding stay in a subsection (d) hospital included at least 3 days in an intensive care unit (ICU) (referred to in this final rule as the ICU criterion) or the discharge from the LTCH is assigned to a MS–LTC–DRG based on the patient's receipt of ventilator services of at least 96 hours (referred to in this final rule as the ventilator criterion).

In this section of the final rule, we discuss our proposed and finalized policies to implement the required changes to the LTCH PPS payment rate, as well as other related finalized policy provisions in accordance with section 1206(a) of Public Law 113–67 under the broad authority of section 123(a)(1) of the BBRA, as amended by section 307(b) of the BIPA.

2. Application of the Site Neutral Payment Rate Under the LTCH PPS

For FY 2016, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24527), we proposed to add a new section to the regulations under 42 CFR part 412 Subpart O (new § 412.522) to establish the site neutral payment rate required by section 1886(m)(6) of the Act as added by section 1206(a)(1) of Public Law 113–67. Specifically, section 1886(m)(6) of the Act requires that, beginning in cost reporting periods occurring on or after October 1, 2015, all LTCH discharges are paid under the site neutral payment rate unless certain criteria are met. All LTCH discharges that meet the criteria for exclusion from the site neutral payment rate will continue to be paid the LTCH PPS standard Federal payment rate. Accordingly, in this final rule, under the broad authority of section 123(a)(1) of the BBRA, as amended by section 307(b) of the BIPA and in accordance with section 1206(a) of Public Law 113–67, we are establishing policies to implement the statutory criteria for excluding cases from the site neutral payment rate under new § 412.522(b), as well as establish the requirements for determining the site neutral payment rate for a given LTCH discharge under new § 412.522(c) (as discussed in detail below).

In addition, we proposed certain changes to § 412.521 in light of our

implementation of the site neutral payment rate under new § 412.522 (80 FR 24527). We did not receive any public comments on our proposed changes to § 412.521, and are adopting these proposals as final, without modification. Specifically, we are finalizing conforming changes to paragraph (a)(2) of § 412.521 to include the new site neutral payment rate established in accordance with new § 412.522 as a method of payment under the LTCH PPS. We also are finalizing a technical change to the language in § 412.521(a)(2) that currently refers to the Federal payment rate by changing the term from ''Federal payment rate'' to ''standard Federal payment rate'' in order to provide consistent terminology when referring to such a payment.

Comment: Many commenters objected to the application of the new site neutral payment rate. Some commenters expressed concern that wound care is not categorically excluded from the application of the new site neutral payment rate and requested that CMS create such a categorical exclusion. Some of these commenters also requested that a study of the relative outcomes of wound care in LTCHs and other settings be conducted. Other commenters requested that CMS pay differently for site neutral payment rate cases treated in rural LTCHs, and recommended paying these hospitals for services performed on a cost basis similar to critical access hospitals (CAHs), or comparably to inpatient rehabilitation facilities (IRFs).

Response: While we acknowledge that the new site neutral payment rate will be lower than the historic standard Federal payment rate for certain LTCH discharges, we do not have the authority to establish regulatory payment policy exceptions to pay rural LTCHs at any rate other than what is provided under the new dual payment rate structure under the LTCH PPS. Further, under the LTCH PPS we do not have the authority to pay anything other than the site neutral payment rate for any LTCH discharge that does not meet the exclusion criteria. The statute explicitly established the dual payment rate structure, which expressly provides that payment for all LTCH discharges will be calculated based on the new site neutral payment rate, unless the LTCH discharge meets the statutorily defined exclusion criteria to be paid based on the LTCH PPS standard Federal payment rate. Because the new site neutral payment rate and the exclusions apply to all LTCH discharges, further legislation would be required if we were to pay any rate other than the site neutral payment rate, or, where the exceptions to that rate apply, the LTCH PPS standard Federal payment rate. Furthermore, Congress did not provide any authority within the statute to delay implementation of the new dual rate LTCH PPS payment structure to allow time for a study to assess the relative outcomes of wound care in LTCHs compared to other settings. We note that CMS is currently engaged in many quality assessment initiatives, including in LTCHs and other postacute settings. In light of that ongoing work, we do not have current plans to conduct a separate study limited to outcomes for wound care cases in different settings. Further information on our quality initiatives is available on the CMS Web site at: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/index.html*.

Comment: Several commenters expressed concerns that exclusion from the lower site neutral payment rate may be dependent upon events that may be outside of the LTCH's control. For example, the commenters stated that an LTCH would have no control over when a subsection (d) hospital submitted its claim for the immediately preceding subsection (d) hospital discharge, or whether an immediately preceding subsection (d) hospital discharge claim would contain a coding error such that the claim would fail to indicate that the patient received ICU services for at least 3 days. Given this lack of control, commenters expressed concern about our setting the LTCH PPS payment rates based in part upon the content of the subsection (d) hospital's claim.

Response: We expect LTCHs and their referring hospitals to be closely engaged with each other in coordination of care efforts with regard to their referred patients. As part of these working relationships, we encourage each party to effectively communicate and exchange information to help ensure that LTCH claims are paid appropriately. We acknowledge the commenters' concerns. The new dual payment rate structure is, by statute, premised on events which occurred prior to the admission to the LTCH. We must look at what happens or did not happen in the immediately preceding subsection (d) hospital inpatient stay, and we believe that the IPPS claim is the best existing source of accurate and complete information for events which occurred during the IPPS hospital inpatient stay.

In fact, we have considered the issues raised by the commenters in our development of the claims processing systems changes needed to implement the new dual rate LTCH PPS payment structure. We believe that these claims processing systems changes will appropriately identify all LTCH discharges, consistent with the statutory requirements under the new dual rate LTCH PPS payment structure, based on the best available data at the time the LTCH discharge claim is processed. Furthermore, our operational design of the claims processing system requirements under this new dual rate LTCH PPS payment structure also includes automatic prompts to appropriately adjust the LTCH PPS payment for an LTCH case if there is a change in either the subsection (d) hospital's claim information or the LTCH's claim information that would result in any change in payment (that is, from the site neutral payment rate to the LTCH PPS standard Federal payment rate or vice versa), consistent with the statutory criteria.

However, we acknowledge that, as this is a new payment structure, it may not work flawlessly in each and every instance. In those rare instances where an obvious error occurs in the determination of the LTCH PPS payment amount for a particular case, LTCHs can contact their MACs and we will reevaluate our available information to ensure that the correct payment is made under current policies. We appreciate ongoing feedback from hospitals concerning ways to make these processes more efficient and cost effective, while continuing to ensure that LTCH claims are paid appropriately. As we gain experience under the revised LTCH PPS, we may modify some of our operational approaches.

Comment: One commenter requested that CMS provide additional payment under the LTCH PPS for end-stage renal disease (ESRD) patients under the same circumstances as under the IPPS, noting that section 1881(b) of the Act does not limit the adjustment to subsection (d) hospitals. The commenter believed that information included in its comment and an analysis previously provided to CMS supported its request for this additional payment amount.

Response: Although we consider this comment to be outside the scope of the proposed rule, we note that we responded to the same suggestion in a detailed response in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50767). As discussed in that final rule, based on our analysis of FY 2012 LTCH PPS claims data, the costs of treating ESRD patients in LTCHs are adequately reflected in data used to determine the MS–LTC–DRG relative weights for nondialysis MS–LTC–DRGs, and that the additional resources associated with

renal dialysis treatments are included in the LTCH PPS payments. Because the commenters failed to present any new evidence to contradict those conclusions, we continue to believe that the standard Federal payment rate accounts for these costs. Furthermore, as we discuss in section VII.B.7.b. of the preamble of this final rule, until we gain experience with the effects and implementation of the new site neutral payment rate and the types of cases paid at this rate, we believe that it is premature to consider whether additional payments are either necessary or appropriate. We may revisit this issue in the future, if data demonstrate such a change is warranted for either LTCH PPS standard Federal payment rate cases or site neutral payment rate cases.

Comment: A few commenters expressed appreciation for the information added to the publically available FY 2014 LTCH MedPAR File for the proposed rule which identifies whether the LTCH discharge in the historical data is site neutral payment rate case or standard payment rate case (that is, meets the criteria for exclusion from the site neutral payment rate) had the new statutory patient criteria been in effect at the time of the discharge. Some commenters also requested additional information be added to the publically available IPPS & LTCH PPS MedPAR files, such as encrypted patient identifiers, and encrypted admission and discharge dates, along with the number of days the patient spent in the ICU in the immediately preceding IPPS hospital stay prior to admission to the LTCH. These commenters believe that such additional information is needed to determine which historical discharges were immediately preceded by a qualifying IPPS hospital stay and could be used to verify the payment rate designation (that is, site neural or standard) CMS has included in the publically available LTCH MedPAR file.

Response: We understand that for commenters that would like to replicate the proposed LTCH PPS rates, factors and payment estimates presented in the proposed rule, it is necessary to be able to identify the LTCH discharges in the historical data that would be standard payment rate cases and the ones that would be site neutral payment rate cases (had the statutory criteria been in effect at the time of the discharge). We are also aware that currently the publically available IPPS and LTCH PPS MedPAR files do not contain any specified direct patient identifiers consistent with CMS's privacy and security standards and as outlined in the HIPAA Privacy Rule. (For additional information on CMS' privacy and security standards under the HIPAA Privacy Rule, we refer readers to the CMSWeb site at: *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/PrivacyandSecurityStandards.html*, and for additional information on CMS' publically available Limited Data Set (LDS) files, we refer readers to the CMS Web site at: To *http://cms.hhs.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/index.html*.) It is for these reasons that, as noted by commenters, we added an identifier to the publically available FY 2014 LTCH MedPAR File to identify the historical LTCH discharges in that file as standard payment rate cases or site neutral payment rate cases (had the statutory dual rate LTCH PPS payment structure been in effect at the time of the discharge). These are the same payment rate identifiers we used to develop the FY 2016 proposed rates, factors and payment estimates as described in the proposed rule. We believe that the addition of this payment rate identifier to the publically available LTCH MedPAR file provides sufficient information for commenters to replicate and evaluate the proposed rates, factors and payment estimates in the proposed rule. We considered adding the encrypted information requested by commenters to the publically available IPPS and LTCH PPS MedPAR files; however, we are not able to do so at this time because to add such specific direct patient identifiers would need to be done in conformance with CMS's privacy and security standards, including any requirements outlined in the HIPAA Privacy Rule. We are, however, adding the information on the number of days the patient spent in the ICU in an immediately preceding IPPS hospital stay prior to admission to the LTCH, as requested by commenters, since this aggregated count of days conforms with CMS's privacy and security standards because it does not result in the identification of specific beneficiaries. We believe including the count of days in the ICU from the immediately preceding IPPS hospital stay to the publically available MedPAR file will allow the public to adequately corroborate the indicator of the historical LTCH discharges as a standard payment rate case or a site neutral payment rate cases (had the statutory criteria been in effect at the time of the discharge).

3. Criteria for Exclusion From the Site Neutral Payment Rate

a. Statutory Provisions

As stated earlier, section 1206(a) of Public Law 113–67 amended section 1886(m) of the Act by adding paragraph (6), which specifies that beginning in cost reporting periods starting on or after October 1, 2015, all LTCH PPS discharges will be paid based on the site neutral payment rate unless certain criteria are met. In general, under section 1886(m)(6)(A)(ii) of the Act, the criteria for exclusion from the site neutral payment rate are: The discharge from the LTCH does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation, the admission to the LTCH was immediately preceded by discharge from a subsection (d) hospital, and that immediately preceding stay in a subsection (d) hospital included at least 3 days in an intensive care unit (ICU) (referred to in this final rule as the ICU criterion) or the discharge from the LTCH is assigned to an MS–LTC–DRG based on the patient's receipt of at least 96 hours of ventilator services during the LTCH stay (referred to in this final rule as the ventilator criterion). Below we summarize our proposals and the public comments received, and provide our responses to those comments and the finalized policies to implement the statutory criteria for exclusion from the site neutral payment rate.

b. Implementation of the Criterion for a Principal Diagnosis Relating to a Psychiatric Diagnosis or to Rehabilitation

Section 1886(m)(6)(A)(ii)(II) of the Act specifies that in order for an LTCH discharge to be excluded from payment under the site neutral payment rate, the LTCH discharge cannot have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation. To implement this criterion, under the broad authority of section 123(a)(1) of the BBRA, as amended by section 307(b) of the BIPA and in accordance with section 1206(a) of Public Law 113–67, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24528 through 24529), we proposed to identify cases with a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation that would be assigned to specific MS–LTC–DRG groupings that we believe indicate such principal diagnoses using the most recent version of the MS–LTC–DRGs. We invited public comments on our proposed approach and our proposed list of applicable MS–LTC–DRGs.

Comment: Several commenters supported our proposal to identify discharges with a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation using the specific MS–LTC–DRGs included in our proposal.

Response: We appreciate the commenters' support.

After consideration of the public comments we received, we are finalizing without change our proposal to identify discharges with a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation that are assigned to the specific MS–LTC–DRG groupings included in our proposal using the most recent version of the MS–LTC–DRGs. (For additional information on the version of the MS–DRGs, and by extension the MS–LTC–DRGs, that is Version 33, we refer readers to section II.G. of the preamble of this final rule.)

Accordingly, as we proposed, we are establishing that an LTCH discharge assigned to one of the following ICD–10 MS–LTC–DRG groupings in the most recent version of the MS–LTC–DRGs (that is, Version 33 for FY 2016) will be identified as a case with a principal diagnosis relating to a psychiatric diagnosis:

- MS–LTC–DRG 876 (O.R. Procedure with Principal Diagnosis of Mental Illness);
- MS–LTC–DRG 880 (Acute Adjustment Reaction & Psychosocial Dysfunction);
- MS–LTC–DRG 881 (Depressive Neuroses);
- MS–LTC–DRG 882 (Neuroses except Depressive);
- MS–LTC–DRG 883 (Disorders of Personality & Impulse Control);
- MS–LTC–DRG 884 (Organic Disturbances & Mental Retardation);
- MS–LTC–DRG 885 (Psychoses);
- MS–LTC–DRG 886 (Behavioral & Developmental Disorders);
- MS–LTC–DRG 887 (Other Mental Disorder Diagnoses);
- MS–LTC–DRG 894 (Alcohol/Drug Abuse or Dependence, Left Ama);
- MS–LTC–DRG 895 (Alcohol/Drug Abuse or Dependence, with Rehabilitation Therapy);
- MS–LTC–DRG 896 (Alcohol/Drug Abuse or Dependence, without Rehabilitation Therapy with MCC); and
- MS–LTC–DRG 897 (Alcohol/Drug Abuse or Dependence, without Rehabilitation Therapy without MCC).

Furthermore, as we proposed, we also are establishing that an LTCH discharge assigned to one of the following ICD–10 MS–LTC–DRG groupings in the most recent version of the MS–LTC–DRGs (that is, Version 33 for FY 2016) will be identified as an LTCH discharge with a principal diagnosis relating to rehabilitation:

- MS–LTC–DRG 945 (Rehabilitation with CC/MCC); and
- MS–LTC–DRG 946 (Rehabilitation without CC/MCC).

Under this finalized policy, as we proposed, an LTCH discharge grouped to any of the MS–LTC–DRG groupings listed above will not meet the criteria under new § 412.522(b)(1)(i) to be excluded from the site neutral payment rate.

c. Addition of Definition of a ''Subsection (d) Hospital'' to LTCH Regulations

The site neutral payment rate established in section 1206(a) of Public Law 113–67 includes several references to ''subsection (d) hospitals.'' The term ''subsection (d) hospital'' is defined in section 1886(d)(1)(B) of the Act as a hospital that is located in 1 of the 50 States or the District of Columbia that is not a psychiatric hospital, a rehabilitation hospital, a children's hospital, an LTCH, or a cancer hospital. However, section 1886(m)(6)(D) of the Act, as added by section 1206(a)(1) of Public Law 113–67, added that, for LTCH PPS purposes, any reference to a ''subsection (d) hospital'' is deemed to include a ''subsection (d) Puerto Rico hospital,'' which is defined by section 1886(d)(9)(A) of the Act (providing that the term ''subsection (d) Puerto Rico hospital'' means a hospital that is located in Puerto Rico and that would be considered a subsection (d) hospital (as defined in paragraph (d)(1)(B)) if it were located in 1 of the 50 States).

Given these statutory provisions, as part of our implementation of section 1206(a) of Public Law 113–67, and under the broad authority under section 123(a)(1) of the BBRA, as amended by section 307(b) of the BIPA, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24529), we proposed to add a definition of the term ''subsection (d) hospital'' to § 412.503 (defined as any hospital qualifying as a subsection (d) hospital under section 1886(d)(1)(B) of the Act and any hospital located in Puerto Rico that would be qualified as a subsection (d) hospital under section 1886(d)(1)(B) of the Act if it were located in 1 of the 50 States).

Comment: Several commenters supported the proposed definition of a ''subsection (d) hospital'' under the LTCH PPS.

Response: We appreciate the commenters' support.

After consideration of the public comments received, we are finalizing our proposal to add the proposed definition for a ''subsection (d) hospital'' under § 412.503, without change.

d. Interpretation of ''Immediately Preceded'' by a Subsection (d) Hospital Discharge

Section 1886(m)(6)(A)(ii)(II) of the Act specifies that, in order to be excluded from payment under the site neutral payment rate, the LTCH discharge must meet the ICU criterion at section 1866(m)(6)(A)(iii) of the Act or the ventilator criterion at section 1866(m)(6)(A)(iv) of the Act. Both the ICU criterion and the ventilator criterion require that the LTCH admission be ''immediately preceded'' by a discharge from a subsection (d) hospital. Therefore, under the broad authority under section 123(a)(1) of the BBRA, as amended by section 307(b) of the BIPA, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24529 through 24530), we proposed to define the phrase ''immediately preceded'' in the context of a discharge from a subsection (d) hospital. Specifically, we proposed that the discharged Medicare patient would have to depart the subsection (d) hospital and arrive for admission to the LTCH without having returned home or being admitted to any other inpatient setting, including an IRF, an IPF, or a SNF. As required by the statute, we proposed that any LTCH admission that did not qualify under this definition as having been ''immediately preceded'' by a discharge from a subsection (d) hospital would not be eligible to qualify for exclusion from the site neutral payment rate based on the ICU or the ventilator criterion. We proposed to codify these proposals at new § 412.522(b)(1)(ii).

To implement these policies, we proposed to look at the Medicare patient's discharge date on the subsection (d) hospital's claim, and compare it to the admission date on the LTCH's Medicare claim for the patient. In doing so, we proposed that the discharge date had to have occurred on the same date as the LTCH admission (or, for those rare circumstances where a patient is discharged from a subsection (d) hospital before the midnight census, but was not admitted to the LTCH until after the midnight census of that date of discharge, the day before the calendar date of the LTCH admission) if a patient's discharge were to qualify as being immediately preceded by a discharge from a subsection (d) hospital.

We also proposed to condition eligibility for exclusion from the site neutral payment rate on the immediately preceding subsection (d) hospital's claim using of certain codes,

namely Patient Discharge Status Code 63, which signifies a patient was discharged or transferred to an LTCH, or Patient Discharge Status Code 91, which signifies a patient was discharged/transferred to a Medicare-certified LTCH with a planned acute care hospital inpatient readmission.

In making these proposals, we also noted that our proposed interpretation of ''immediately preceded'' by a subsection (d) hospital would work in tandem with our existing interrupted stay policy at § 412.531. An interruption of stay occurs when, during the course of an LTCH hospitalization, the patient is discharged to an inpatient acute care hospital, an IRF, or a SNF for treatment for a service that is not available at the LTCH for a specified period followed by readmittance within a specified number of days to the same LTCH. In such cases, the care following readmission is considered a continuation of the care interrupted by the first discharge, so both ''halves'' of the LTCH episode of care are bundled, and Medicare makes a single payment based on the second date of discharge. As the two halves constitute a single episode of care, the discharge that is relevant to determining if that episode of care was immediately preceded by the required subsection (d) hospital stay is the care provided prior to the first admission to the LTCH. Using these concepts, any interruption of stay defined under § 412.531 would not invalidate the immediately preceded status for the single episode of care—only the care provided prior to the first LTCH admission would be relevant.

Comment: Some commenters generally supported CMS' proposal to define the phrase ''immediately preceded'' in the context of the subsection (d) hospital discharge occurring on the same calendar date as the LTCH admission (or, in certain rare circumstances, the calendar date before the date of the LTCH admission). However, many commenters expressed concern with CMS' proposal to require specific patient discharge status codes on the subsection (d) hospital claim. These commenters believed that reliance on these status codes was unnecessary, given the high percentage of LTCH admissions that occur on the same date as preceding subsection (d) hospital discharges, and noted that there is inconsistency in the use of discharge status codes by subsection (d) hospitals. The commenters also believed that it would be difficult and burdensome for LTCHs to get information from the referring hospital regarding the discharge status code. Some of these commenters suggested that CMS determine whether the immediately preceding requirement for LTCH discharges paid at the LTCH PPS standard Federal payment rate is met solely from information provided by the LTCH, such as through some form of self-attestation.

Response: After considering the comments we received, we believe that reliance on the discharge and admission dates may adequately address our concerns and, therefore, we agree that requiring the presence of specific discharge status code(s) on the preceding subsection (d) hospital claim as a condition of qualifying for the exclusions from the site neutral payment rate may not be necessary at this time. We considered continuing to require the discharge status codes when LTCH admission occurred the day after the subsection (d) hospital discharge, which would allow additional time for intervening services to be received by the patient. However, the commenters' analyses showed that between 95 percent and 99 percent of LTCH admissions that occur within 1 day of a subsection (d) hospital discharge occur on the same date as the subsection (d) hospital discharge and provides adequate protection against inappropriate payments at this time. Based on this assessment, we are not finalizing the discharge status code requirements at this time. However, we may revisit this issue in future rulemaking, and may propose changes to this policy if reliance on the discharge and admission dates prove inadequate to determine appropriate payment. We also are taking this opportunity to remind all hospitals of their responsibility to bill accurately, including the use of the appropriate patient discharge status codes. Regarding the specific suggestions that we determine immediately preceding discharges based solely on LTCH claims, we do not believe such an approach would serve as adequate protection against misuses and inappropriate payments under the new dual rate LTCH PPS payment structure. We believe that claims data, which hospitals submit for Medicare payment, should be a reliable data source upon which to base a determination of whether an immediately preceding subsection (d) hospital stay occurred. When such reliable primary source data are available, we see little reason to rely on a secondary source, such as an LTCH conveying assurances of an immediately preceding discharge. We do not believe that it would be appropriate to rely upon, either presumptively or otherwise, an attestation or assertion about what the LTCH's may believe occurred in the previous subsection (d) hospital admission, when more reliable data are available directly from the subsection (d) hospital that delivered that preceding care rather than in our claims processing systems.

After consideration of the public comments we received, we are finalizing our proposed policy that conditions eligibility for exclusion from the site neutral payment rate on the LTCH admission having been ''immediately preceded'' by a subsection (d) hospital stay, as evidenced by the admission to the LTCH occurring either on the date of or, in certain rare circumstances, the calendar date after the discharge from the preceding subsection (d) hospital. As discussed above, we are not finalizing our proposals regarding the discharge status codes as reported on the preceding subsection (d) hospital's claim. As finalized at new § 412.522(b)(1)(ii), an LTCH discharge will be considered to have been immediately preceded by a discharge from a subsection (d) hospital if there was a direct admission from such a hospital, as evidenced by the dates of discharge and admission, to the LTCH.

e. Implementation of the Intensive Care Unit (ICU) Criterion

Section 1886(m)(6)(A)(iii)(I) of the Act specifies that in order to be excluded from payment under the site neutral payment rate under the ICU criterion, the LTCH admission must be immediately preceded by a discharge from a subsection (d) hospital that included at least 3 days in an intensive care unit (ICU), as determined by the Secretary. In doing so, section 1886(m)(6)(A)(iii)(II) of the Act requires the use of data from revenue center codes 020X or 021X (or such successor codes as the Secretary may establish). As discussed in the proposed rule (80 FR 24530), revenue center codes are reported on the hospital claim with revenue center code 020X (indicating intensive care), and the revenue center code 021X (indicating coronary care). Both of these revenue center codes are used to bill Medicare for services provided by ''intensive care units (ICUs)'' as defined under our existing definition at § 413.53(d) of the regulations, and, as indicated by the ''X'' in the revenue code descriptions both are further divided into subcategories that form a revenue center code series.

As described in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24530), we proposed to implement the ICU criterion under new § 412.522(b)(2). In that section, we proposed that the claim

from the subsection (d) hospital that immediately preceded the admission to the LTCH had to indicate receipt of at least 3 days of care in an ICU using revenue center codes 020X or 021X (or such successor code as the Secretary may establish), the use of which must be consistent with our definition of an ICU under § 413.53(d), in order to fulfill the ICU criterion for exclusion from the site neutral payment rate. We re refer readers to the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24530) for more information on the development of our proposal for the implementation of the ICU criterion under section 1886(m)(6)(A)(iii) of the Act, including our explanation as to why we believe that our proposed implementation of the ICU criterion will work in tandem with our existing LTCH policies governing interrupted stays. As we noted in the context of our ''immediately preceded'' policy discussion above, because the two halves of an interrupted stay constitute a single episode of care (as shown by the issuance of a single payment), the discharge that is relevant to determining if that episode of care was immediately preceded by a subsection (d) hospital stay that included 3 days in the ICU is the first admission to the LTCH.

Comment: Some commenters generally supported CMS' proposal to use the presence or absence of revenue center codes 020X or 021X on the preceding subsection (d) hospital claim as the basis for concluding that an LTCH admission was or was not preceded by a subsection (d) hospital stay including at least 3 days in the ICU, and, based on that finding, whether the LTCH admission was eligible for exclusion from the site neutral payment rate. Some commenters opined that CMS lacks the authority to exclude certain subsets of these codes. Other commenters disagreed with the proposal to rely on the subsection (d) hospital's reporting of these revenue center codes because doing so would increase administrative burdens imposed upon subsection (d) hospitals and LTCHs. Some commenters recommended that CMS adopt a policy by which compliance would be determined based solely on the information an LTCH submitted on its claims, others suggested reliance on self-attestation. Others suggested specific focus on, and the adoption of indicators based on, the severity of a patient's illness rather than relying on the use of revenue center codes. Some commenters also disagreed with CMS' proposal to define an ICU stay in a manner that required the subsection (d) hospital's adherence to § 413.53(d), asserting that there was no statutory basis for such a requirement.

Response: We appreciate the commenters' suggestions, but we disagree with the commenters who asserted we lacked the authority to exclude certain subsets of revenue center codes. The statute merely requires us to use data from the sequences of revenue center codes, not every code within the sequences. We also disagree with commenters who asserted that there is no legal obligation to require consistency between the use of revenue center codes 020X or 021X for purposes of determining LTCH PPS payment rates and the subsection (d) hospital's coding of its claim in a manner that complies with our definition of ICU services under § 413.53(d). Hospitals must comply with all applicable requirements when they submit a claim for Medicare reimbursement. Section 1886(m)(6)(A)(iii) of the Act does not exempt subsection (d) hospitals from any of the requirements that govern their delivery of services, or their billing for those services. As such, the requirements governing their use of revenue center codes 020X or 021X on their claims are unchanged by our policy to use those codes as the basis for determining exclusion of an LTCH discharge from the site neutral payment rate. Furthermore, we also disagree with the commenters who suggested it would be appropriate to determine compliance with the ICU criterion based solely on data obtained from an LTCH's claim. Congress expressly mandated that the ICU criterion was to be based on events that occurred prior to the LTCH admission. The best source of data for what happened in a subsection (d) hospital is that subsection (d) hospital, and the information needed to determine ICU exclusion eligibility should be readily available on any properly billed subsection (d) hospital claim. Furthermore, given the potential for audit, and the penalties for filing false claims, we believe that claims data should be a reliable data source upon which to make a determination for exclusion from the site neutral payment rate under the ICU criteria. When such reliable primary source data is available, we see little reason to rely on a secondary source such as an LTCH conveying its understanding of the services received at the preceding subsection (d) hospital at the time of patient transfer. We do not believe that it would be appropriate to rely upon, presumptively or otherwise, assertions about the LTCH's understanding about the previous medical care received by the patient, when more reliable data is available directly from the subsection (d) hospital that provided that care in our claims processing systems. Again, as discussed above, we recognize the commenters' concerns and have in fact considered these issues in our development of claims processing systems changes to implement the new system. We believe that these systems changes will allow for appropriate payment for all LTCH discharges under the new dual rate LTCH PPS payment structure. As part of the relationship between referring IPPS hospitals and LTCHs, we encourage each party to communicate and exchange information to help ensure that LTCH claims are paid appropriately. While final payment of the LTCH claim will be based in part on information from preceding subsection (d) hospital's IPPS claim, we would encourage LTCHs to ask questions of the referring hospitals in order to ascertain all necessary information prior to admitting a patient. We may revisit these issues as we gain more experience under the revised LTCH PPS particularly if we observe an unusual change in hospital ICU coding behavior or if we become aware of data which demonstrates that use of particular codes within the 020X or 021X are inappropriate bases for meeting the ICU criterion. We do, however, acknowledge that as this is a new payment structure, it may not work flawlessly in each and every instance. In those rare instances where obvious errors occur in the determination of the LTCH PPS payment amount for a particular case, LTCHs can contact their MACs and we will recheck our available information to ensure that correct payments are made under our policies.

Comment: One commenter requested clarification of how the proposals to implement the ICU criterion would interact with CMS' existing interrupted stay policy.

Response: As we previously noted in our discussion of our policies regarding the ''immediately preceded'' requirement, our dual rate LTCH PPS payment structure policies were designed to complement our existing interrupted stay policies. Both halves of an interrupted stay constitute a single episode of care (as demonstrated by the issuance of a single payment). As such interrupted stays have historically been treated as a single episode of care, we established in this final rule that the relevant subsection (d) hospital discharge for purposes of the payment of interrupted stays under the dual rate LTCH PPS payment structure is the first subsection (d) discharge. Under this policy, any time spent in a subsection

(d) hospital's ICU during an interrupted LTCH stay would not be considered in the evaluation of whether the interrupted LTCH stay met the ICU criterion because such care would not have immediately preceded the initial admission to the LTCH. Conversely, if the subsection (d) hospital discharge that immediately preceded the initial LTCH admission meets the ICU criterion (that is, includes at least 3 ICU days), and the period of time relating to an intervening interrupted stay does not include any days in a subsection (d) hospital's ICU, the ICU criterion would still be met because the initial LTCH admission fulfilled the ICU criterion for exclusion from the site neutral payment rate. However, we note that if the intervening stay in the acute care hospital is 10 days or longer (such that our interrupted stay policy would be inapplicable with respect to the readmission to the LTCH), in order for the second admission to meet the ICU criterion to be excluded from the site neutral payment rate, the acute care hospital stay would have to include at least 3 days in an ICU.

After consideration of the public comments we received, we are finalizing without modification our proposal that at least 3 days of ICU services must be reported on the preceding subsection (d) hospital claim using revenue center codes 020X or 021X, and that such coding must be consistent with our policies governing ICU services under § 413.53(d) in order for an LTCH discharge to fulfill the requirements of the ICU criterion for exclusion from the site neutral payment rate. As we proposed, we are codifying this policy under new § 412.522(b)(2).

f. Implementation of the Ventilator Criterion

Section 1886(m)(6)(A)(vi) of the Act specifies that in order to be excluded from payment under the site neutral payment rate under the ventilator criterion, the LTCH admission must be immediately preceded by a discharge from a subsection (d) hospital (as discussed in section VII.B.3.d. of the preamble of this final rule), and the LTCH discharge must be assigned to an MS–LTC–DRG based on the beneficiary's receipt of at least 96 hours of ventilator services in the LTCH. As we discussed in the preamble of the proposed rule (80 FR 24531), we proposed that, for the purposes of a discharge being excluded from the site neutral payment rate based on the ventilator criterion, the discharge must use the applicable procedure code to indicate that at least 96 hours of ventilator services were received during the LTCH stay. Currently, under the ICD–9–CM coding system, procedure code 96.72 (Continuous invasive mechanical ventilation for 96 consecutive hours or more) is used to describe such long-term mechanical ventilator services. As discussed in sections II.G.1.a. and VII.C. of the preamble of this final rule, the use of the ICD–10–CM/PCS coding system is required beginning October 1, 2015. Under the ICD–10–PCS coding system, procedure code 5A1955Z (Respiratory ventilation, greater than 96 consecutive hours) describes such long-term mechanical ventilator services. Therefore, we further proposed, effective with discharges in cost reporting periods beginning on or after October 1, 2015, to determine if a discharge meets the requirements of the ventilator criterion in order to be eligible for exclusion from the site neutral payment rate based on whether the LTCH reports procedure code 5A1955Z on its hospital claim. If finalized, we proposed to place these requirements under new § 412.522(b)(3).

Under this proposal, any LTCH claims that do not report this procedure code would not meet the requirements of the ventilator criterion in order to be eligible for exclusion from the site neutral payment rate. For more detail regarding the ventilator criterion proposals and the alternatives that we had considered in developing those proposals (including the use of MS–LTC–DRGs in lieu of this procedure code), we refer readers to the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24531).

Comment: Commenters generally supported CMS' proposal to determine whether an LTCH discharge meets the ventilator criterion based on the use of ICD–10–PCS procedure code 5A1955Z. However, some commenters expressed concern that CMS' proposal failed to identify and include cases that receive *exactly* 96 hours of ventilator services. The commenters pointed out that, under the statutory language, cases representing patients receiving *exactly* 96 hours of ventilation should also be paid the LTCH PPS standard Federal payment rate, assuming the other relevant criteria are met. Some commenters suggested that discharges identified by ICD–10–PCS procedure code 5A1945Z (Continuous invasive mechanical ventilation, 24—96 consecutive hours) and were grouped into one of the six long-term mechanical ventilator MS–LTC–DRGs (that is, MS–LTC–DRGs 003, 004, 207, 870, 927, 933) should also be used as an additional procedure code to identify discharges meeting the ventilator criterion. Doing so, they believed, would ensure proper payment of cases that received *exactly* 96 hours of ventilator services. Other commenters noted their belief that the statute does not require consecutive hours on ventilator services and, therefore, were concerned that the use of ICD–10–PCS procedure code 5A1945Z, which they believed specified more than 96 hours of *continuous* ventilation, would not recognize discharges that receive 96 hours or more of *noncontinuous* of ventilator services. For example, the commenters indicated that ICD–10–PCS procedure code 5A1945Z may not appropriately account for hours used during ventilator weaning, which could discourage LTCHs from weaning patients off of ventilator services within less than 96 hours, if the number of hours provide during the weaning process would result in less than 96 hours of services being provided.

Response: The commenters are correct in noting that the range of consecutive hours for mechanical ventilation services under the ICD–10–PCS differs from the ICD–9–CM, with the primary difference being the handling of the 96th hour. The ICD–9–CM system provides three unique procedure codes for mechanical ventilator services based on the number of consecutive hours: ICD–9–CM procedure code 96.70 for an unspecified duration of service, ICD–9–CM procedure code 96.71 for services less than 96 consecutive hours in duration, and ICD–9–CM procedure code 96.72 for services consisting of 96 consecutive hours or more. Whereas, the ICD–10–PCS provides three unique codes for mechanical ventilator services based on the number of consecutive hours with the following ranges: services consisting of less than 24 consecutive hours (ICD–10–PCS procedure code 5A1935Z); services consisting of 24 to 96 consecutive hours (ICD–10–PCS procedure code 5A1945Z); and services consisting of greater than 96 consecutive hours (ICD–10–PCS procedure code 5A1955Z). Consequently, under the ICD–10–PCS, mechanical ventilation services in duration of exactly 96 hours are no longer grouped in the same range as services consisting of more than 96 hours, as it is under ICD–9–CM system.

We have considered the commenters' suggestions. While we agree that our proposed use of procedure code 5A1945Z would not identify a case where the patient received *exactly* 96 hours of ventilator services and that such a case should be paid the LTCH PPS standard Federal payment rate. Despite that, for the reasons noted below, we continue to believe that the

most appropriate means of implementing the ventilator criterion is by the use of ICD–10–PCS procedure code 5A1955Z.

We first considered the commenters' suggested alternative method, but determined that it was not a viable option because, under the ICD–10 coding guidelines and Version 33.0 MS–DRGs (discussed in section II.G.1.a. of this preamble) and by extension the MS–LTC–DRGs, discharges with ICD–10–PCS procedure code 5A1945Z (Respiratory ventilation, 24–96 consecutive hours), but not ICD–10–PCS procedure code 5A1955Z (Respiratory ventilation, greater than 96 consecutive hours), will not be grouped into any of the MS–LTC–DRGs suggested by the commenters. That is, the commenters' suggested alternative is not possible because the GROUPER logic for those MS–LTC–DRGs only includes ICD–10–PCS procedure code 5A1955Z. Furthermore, based on existing claims elements and ICD–10–PCS procedure codes' descriptions, we were unable to identify any feasible alternative procedure code to identify a case where the patient received *exactly* 96 hours of ventilator services, and the commenters did not provide any data or anecdotal evidence of such situations regularly occurring. We do not believe that many patients receive exactly 96 hours of ventilator services, and we expect that this problem will rarely, if ever, arise. However, if these rare instances occur, the LTCH should contact its MAC to have the appropriate LTCH PPS payment amount under the new dual rate LTCH PPS payment structure determined for any such claims (which should be coded with the appropriate use of ICD–10–PCS procedure code 5A1945Z).

With respect to the commenters' concerns regarding counting the number of hours in which a patient is being weaned from mechanical ventilator services, the AHA Coding Clinic (4th Quarter 2014) instructs coders that, in general, ''[w]hen the patient is being weaned from mechanical ventilation, the entire duration of the weaning process is counted to determine the correct code assignment.'' We also refer readers to the AHA Coding Clinic guidelines, which provide guidance on determining the duration of mechanical ventilation services, including any weaning period. Therefore, we do not believe that the use of ICD–10–PCS procedure code 5A1955Z, which specifies more than 96 hours of continuous ventilation, would discourage LTCHs from weaning patients of a ventilator in less than 96 hours because the use of this procedure code accounts for hours spent during the ventilator weaning process. However, we remind providers that providing medically unnecessary services to patients (including additional time on a ventilator in order to meet the requirements for exclusion from the site neutral payment rate) and reporting charges for such services constitutes fraudulent behavior for which we will monitor. We also intend to continue to monitor the appropriateness of the use of ICD–10–PCS procedure code 5A1955Z, and may propose alternative implementation measures for the ventilator criterion to the extent experience under the revised LTCH PPS demonstrates such action is necessary.

After consideration of the public comments we received, we are finalizing our proposal, without modification, and codifying our ventilator criterion under new § 412.522.

4. Determination of the Site Neutral Payment Rate (New § 412.522(c))

a. General

Section 1206(a) of Public Law 113–67 amended section 1886(m) of the Act by adding paragraph (6), which specifies that beginning with cost reporting periods starting on or after October 1, 2015, all LTCH PPS discharges are paid according to the site neutral payment rate unless certain criteria are met. In general, section 1886(m)(6)(B)(ii) of the Act specifies that the site neutral payment rate is the lower of the IPPS comparable per diem amount under § 412.529(d)(4), including any applicable outlier payments under § 412.525(a), or 100 percent of the estimated cost of the case. Consistent with the requirements of section 1886(m)(6)(B)(ii) of the Act, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24531 through 24532), we proposed under new § 412.522(c)(1) that the site neutral payment rate is the lower of the IPPS comparable per diem amount determined under § 412.529(d)(4), including any applicable outlier payments under § 412.525(a), or 100 percent of the estimated cost of the case determined under § 412.529(d)(2).

Under our proposed calculation of the site neutral payment rate, new § 412.522(c)(1)(i) provides that the IPPS comparable per diem amount would be calculated using the same method used to determine an amount comparable to the hospital IPPS per diem amount as set forth in the existing regulations at§ 412.529(d)(4), consistent with section 1886(m)(6)(B)(ii)(I) of the Act. Specifically, in the RY 2007 LTCH PPS final rule (71 FR 27852 through 27853), we established a method to determine an amount payable under 42 CFR part 412, subpart O, that is comparable to what would otherwise be paid under the IPPS for the costs of inpatient operating services, which is commonly referred to as the ''the IPPS comparable per diem amount.'' Accordingly, consistent with § 412.529(d)(4), we proposed to determine the IPPS comparable per diem amount based on the standardized amount determined under § 412.64(c), adjusted by the applicable DRG weighting factors determined under § 412.60 as specified at § 412.64(g). We also proposed to further adjust this amount to account for differences in area wage levels based on geographic location using the applicable IPPS labor-related share and the IPPS wage index for nonreclassified hospitals published in the annual IPPS final rule in accordance with § 412.525(c). For LTCHs located in Alaska and Hawaii, we proposed that this amount would be further adjusted by the applicable COLA factors established annually during the rulemaking cycle. We also proposed that the IPPS comparable per diem amount include an adjustment for treating a disproportionate share of low-income patients, consistent with the DSH payment adjustment under § 412.106, as applicable, which would include a proxy adjustment for the uncompensated care payment (78 FR 50765 through 50767). In the case of an LTCH that is a teaching hospital, we proposed that the IPPS comparable per diem amount include an IME payment adjustment, consistent with the formula set forth under § 412.105, where the LTCH's IME cap (that is, the limit on the number of full-time equivalent (FTE) residents that may be counted for IME) would be imputed from the LTCH's direct GME cap as set forth at § 413.79(c)(2). In addition, we proposed that the IPPS comparable per diem amount also include payment for inpatient capital-related costs, based on the capital IPPS Federal rate determined in accordance with § 412.308(c), adjusted by the applicable IPPS DRG weighting factors. We proposed to further adjust the capital IPPS Federal rate by the applicable geographic adjustment factors based on the geographic location of the LTCH and the COLA factors for LTCHs located Alaska and Hawaii, consistent with § 412.316. In addition, we proposed to include in this amount the adjustments to the capital IPPS Federal rate for DSH payments in accordance with § 412.320 and IME payments in accordance with § 412.322. Consistent with

§§ 412.529(d)(4)(i)(B) and (C), we proposed to determine the IPPS comparable per diem amount by dividing the IPPS comparable payment amount described above by the geometric average length of stay of the specific MS–DRG under the IPPS and multiplying that amount by the covered days of the LTCH stay. We proposed that the IPPS comparable per diem amount is limited to the full comparable amount to what would otherwise be paid under the IPPS.

Comment: Several commenters expressed concern regarding CMS' proposal to establish that the new LTCH site neutral payment rate as the lesser of the IPPS comparable per diem amount, or 100 percent of the estimated cost of the case. Specifically, the commenters stated that an LTCH would receive a lower payment than an IPPS hospital for treating the same type of case. Therefore, the commenters recommended that CMS pay LTCH site neutral payment rate cases the exact amount that would be paid for the case under the IPPS.

Response: We acknowledge the commenters' concerns. However, section 1886(m)(6)(B)(ii) of the Act specifies that the site neutral payment rate is the lower of the IPPS comparable per diem amount under § 412.529(d)(4), including any applicable outlier payments under § 412.525(a), or 100 percent of the estimated cost of the case. Without the enactment of further legislation, we do not have the authority to make any further adjustments to the calculation of the site neutral payment rate that would guarantee that payment for such a case would equal the exact amount paid for an identical discharge from an IPPS hospital.

After consideration of the public comments we received, we are finalizing, without modification, our proposal to establish that the site neutral payment rate is the lesser of the IPPS comparable per diem amount, or 100 percent of the estimated cost of the case.

The IPPS comparable per diem amount described under § 412.529(d)(4) does not include additional payments for extraordinarily high-cost cases under the IPPS outlier policy. Therefore, consistent with the requirements of section 1886(m)(6)(B)(ii)(I) of the Act, under our proposed calculation of the site neutral payment rate under new § 412.522(c)(1), we proposed to add any high-cost outlier (HCO) payment that may be payable under § 412.525(a) to the IPPS comparable per diem amount. To do so, we also proposed to revise the HCO policy under existing § 412.525(a) to provide for high-cost outlier payments under the site neutral payment rate calculated under proposed new § 412.522(c) (as discussed in greater detail in section VII.B.7.b. of the preamble of this final rule). We proposed that site neutral payment rate cases receive an additional payment for HCOs that would be equal to 80 percent of the difference between the estimated cost of the case and the HCO threshold, which we are proposing would be the sum of site neutral payment rate for the case and the IPPS fixed-loss amount. We also proposed that HCO payments for site neutral payment rate cases would be budget neutral and proposed to apply a budget neutrality factor to the LTCH PPS payments for those cases to maintain budget neutrality. (For additional information on our revised HCO policy in regard to site neutral payment rate cases under § 412.525(a), we refer readers to section VII.B.7.b. of the preamble of this final rule.)

Comment: Commenters supported the proposal to under new § 412.522(c)(1) to include any applicable HCO payments specified in § 412.525(a) in the IPPS comparable per diem amount determined under § 412.529(d)(4) when determining the payment for site neutral payment rate cases. We also received comments on our proposed revisions to the HCO policy under existing § 412.525(a) to determine high-cost outlier payments under the site neutral payment rate, which are discussed in section VII.B.7.b. of the preamble of this final rule.

Response: We appreciate the commenters' support. We are adopting this proposal, without modification. As noted above, we refer readers to section VII.B.7.b. of the preamble of this final rule for a discussion of our revisions to the HCO policy under existing § 412.525(a) to determine high-cost outlier payments under the site neutral payment rate, and summations of the public comments we received, including our responses to those comments, and a statement of our final policy.

Furthermore, under our proposed calculation of the site neutral payment rate, under proposed new § 412.522(c)(1)(ii), we proposed to calculate 100 percent of the estimated cost of a case by multiplying the LTCH's hospital-specific cost-to-charge ratio (CCR) by the Medicare allowable charges for the LTCH case, which is the same method we use to determine SSO payments under § 412.529(d)(2), as well as HCO payments under the HCO policy under § 412.525(a). Consistent with our existing policies for computing CCRs under the LTCH PPS, we also proposed to apply the payment policies described under §§ 412.529(f)(4)(i) through (f)(4)(iii) to the calculation of the estimated cost of the case for site neutral payment rate cases under proposed new § 412.522(c)(1)(ii). Under this proposal, the CCR applied at the time a claim is processed would generally be based on either the most recent settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period. CMS may specify an alternative to the CCR otherwise applicable if we believe that the CCR being applied is inaccurate, in accordance with section 150.24 of Chapter 3 of the Medicare Claims Processing Manual (Pub. 100–4), or an LTCH may request an alternate (higher or lower) CCR based on its presentation of substantial evidence in support of that alternate. The CMS Regional Office must approve the request, and the MAC notifies the LTCH whenever a change is made to its CCR. The applicable MAC may also use the statewide average CCR that is established annually by CMS if it is unable to determine an accurate CCR for an LTCH under one of the circumstances specified at existing § 412.529(f)(4)(iii) (that is, in general, for a new LTCH, when the LTCH's CCR exceeds 3 standard deviations from the corresponding national geometric mean CCR, and for an LTCH for which data to calculate a CCR are otherwise not available). These same CCR policies also are applicable under the LTCH PPS HCO policy (§§ 412.525(a)(4)(iv)(B) and (a)(4)(iv)(C)).

We did not receive any public comments on our proposal to calculate 100 percent of the estimated cost of a site neutral payment rate case by multiplying the LTCH's hospital-specific CCR by the Medicare allowable charges for the LTCH case, and to codify this policy under new § 412.522(c)(1)(ii). Therefore, we are adopting that proposal, without modification.

In the FY 2016 IPPS/LTCH PPS (80 FR 24532), we proposed to include a reconciliation adjustment to site neutral payment rate cases. Currently, under the LTCH PPS, payments for HCO and SSO cases may be subject to reconciliation at cost report settlement under § 412.525(a)(4)(iv)(D) and § 412.529(f)(4)(iv), respectively. Under these policies, reconciliation is based on the CCR calculated using the CCR computed from the settled cost report that coincides with the discharge. Under our existing criteria, reconciliation occurs in instances where an LTCH's actual CCR for the cost reporting period fluctuates plus or minus 10 percentage points compared to the interim CCR used to calculate payments when a

claim is processed. We adopted this reconciliation policy for the LTCH PPS HCO and SSO cases because CCRs based on settled cost reports are not available when claims are processed unless significant delays are imposed on the payment of claims. (For additional information, we refer readers to the June 9, 2003 IPPS/LTCH PPS high-cost outlier final rule (68 FR 34507) and sections 150.26 through 150.28 of the Medicare Claims Processing Manual (Pub. 100–4).) Given the use of LTCH CCRs to calculate the estimated cost of cases under the proposed site neutral payment rate, we stated in the proposed rule that we believe that it would be equally appropriate to apply the current CCR reconciliation policy principles to site neutral payment rate payments. Therefore, we proposed under new § 412.522(c)(4) to reconcile site neutral payment rate payments based on the CCR calculated using the settled cost report that coincides with the discharge. We also proposed that, at the time of any such reconciliation of site neutral payment rate payments, such payments be adjusted to account for the time value of any underpayments or overpayments. Any adjustment would be based upon a widely available index to be established in advance by the Secretary and will be applied from the midpoint of the cost reporting period to the date of reconciliation. The index that would be used to calculate the time value of money is the monthly rate of return that the Medicare Trust Fund earns, which can be found at: *http://www.ssa.gov/OACT/ProgData/newIssueRates.html*, consistent with our current reconciliation policy described in section 150.27 of Chapter 3 of the Medicare Claims Processing Manual (Pub. 100–4). Furthermore, we proposed that our existing policies governing CCRs for both HCO (under §§ 412.525(a)(4)(iv)(A) through (C)) and SSO payments (under §§ 412.529(f)(4)(i) through (iii)) would apply to the CCRs used to determine the estimated cost of a case under proposed new § 412.522(c)(4).

Comment: Several commenters disagreed with CMS' proposal to apply our existing reconciliation policy to payments made for site neutral payment rate cases. The commenters stated that such a policy is unprecedented and contrary to the predictability of a PPS. They believed that applying a reconciliation policy to payments for site neutral payment rate cases would result in an adjustment to all LTCH site neutral payment rate cases for every LTCH at the conclusion of every cost reporting period.

Response: We disagree with the commenters. Consistent with the current reconciliation policy, payments for site neutral payment rate cases would be subject to reconciliation only when certain criteria are met. As noted above and referenced by several commenters, the current criteria for reconciliation are presented in sections 150.26 through 150.28 of the Medicare Claims Processing Manual (Pub. 100 4), and include the criterion that the LTCH's actual CCR must be plus or minus 10 percentage points from the CCR used during that cost reporting period to trigger outlier payments. The purpose of the policy was not intended to automatically require that all payments for site neutral payment rate cases in every LTCH's cost reporting period be reconciled. Nevertheless, we understand the commenters' concerns regarding the need for predictability and stability in LTCH PPS payments. Therefore, we believe that it would be appropriate to generally postpone the implementation of a reconciliation policy for site neutral payments until we have gained more experience under the revised LTCH PPS. This approach would allow CMS the opportunity to review the existing reconciliation criteria, and revise, if appropriate, that criteria to identify the circumstances under which it would be appropriate to reconcile the entire site neutral payment rate payment amount, should it be determined that such a policy is warranted. However, we continue to believe that it is appropriate to include any HCO payments made to site neutral payment rate cases in our existing reconciliation policy. Such a policy provides for a consistent application of the reconciliation policy to both site neutral payment rate cases and LTCH PPS standard Federal payment rate cases, while we monitor whether it may be appropriate to apply a reconciliation policy to the entire site neutral payment rate as we gain experience under the revised LTCH PPS.

Therefore, we are not finalizing the proposal to apply, under new § 412.522(c)(4), a reconciliation policy to payments made for site neutral payment rate cases. However, we are finalizing the proposal to include any HCO payments made for site neutral payment rate cases under the existing reconciliation policy at § 412.525(a)(4)(iv)(D). (As noted previously, our HCO policy for site neutral payment rate cases is discussed in detail in section VII.B.7.b. of the preamble of this final rule.)

b. Blended Payment Rate for FY 2016 and FY 2017

Section 1886(m)(6)(B) of the Act establishes a transitional payment method for cases that will be paid the site neutral payment rate for LTCH discharges occurring in cost reporting periods beginning during FY 2016 or FY 2017. For those discharges, the applicable site neutral payment rate is to be the blended payment rate specified in section 1886(m)(6)(B)(iii) of the Act. For LTCH discharges occurring in cost reporting periods beginning during FY 2018 or later, the applicable site neutral payment rate will be the site neutral payment rate as defined in section 1886(m)(6)(B)(ii) of the Act.

Section 1886(m)(6)(B)(iii) of the Act specifies that the blended payment rate is comprised of 50 percent of the site neutral payment rate for the discharge under section 1886(m)(6)(B)(ii) of the Act and 50 percent of the LTCH PPS standard Federal payment rate that would have applied to the discharge if paragraph (6) of section 1886(m) of the Act had not been enacted. As previously discussed, we proposed to codify the site neutral payment rate specified under section 1886(m)(6)(B)(ii) of the Act under proposed new § 412.522(c)(1), as adjusted under proposed new § 412.522(c)(2). Under proposed new § 412.522(c)(1), the site neutral payment rate is the lower of the IPPS comparable per diem amount determined under § 412.529(d)(4), including any applicable outlier payments under § 412.525(a), or 100 percent of the estimated cost of the case determined under § 412.529(d)(2). For purposes of the blended payment rate, we proposed that the payment rate that would otherwise be applicable if section 1886(m)(6) of the Act had not been enacted would be the LTCH PPS standard Federal payment; which, in light of other proposals presented in the proposed rule, would be the LTCH PPS standard Federal payment rate that is applicable to discharges that meet the criteria for exclusion from the site neutral payment rate under proposed new § 412.522(a)(2). That rate is the LTCH PPS standard Federal payment rate determined under § 412.523. Therefore, consistent with the requirements of section 1886(m)(6)(B)(ii) of the Act, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24533), we proposed under proposed new § 412.522(c)(3), for LTCH discharges occurring in cost reporting periods beginning on or after October 1, 2015, and on or before September 30, 2017 (that is, discharges occurring in cost reporting periods beginning during

FYs 2016 and 2017), that the payment amount for site neutral payment rate cases would be a blended payment rate, which would be calculated as 50 percent of the applicable site neutral payment rate amount for the discharge as determined under proposed new § 412.522(c)(1) and 50 percent of the applicable LTCH PPS standard Federal payment rate determined under § 412.523. Under this proposal, the payment amounts determined under proposed new § 412.522(c)(1) (the site neutral payment rate) and under § 412.523 (the LTCH PPS standard Federal rate) would include any applicable adjustments, such as HCO payments, as applicable, consistent with the requirements under § 412.523(d). For example, the portion of the blended payment for the discharge that is based on proposed new § 412.522(c)(3) would include 50 percent of any applicable site neutral payment rate HCO payment under our revised HCO payment policy (discussed in detail in section VII.B.7.b. of the preamble of this final rule), consistent with proposed new § 412.522(c)(1)(i), which provides for HCO payments under § 412.525(a). Similarly, the portion of the blended payment for the discharge that is based on the LTCH PPS standard Federal payment rate would include any applicable HCO payment under existing § 412.525(a).

Comment: Some commenters requested that CMS establish a longer transitional period for LTCHs to receive blended payments because of the concern that reduced payments to LTCHs under the revised LTCH PPS would create a negative impact on these providers.

Response: We acknowledge the commenters' concerns. However, the blended payment rate provided under the statute is only applicable to LTCH discharges occurring during FY 2016 and FY 2017, and does not extend applicability to discharges occurring during cost reporting periods beginning in FY 2018 and subsequent fiscal years.

After consideration of the public comments we received, we are finalizing our proposed policy, without modification.

c. LTCH PPS Standard Federal Payment Rate

Section 1206(a) of Public Law 113–67 amended section 1886(m) of the Act by adding paragraph (6), which specifies that beginning with cost reporting periods starting on or after October 1, 2015, all LTCH PPS discharges are paid according to the site neutral payment rate, unless certain criteria are met. For detailed discussion of our proposed and finalized policies regarding the criteria for exclusion from the site neutral payment rate, we refer readers to section VII.B.3. of the preamble of this final rule. For LTCH cases that meet the criteria for exclusion from the site neutral payment rate, section 1886(m)(6)(A)(ii) of the Act specifies that the site neutral payment rate will not apply and payment will be made without regard to requirements of section 1886(m)(6)(A)(ii) of the Act. Consistent with these statutory requirements, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24533), we proposed under new § 412.522(a)(2) that for LTCH discharges that meet the criteria for exclusion from site neutral payment rate under new § 412.522(b), payment will be based on the LTCH PPS standard Federal payment rate as determined in § 412.523. That is, under new § 412.522(a)(2), LTCH PPS standard Federal payment rate cases would continue to be paid based on the LTCH PPS standard Federal payment rate. Under this policy, all of the existing payment adjustments under § 412.525(d), that is, the adjustments for SSO cases under § 412.529, the adjustments for interrupted stays under § 412.531, and the 25-percent threshold policy under § 412.534 and § 412.536, would still apply if appropriate. In addition, as discussed in greater detail in section VII.B.7.b. of the preamble of the proposed rule and this final rule, we proposed that our existing HCO policy would apply to LTCH PPS standard Federal payment rate cases, except that the 8 percent HCO target would be established using only data from LTCH PPS standard Federal payment rate cases.

We did not receive any public comments on our proposal to pay for LTCH discharges that meet the criteria for exclusion from the site neutral payment rate under new § 412.522(a)(2) based on the LTCH PPS standard Federal payment rate. We are adopting this policy as final, without modification. We note that we proposed changes to the MS–LTC–DRG relative weight calculations and HCO policy for LTCH PPS standard Federal payment rate cases, which are discussed in in section VII.B.7. of the preamble of this final rule and include summations of the public comments we received and our responses.

5. Application of Certain Existing LTCH PPS Payment Adjustments to Payments Made Under the Site Neutral Payment Rate

Consistent with current LTCH PPS payment policies for adjusting Federal prospective payments, under the broad authority under section 123(a)(1) of the BBRA, as amended by section 307(b) of the BIPA, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24533 through 24534), we proposed that certain existing payment adjustments under the special payment provisions set forth at existing § 412.525(d), with the exception of the SSO adjustment described under § 412.525(d)(1) would apply to site neutral payment rate cases. These adjustments include the interrupted stay policy and the 25-percent threshold policy. The current payment adjustment under the interrupted stay policy at § 412.531 was developed and implemented prior to the statutory LTCH PPS dual rate payment structure and contains terms specific to payment based on the LTCH PPS standard Federal payment rate (such as LTC–DRG payment and Federal LTC–DRG prospective payment). Under our proposal, the site neutral payment rate would not be calculated based on the LTCH PPS standard Federal payment rate because the payment would generally be the lower of the IPPS comparable per diem amount (including any applicable outlier payments), or 100 percent of the estimated cost of the case. Consequently, in order to apply the provisions of the existing interrupted stay policy at § 412.531 to site neutral payment rate cases, under proposed new § 412.522(c)(2)(ii), we proposed to specify that, for purposes of the application of the provisions of § 412.531 to LTCH discharges described under § 412.522(a)(1), the LTCH PPS standard payment-related terms, such as ''LTC–DRG payment'', ''full Federal LTC–DRG prospective payment'', and ''Federal prospective payment,'' mean the site neutral payment rate calculated under proposed new § 412.522(c).

We stated in the proposed rule that we believe that it is appropriate to apply these adjustments to the site neutral payment rate cases because the site neutral payment rate merely establishes an alternate payment amount under the LTCH PPS, as opposed to creating an exception from the LTCH PPS. Additionally, we believe that the policy concerns upon which these policies are based apply equally to payments made under the LTCH PPS site neutral payment rates and the standard Federal payment rates.

We established the interrupted stay policy to address instances in which a patient is discharged from an LTCH and later readmitted to that LTCH within a certain amount of time. This kind of readmission to the LTCH represents a continuation or resumption of the initial, interrupted treatment, rather than a new episode of care. (For a

discussion of our implementation of the interrupted stay policy, we refer readers to the RY 2003 LTCH PPS final rule (67 FR 56002).) We continue to believe that the interrupted stay policy serves as an effective instrument to protect the Medicare Trust Fund from significant and inappropriate expenditures (78 FR 50768), and we do not believe that the site neutral payment rate will address these concerns unless the interrupted stay policy is applied to site neutral payment rate cases in the same manner as it is applied to standard Federal payment rate cases.

The 25-percent threshold payment adjustment policy was implemented based on analyses of Medicare discharge data that indicated that patterns of patient shifting appeared to be occurring more for provider financial advantage than for patient benefit. In order to discourage such activity, a payment adjustment was applied to LTCH discharges of patients who were admitted to the LTCH from the same referring hospital in excess of an applicable percentage threshold (79 FR 50185). We refer readers to the detailed discussions of the 25-percent threshold payment adjustment policy for LTCH hospital-within-hospitals (HwHs) and LTCH satellite facilities in the FY 2005 IPPS/LTCH final rule (69 FR 49191 through 49214) and its application to all other LTCHs in the RY 2008 LTCH PPS final rule (72 FR 26919 through 26944), as well as our discussion in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50185 through 50187), for additional details on the 25-percent threshold payment adjustment. We do not believe that the site neutral payment rate will address these patient shifting concerns unless the 25-percent threshold payment adjustment is applied to site neutral payment rate cases in the same manner as it is applied to LTCH PPS standard Federal payment rate cases.

In considering the potential policy proposals, we recognized that there is a current statutory moratorium on the full implementation of the 25-percent threshold payment adjustment policy under section 1206(b)(1)(A) of Public Law 113–67 that is scheduled to expire in FY 2016. (For a discussion of our implementation of the current statutory moratorium on the full implementation of the 25-percent threshold payment adjustment policy, we refer readers to the FY 2015 IPPS/LTCH PPS final rule (79 FR 50185 through 50187).) In the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24533 through 24534), we proposed to apply all of the payment adjustments to site neutral payment rates in the same manner as they are currently applied (and will continue to be applied for the foreseeable future) to LTCH PPS standard Federal payment rates—including, as applicable, the moratorium on implementing the 25-percent threshold payment adjustment.

We did not propose to apply the SSO payment adjustment to the site neutral payment rate at this time because, while the policy goal of ensuring patients in an LTCH receive a full course of treatment remains, under our current method of paying for SSOs as described under § 412.529, we pay for SSOs based on the lowest of several payment options, one of which is the LTCH's estimated cost of the case. As described above, site neutral payment rate cases are paid the lower of the IPPS comparable per diem amount, or 100 percent of the estimated cost of the case. Because the estimated cost option is used in determining both SSO payments and site neutral payment rates and both methods make payment based on the lowest of their respective payment options, in most cases, applying our current SSO payment adjustment to site neutral payment rate cases would not affect the resulting LTCH PPS payment made for the discharge. We may consider proposing the application of an alternative SSO payment adjustment in the future if we find evidence that Medicare beneficiaries are not regularly receiving the full course of treatment when such treatment is paid for at the site neutral payment rate.

Comment: MedPAC supported the CMS proposal to apply the interrupted stay policy and the 25-percent threshold policy to site neutral payment rate cases. However, other commenters disagreed with the proposal and indicated that one or both of these policies should be eliminated entirely because the concerns that led to these policies are addressed with the statutory revisions to the payment rates under the LTCH PPS. The commenters stated that if the policies are not eliminated entirely that, at a minimum, the provisions should not apply to site neutral payment rate cases because payments for site neutral payment rate cases are similar to the payments under the IPPS for these types of cases, and the lengths of stay for site neutral payment rate cases should be similar to the lengths of stay for similar cases paid under the IPPS. Some commenters suggested that CMS establish an IRF-like interrupted stay policy as an alternative to the LTCH interrupted stay policy. Some commenters noted that CMS indicated in prior rulemakings that the revised LTCH PPS would render the 25-percent threshold policy unnecessary. Other commenters suggested that CMS apply the 25-percent threshold policy to site neutral payment rate cases prior to applying the policy to LTCH PPS standard Federal payment rate cases as an alternative to excluding site neutral payment rate cases from the 25-percent threshold policy altogether.

Response: We appreciate MedPAC's support. In response to the commenters who disagreed with the proposals, we believe that it is premature to determine if modifications should be made to these polices, including their applicability to site neutral payment rate cases, without the benefit of experience gained under the revised LTCH PPS; especially given that the higher blended payment rate will apply to LTCH discharges that do not meet the criteria for exclusion from the site neutral payment rate until cost reporting periods beginning on or after October 1, 2017. In addition, we did not indicate in prior rulemakings that these policies were unnecessary. We stated that, at that time, the policies may no longer be necessary in light of the intended changes to the LTCH PPS. We believe that it would be prudent to maintain these policies as they currently exist, including their applicability to site neutral payment rate cases, while we gain more experience. However, we will keep this suggestion in mind when contemplating whether the current policy should be modified. In the event that we determine that policy modifications are warranted, we will address them through future rulemaking.

Comment: One commenter requested clarification about our proposed application of the 25-percent threshold policy to site neutral payment rate cases.

Response: The 25-percent threshold policy would apply to site neutral payment rate cases in the same manner as it would apply to LTCH PPS standard Federal payment cases; all LTCH discharges (site neutral payment rate cases or LTCH PPS standard Federal payment rate cases) that are beyond an LTCH's applicable threshold from a single referring hospital would be subjected to an adjustment in accordance with the 25-percent threshold policy.

Comment: Several commenters expressed support for our proposal not to apply the SSO policy to site neutral payment rate cases. Other commenters believed that the SSO policy should be modified in consideration of site neutral payment rate cases.

Response: We appreciate the commenters' support. We will consider the commenters' suggestions to revise the SSO policy, and may consider additional policy proposals to address this issue in future rulemaking.

After consideration of public comments we received, we are finalizing, without modification, our proposals to apply the interrupted stay policy and the 25-percent threshold policy to site neutral payment rate cases, and not to apply the SSO policy to site neutral payment rate cases at this time.

6. Policies Relating to the LTCH Discharge Payment Percentage

Section 1886(m)(6)(C) of the Act, as added by section 1206 of Public Law 113–67, imposes several requirements related to an LTCH's discharge payment percentage. As defined by section 1886(m)(6)(C)(iv) of the Act, the term ''LTCH discharge payment percentage'' is a ratio, expressed as a percentage, of Medicare discharges not paid the site neutral payment rate to total number of Medicare discharges occurring during the cost reporting period. In other words, an LTCH's discharge payment percentage would be the ratio of an LTCH's Medicare discharges that meet the criteria for exclusion from the site neutral payment rate (as described under new § 412.522(a)(2)) to an LTCH's total number of Medicare discharges paid under the LTCH PPS (that is, both Medicare discharges paid under the site neutral payment rate and those that meet the criteria for exclusion from the site neutral payment rate, as described under new §§ 412.522(a)(1) and (2), respectively) during the cost reporting period. Therefore, consistent with the statutory requirement at section 1886(m)(6)(C)(iv) of the Act and under the broad authority under section 123(a)(1) of the BBRA, as amended by section 307(b) of the BIPA, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24534) under proposed new § 412.522(d)(1), we proposed to define an LTCH's discharge payment percentage as a ratio, expressed as a percentage, of Medicare discharges excluded from the site neutral payment rate as described under proposed new § 412.522(a)(2) to total Medicare discharges paid under the LTCH PPS (in accordance with 42 CFR part 412, subpart O) during the cost reporting period.

Comment: One commenter requested clarification about whether our proposed definition of the discharge payment percentage included Medicare Advantage beneficiaries, and noted that the statute expressly excludes these beneficiaries from the percentage.

Response: We agree with the commenter that the exclusion of Medicare Advantage beneficiaries is consistent with the statute. We believe that our proposed use of the phrase ''Medicare discharges paid under the LTCH PPS (in accordance with 42 CFR part 412, subpart O)'' was a clear statement concerning the exclusion of Medicare Advantage beneficiaries from the discharge patient percentage (80 FR 24534). However in the interest of clarity, we are taking this opportunity to reiterate that the LTCH's discharge payment percentage under new § 412.522(d)(1) would not include Medicare Advantage patients in either the numerator or denominator of that ratio.

Comment: One commenter requested we develop a procedure by which LTCHs who demonstrate ''highly compliant'' discharge payment percentages would receive payment for all discharges at the LTCH PPS standard Federal payment rate.

Response: As explained more fully previously in this preamble, we do not have the authority to pay any rate other than the site neutral payment rate for discharges that do not meet the exclusion statutory criteria.

After consideration of the public comments we received, we are finalizing our proposed definition of the discharge patient percentage under new § 412.522(d)(1), including the technical correction of the typographical error in the phrase ''paid under this Subpart O'' that we are correcting to read as ''paid under this subpart'' for clarity.

In addition, section 1886(m)(6)(C)(i) of the Act requires that we provide notice to each LTCH of the LTCH's discharge payment percentage (as defined in section 1886(m)(6)(C)(iv) of the Act) for LTCH cost reporting periods beginning during or after FY 2016. Therefore, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24534 through 24535), we proposed to codify this statutory requirement at proposed new § 412.522(d)(2). Under this proposal, for cost reporting periods beginning on or after October 1, 2015, as required by the statute, we would inform each LTCH of their discharge payment percentage as defined under proposed new § 412.522(d)(1). We stated that we plan to develop such a notification process through subregulatory guidance. We also note that, under section 1886(m)(6)(C)(ii) of the Act, for cost reporting periods beginning on or after October 1, 2020, the statute requires that any LTCH whose discharge payment percentage for the period is not at least 50 percent will be informed of such a fact and all of the LTCH's discharges in each successive cost reporting period will be paid the payment amount that would apply under subsection (d) for the discharge if the hospital were a subsection (d) hospital, subject to the process for reinstatement provided for by section 1886(m)(6)(C)(iii) of the Act.

Because this statutory requirement is not effective until cost reporting periods beginning on or after October 1, 2020, we did not propose to make any changes related to the limitation requirement or the process for reinstatement at this time. However, we invited public comments on the development and implementation of the process for reinstatement under section 1886(m)(6)(C)(iii) of the Act.

Comment: Several commenters requested that CMS develop internal procedures and instructional mechanisms that explain how LTCHs will be notified of their discharge patient percentage through rulemaking.

Response: We appreciate the commenters' input regarding the limitation requirements or the process for reinstatement as a result of the discharge patient percentage policy, including suggestions for ''cure periods'' for LTCHs whose discharge patient percentages fall below 50 percent. We will consider these comments as we develop proposals in these areas for discharges occurring in cost reporting periods beginning on or after October 1, 2020. However, we note that the development of operational guidance consistent with the law and our regulations does not require rulemaking. We will continue to engage with stakeholders as we develop operational guidance for our contractors.

After consideration of the public comments we received, we are finalizing, without modification, our proposals to codify the statutory requirement under new § 412.522(d)(2) that we provide notice to each LTCH of its discharge payment percentage for each cost reporting period beginning on or after October 1, 2015.

7. Additional LTCH PPS Policies Related to the Implementation of the Site Neutral Payment Rate Required by Section 1206(a) of Public Law 113–67

As discussed earlier in this section, section 1206(a) of Public Law 113–67 amended section 1886(m) of the Act by adding paragraph (6), which establishes patient-level criteria for payments made under the LTCH PPS for LTCH discharges occurring during cost reporting periods beginning on or after October 1, 2015 (FY 2016). In the FY 2015 IPPS/LTCH PPS proposed and final rules, we stated our intent to implement the requirements established by section 1206(a) of Public Law 113–67 through notice and comment rulemaking during the FY 2016 IPPS/LTCH PPS rulemaking cycle. In the FY

2015 IPPS/LTCH PPS proposed rule (79 FR 28205 through 28206), we discussed several significant issues arising from the statutory changes to the LTCH PPS required by section 1206(a) of Public Law 113–67, which establishes two distinct payment groups for LTCH discharges under the revised system: Discharges meeting specified patient-level criteria that will be paid under the LTCH PPS standard Federal payment rate and all other patient discharges that will be paid under the site neutral payment rate. In that same proposed rule, we expressed our interest in receiving feedback from LTCH stakeholders on our plans to evaluate whether it would be appropriate to modify any of our historical policies or methodologies as we began to develop proposals to implement the statutory changes to the LTCH PPS. In particular, we solicited public feedback on the policies relating to the MS–LTC–DRG relative payment weights and high-cost outlier payments in preparation of developing proposals to implement the statutory changes to the LTCH PPS beginning in FY 2016. We explained that in setting the payment rates and factors under the LTCH PPS in accordance with requirements of section 1206(a) of Public Law 113–67, for certain LTCH PPS payment adjustments we planned to evaluate whether it would be appropriate to modify our historical methodology to account for the establishment of the two distinct payment rates for LTCH discharges. In particular, we stated our intent to examine whether, beginning in FY 2016, it would continue to be appropriate to include data for all LTCH PPS cases, including site neutral payment rate cases, in the methodology used to set the MS–LTC–DRGs relative payment weights. We also stated our intent to explore the possibility of changes to the current LTCH PPS high-cost outlier payment policy. Given the fact that, for a number of LTCH discharges, payment would be made based on the lower site neutral payment rate (that is, the lesser of an ''IPPS comparable'' per diem payment amount or 100 percent of the estimated cost of the case), we believed that it would be appropriate to evaluate whether a single high-cost outlier threshold could be applied to all LTCH PPS cases (both LTCH PPS standard Federal payment rate and site neutral payment rate cases), or whether it may be more appropriate to have separate high-cost outlier thresholds for each of the two payment rates under the statutory revisions to the LTCH PPS.

In the FY 2015 IPPS/LTCH PPS final rule (79 FR 50197 through 50198), we summarized the comments we received in response to our request for input from LTCH stakeholders. As we stated in that same final rule, we appreciated the commenters' thoughtful and detailed feedback, particularly those comments regarding the MS–LTC–DRG relative payment weights and the high-cost outlier policy under the new LTCH PPS dual rate payment structure established by section 1206(a) of Public Law 113–67. In developing the proposals presented in the FY 2016 IPPS/LTCH PPS proposed rule, we considered the recommendations and information provided by those commenters. Below we discuss our proposed and finalized policies related to the MS–LTC–DRG payment relative weights and high-cost outlier policy in regard to our implementation policies under the LTCH PPS dual rate payment structure required by section 1206(a) of Public Law 113–67.

a. MS–LTC–DRG Relative Payment Weights

Under the LTCH PPS, relative payment weights for each MS–LTC–DRG are a primary element used to account for the variations in cost per discharge and resource utilization between the diagnosis-related groups (§ 412.515). Each year, based on the latest available LTCH claims data, we calculate a relative payment weight for each MS–LTC–DRG that represents the resources used for an average inpatient LTCH case assigned to that MS–LTC–DRG to ensure that Medicare patients with conditions or illnesses classified under each MS–LTC–DRG have access to an appropriate level of services and to encourage efficiency (79 FR 50170). CMS adjusts the classifications and weighting factors annually to reflect changes in factors affecting the relative use of hospital resources, such as treatment patterns, technology, and the number of discharges (§ 412.517).

Under the new dual rate LTCH PPS payment structure, section 1206(a) of Public Law 113–67 establishes two distinct payment rates for LTCH discharges: discharges meeting specified patient-level criteria that will be excluded from the site neutral payment rate and all other patient discharges that will be paid under the site neutral payment rate. As discussed in greater detail in section VII.B.4.c. of the preamble of our proposed rule and this final rule, under new § 412.522(a)(2), we are establishing that LTCH discharges that meet the criteria for exclusion from site neutral payment rate will be paid using the LTCH PPS standard Federal payment rate described under § 412.523, as adjusted. In general, the LTCH PPS standard Federal payment rate is calculated by adjusting the standard Federal rate (determined under § 412.523(c)(3)) by the applicable MS–LTC–DRG relative payment weight for that Medicare cases. Under new § 412.522(c) (as discussed in greater detail in section VII.B.4.a. of the preamble of this final rule), consistent with section 1886(m)(6)((B)(ii) of the Act, we are establishing that the site neutral payment rate is the lower of the IPPS comparable per diem amount (including any applicable outlier payments), or 100 percent of the estimated cost of the case. Under this policy, the IPPS comparable per diem amount is determined using the same method to determine adjusted payments under the SSO policy at § 412.529(d)(4), and the estimated cost of the case is determined using the same method to determine estimated costs under the SSO policy at § 412.529(d)(2). We also note that the methodology we are adopting to determine payments for site neutral payment rate cases does not use the LTCH PPS standard Federal payment rate or the applicable MS–LTC–DRG relative payment weights.

As discussed above, in preparation for the proposed rule, we considered LTCH stakeholder input and evaluated whether it would be appropriate to modify our historical MS–LTC–DRG relative payment weight methodology to account for the establishment of the two distinct payment rates for LTCH discharges under the statutory changes to the LTCH PPS. Specifically, we examined whether our historical methodology, which uses data from all LTCH PPS discharges, should be continued when we calculate the MS–LTC–DRG relative payment weights under the new LTCH PPS dual rate payment structure, or whether it would be more appropriate to limit the data used to calculate relative payment weights to that obtained from discharges paid based on the LTCH PPS standard Federal payment rate (that is, discharges that would have met the criteria to be excluded from the site neutral payment rate had those criteria been in effect at the time of the discharge). Our existing methodology for developing the MS–LTC–DRG relative payment weights includes established policies related to the data used to calculate the relative payment weights, the hospital-specific relative value methodology, the treatment of severity levels in the MS–LTC–DRGs, the low-volume and no-volume MS–LTC–DRGs, adjustments for nonmonotonicity, and the calculation of the MS–LTC–DRG relative payment weights with a budget neutrality factor

(79 FR 50171). Our most recent discussion of the existing methodology for calculating the MS–LTC–DRG relative payment weights can be found in the FY 2015 IPPS/LTCH final rule (79 FR 50168 through 50176). For FY 2016, our finalized methodology for calculating the FY 2016 MS–LTC–DRG relative payment weights (including the policy we are finalizing below to use only data from cases that would have been LTCH PPS standard Federal payment rate cases had the new LTCH PPS payment structure been in effect at the time of the discharge) is discussed in section VII.C.3. of the preamble of this final rule.

In response to our solicitation for stakeholder input during the FY 2015 rulemaking cycle, we received numerous comments that addressed the calculation of the MS–LTC–DRG relative payment weights under the new statutory LTCH PPS structure. In its comment, MedPAC urged CMS to establish '' . . . new relative payment weights for each MS–LTC–DRG based solely on the most recent available standardized data associated with discharges meeting the specified patient-level criteria'' because those discharges under the new law would represent cases treating the most severely ill, incurring higher resource costs that warrant higher LTCH payments. MedPAC also stated that the change in methodology should not result in increased aggregate payments for the cases paid under the LTCH PPS standard Federal payment rate under the new statutory LTCH PPS structure. Most of the other commenters agreed with MedPAC's recommendation that the MS–LTC–DRG relative payment weights under the new statutory structure should be calculated using only the data from cases that meet the statutory patient-level criteria for exclusion from the site neutral payment rate (or cases that would have qualified for exclusion had the new LTCH PPS payment structure been in effect at the time of discharge) A few commenters conducted their own analyses and found that both relative payment weight approaches (that is, using data from all LTCH PPS cases as compared to using only data from standard Federal payment rate cases) produce MS–LTC–DRG relative payment weights that are similar. In addition, some of the commenters urged CMS to focus on keeping payments for LTCH PPS standard Federal payment rate cases at the same level that would have been in the absence of the statutory changes, or otherwise consider employing a methodology that promotes stability and predictability in the MS–LTC–DRG relative payment weights. Therefore, the overwhelming majority of the preliminary stakeholder feedback we received did not support using data from all LTCH PPS cases to determine the MS–LTC–DRG relative payment weights for the LTCH PPS standard Federal payment rate cases (80 FR 24536).

In the FY 2016 IPPS/LTCH PPS proposed rule, we expressed our appreciation for the commenters' detailed feedback and took into consideration their concerns and recommendations in our evaluation the issue of the MS–LTC–DRG relative payment weights under the new LTCH PPS structure required by section 1206(a) of Public Law 113–67 in preparation for that proposed rule. As part of our evaluation, as we discussed in the proposed rule (80 FR 24536), we examined the FY 2013 LTCH claims data used to determine the FY 2015 MS–LTC–DRG relative weights and found that approximately 54 percent of LTCH cases would meet the criteria for exclusion from the site neutral payment rate (that is, those cases would be paid the LTCH PPS standard Federal payment rate had the new criteria been in effect at the time of the discharge) and approximately 46 percent of LTCH cases would be paid the site neutral payment rate (had the new criteria been in effect at the time of the discharge). We then compared the MS–LTC–DRG relative payment weights computed using data from all LTCH PPS cases to the MS–LTC–DRG relative payment weights computed using only data from the LTCH PPS standard Federal payment rate cases (had those criteria been in effect at the time of the discharge). Specifically, using the FY 2013 LTCH claims data (the same LTCH claims data used in the FY 2015 IPPS/LTCH PPS final rule), we calculated FY 2015 MS–LTC–DRG relative payment weights using only data from the 54 percent of LTCH PPS cases that would be paid the LTCH PPS standard Federal payment rate, and compared them to the FY 2015 MS–LTC–DRG relative payment weights established in Table 11 of the FY 2015 IPPS/LTCH PPS final rule, which were calculated using data from all LTCH cases (that is, both case that would have been LTCH PPS standard Federal payment rate cases and would have been site neutral payment rate cases had those criteria been in place at the time of the discharge). Similar to results found by industry stakeholders, we found that both approaches produced comparable MS–LTC–DRG payments for LTCH PPS standard Federal payment rate cases. For example, our analysis of the average MS–LTC–DRG relative payment weight (that is, the case-mix) of LTCH PPS cases that would be paid the LTCH PPS standard Federal payment rate showed that the average case-mix using relative payment weights determined from using only data from LTCH PPS standard Federal payment rate cases differed by only approximately 0.01 percentage point from the average case-mix of those same cases using relative weights determined from data from all LTCH PPS cases.

However, we also discussed our belief that the costs and resource use for cases paid at the site neutral payment rate in the future may be lower on average than the costs and resource use for LTCH cases in our historical data that would have been paid at the site neutral payment rate if the statutory changes were in place when the discharges occurred. We believe that this is likely, even if the proportion of site neutral payment rate cases in future data remains similar to the historical data (that is, 46 percent). (We discuss our assumptions about cases paid at the site neutral payment rate in the future in more detail in section VII.B.7.b. of the preamble of this final rule, where we present our proposed and final policies regarding outlier payments for site neutral payment rate cases.) Therefore, even though the analysis described shows that including or excluding what would have been site neutral payment rate cases if the new statutory requirements were applied to the historical discharges would not have much impact on the relative payment weight calculation for FY 2016, over time we believe that the relative payment weights could become distorted if future site neutral payment rate cases involve less intensive resource use and lower costs, which we believe is a plausible response to the lower site neutral payment rates under the statutory LTCH PPS changes. This also could lead to less stability in the MS–LTC–DRG relative payment weights because these cases become incorporated into data used to calculate the relative payment weights.

Taking all of this information into account and given the feedback we received on this issue in the FY 2015 rulemaking cycle, we believe that computing the MS–LTC–DRG relative payment weights using only data from LTCH PPS cases that will be (or, in the future, are) paid the LTCH PPS standard Federal payment rate (that is, cases that meet the criteria for exclusion from the site neutral payment rate) will result in the most appropriate payments under

the new statutory structure. Therefore, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24537), we proposed that, beginning with FY 2016, the annual recalibration of the MS–LTC–DRG relative payment weighting factors would be determined using only data from LTCH discharges that meet the criteria for exclusion from the site neutral payment rate (that is, LTCH PPS standard Federal payment rate cases). Accordingly, we proposed to codify this proposal by adding paragraph (c) to § 412.517 to specify that, beginning in FY 2016, the annual recalibration of the MS–LTC–DRG relative weighting factors are determined using data from LTCH discharges described under new § 412.522(a)(2), or that would have been described by that section had the new dual rate LTCH PPS payment structure been in effect at the time of discharge.

In addition, we proposed to continue to apply the existing budget neutrality requirement for the annual changes to the MS–LTC–DRG classifications and relative payment weights at § 412.517(b), which specifies that any such changes must be made in a budget neutral manner such that estimated aggregate LTCH PPS payments are not affected. We explained that we believe that a budget neutrality requirement is appropriate for the MS–LTC–DRG relative payment weights that would be used to determine LTCH PPS payments for LTCH PPS standard Federal payment rate cases for the same reasons discussed when the policy was originally adopted in the FY 2008 LTCH PPS final rule (72 FR 26880 through 26884). Therefore, we did not propose to make any changes to the budget neutrality requirement at § 412.517(b).

Comment: Several commenters, including the MedPAC, supported CMS' proposal, in general, to compute the MS–LTC–DRG relative payment weights using only data from LTCH PPS cases that meet the criteria for exclusion from the site neutral payment rate (that is, LTCH PPS standard Federal payment rate cases). The commenters stated that this policy would result in appropriate LTCH PPS standard Federal payment rate payments under the new dual rate LTCH PPS because the discharges meeting the LTCH PPS standard Federal payment rate criteria are ''considered under the law to warrant the LTCH higher payments.'' Some of these commenters supported adopting this approach beginning in FY 2016, to correspond with the commencement of the new dual rate LTCH PPS payment structure. However, other commenters believed that, for FY 2016, the calculation of MS–LTC–DRG weights should be based on all LTCH cases in the available data, and then in subsequent years, the MS–LTC–DRG weights should be based on only LTCH cases meeting the new LTCH PPS standard Federal payment rate criteria. These commenters asserted that CMS' proposal was based upon the incorrect assumption that all LTCH discharges are immediately subject to the new dual rate LTCH PPS payment system after October 1, 2015, rather than LTCH discharges becoming subject to the new dual rate LTCH PPS payment structure based on the LTCH's cost reporting periods beginning on or after October 1, 2015. The commenters believed that because some LTCH discharges will be subject to the new dual rate LTCH PPS payment structure after October 1, 2015, CMS should set payment weights for those discharges using all LTCH claims in the available data because there should be no difference in the MS–LTC–DRG weighting methodology for the LTCH discharges that will not be subject to the new dual rate LTCH PPS payment structure until after October 1, 2015 (that is, LTCH discharges in cost reporting periods beginning before October 1, 2015). Some of these commenters requested that CMS establish two sets of MS–LTC–DRG relative weights for FY 2016—one set of relative weights computed using only data from LTCH PPS cases that would meet the criteria for exclusion from the site neutral payment rate as CMS proposed, which would apply to discharges in LTCH cost reporting periods that begin on or after October 1, 2015, and a second set of weights computed using all LTCH cases, regardless of whether they would meet the new patient criteria, which would apply to discharges in LTCH cost reporting periods that begin before October 1, 2015. Some commenters acknowledged the result of CMS' analyses included in the proposed rule that indicate that the MS–LTC–DRG relative weights overall are similar when using all LTCH cases or only those that meet the new criteria. However, these commenters stated that there could be notable variation for specific MS- LTC–DRGs. In addition, several commenters recommended that CMS explore options for improving the year-to-year stability of the MS–LTC–DRG weights and reducing any year-to-year variation that could result from smaller sample sizes, as they recommended previously when providing feedback during the FY 2015 rulemaking cycle.

Some commenters agreed with CMS' proposal to continue to make the annual changes to the MS–LTC–DRG classifications and relative payment weights in a budget neutral manner such that estimated aggregate LTCH PPS payments are not affected. One commenter believed that the budget neutrality requirement should not be included until the new payment system is in place, consistent the original implementation of the budget neutrality requirement, which was introduced a few years after the initial implementation of the LTCH PPS.

Response: We appreciate the commenters' support. However, we believe that the commenters are mistaken that, under this proposal, we did not consider the statutory phase-in and that we assumed that all LTCH discharges are immediately subject to the new dual rate payment structure after October 1, 2015. As explained in the proposed rule and reiterated above, we believe that this policy would result in appropriate LTCH PPS standard Federal payment rate payments under the new dual rate LTCH PPS, which becomes effective beginning on October 1, 2015. We also believe that this approach will promote stability and predictability in the MS–LTC–DRG relative weights under the revised LTCH PPS, which was a statement made by many commenters in the feedback they provided during the FY 2015 rulemaking cycle.

Furthermore, using only data from LTCH PPS cases that meet the criteria for exclusion from the site neutral payment rate (that is, LTCH PPS standard Federal payment rate cases) to compute the MS–LTC–DRG relative payment weights for FY 2016 is consistent with the HCO policy calculations we are finalizing in this final rule after consideration of public comments, which are discussed in section VII.B.7.b. of the preamble of this final rule. While we appreciate the commenters' recognition that using all of the cases in the historical data or only using cases that would have met the criterial for exclusion for the site neutral payment rate (had those criteria been in effect at the time of the discharge) would not have substantial impact on the relative weight calculation for FY 2016, we are aware that variation for specific MS–LTC–DRGs would occur as noted by commenters. However, such a variation can occur with the annual update of the relative weights based on the latest available LTCH PPS data under existing § 412.517, and, in general, appropriately adjusts the relative weights to reflect the resource use of LTCHs based on the best available data. For these reasons, we are not adopting the commenters' suggestions to calculate the FY 2016

MS–LTC–DRG relative weights based on all of the cases in the historical data or to calculate two sets of relative weights for FY 2016. As suggested by commenters, we intend to monitor the year-to-year changes in the MS–LTC–DRG relative weights, and to the extent issues such as stability or inappropriate variation are encountered, we would explore possible options to address those issues once we have more experience under the changes to the LTCH PPS.

We appreciate the comments we received in support of our proposal to continue to make the annual changes to the MS LTC DRG classifications and relative payment weights in a budget neutral manner such that estimated aggregate LTCH PPS payments are not affected. In addition to resulting in appropriate payments, we believe that this adjustment will continue to help to provide stability in LTCH PPS payments that are computed using the MS–LTC–DRG weights because the purpose of the budget neutrality adjustment is to ensure that estimated aggregate LTCH PPS payments do not increase or decrease as a result of the annual update of the MS–LTC–DRG classifications and relative weights. We do not believe that this change in Medicare payments to LTCHs is parallel to the change in Medicare payments to LTCHs under the initial implementation of the LTCH PPS in a way that would make it necessary to delay the continued application of the MS–LTC–DRG budget neutrality requirement. The period under which there was no MS–LTC–DRG budget neutrality requirement allowed LTCHs to adjust to a complete change in the structure of Medicare reimbursement; that is, from reasonable cost-based payments to a DRG-based prospective payment system, in which one of the primary elements for the basis of payments the coding of the diagnosis and procedure codes that are used to determine DRG assignment. As we explained when the policy was originally adopted, there had been fluctuations in the MS–LTC–DRG relative weights during the first 4 years of the LTCH PPS that were, in part, due to actual improvements in coding so that cases are appropriately assigned to MS–LTC–DRGs. We believed it was appropriate to establish the MS–LTC–DRG budget neutrality adjustment in the 5th year of the LTCH PPS when our annual case-mix index analysis indicated that changes in LTCH coding practices, which we believe were a primary contributor to in fluctuations in the MS–LTC–DRG relative weights in the past, had appeared to be stabilizing as LTCHs became more familiar with a DRG-based system (72 FR 26880). While the new dual rate LTCH PPS payment structure is arguably the most extensive change since the implementation of the LTCH PPS, it is not a complete change in the structure of Medicare payments to LTCHs, as was the case when LTCHs moved from cost-based payments to prospective payments. Therefore, we disagree with the commenter that it would be appropriate to delay the application of the MS–LTC–DRG budget neutrality requirement until LTCHs gain experience under the revised LTCH PPS.

After consideration of public commenters we received, for the reasons discussed above, we are finalizing, without modification, our proposal to compute the MS–LTC–DRG relative payment weights using only data from LTCH PPS cases that met the criteria for exclusion from the site neutral payment rate (that is, LTCH PPS standard Federal payment rate cases), or that would have met the criteria had the new dual rate LTCH PPS payment structure been in effect at the time of discharge, and to continue to apply the existing budget neutrality requirement for the annual changes to the MS–LTC–DRG classifications and relative payment weights. Furthermore, we are clarifying the language we proposed to codify this policy under new paragraph (c) of § 412.517, to specify that beginning in FY 2016, the annual recalibration of the MS–LTC–DRG relative weights is determined using LTCH PPS discharges described in § 412.522(a)(2) (or that would have been described in such section had the application of site neutral payment rate been in effect at the time of the discharge).

b. High-Cost Outliers

Under the LTCH PPS, the existing regulations at § 412.525(a) provide for an additional adjustment to LTCH PPS payments to account for outlier cases that have extraordinarily high costs relative to the costs of most discharges (referred to as high-cost outliers (HCOs).) Providing such adjustments for HCOs strongly improves the accuracy of the LTCH PPS in determining resource costs at the patient and hospital level. In addition, HCO payments reduce the financial losses that would otherwise be incurred by hospitals when treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients. Currently, we set the HCO threshold before the beginning of the payment year so that total estimated HCO payments are projected to equal 8 percent of estimated total payments under the LTCH PPS. Under our current HCO policy, an LTCH would receive an additional payment if the estimated cost of a case exceeds the adjusted LTCH PPS payment plus a fixed-loss amount. In such cases, the additional HCO payment amount is equal to 80 percent of the difference between the estimated cost of the case and the HCO threshold, which is the sum of the adjusted Federal MS–LTC–DRG prospective payment amount for the case and the fixed-loss amount. The fixed-loss amount is the amount used to limit the loss that an LTCH would incur under the HCO policy for a case with unusually high costs. This results in Medicare and the LTCH sharing financial risk in the treatment of extraordinarily costly cases. Under the HCO policy, the fixed-loss amount is the maximum loss that an LTCH can incur for a case with unusually high costs before receiving an additional payment amount. The additional payment amount under the LTCH PPS HCO policy is determined using a marginal cost factor, which is a fixed percentage of costs above the HCO threshold. The marginal cost factor under the LTCH PPS HCO policy is 80 percent.

Under the current HCO policy, we annually determine a fixed-loss amount, that is, the maximum loss that an LTCH can incur under the LTCH PPS for a case with unusually high costs before an adjustment is made to the payment for the case. We do so by using the best available data to estimate aggregate LTCH PPS payments with and without a HCO policy, and, based on those estimates, set the fixed-loss amount at an amount that result in estimated total HCO payments being equal to 8 percent of estimated total LTCH PPS payments. Additional information on the LTCH PPS HCO methodology can be found in the FY 2003 LTCH PPS final rule (67 FR 56022 through 56027) and the FY 2015 IPPS/LTCH PPS final rule (79 FR 50398 through 50400).

As discussed in the previous section, under the new statutory LTCH PPS structure, section 1206(a) of Public Law 113–67 establishes two distinct payment rates for LTCH discharges beginning in FY 2016. To implement this statutory change, in the FY 2016 IPPS/LTCH PPS proposed rule, under proposed new § 412.522(a)(2), we proposed to pay for LTCH discharges that meet the criteria for exclusion from site neutral payment rate based on the LTCH PPS standard Federal payment rate, which includes HCO payments. Under proposed new § 412.522(c), consistent with the statute, we proposed that the site neutral payment rate is the lower of the IPPS comparable per diem amount as determined under existing

§ 412.529(d)(4) (including any applicable adjustments, such as outlier payments), or 100 percent of the estimated cost of the case as determined under existing § 412.529(d)(2). Below we discuss our proposed and finalized policies for determining HCO payments under the new statutory LTCH PPS payment structure.

In response to our solicitation for stakeholder input included in the FY 2015 IPPS/LTCH PPS proposed rule, we received numerous comments that addressed the HCO policy under the new statutory LTCH PPS structure. In its comment, MedPAC recommended that both LTCH PPS standard Federal payment rate cases and site neutral payment rate cases receive HCO payments, and that estimated total HCO payments under the LTCH PPS continue to be projected to be equal to 8 percent of estimated total LTCH PPS payments for all cases (that is, both the LTCH PPS standard Federal payment rate cases and the site neutral payment rate cases). In contrast, most of the other commenters recommended that separate HCO fixed-loss amounts and separate HCO payment ''targets'' (that is, the projected percentage that estimated HCO payments are of estimated total payments) be determined for LTCH PPS standard Federal payment rate cases and site neutral payment rate cases. Specifically, these commenters recommended that we calculate a fixed-loss amount under the current HCO policy for LTCH PPS standard Federal payment rate cases using only data (and estimated payments) from what would have been or are LTCH PPS standard Federal payment rate cases, without including data (and estimated payments) from cases that would have been or are paid the site neutral payment rate. In addition, some of the commenters recommended initially applying the existing HCO policy separately to both LTCH PPS standard Federal payment rate cases and site neutral payment rate cases; that is, determining separate HCO fixed-loss amounts so that estimated HCO payments would be equal to 8 percent of estimated total payments for each of the two LTCH PPS payment types (the LTCH PPS standard Federal payment rate cases and site neutral payment rate cases), respectively, and then adjusting the HCO targets as more data under the statutory revisions to the LTCH PPS become available. In other words, commenters suggested that it may be more appropriate to have different HCO targets for the two LTCH PPS payment types rather than two HCO targets of 8 percent. When making recommendations regarding the HCO policy under the statutory LTCH PPS changes, several commenters urged CMS to focus on maintaining LTCH PPS payments for LTCH PPS standard Federal payment rate cases at the same payment level as they are currently under the LTCH PPS, including the level of HCO payments, and to mitigate any instability in the HCO fixed-loss amount for LTCH PPS standard Federal payment rate cases.

Several commenters conducted independent analyses that looked at separate HCO fixed-loss amounts for LTCH PPS standard Federal payment rate cases and site neutral payment rate cases. Upon review of their analyses, these commenters specifically recommended that separate HCO fixed-loss amounts be used for the two LTCH PPS payment types. A few of the commenters' analyses included assumptions about LTCH behavioral response to statutory changes to the LTCH PPS (such as changes in patient volume and costs). A few commenters indicated that using historical data would not reflect the anticipated behavioral response as a result of the new statutory payment structure and, therefore, may lead to an overestimation of costs and HCO payments (particularly with regard to payments for site neutral payment rate cases), resulting in a fixed-loss amount that is set too high relative to the HCO target. If this were to occur, these commenters expressed concern that LTCHs would be ''underpaid'' because HCO payments are budget neutral and actual HCO payments would fall below the HCO payments target.

In the FY 2016 IPPS/LTCH PPS proposed rule, we stated our appreciation for the commenters' detailed feedback and indicated that we had taken their concerns and recommendations into consideration while framing our proposed HCO policy under the new statutory LTCH PPS structure. As we always have for the LTCH PPS, we designed our proposed HCO policy under the new statutory structure to achieve a balance of the following goals: To reduce financial risk, reduce incentives to underserve costly beneficiaries, and improve the overall fairness of the PPS (67 FR 56023). With these goals in mind, we evaluated whether it would be appropriate to modify our current HCO policy to account for the establishment of the new dual rate LTCH PPS payment structure. This included examining whether our current HCO target, under which we set a single fixed-loss amount so that estimated total HCO payments are projected to equal 8 percent of estimated total LTCH PPS payments, should continue to be used upon implementation of the statutory LTCH PPS payment changes, or whether it would be more appropriate to have two separate HCO targets (one for LTCH PPS standard Federal payment rate cases and one for site neutral payment rate cases).

In examining this issue, we considered how LTCH discharges based on historical claims data would have been classified under the new dual rate LTCH PPS payment structure and the CMS' Office of the Actuary (OACT) projections regarding how LTCHs would likely respond to our proposed implementation of policies resulting from the statutory payment changes. For FY 2016, our actuaries currently project that the proportion of cases that would qualify as LTCH PPS standard Federal payment rate cases verses site neutral payment rate cases under the new statutory provisions would remain consistent with what is reflected in the historical LTCH PPS claims data. (As previously noted, based on FY 2013 LTCH claims data, we found that approximately 54 percent of LTCH cases would have been paid the LTCH PPS standard Federal payment rate and approximately 46 percent of LTCH cases would have been paid the site neutral payment rate if those rates had been in effect at that time.) While our actuaries do not project an immediate change in these proportions, they do project cost and resource changes to take into account the lower payment rates. Our actuaries also project that the costs and resource use for cases paid at the site neutral payment rate would likely be lower, on average, than the costs and resource use for cases paid at the LTCH PPS standard Federal payment rate and would likely mirror the costs and resource use for IPPS cases assigned to the same MS–DRG, regardless of whether the proportion of site neutral payment rate cases in the future remains similar to what is found based on the historical data. This actuarial assumption is based on our expectation that site neutral payment rate cases would generally be paid based on an IPPS comparable per diem amount under the statutory LTCH PPS payment changes, which, in the majority of cases, is much lower than the payment that would have been paid if these statutory changes were not enacted. These assumptions are consistent with statements from several commenters who noted that the type of site neutral payment rate cases may change in cost and severity over time in response to the new statutory payment structure because the payment for those cases

would generally be lower than the current payment made under the LTCH PPS for these types of cases (80 FR 24538).

In light of these projections and expectations, we stated in the proposed rule that we believe that the use of a single fixed-loss amount and HCO target for all LTCH PPS cases would be problematic. Currently, the FY 2015 LTCH PPS fixed-loss amount is $14,972, which was determined using FY 2013 LTCH claims data (79 FR 50400). The FY 2015 IPPS fixed-loss amount is $25,799 (79 FR 50374). A single fixed-loss amount and target under the LTCH PPS would allow LTCH cases paid at the site neutral payment rate to qualify for HCO payments much more easily than comparable IPPS cases assigned to the same MS–DRG. This would occur because the HCO threshold (which is generally the sum of the adjusted Federal PPS payment for the case and the fixed-loss amount) under the IPPS would be higher than the HCO threshold under the LTCH PPS for a case assigned to the same MS–DRG (which would be expected to have a comparable adjusted Federal PPS payment, costs and resource use to a case paid as a LTCH PPS site neutral payment rate case). We also stated in the proposed rule that while we recognize that differing statutory requirements between the two payment systems result in comparable LTCH PPS site neutral payment rate cases and IPPS cases not being paid exactly the same amount, we did not believe that it would be appropriate for comparable LTCH PPS site neutral payment rate cases to receive dramatically different HCO payments from those cases that would be paid under the IPPS. Based on the FY 2015 figures, an IPPS hospital would have to absorb approximately $11,000 more in additional estimated costs than the LTCH treating a comparable case based on the difference between the IPPS fixed-loss amount of $25,799 and the LTCH PPS fixed-loss amount of $14,792 before it would begin to receive HCO payments. We believe that the most appropriate fixed-loss amount for site neutral payment rate cases under the LTCH PPS for a given fiscal year beginning with FY 2016 would be the IPPS fixed-loss amount for that fiscal year. Therefore, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24538 through 24539), for FY 2016, we proposed a fixed-loss amount for site neutral payment rate cases of $24,485, which was the same proposed FY 2016 IPPS fixed-loss amount discussed in section II.A.4.g.(1) of the Addendum to the proposed rule and this final rule. We believe that this policy will reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems. We also proposed to make a payment adjustment for HCOs paid under the site neutral payment rate at a rate equal to 80 percent of the difference between the estimated cost of the case and the proposed IPPS HCO threshold, which is consistent with the current LTCH PPS HCO policy. The proposed IPPS HCO threshold for site neutral payment rate cases would be the sum of the LTCH PPS payment for such cases and the proposed IPPS fixed-loss amount of $24,485. As stated above, we believe that this policy will reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems. We also proposed to codify these proposals by making revisions to the existing HCO policy at § 412.525(a). In light of these proposals, we noted that any site neutral payment rate case that is paid 100 percent of the estimated cost of the case because that amount is lower than the IPPS comparable per diem amount will never be eligible to receive a HCO payment because, by definition, the estimated costs of such cases will never exceed the IPPS comparable per diem amount by any threshold.

Comment: Commenters supported the proposed HCO policy under the new statutory LTCH PPS structure, under which there would be separate HCO fixed-loss amounts and separate HCO payment targets for LTCH PPS standard Federal payment rate cases and site neutral payment rate cases. Commenters also expressed support for the proposals concerning the methodology for determining the HCO payment amount for site neutral payment rate cases, including the use of the IPPS FLT for FY 2016. While commenters generally agreed with our assumptions that the costs and resource use for site neutral payment rate cases would likely mirror the costs and resource use for IPPS cases assigned to the same MS–DRG, some commenters also noted their belief that the type of site neutral payment rate cases may change in cost and severity over time in response to the new dual rate LTCH PPS payment structure. These commenters requested that CMS revisit the use of the IPPS fixed-loss amount once we have actual experience under the revised LTCH PPS, and possibly develop a HCO fixed-loss amount for site neutral payment rate cases that is independent of the IPPS's amount in the future. (Commenters also provided comments regarding the proposed budget neutrality adjustment for HCO payments to site neutral payment rate cases, which are discussed later in this section.)

Response: We appreciate the commenters' support of these proposals. As we indicated in the proposed rule, we believe having a single HCO policy for both standard Federal payment rate cases and site neutral payment rate cases under the revised LTCH PPS would be problematic in light of our projections and expectations of LTCHs' behavioral response to statutory changes to the LTCH PPS. We also explained that, given the expectation that cases paid at the site neutral payment rate would likely be similar to IPPS cases assigned to the same MS–DRG, the most appropriate fixed-loss amount for site neutral payment rate cases would be the IPPS fixed-loss amount for that fiscal year. To the extent experience under the revised LTCH PPS indicates site neutral payment rate cases differ sufficiently from these expectations, we agree it would be appropriate to revisit in future rulemaking the most appropriate fixed-loss amount used to determine HCO payments for site neutral payment rate cases.

After consideration of public comments we received, we are finalizing without modification our proposals to have separate HCO policies under the new dual rate LTCH PPS payment structure and our proposed methodology for calculating site neutral payment rate case the HCO payments, including the use of the IPPS FLT. We also are finalizing proposed revisions to the existing HCO policy at § 412.525(a) to codify these policies, as discussed below in this section.

Therefore, in this final rule, we are establishing a fixed-loss amount for site neutral payment rate cases for FY 2016 of $22,544, which was the same FY 2016 IPPS fixed-loss amount discussed in section II.A.4.g.(1) of the Addendum to this final rule. As stated above, we believe that this policy will reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems.

In the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24539), after having established the IPPS fixed-loss amount as an appropriate threshold to propose for HCOs paid under the site neutral payment rate, we next examined how to establish an appropriate fixed-loss amount and HCO target for LTCH PPS standard Federal payment rate

cases. Therefore, we agreed with the commenters who recommended in response to our solicitation for input during the FY 2015 rulemaking cycle that we establish a fixed-loss amount and target for LTCH PPS standard Federal payment rate cases using the current LTCH PPS HCO policy, but limiting the data used under that policy to was and/or what would have been LTCH PPS standard Federal payment rate cases if the new dual rate LTCH PPS payment structure was/had been in effect at the time of those discharges. We also agreed with the commenters from the FY 2015 rulemaking cycle that believed this policy would result in increased stability over time with respect to HCO payments for the LTCH PPS standard Federal payment rate cases. We also believed that this approach would meet the goals cited for our revised and current HCO policy; that is, reducing financial risk, reducing incentives to underserve costly beneficiaries, and improving the overall fairness of the LTCH PPS (67 FR 56023). Therefore, in the FY 2016 IPPS/LTCH PPS proposed rule, we did not propose to make any modifications to the HCO methodology as it applies to LTCH PPS standard Federal payment rate cases, other than determining a fixed-loss amount using only data from LTCH PPS standard Federal payment rate cases. Specifically, under our proposal, LTCH PPS standard Federal payment rate cases as described under proposed new § 412.522(a)(2) would receive an additional payment for an HCO case that is equal to 80 percent of the difference between the estimated cost of the case and the HCO threshold, which would be the sum of the LTCH PPS payment for the LTCH PPS standard Federal payment rate case and the fixed-loss amount for such cases. The fixed-loss amount for LTCH PPS standard Federal payment rate cases would continue to be determined so that estimated HCO payments would be projected to be equal to 8 percent of estimated total LTCH PPS payments for LTCH PPS standard Federal payment rate cases.

In the FY 2016 IPPS/LTCH PPS proposed rule, to codify our proposed changes to the HCO policy to account for the new dual rate LTCH PPS payment structure, we proposed to revise paragraphs (a)(1), (a)(2), and (a)(3), and add a new paragraph (a)(4) to existing § 412.525. In existing § 412.525 (a)(1), (a)(2), and (a)(3), we proposed to make technical changes to the existing language to make it clear that the provisions in those paragraphs apply to LTCH discharges under both LTCH PPS payment rates (that is, site neutral payment rate cases as described at new § 412.522(a)(1) and the standard Federal payment rate cases as described at new § 412.522(a)(2)). Under the proposed new paragraph (a)(4) to § 412.525, we also proposed to specify what the terms ''applicable LTCH PPS prospective payment'' and ''applicable fixed-loss amount'' mean for purposes of this paragraph. Specifically, we proposed that, for purposes of § 412.525(a), ''applicable LTCH PPS prospective payment'' means either the site neutral payment rate under new § 412.522(c) for LTCH discharges described under new § 412.522(a)(1) or the standard Federal prospective payment rates under § 412.523 for LTCH discharges described under new § 412.522(a)(2). Similarly, we proposed that, for purposes of § 412.525(a), ''applicable fixed-loss amount'' means either, for LTCH described under new § 412.522(a)(1), the fixed-loss amount established for such cases, or, for LTCH discharges described under new § 412.522(a)(2), the fixed-loss amount established for such cases. In addition, we proposed to add language to paragraph (a) of § 412.525 to clarify that the fixed-loss is the maximum loss that a LTCH can incur under the LTCH PPS for a case with unusually high costs ''before receiving an additional payment,'' and is not the maximum loss an LTCH can incur. We proposed to make this clarification to highlight that the additional payment under the revised HCO policy is 80 percent (not 100 percent) of the estimated costs above the outlier threshold (that is, the sum of the applicable LTCH PPS prospective payment and the applicable fixed-loss amount).

Comment: Commenters supported the proposals to apply the existing HCO policy to LTCH PPS standard Federal payment rate cases, including the 8 percent HCO payment percentage target. However, some commenters requested that, when calculating the fixed-loss amount for cases that will be paid using the LTCH PPS standard Federal payment rate in FY 2016, CMS include all of the cases in the historical data that would have been paid using the LTCH PPS standard Federal payment rate had the revised FY 2016 LTCH PPS been in effect at the time of the discharge, not just the historical data for cases meeting the criteria for exclusion from the site neutral payment rate. These commenters believed that CMS' use of only the historical cases meeting the criteria for exclusion from the site neutral payment rate in the calculation of the fixed-loss amount for FY 2016 is inaccurate. They also stated that the proposed approach results in estimated aggregate FY 2016 high-cost outlier payments for cases paid using the LTCH PPS standard Federal payment rate that are less than 8 percent of estimated aggregate FY 2016 payments for such cases (that is, paid using the LTCH PPS standard Federal payment rate during FY 2016). These commenters also requested that CMS modify the proposed conforming changes to the existing HCO policy at § 412.525(a) to reflect their requested changes to the fixed-loss amount.

Response: We appreciate the commenters' support of our proposals to determine HCO for LTCH PPS standard Federal payment rate cases using our existing HCO policies, including the 8 percent HCO payment percentage target. We proposed that the fixed-loss amount for LTCH PPS standard Federal payment rate cases would continue to be determined so that estimated HCO payments would be projected to be ''equal to 8 percent of estimated total LTCH PPS payments for LTCH PPS standard Federal payment rate cases'' (80 FR 24539). In the proposed rule, we clearly indicated that the phrase ''LTCH PPS standard Federal payment rate case''' refers to a LTCH PPS case that meets the criteria for exclusion from the site neutral payment rate under section 1886(m)(6)(A)(ii) of the Act (80 FR 24527). The commenters' concern regarding the calculation of the fixed-loss amount for FY 2016 comes from the distinction between ''cases paid using the LTCH PPS standard Federal payment rate in FY 2016'' and ''LTCH PPS standard Federal payment rate cases in FY 2016.'' Under the statutory phase-in of the LTCH PPS for FY 2016, cases in an LTCH with a cost reporting period starting before October 1, 2015, that do not meet the criteria for exclusion from the site neutral payment rate will nevertheless be ''paid using the LTCH PPS standard Federal payment rate'' until the start of that LTCH's first cost reporting period beginning in FY 2016. These cases are the historical cases that the commenters requested be included in the calculation of the FY 2016 fixed-loss amount for ''LTCH PPS standard Federal payment rate cases'' even though those cases would not meet the criteria to be excluded from the site neutral payment rate had the revised LTCH PPS been in effect at the time of the discharge.

For the calculation of the fixed-loss amount in the second year of the revised LTCH PPS (that is, FY 2017), there is no difference between the historical cases that would have been paid using the LTCH PPS standard Federal payment

rate and the historical cases that would meet the criteria for exclusion from the site neutral payment rate (that is, LTCH PPS standard Federal payment rate cases) had the revised FY 2017 LTCH PPS been in effect at the time of the discharge. The distinction between them under the revised FY 2016 LTCH PPS (explained above) no longer exists—they are the same cases. It is only in the first year of the revised LTCH PPS (FY 2016) that there is a difference. As explained above, this difference is due to the statutory phase-in of the revised LTCH PPS in FY 2016: cases in an LTCH with a cost reporting period starting before October 1, 2015, that do not meet the criteria for exclusion from the site neutral payment rate will continue to be paid at the higher LTCH PPS standard Federal payment rate until the start of that hospital's first cost reporting period in FY 2016.

We considered the approach requested by commenters of using the historical cases that would have been paid using the LTCH PPS standard Federal payment rate had the revised FY 2016 PPS been in effect at the time of the discharge to calculate the fixed-loss amount for FY 2016. However, we believe that approach would lead to less stability in the fixed-loss amount between FY 2016 and FY 2017 because cases not meeting the criteria for exclusion from the site neutral payment rate (had those criteria been in effect) would be included in the calculation of the fixed-loss amount for FY 2016 and then not included in the calculation for FY 2017. As we stated in the proposed rule, we believe our proposal would result in increased stability over time with respect to HCO payments for the LTCH PPS standard Federal payment rate cases (80 FR 24539). In addition, as noted earlier, there is uncertainty surrounding the site neutral payment rate case population under the new dual rate LTCH PPS payment structure. For the portion of the site neutral payment rate case population that will continue to be paid at the LTCH PPS standard Federal payment rate for a portion of FY 2016 (that is, those FY 2016 cases that would not meet the criteria for exclusion and would be paid the site neutral payment rate were those cases in LTCH cost reporting periods subject to those criteria at the time of the discharge), there is even greater uncertainty as to what the costs of those cases will be during that time. Therefore, we disagree that our proposed methodology is inaccurate. However, we acknowledge that these two approaches result in different estimated aggregate FY 2016 payments for cases paid using the LTCH PPS standard Federal payment rate, but that is due to the transitory effect of the statutory phase-in of the revised LTCH PPS. In FY 2017, the two approaches would result in the same estimated aggregate FY 2017 LTCH PPS expenditures.

After consideration of the public comments we received, for the reasons discussed, we are finalizing our policy as proposed without modification. In this final rule, we are calculating the fixed-loss amount for FY 2016 so that estimated aggregate FY 2016 HCO payments for cases that meet the criteria for exclusion from the site neutral payment rate are estimated to be equal to 8 percent of estimated aggregate FY 2016 payments for cases that meet the criteria for exclusion from the site neutral payment rate, rather than calculating the fixed-loss amount so that estimated aggregate FY 2016 HCO payments for cases paid using the LTCH PPS standard Federal payment rate are estimated to be equal to 8 percent of estimated aggregate FY 2016 payments for cases paid using the LTCH PPS standard Federal payment rate. We also are finalizing our proposals, without modification, to codify the changes to the HCO policy to account for the new dual rate LTCH PPS payment structure in existing § 412.525.

The current LTCH PPS HCO policy has a budget neutrality requirement in which the LTCH PPS standard Federal payment rate is reduced by an adjustment factor to account or the estimated proportion of HCO payments to total estimated LTCH PPS payments, that is, 8 percent. (We refer readers to § 412.523(d)(1) of the regulations.) This budget neutrality requirement is intended to ensure that the HCO policy would not result in any change in estimated aggregate LTCH PPS payments. Under our proposal to continue to apply the current HCO methodology as it relates to LTCH PPS standard Federal payment rate cases (other than determining a fixed-loss amount using only data from LTCH PPS standard Federal payment rate cases (had the new statutory patient criteria been in effect at the time of the discharge), we also would continue to apply the current budget neutrality requirement (described above). In accordance with the current LTCH PPS HCO policy budget neutrality requirement, we believe that the HCO policy for site neutral payment rate cases should also be budget neutral, meaning that the proposed site neutral payment rate HCO payments should not result in any change in estimated aggregate LTCH PPS payments. In order to achieve this, under new § 412.522(c)(2)(i), we proposed to apply a budget neutrality factor to the payment for all site neutral payment rate cases described under proposed new § 412.522(a)(1), which would also be established on an estimated basis. This approach was consistent with the HCO policy proposed LTCH PPS standard Federal payment rate cases HCO policy, which is budget neutral within the universe of LTCH PPS standard Federal payment rate cases (had the new statutory patient criteria been in effect at the time of the discharge). We invited public comments on this approach and the alternative approach of applying a single budget neutrality factor to all LTCH PPS cases, irrespective of the site neutral payment rate.

In order to estimate the magnitude a proposed budget neutrality adjustment under our proposed HCO payment budget neutrality requirement for site neutral payment rate cases, we again relied on the assumption by our actuaries that site neutral payment rate cases would have lengths of stay and costs comparable to IPPS cases assigned to the same MS–DRG. Under the IPPS, the fixed-loss amount is estimated based on a 5.1 percent target (79 FR 50378). In accordance with section 1886(d)(5)(A)(iv) of the Act, estimated operating IPPS HCO payments for any year are projected to be at least 5 percent, but no more than 6 percent of estimated total operating DRG payments, which does not include IME and DSH payments plus HCO payments. When setting the HCO threshold, we historically compute a 5.1 percent target by dividing the total operating IPPS HCO payments by the total operating IPPS DRG payments plus operating IPPS HCO payments (79 FR 50374). We believe that it is reasonable to set the site neutral payment rate case HCO target at the IPPS HCO target because these cases are expected to have lengths of stay and costs comparable to IPPS cases assigned to the same MS–DRG. Furthermore, using the IPPS fixed-loss threshold for the site neutral payment rate cases would be expected to result in HCO payments for site neutral payment rate cases that are similar in proportion as is seen in IPPS cases assigned to the same MS–DRG; that is, 5.1 percent. We recognize that, given the uncertainty surrounding the site neutral payment rate case population under the revised LTCH PPS and differences between the relative utilization of the MS–DRGs and MS–LTC–DRGs between the two systems, this prediction may not

take effect. However, we must begin somewhere, and we believed that this proposed policy seems to be the best budget neutrality option at this time based on the information available to ensure LTCH PPS spending does not inappropriately increase under our proposal for site neutral payment rate HCO cases. As with all of our finalized policies, we will continue to monitor HCOs payments under the LTCH PPS and, as necessary, propose modifications to the proposed method as needed based on what is observed during the implementation process.

Therefore, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24540 through 24541), under proposed new § 412.522(c)(2)(i), we proposed to adjust payments to site neutral payment rate cases (that is, LTCH PPS discharges described under proposed new § 412.522(a)(1)) by a budget neutrality factor so that the estimated HCO payments payable to site neutral payment rate cases do not result any increase in aggregate LTCH PPS payments. As discussed in greater detail in section V.D.4. of the Addendum to the proposed rule and this final rule, in estimating total LTCH PPS payments in Federal FY 2016, we proposed to apply an adjustment to account for the varying effective dates of the statutory LTCH PPS payment changes required by section 1886(m)(6) of the Act, as amended by section 1206 of Public Law 113–67, which are effective for discharges occurring in cost reporting periods beginning on or after October 1, 2015.

Comment: Commenters objected to the proposed site neutral payment rate HCO budget neutrality adjustment, claiming that it would result in savings instead of being budget neutral. The commenters' primary objection was based on their belief that, because the IPPS base rates used in the IPPS comparable per diem amount calculation of the site neutral payment rate include a budget neutrality adjustment for IPPS HCO payments (for example, a 5.1 percent adjustment on the operating IPPS standardized amount), an ''additional'' budget neutrality factor is not necessary and is, in fact, duplicative. Based on their belief that the proposed site neutral payment rate HCO budget neutrality adjustment is duplicative, some commenters recommended that if CMS continues with the application of that budget neutrality adjustment, the calculation of the IPPS comparable per diem amount should be revised to use the IPPS operating standardized amount prior to the application of the IPPS HCO budget neutrality adjustment. The commenters also disagreed with CMS' proposed approach for determining the proposed site neutral payment rate HCO budget neutrality factor, and also noted some technical changes to the calculation should CMS finalize this proposal.

Response: We disagree with the commenters that a budget neutrality adjustment for site neutral payment rate HCO payments is unnecessary or duplicative. While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments, that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate. The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS. Without a budget neutrality adjustment when determining payment for a case under the LTCH PPS, any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases. Therefore, our proposed approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases. For these reasons, we are not adopting the commenters' recommendation to change the calculation of the IPPS comparable per diem amount to adjust the IPPS operating standardized amount used in that calculation to account for the application of the IPPS HCO budget neutrality adjustment.

After consideration of the public comments we received, for the reasons discussed above, we are adopting our proposal to adjust payments to site neutral payment rate cases by a budget neutrality factor so that the estimated HCO payments payable to site neutral payment rate cases do not result any increase in aggregate LTCH PPS payments (relative to LTCH PPS payments without HCO payments to site neutral payment rate cases), without modification. In doing so, we note that we present and respond to the comments on CMS' proposed approach for determining the proposed site neutral payment rate budget neutrality factor, including the technical changes recommended by some commenters, in section V.D.4. of the Addendum to this final rule.

In addition to the proposed changes to the existing HCO policy under § 412.525(a) and the budget neutrality adjustment to account for site neutral payment rate HCO payments under proposed § 412.522(c)(2)(i), we proposed to make conforming changes to existing § 412.523 under paragraph (d)(1) to specify that the HCO target of 8 percent in that provision only applies to HCO payments under § 412.525(a) as they relate to LTCH PPS standard Federal payment rate cases; that is, HCO payments made for discharges described under proposed new § 412.522(a)(2) and not all HCO payments described under proposed new § 412.525(a).

We did not receive any public comments on the proposed conforming changes to existing § 412.523(d)(1). Therefore, we are adopting these changes as final without modification.

In summary, in this final rule, we are finalizing the policy to have separate HCO fixed-loss amounts and HCO targets (and corresponding budget neutrality adjustments) for site neutral payment rate cases and LTCH PPS standard Federal payment rate cases, respectively, under the new dual rate LTCH PPS payment structure. For the reasons discussed above, we believe that separate and independent HCO fixed-loss amounts for each of the two types of LTCH PPS cases will result in the most appropriate payments under the LTCH PPS and achieve the stated goals of our HCO policy. In accordance with our revised HCO policy for LTCH PPS standard Federal payment rate cases and site neutral payment rate cases, we are establishing that, beginning with FY 2016, our current HCO policy will apply to LTCH PPS standard Federal payment rate cases, such that LTCH PPS standard Federal payment rate cases will receive an additional payment for an HCO case that is equal to 80 percent of the difference between the estimated cost of the case and the LTCH PPS standard Federal payment HCO threshold (which is the sum of the LTCH PPS standard Federal payment rate for the case and the fixed-loss amount for such cases). The fixed-loss amount for LTCH PPS standard Federal payment rate cases will be determined so that estimated HCO payments will be projected to equal 8 percent of estimated total LTCH PPS payments for LTCH PPS standard Federal payment rate cases. To maintain budget neutrality, the LTCH PPS standard Federal payment rate will

continue to be adjusted by 8 percent to account for the estimated HCO payments to LTCH PPS standard Federal payment rate cases. Similarly, we are establishing that site neutral payment rate cases will receive an additional payment for an HCO case that is equal to 80 percent of the difference between the estimated cost of the case and the site neutral payment rate HCO threshold, which is the sum of site neutral payment rate for the case and the fixed-loss amount for such cases. For site neutral payment rate cases, we are finalizing the proposal to use the fixed-loss amount determined annually under the IPPS HCO policy, and we estimate that this will result in an estimated proportion of HCO payments to total LTCH PPS payments for site neutral payment rate cases of 5.1 percent. We are establishing that HCO payments to site neutral payment rate cases will be budget neutral, consistent with the current LTCH PPS HCO policy. To maintain budget neutrality, we are finalizing the proposal to apply a budget neutrality factor to the LTCH PPS payments for site neutral payment rate cases. (The details of the determination of the site neutral payment rate HCO budget neutrality factor are discussed in section V.D.4. of the Addendum to this final rule.) To codify the policies discussed in this section, we are making changes to the existing HCO policy under § 412.525(a) and conforming changes to existing § 412.523(d)(1), as well as a budget neutrality requirement for HCO payments to site neutral payment rate cases under new § 412.522(c)(2)(i).

c. Limitation on Charges to Beneficiaries

In accordance with existing regulations and for the consistency with other established hospital prospective payment systems polices, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24541), we proposed to revise § 412.507 to establish allowable charges to Medicare beneficiaries whose discharge from the LTCH is paid under the site neutral payment rate (as described in section VII.B.4. of the preamble of the proposed rule and this final rule). Section 1206(a)(1) of Public Law 113–67 requires that, beginning with cost reporting periods occurring on or after October 1, 2015, all LTCH discharges be paid at the applicable site neutral payment rate unless certain criteria are met. In general, the site neutral rate payment is based on the lesser of 100 percent of the estimated cost of the case or the IPPS comparable per diem amount (as discussed more detail in section VII.B.4.a. of the preamble of this final rule). We believe that, in general, the LTCH PPS payment an LTCH receives at the site neutral payment rate represents a full payment for purposes of determining allowable beneficiary charges for covered services. As such, using the broad authority conferred upon the Secretary under section 123(a)(1) of the BBRA, as amended by section 307(b) of the BIPA, in the proposed rule, we proposed to revise § 412.507 to limit allowable charges to beneficiaries. Specifically, we proposed that, if Medicare has paid the full site neutral payment rate for a discharge, an LTCH may only charge the beneficiary applicable deductibles and copay amounts until the high-cost outlier threshold is met. In addition, we proposed to revise the terminology used under § 412.507 to differentiate between cases paid under the site neutral payment rate and those paid under the LTCH PPS standard Federal payment rate. We noted that, under this proposed revision, for a case paid under the site neutral payment rate, that payment applies to the LTCH's costs for services furnished until the high-cost outlier threshold is met, and LTCHs may charge the beneficiary for noncovered services in the same manner as if the case were paid under the LTCH PPS standard Federal payment rate, as specified under existing § 412.507. We did not propose to make any additional changes to our current provisions limiting charges to beneficiaries for discharges paid as SSO cases because, as explained in section VII.B.5. of the preamble of the proposed rule and this final rule, we did not propose to adopt any SSO payment adjustment policies for discharges paid under the site neutral payment rate at this time. We stated that we believe that these proposals concerning the limitation on charges to beneficiaries are in accordance with existing regulations and consistent with other established hospital payment systems policies.

We did not receive any public comments concerning our proposed changes to the regulations limiting charges to beneficiaries. Therefore, we are finalizing, without modification, our proposals to limit charges to beneficiaries.

C. Medicare Severity Long-Term Care Diagnosis-Related Group (MS–LTC–DRG) Classifications and Relative Weights for FY 2016

1. Background

Section 123 of the BBRA required that the Secretary implement a PPS for LTCHs to replace the cost-based payment system under TEFRA. Section 307(b)(1) of the BIPA modified the requirements of section 123 of the BBRA by requiring that the Secretary examine the feasibility and the impact of basing payment under the LTCH PPS on the use of existing (or refined) hospital DRGs that have been modified to account for different resource use of LTCH patients.

When the LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002, we adopted the same DRG patient classification system utilized at that time under the IPPS. As a component of the LTCH PPS, we refer to this patient classification system as the ''long-term care diagnosis-related groups (LTC–DRGs).'' Although the patient classification system used under both the LTCH PPS and the IPPS are the same, the relative weights are different. The established relative weight methodology and data used under the LTCH PPS result in relative weights under the LTCH PPS that reflect the differences in patient resource use of LTCH patients, consistent with section 123(a)(1) of the BBRA (Pub. L. 106–113).

As part of our efforts to better recognize severity of illness among patients, in the FY 2008 IPPS final rule with comment period (72 FR 47130), the MS–DRGs and the Medicare severity long-term care diagnosis-related groups (MS–LTC–DRGs) were adopted under the IPPS and the LTCH PPS, respectively, effective beginning October 1, 2007 (FY 2008). For a full description of the development, implementation, and rationale for the use of the MS–DRGs and MS–LTC–DRGs, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47141 through 47175 and 47277 through 47299). (We note that, in that same final rule, we revised the regulations at § 412.503 to specify that for LTCH discharges occurring on or after October 1, 2007, when applying the provisions of 42 CFR part 412, subpart O applicable to LTCHs for policy descriptions and payment calculations, all references to LTC–DRGs would be considered a reference to MS–LTC–DRGs. For the remainder of this section, we present the discussion in terms of the current MS–LTC–DRG patient classification system unless specifically referring to the previous LTC–DRG patient classification system that was in effect before October 1, 2007.)

The MS–DRGs adopted in FY 2008 represent an increase in the number of DRGs by 207 (that is, from 538 to 745) (72 FR 47171). The MS–DRG classifications are updated annually. There are currently 753 MS–DRG groupings. For FY 2016, there are 758 MS–DRG groupings that we are

finalizing in conjunction with all of the changes discussed in section II.G. of the preamble of this final rule. Consistent with section 123 of the BBRA, as amended by section 307(b)(1) of the BIPA, and § 412.515 of the regulations, we use information derived from LTCH PPS patient records to classify LTCH discharges into distinct MS–LTC–DRGs based on clinical characteristics and estimated resource needs. We then assign an appropriate weight to the MS–LTC–DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCHs. Below we provide a general summary of our existing methodology for determining the FY 2016 MS–LTC–DRG relative weights under the LTCH PPS.

In this final rule, in general, for FY 2016, we are using our existing methodology to determine the MS–LTC–DRG relative weights (as discussed in greater detail in section VII.C.3. of the preamble of this final rule). However, under the new dual rate LTCH PPS payment structure, we are establishing that, beginning with FY 2016, the annual recalibration of the MS–LTC–DRG relative weights will be determined (1) using only data from available LTCH PPS claims that would have qualified for payment under the new LTCH PPS standard Federal payment rate if that rate were in effect when claims data from time periods before the new dual rate LTCH PPS payment structure applies were used to calculate the relative weights, and (2) using only data from available LTCH PPS claims that qualify for payment under the new LTCH PPS standard Federal payment rate when claims data from time periods after the dual rate LTCH PPS payment structure applies are used to calculate the relative weights. For the remainder of this discussion, we use the phrase ''applicable LTCH cases'' or ''applicable LTCH data'' when referring to the resulting claims data set used to calculate the relative weights (as described in greater detail in section VII.C.3.c. of the preamble of this final rule). In addition, we are continuing to exclude the data from all-inclusive rate providers and LTCHs paid in accordance with demonstration projects, as well as any Medicare Advantage claims from the MS–LTC–DRG relative weight calculations for the reasons discussed in section VII.C.3.c. of the preamble of this final rule.

Under our finalized policies, the MS–LTC–DRG relative weights will not be used to determine the LTCH PPS payment for cases paid at the site neutral payment rate and data from cases paid at the site neutral payment rate or that would have been paid at the site neutral payment if the dual rate LTCH PPS payment structure had been in effect will not be used to develop the relative weights. (For details on our finalized policies regarding the application of the site neutral payment rate, we refer readers to section VII.B. of the preamble of this final rule. For additional information on our finalized policy to use data from applicable LTCH cases to determine the MS–LTC–DRG relative weights under the new dual rate LTCH PPS payment structure, we refer readers to section VII.B.7.a. of the preamble of this final rule.)

Furthermore, for FY 2016, in using data from applicable LTCH cases to establish MS–LTC–DRG relative weights, we will continue to establish low-volume MS–LTC–DRGs (that is, MS–LTC–DRGs with less than 25 cases) using our quintile methodology in determining the MS–LTC–DRG relative weights because LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. Therefore, for purposes of determining the relative weights for the large number of low-volume MS–LTC–DRGs, we group all of the low-volume MS–LTC–DRGs into five quintiles based on average charges per discharge. Then, under our existing methodology, we account for adjustments made to LTCH PPS standard Federal payment rate payments for short-stay outlier (SSO) cases (that is, cases where the covered length of stay at the LTCH is less than or equal to five-sixths of the geometric average length of stay for the MS–LTC–DRG), and we make adjustments to account for nonmonotonically increasing weights, when necessary. The methodology is premised on more severe cases under the MS–LTC–DRG system requiring greater expenditure of medical care resources and higher average charges such that, in the severity levels within a base MS–LTC–DRG, the relative weights should increase monotonically with severity from the lowest to highest severity level. (We discuss each of these components of our MS–LTC–DRG relative weight methodology in greater detail in section VII.C.3.g. of the preamble of this final rule.)

2. Patient Classifications into MS–LTC–DRGs

a. Background

The MS–DRGs (used under the IPPS) and the MS–LTC–DRGs (used under the LTCH PPS) are based on the CMS DRG structure. As noted above in this section, we refer to the DRGs under the LTCH PPS as MS–LTC–DRGs although they are structurally identical to the MS–DRGs used under the IPPS.

The MS–DRGs are organized into 25 major diagnostic categories (MDCs), most of which are based on a particular organ system of the body; the remainder involve multiple organ systems (such as MDC 22, Burns). Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Surgical DRGs are assigned based on a surgical hierarchy that orders operating room (O.R.) procedures or groups of O.R. procedures by resource intensity. The GROUPER software program does not recognize all ICD–9–CM procedure codes as procedures affecting DRG assignment. That is, procedures that are not surgical (for example, EKGs), or minor surgical procedures (for example, a biopsy of skin and subcutaneous tissue (procedure code 86.11)) do not affect the MS–LTC–DRG assignment based on their presence on the claim.

Generally, under the LTCH PPS, a Medicare payment is made at a predetermined specific rate for each discharge and that payment varies by the MS–LTC–DRG to which a beneficiary's stay is assigned. Cases are classified into MS–LTC–DRGs for payment based on the following six data elements:

- Principal diagnosis;
- Additional or secondary diagnoses;
- Surgical procedures;
- Age;
- Sex; and
- Discharge status of the patient.

Currently, for claims submitted on the 5010 format, up to 25 diagnosis codes and 25 procedure codes are considered for an MS–DRG assignment. This includes one principal diagnosis and up to 24 secondary diagnoses for severity of illness determinations. (For additional information on the processing of up to 25 diagnosis codes and 25 procedure codes on hospital inpatient claims, we refer readers to section II.G.11.c. of the preamble of the FY 2011 IPPS/LTCH PPS final rule (75 FR 50127).)

Under HIPAA transactions and code sets regulations at 45 CFR parts 160 and 162, covered entities must comply with the adopted transaction standards and operating rules specified in Subparts I through S of Part 162. Among other requirements, by January 1, 2012, covered entities were required to use the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Institutional (837), May 2006, ASC X12N/005010X223, and Type 1 Errata to Health Care Claim: Institutional (837) ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October 2007,

ASC X12N/005010X233A1 for the health care claims or equivalent encounter information transaction (45 CFR 162.1102).

HIPAA requires covered entities to use the applicable medical data code set requirements when conducting HIPAA transactions (45 CFR 162.1000). Currently, upon the discharge of the patient, the LTCH must assign appropriate diagnosis and procedure codes from the most current version of the Internal Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM). For additional information on the ICD–9–CM coding system, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47241 through 47243 and 47277 through 47281). We also refer readers to the detailed discussion on correct coding practices in the August 30, 2002 LTCH PPS final rule (67 FR 55981 through 55983).

Currently, providers use the code sets under the ICD–9–CM coding system to report diagnoses and procedures for Medicare hospital inpatient services under the MS–DRG system. We have been discussing the conversion to the ICD–10 coding system for many years. Hospitals, including LTCHs, are required to use the ICD–10 coding system effective October 1, 2015. Consequently, providers will begin using the code sets under the ICD–10 coding system to report diagnoses (ICD–10–CM codes) and procedures (ICD–10–PCS codes) for Medicare hospital inpatient services under the MS–DRG system (and by extension the MS–LTC–DRG system) beginning October 1, 2015. For additional information on the implementation of the ICD–10 coding system, we refer readers to section II.G.1. of the preamble of this final rule. Additional coding instructions and examples are published in the AHA's *Coding Clinic for ICD–10–CM/PCS*.

To create the MS–DRGs (and by extension, the MS–LTC–DRGs), base DRGs were subdivided according to the presence of specific secondary diagnoses designated as complications or comorbidities (CCs) into one, two, or three levels of severity, depending on the impact of the CCs on resources used for those cases. Specifically, there are sets of MS–DRGs that are split into 2 or 3 subgroups based on the presence or absence of a CC or a major complication or comorbidity (MCC). We refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a detailed discussion about the creation of MS–DRGs based on severity of illness levels (72 FR 47141 through 47175).

MACs enter the clinical and demographic information submitted by LTCHs into their claims processing systems and subject this information to a series of automated screening processes called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before assignment into a MS–LTC–DRG can be made. During this process, certain cases are selected for further development (74 FR 43949).

After screening through the MCE, each claim is classified into the appropriate MS–LTC–DRG by the Medicare LTCH GROUPER software on the basis of diagnosis and procedure codes and other demographic information (age, sex, and discharge status). The GROUPER software used under the LTCH PPS is the same GROUPER software program used under the IPPS. Following the MS–LTC–DRG assignment, the Medicare contractor determines the prospective payment amount by using the Medicare PRICER program, which accounts for hospital-specific adjustments. Under the LTCH PPS, we provide an opportunity for LTCHs to review the MS–LTC–DRG assignments made by the Medicare contractor and to submit additional information within a specified timeframe as provided in § 412.513(c).

The GROUPER software is used both to classify past cases to measure relative hospital resource consumption to establish the MS–LTC–DRG relative weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible MS–DRG and MS–LTC–DRG classification changes and to recalibrate the MS–DRG and MS–LTC–DRG relative weights during our annual update under both the IPPS (§ 412.60(e)) and the LTCH PPS (§ 412.517), respectively.

b. Changes to the MS–LTC–DRGs for FY 2016

As specified by our regulations at § 412.517(a), which require that the MS–LTC–DRG classifications and relative weights be updated annually, and consistent with our historical practice of using the same patient classification system under the LTCH PPS as is used under the IPPS, we are updating the MS–LTC–DRG classifications effective October 1, 2015, through September 30, 2016 (FY 2016) consistent with the changes to specific MS–DRG classifications presented in section II.G. of the preamble of this final rule. Therefore, the MS–LTC–DRGs for FY 2016 presented in this final rule are the same as the MS–DRGs that are being used under the IPPS for FY 2016. Specifically, as discussed in section II.G.1.b. of this preamble of this final rule, we are using the ICD–10 MS–DRGs Version 33 as the replacement logic for the ICD–9–CM based MS–DRGs Version 32 as part of the MS–DRG updates (and by extension the MS–LTC–DRG) updates for FY 2016. The GROUPER Version 33 is based on ICD–10–CM/PCS diagnoses and procedure codes, consistent with the requirement to use ICD–10 beginning October 1, 2015, as noted above and discussed in greater detail in section II.G.1. of the preamble of this final rule.

In the proposed rule, we invited public comments on how well the ICD–10 MS–DRGs Version 33 (and by extension the ICD–10 MS–LTC–DRGs Version 33) replicates the logic of the ICD–9 MS–DRGs Version 32 (and by extension ICD–9 MS–LTC–DRGs Version 32). These comments and our responses are discussed in section II.G.1.a. of the preamble of this final rule. (We note that, when referencing MS–LTC–DRGs Version 33 in the remainder of this section, we are referring to the ICD–10-based MS–LTC–DRGs Version 33 unless otherwise stated. Similarly, when referencing MS–LTC–DRGs Version 32 for the remainder of this section, we are referring to the ICD–9-based MS–LTC–DRGs Version 32 unless otherwise stated.) In addition, because the MS–LTC–DRGs for FY 2016 are the same as the MS–DRGs for FY 2016, the other changes that affect MS–DRG (and by extension MS–LTC–DRG) assignments under GROUPER Version 33, as discussed in section II.G. of the preamble of this final rule, including the changes to the MCE software and the ICD–10 coding system, will also be applicable under the LTCH PPS for FY 2016.

3. Development of the FY 2016 MS–LTC–DRG Relative Weights

a. General Overview of the Development of the MS–LTC–DRG Relative Weights

One of the primary goals for the implementation of the LTCH PPS is to pay each LTCH an appropriate amount for the efficient delivery of medical care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly (67 FR 55984). To accomplish these goals, we have annually adjusted the LTCH PPS standard Federal prospective payment system rate by the applicable relative weight in determining payment to LTCHs for each case. In order to make these annual

adjustments under the new dual rate LTCH PPS payment structure, as previously discussed in section VII.B.7.a. of the preamble of this final rule, we are finalizing the policy, beginning with FY 2016, to recalibrate the MS–LTC–DRG relative weighting factors annually using data from applicable LTCH cases. Under this policy, the resulting MS–LTC–DRG relative weights will continue to be used to adjust the LTCH PPS standard Federal rate when calculating the payment for LTCH PPS standard Federal payment rate cases. However, the MS–LTC–DRG relative weights will not be used to determine the LTCH PPS payment for cases paid under the site neutral payment rate. (For details on our finalized policies regarding application of the site neutral payment rate, we refer readers to section VII.B. of the preamble of this final rule.)

The established methodology to develop the MS–LTC–DRG relative weights is consistent with the methodology established when the LTCH PPS was implemented in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991), with the exception of some modifications of our historical procedures for assigning relative weights in cases of zero volume and/or nonmonotonicity resulting from the adoption of the MS–LTC–DRGs. (For details on these modifications to our historical procedures for assigning relative weights in cases of zero volume and/or nonmonotonicity, we refer readers to the FY 2008 IPPS final rule with comment period (72 FR 47289 through 47295) and the FY 2009 IPPS final rule (73 FR 48542 through 48550).) Under the LTCH PPS, relative weights for each MS–LTC–DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients classified to each MS–LTC–DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each MS–LTC–DRG that represents the resources needed by an average inpatient LTCH case in that MS–LTC–DRG. For example, cases in a MS–LTC–DRG with a relative weight of 2 will, on average, cost twice as much to treat as cases in a MS–LTC–DRG with a relative weight of 1.

b. Development of the MS–LTC–DRG Relative Weights for FY 2016

In the FY 2015 IPPS/LTCH PPS final rule (79 FR 50170 through 50176), we presented our policies for the development of the MS–LTC–DRG relative weights for FY 2015.

In this final rule, as proposed, we are continuing to use our existing methodology to determine the MS–LTC–DRG relative weights for FY 2016, including the application of established policies related to, the hospital-specific relative value methodology, the treatment of severity levels in the MS–LTC–DRGs, low-volume and no-volume MS–LTC–DRGs, adjustments for nonmonotonicity, and the steps for calculating the MS–LTC–DRG relative weights with a budget neutrality factor. However, as previously noted and discussed in greater detail in section VII.B.7.a. of the preamble of this final rule, under the new dual rate LTCH PPS payment structure, after consideration of public comments, as we proposed, we are establishing that the FY 2016 MS–LTC DRG relative weights will be determined based only on data from applicable LTCH cases (which includes our finalized policy of using only cases that would meet the criteria for exclusion from the site neutral payment rate (had those criteria been in effect at the time of the discharge)). We discuss the effects of our finalized policies concerning the data used to determine the FY 2016 MS–LTC–DRG relative weights on the various components of our existing methodology in the discussion that follows.

Furthermore, as we have done since the FY 2008 update, and as we proposed, we are applying a two-step budget neutrality adjustment to the annual update to the MS–LTC–DRG classifications and relative weights at § 412.517(b) (in conjunction with § 412.503), such that estimated aggregate LTCH PPS payments would be unaffected, that is, would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the classification and relative weight changes (72 FR 26882 through 26884). For additional information on the established two-step budget neutrality methodology, we refer readers to the FY 2008 IPPS final rule (72 FR 47295 through 47296). Below we present our proposed methodology for determining the proposed MS–LTC–DRG relative weights for FY 2016 LTCH PPS standard Federal payment rate payments, which is generally consistent with our existing methodology, except for the proposed use of applicable LTCH data.

c. Applicable LTCH Data

For this final rule, to calculate the MS–LTC–DRG relative weights for FY 2016 LTCH PPS standard Federal payment rate payments, we obtained total charges from FY 2014 Medicare LTCH claims data from the March 2015 update of the FY 2014 MedPAR file, which are the best available data at this time, and the finalized Version 33 of the GROUPER to classify LTCH cases. Consistent with our historical practice and as we proposed, we are using those data and the finalized Version 33 of the GROUPER in establishing the FY 2016 MS–LTC–DRG relative weights in this final rule. To calculate the FY 2016 MS–LTC–DRG relative weights under the new dual rate LTCH PPS payment structure that will be effective beginning October 1, 2015, beginning with the annual recalibration of the MS–LTC–DRG relative weights for FY 2016, we are using applicable LTCH data, which, as previously discussed in section VII.B.7.a. of this preamble of, includes our finalized policy of using only cases that meet the criteria for exclusion from the site neutral payment rate (or would meet the criteria had they been in effect at the time of the discharge). Accordingly, as we proposed, we began by first evaluating the LTCH claims data in the March 2015 update of the FY 2014 MedPAR file to determine which LTCH cases would have met the criteria for exclusion from the site neutral payment rate under § 412.522(b) (as discussed in greater detail in section VII.B.3. of the preamble of this final rule) had the new dual rate LTCH PPS payment structure been in effect at the time of discharge. We identified the FY 2014 LTCH cases that were not assigned to MS–LTC–DRGs 876, 880, 881, 882, 883, 884, 885, 886, 887, 894, 895, 896, 897, 945 and 946, which, under our finalized policies, will identify LTCH cases that do not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation (as discussed in section VII.B.3.b. of the preamble of this final rule); and that either—

- The admission to the LTCH was ''immediately preceded'' by discharge from a subsection (d) hospital and the immediately preceding stay in that subsection (d) hospital included at least 3 days in an ICU, as we define under the ICU criterion (discussed in section VII.B.3.e. of the preamble of this final rule); or
- The admission to the LTCH was ''immediately preceded'' by discharge from a subsection (d) hospital and the claim for the LTCH discharge includes the applicable procedure code that indicates at least 96 hours of ventilator services were provided during the LTCH stay, as we define under the ventilator criterion (discussed in section VII.B.3.f. of the preamble of this final rule).

Claims data from the March 2015 update of the FY 2014 MedPAR file that reported ICD–9–CM procedure code

96.72 were used to identify cases involving at least 96 hours of ventilator services in accordance with the ventilator criterion. (We note that the corresponding ICD–10–PCS code for cases involving at least 94 hours of ventilation services is 5A1955Z, effective as of October 1, 2015.)

Then, consistent with our historical methodology and as we proposed, we excluded any claims in the resulting data set that were submitted by LTCHs that are all-inclusive rate providers and LTCHs that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90–248 or section 222(a) of Public Law 92–603. In addition, consistent with our historical practice and as we proposed, we excluded the Medicare Advantage (Part C) claims that were in the resulting data set based on the presence of a GHO Paid indicator value of ''1'' in the MedPAR files. The claims that remained after these three trims (that is, the applicable LTCH data) were then used to calculate the relative weights for the LTCH PPS standard Federal payment rate payments for FY 2016.

In summary, in identifying the claims data for the development of the FY 2016 MS–LTC–DRG relative weights in this final rule, we are using claims data after we trim the claims data of 10 all-inclusive rate providers reported in the March 2015 update of the FY 2014 MedPAR file, as well as any Medicare Advantage claims data for cases that would have met the criteria for exclusion from the site neutral payment rate under § 412.522(b) if the new dual rate LTCH PPS payment structure were in effect at the time of discharge. (We note, there were no data from any LTCHs that are paid in accordance with a demonstration project reported in the March 2015 update of the FY 2014 MedPAR file. However, had there been we would we trim the claims data from those LTCHs as well, in accordance with our established policy.) We are using the remaining data (that is, the applicable LTCH data) to calculate the relative weights for the LTCH PPS standard Federal payment rate payments for FY 2016. We note, the public comments we received, our responses to those comments, and our finalized policy of using only cases that would meet the criteria for exclusion from the site neutral payment rate (had those criteria been in effect at the time of the discharge) for the annual recalibration of the MS–LTC–DRG relative weights beginning for FY 2016 is presented in section VII.B.7.a. of this preamble of this final rule. We did not receive any public comments on the other parts of our proposals on the applicable LTCH data used to determine the relative weights for MS–LTC–DRGs for FY 2016, and are adopting those proposals as final without change.

After consideration of the public comments we received, we are finalizing our proposals on the applicable LTCH data used to determine the relative weights for MS–LTC–DRGs for FY 2016 without change.

d. Hospital-Specific Relative Value (HSRV) Methodology

By nature, LTCHs often specialize in certain areas, such as ventilator-dependent patients. Some case types (MS–LTC–DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. This nonrandom distribution of cases with relatively high (or low) charges in specific MS–LTC–DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, consistent with the methodology we have used since the implementation of the LTCH PPS, as proposed, we are continuing to use a hospital-specific relative value (HSRV) methodology to calculate the MS–LTC–DRG relative weights for FY 2016 LTCH PPS standard Federal payment rate payments. We believe this method removes this hospital-specific source of bias in measuring LTCH average charges (67 FR 55985). Specifically, under this methodology, we are reducing the impact of the variation in charges across providers on any particular MS–LTC–DRG relative weight by converting each LTCH's charge for an applicable LTCH case to a relative value based on that LTCH's average charge for such cases.

Under the HSRV methodology, we standardize charges for each LTCH by converting its charges for each applicable LTCH case to hospital-specific relative charge values and then adjusting those values for the LTCH's case-mix. The adjustment for case-mix is needed to rescale the hospital-specific relative charge values (which, by definition, average 1.0 for each LTCH). The average relative weight for a LTCH is its case-mix; therefore, it is reasonable to scale each LTCH's average relative charge value by its case-mix. In this way, each LTCH's relative charge value is adjusted by its case-mix to an average that reflects the complexity of the applicable LTCH cases it treats relative to the complexity of the applicable LTCH cases treated by all other LTCHs (the average LTCH PPS case-mix of all applicable LTCH cases across all LTCHs).

In accordance with our established methodology, for FY 2016, we standardized charges for each applicable LTCH case by first dividing the adjusted charge for the case (adjusted for SSOs under § 412.529 as described in section VII.C.3.g. (Step 3) of the preamble of this final rule) by the average adjusted charge for all applicable LTCH cases at the LTCH in which the case was treated. SSO cases are cases with a length of stay that is less than or equal to five-sixths the average length of stay of the MS–LTC–DRG (§ 412.529 and § 412.503). The average adjusted charge reflects the average intensity of the health care services delivered by a particular LTCH and the average cost level of that LTCH. The resulting ratio was multiplied by that LTCH's case-mix index to determine the standardized charge for the case (67 FR 55989).

Multiplying the resulting ratio by the LTCH's case-mix index accounts for the fact that the same relative charges are given greater weight at a LTCH with higher average costs than they would at a LTCH with low average costs, which is needed to adjust each LTCH's relative charge value to reflect its case-mix relative to the average case-mix for all LTCHs. Because we standardized charges in this manner, we count charges for a Medicare patient at a LTCH with high average charges as less resource intensive than they would be at a LTCH with low average charges. For example, a $10,000 charge for a case at a LTCH with an average adjusted charge of $17,500 reflects a higher level of relative resource use than a $10,000 charge for a case at a LTCH with the same case-mix, but an average adjusted charge of $35,000. We believe that the adjusted charge of an individual case more accurately reflects actual resource use for an individual LTCH because the variation in charges due to systematic differences in the markup of charges among LTCHs is taken into account.

We did not receive any public comments concerning our proposal to continue to use HSRV methodology to determine the MS–LTC–DRG relative weights for FY 2016, and therefore, we are finalizing this proposed policy, without modification.

e. Treatment of Severity Levels in Developing the MS–LTC–DRG Relative Weights

For purposes of determining the MS–LTC–DRG relative weights, under our historical methodology, there are three different categories of MS–DRGs based on volume of cases within specific MS–LTC–DRGs: (1) MS–LTC–DRGs with at

least 25 applicable LTCH cases in the data used to calculate the relative weight, which are each assigned a unique relative weight; (2) low-volume MS–LTC–DRGs (that is, MS–LTC–DRGs that contain between 1 and 24 applicable LTCH cases that are grouped into quintiles (as described below) and assigned the relative weight of the quintile; and (3) no-volume MS–LTC–DRGs that are cross-walked to other MS–LTC–DRGs based on the clinical similarities and assigned the relative weight of the cross-walked MS–LTC–DRG (as described in greater detail below). For FY 2016, we are using applicable LTCH cases to establish the same volume-based categories to calculate the FY 2016 relative weights for LTCH PPS standard Federal payment rate payments. This approach is consistent with our policies regarding the continued use of our existing methodology related to the treatment of severity levels as presented in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50172).

We provide in-depth discussions of our finalized policy regarding weight-setting for low-volume MS–LTC–DRGs in section VII.C.3.f. of the preamble of this final rule and for no-volume MS–LTC–DRGs, under Step 5 in section VII.C.3.g. of the preamble of this final rule.) Furthermore, in determining the FY 2016 MS–LTC–DRG relative weights for LTCH PPS standard Federal payment rate payments, when necessary, as proposed, we made adjustments to account for nonmonotonicity, as discussed in greater detail below in Step 6 of section VII.C.3.g. of the preamble of this final rule. We refer readers to the discussion in the FY 2010 IPPS/RY 2010 LTCH PPS final rule for our rationale for including an adjustment for nonmonotonicity (74 FR 43953 through 43954).

f. Low-Volume MS–LTC–DRGs

In order to account for MS–LTC–DRGs for LTCH PPS Standard Federal payment rate cases with low-volume (that is, with fewer than 25 applicable LTCH cases), consistent with our existing methodology for purposes of determining the FY 2015 MS–LTC–DRG relative weights, as proposed, we are employing the quintile methodology for low-volume MS–LTC–DRGs, such that we grouped the ''low-volume MS–LTC–DRGs'' (that is, MS–LTC–DRGs that contained between 1 and 24 applicable LTCH cases into one of five categories (quintiles) based on average charges (67 FR 55984 through 55995 and 72 FR 47283 through 47288). In cases where the initial assignment of a low-volume MS–LTC–DRG to a quintile resulted in nonmonotonicity within a base-DRG, as proposed, we made adjustments to the resulting low-volume MS–LTC–DRGs to preserve monotonicity, as discussed in detail below in section VII.C.3.g. (Step 6) of the preamble of this final rule.

In the proposed rule, using the most current available data at that time, we noted our identification of 250 MS–LTC–DRGs that contained between 1 and 24 applicable LTCH cases. Based on the best available data for this final rule (that is, the March 2015 update of the FY 2014 MedPAR files, we now identified 251 MS–LTC–DRGs that contained between 1 and 24 applicable LTCH cases. This list of MS–LTC–DRGs was then divided into one of the 5 low-volume quintiles, each containing 50 MS–LTC–DRGs (251/5 = 50, with a remainder of 1). We assigned the low-volume MS–LTC–DRGs to specific low-volume quintiles by sorting the low-volume MS–LTC–DRGs in ascending order by average charge in accordance with our established methodology. Based on the data available for the proposed rule, the number of MS–LTC–DRGs with less than 25 applicable LTCH cases was evenly divisible by 5. Therefore, it was not necessary to employ our historical methodology for determining which of the low-volume quintiles contain an additional low-volume MS–LTC–DRG. However, for this final rule, based on the most current data available at this time, because the number of MS–LTC–DRGs with less than 25 applicable LTCH cases has shifted to 251 (which does not divide evenly), as proposed, we used our historical methodology for determining which quintiles would contain the additional MS–LTC–DRGs. Specifically for this final rule, after organizing the MS–LTC–DRGs by ascending order by average charge, we assigned the first fifth (1st through 50th) of low-volume MS–LTC–DRGs (with the lowest average charge) into Quintile 1. The 50 MS–LTC–DRGs with the highest average charge cases were assigned into Quintile 5. Because the average charge of the 151st low-volume MS–LTC–DRG in the sorted list was closer to the average charge of the 150th low-volume MS–LTC–DRG (assigned to Quintile 3) than to the average charge of the 152nd low-volume MS–LTC–DRG (assigned to Quintile 4), we are assigning it to Quintile 3 (such that Quintile 3 contains 51 low-volume MS–LTC–DRGs before any adjustments for nonmonotonicity, as discussed below). This results in 4 of the 5 low-volume quintiles containing 50 MS–LTC–DRGs (Quintiles 1, 2, 4 and 5) and one low-volume quintile containing 51 MS–LTC–DRGs (Quintiles 3). Table 13A, listed in section VI. of the Addendum to this final rule and available via the Internet, lists the composition of the low-volume quintiles for MS–LTC–DRGs for FY 2016.

Accordingly, in order to determine the FY 2016 relative weights for the MS–LTC–DRGs with low-volume, as proposed, we are using the five low-volume quintiles described above. We determined a relative weight and (geometric) average length of stay for each of the five low-volume quintiles using the methodology described in section VII.C.3.g. of the preamble of this final rule. As we proposed, we assigned the same relative weight and average length of stay to each of the low-volume MS–LTC–DRGs that make up an individual low-volume quintile. We note that, as this system is dynamic, it is possible that the number and specific type of MS–LTC–DRGs with a low-volume of applicable LTCH cases will vary in the future. Furthermore, we note that we will continue to monitor the volume (that is, the number of applicable LTCH cases) in the low-volume quintiles to ensure that our quintile assignments used in determining the MS–LTC–DRG relative weights for LTCH PPS standard Federal payment rate payments result in appropriate payment for LTCH cases that will be grouped to low-volume MS–LTC–DRGs and do not result in an unintended financial incentive for LTCHs to inappropriately admit these types of cases.

We did not receive any public comments concerning our proposals related to low-volume MS–LTC–DRGs. Therefore, we are finalizing, without modification, these proposals.

g. Steps for Determining the FY 2016 MS–LTC–DRG Relative Weights

In this final rule, as proposed, we are generally using our existing methodology to determine the FY 2016 MS–LTC–DRG relative weights for LTCH PPS standard Federal payment rate payments. However, in doing so, we are using only applicable LTCH cases and data to determine the FY 2016 MS–LTC–DRG relative weights (including our finalized policy of using only cases that met or would have met the criteria for exclusion from the site neutral payment rate (had those criteria been in effect at the time of the discharge as discussed in section VII.B.7.a. of the preamble of this final rule).

Comment: Based on their analysis of the proposed FY 2016 MS–LTC–DRG weights, some commenters stated that there may be reversal in the description of the steps of the CMS methodology for

calculating the MS–LTC–DRG relative weights. Commenters also noted that the data trimming in the step to remove statistical outliers appears to only address the removal of statistical outliers based on total charges and not the total charges per day requirement.

Response: We reexamined the description of the methodology for calculating the MS–LTC–DRG relative weights and found an inadvertent error in the order in which we have been presenting steps 1 and 2 of our methodology. Under our longstanding historical methodology to calculate the MS–LTC–DRG relative weights, we first remove cases with a length of stay of 7 days or less (which has been mistakenly described at step 2 in our methodology) and then remove statistical outliers (which has been mistakenly described at step 1 in our methodology). Cases with a length of stay of 7 days or less are removed in the initial step because leaving them in would distort the relative weights of the MS–LTC–DRGs. It is essential to remove such cases prior to trimming for statistical outliers in order to appropriately identify aberrant data when removing statistical outliers that would distort the measure of average resource use reflected in the MS–LTC–DRG relative weights. We thank commenters for pointing out this error in the description of the methodology. We note that the differences between applying steps 2 and 1 in the correct order (as we have always calculated these values) as opposed to the reversed order described in the proposed rule have heretofore been negligible (in fact, our understanding is that certain outside parties have replicated and/or performed analyses of the MS–LTC–DRG relative weights in prior years). However, under our finalized policy to use only cases that would meet the criteria for exclusion from the site neutral payment rate (had those criteria been in effect at the time of the discharge), the new dual rate LTCH PPS payment structure has reduced the number of cases we are using to calculate MS–LTC–DRG relative weights, making the description/order of the steps more significant. We appreciate the commenters bringing this to our attention and regret any confusion caused by our misstatement regarding the order of the steps one must take to calculate relative weights. We assure the industry that since the advent of the LTCH PPS we have been calculating these values by first removing the cases with an average length of stay of 7 days or less, and then removing statistical outliers. In addition, we agree with commenters that, for the FY 2016 proposed rule, we made a technical error in our application of the data trimming to remove statistical outliers. We appreciate commenters bringing this to our attention and the MS–LTC–DRG relative weights calculated for this final rule reflect the correct application of the data trimming. That is, we have ensured that to identify statistical outliers, we have applied the trim based on both charges per case and the charges per day (see step 2 below), consistent with our longstanding methodology.

After consideration of the public comments we received, we are finalizing our proposal to continue to use our existing methodology to calculation the MS–LTC–DRG relative weights for FY 2016, including calculating the values in the ordered steps we have employed in this calculation from the onset of the LTCH PPS. To reflect this, in this final rule, we are correcting the order of steps described in this preamble to reflect the order in which they have been, and will continue to be applied in the application of our existing policy.

In summary, to determine the FY 2016 MS–LTC–DRG relative weights, we grouped applicable LTCH cases to the appropriate MS–LTC–DRG, while taking into account the low-volume quintiles (as described above) and cross-walked no-volume MS–LTC–DRGs as described below. After establishing the appropriate MS–LTC–DRG (or low-volume quintile), we calculated the FY 2016 relative weights for LTCH PPS standard Federal payment rate payments by first removing cases with a length of stay of 7 days or less and statistical outliers (Steps 1 and 2 below). Next, we adjusted the number of applicable LTCH cases in each MS–LTC–DRG (or low-volume quintile) for the effect of SSO cases (Step 3 below). After removing applicable LTCH cases with a length of stay of 7 days or less (Step 1 below) and statistical outliers (Step 2 below) and, which are the SSO-adjusted applicable LTCH cases and corresponding charges (step 3 below), we calculated ''relative adjusted weights'' for each MS–LTC–DRG (or low-volume quintile) using the HSRV method. Below we discuss in detail the steps for calculating the FY 2016 MS–LTC–DRG relative weights for LTCH PPS standard Federal payment rate payments.

Step 1—Remove cases with a length of stay of 7 days or less.

The first step in our calculation of the FY 2016 MS–LTC–DRG relative weights for LTCH PPS standard Federal payment rate payments is to remove cases with a length of stay of 7 days or less. The MS–LTC–DRG relative weights reflect the average of resources used on representative cases of a specific type. Generally, cases with a length of stay of 7 days or less do not belong in a LTCH because these stays do not fully receive or benefit from treatment that is typical in a LTCH stay, and full resources are often not used in the earlier stages of admission to a LTCH. If we were to include stays of 7 days or less in the computation of the FY 2016 MS–LTC–DRG relative weights, the value of many relative weights would decrease and, therefore, payments would decrease to a level that may no longer be appropriate. We do not believe that it would be appropriate to compromise the integrity of the payment determination for those LTCH cases that actually benefit from and receive a full course of treatment at a LTCH by including data from these very short stays. Therefore, consistent with our existing relative weight methodology, in determining the FY 2016 MS–LTC–DRG relative weights for LTCH PPS standard Federal payment rate payments, we removed LTCH cases with a length of stay of 7 days or less from applicable LTCH cases. (For additional information on what would be removed in this step of the relative weight methodology, we refer readers to 67 FR 55989 and 74 FR 43959.)

Step 2—Remove statistical outliers.

The next step in our calculation of the FY 2016 MS–LTC–DRG relative weights for LTCH PPS standard Federal payment rate payments is to remove statistical outlier cases from the LTCH cases with a length of stay of at least 8 days. Consistent with our existing relative weight methodology, as proposed, we are continuing to define statistical outliers as cases that are outside of 3.0 standard deviations from the mean of the log distribution of both charges per case and the charges per day for each MS–LTC–DRG. These statistical outliers are removed prior to calculating the relative weights because we believe that they may represent aberrations in the data that distort the measure of average resource use. Including those LTCH cases in the calculation of the relative weights for LTCH PPS standard Federal payment rate payments could result in an inaccurate relative weight that does not truly reflect relative resource use among those MS–LTC–DRGs. (For additional information on what would be removed in this step of the relative weight methodology, we refer readers to 67 FR 55989 and 74 FR 43959.) After removing cases with a length of stay of 7 days or less and statistical outliers, we are left with applicable LTCH cases that have a length of stay greater than or

equal to 8 days. In this final rule, we refer to these cases as ''trimmed applicable LTCH cases.''

Step 3—Adjust charges for the effects of SSOs.

As the next step in the calculation of the FY 2016 MS–LTC–DRG relative weights for LTCH PPS standard Federal payment rate payments, consistent with our historical approach, we adjusted each LTCH's charges per discharge for those remaining cases (that is, trimmed applicable LTCH cases) for the effects of SSOs (as defined in § 412.529(a) in conjunction with § 412.503). Specifically, we made this adjustment by counting an SSO case as a fraction of a discharge based on the ratio of the length of stay of the case to the average length of stay for the MS–LTC–DRG for non-SSO cases. This has the effect of proportionately reducing the impact of the lower charges for the SSO cases in calculating the average charge for the MS–LTC–DRG. This process produces the same result as if the actual charges per discharge of an SSO case were adjusted to what they would have been had the patient's length of stay been equal to the average length of stay of the MS–LTC–DRG.

Counting SSO cases as full LTCH cases with no adjustment in determining the FY 2016 MS–LTC–DRG relative weights for LTCH PPS standard Federal payment rate payments will lower the FY 2016 MS–LTC–DRG relative weight for affected MS–LTC–DRGs because the relatively lower charges of the SSO cases will bring down the average charge for all cases within a MS–LTC–DRG. This will result in an ''underpayment'' for non-SSO cases and an ''overpayment'' for SSO cases. Therefore, as proposed, we are continuing to adjust for SSO cases under § 412.529 in this manner because it results in more appropriate payments for all LTCH PPS standard Federal payment rate cases. (For additional information on this step of the relative weight methodology, we refer readers to 67 FR 55989 and 74 FR 43959.)

Step 4—Calculate the FY 2016 MS–LTC–DRG relative weights on an iterative basis.

Consistent with our historical relative weight methodology, we then calculated the FY 2016 MS–LTC–DRG relative weights for LTCH PPS standard Federal payment rate payments using the HSRV methodology, which is an iterative process. First, for each SSO-adjusted trimmed applicable LTCH case, we calculated a hospital-specific relative charge value by dividing the charge per discharge after adjusting for SSOs of the LTCH case (from Step 3) by the average charge per SSO-adjusted discharge for the LTCH in which the case occurred. The resulting ratio was then multiplied by the LTCH's case-mix index to produce an adjusted hospital-specific relative charge value for the case. An initial case-mix index value of 1.0 was used for each LTCH.

For each MS–LTC–DRG, we calculated the FY 2016 relative weight by dividing the SSO-adjusted average of the hospital-specific relative charge values for applicable LTCH cases (that is, the sum of the hospital-specific relative charge value from above divided by the sum of equivalent cases from step 3 for each MS–LTC–DRG) for the MS–LTC–DRG by the overall SSO-adjusted average hospital-specific relative charge value across all applicable LTCH cases for all LTCHs (that is, the sum of the hospital-specific relative charge value from above divided by the sum of equivalent applicable LTCH cases from step 3 for each MS–LTC–DRG). Using these recalculated MS–LTC–DRG relative weights, each LTCH's average relative weight for all of its SSO-adjusted trimmed applicable LTCH cases (that is, its case-mix) was calculated by dividing the sum of all the LTCH's MS–LTC–DRG relative weights by its total number of SSO-adjusted trimmed applicable LTCH cases. The LTCHs' hospital-specific relative charge values (from above) were then multiplied by the hospital-specific case-mix indexes. The hospital-specific case-mix adjusted relative charge values were then used to calculate a new set of MS–LTC–DRG relative weights across all LTCHs. This iterative process was continued until there was convergence between the relative weights produced at adjacent steps, for example, when the maximum difference was less than 0.0001. (We note that, although we are not making any changes to this step of our relative weight methodology in this final rule, we have made some minor changes to the description of this step to clarify the application of our existing policy.)

Step 5—Determine a FY 2016 relative weight for MS–LTC–DRGs with no applicable LTCH cases.

Using the trimmed applicable LTCH cases, we identified the MS–LTC–DRGs for which there were no claims in the March 2015 update of the FY 2014 MedPAR file and, therefore, for which no charge data was available for these MS–LTC–DRGs. Because patients with a number of the diagnoses under these MS–LTC–DRGs may be treated at LTCHs, consistent with our historical methodology, we are generally assigning a relative weight to each of the no-volume MS–LTC–DRGs for LTCH PPS standard Federal payment rate cases based on clinical similarity and relative costliness (with the exception of ''transplant'' MS–LTC–DRGs, ''error'' MS–LTC–DRGs, and MS–LTC–DRGs that indicate a principal diagnosis related to a psychiatric diagnosis or rehabilitation (referred to as the ''psychiatric or rehabilitation'' MS–LTC–DRGs), as discussed below). (For additional information on this step of the relative weight methodology, we refer readers to 67 FR 55991 and 74 FR 43959 through 43960.)

As proposed, we are cross-walking each no-volume MS–LTC–DRG to another MS–LTC–DRG for which we calculated a relative weight (determined in accordance with the methodology described above). Then, the ''no-volume'' MS–LTC–DRG was assigned the same relative weight (and average length of stay) of the MS–LTC–DRG to which it was cross-walked (as described in greater detail below).

Of the 758 MS–LTC–DRGs for FY 2016, we identified 367 MS–LTC–DRGs for which there are no trimmed applicable LTCH cases (the number identified includes no trimmed applicable LTCH cases in the 8 ''transplant'' MS–LTC–DRGs, the 2 ''error'' MS–LTC–DRGs, and the 15 ''psychiatric or rehabilitation'' MS–LTC–DRGs, which are discussed below). As proposed, we are assigning relative weights to each of the 342 no-volume MS–LTC–DRGs that contained trimmed applicable LTCH cases based on clinical similarity and relative costliness to one of the remaining 391 (758—367= 391) MS–LTC–DRGs for which we were able to calculate relative weights based on the trimmed applicable LTCH cases in the FY 2014 MedPAR file data using the steps described above. (For the remainder of this discussion, we refer to the ''cross-walked'' MS–LTC–DRGs as the MS–LTC–DRGs to which we cross-walked one of the 342 ''no volume'' MS–LTC–DRGs.) Then, we generally assigned the 342 no-volume MS–LTC–DRG the relative weight of the cross-walked MS–LTC–DRG. (As explained below in Step 6, when necessary, we made adjustments to account for nonmonotonicity.)

As proposed, we cross-walked the no-volume MS–LTC–DRG to a MS–LTC–DRG for which we were able to calculate relative weights based on the March 2015 update of the FY 2014 MedPAR file, and to which it is similar clinically in intensity of use of resources and relative costliness as determined by criteria such as care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, postoperative care, and length of stay.

(For more details on our process for evaluating relative costliness, we refer readers to the FY 2010 IPPS/RY 2010 LTCH PPS final rule (73 FR 48543).) We believe in the rare event that there would be a few LTCH cases grouped to one of the no-volume MS–LTC–DRGs in FY 2015, the relative weights assigned based on the cross-walked MS–LTC–DRGs would result in an appropriate LTCH PPS payment because the crosswalks, which are based on clinical similarity and relative costliness, would be expected to generally require equivalent relative resource use.

We then assigned the relative weight of the cross-walked MS–LTC–DRG as the relative weight for the no-volume MS–LTC–DRG such that both of these MS–LTC–DRGs (that is, the no-volume MS–LTC–DRG and the cross-walked MS–LTC–DRG) have the same relative weight (and average length of stay) for FY 2016. We note that, if the cross-walked MS–LTC–DRG had 25 applicable LTCH cases or more, its relative weight (calculated using the methodology described in Steps 1 through 4 above) was assigned to the no-volume MS–LTC–DRG as well. Similarly, if the MS–LTC–DRG to which the no-volume MS–LTC–DRG was cross-walked had 24 or less cases and, therefore, was designated to one of the low-volume quintiles for purposes of determining the relative weights, we assigned the relative weight of the applicable low-volume quintile to the no-volume MS–LTC–DRG such that both of these MS–LTC–DRGs (that is, the no-volume MS–LTC–DRG and the cross-walked MS–LTC–DRG) have the same relative weight for FY 2016. (As we noted above, in the infrequent case where nonmonotonicity involving a no-volume MS–LTC–DRG resulted, additional adjustments as described in Step 6 were required in order to maintain monotonically increasing relative weights.)

For this final rule, a list of the no-volume MS–LTC–DRGs and the MS–LTC–DRGs to which each was cross-walked (that is, the cross-walked MS–LTC–DRGs) for FY 2016 is shown in Table 13B, which is listed in section VI. of the Addendum to this final rule and is available via the Internet on the CMS Web site.

To illustrate this methodology for determining the relative weights for the FY 2016 MS–LTC–DRGs with no applicable LTCH cases, we are providing the following example, which refers to the no-volume MS–LTC–DRGs crosswalk information for FY 2016 provided in Table 13B.

Example: There were no trimmed applicable LTCH cases in the FY 2014 MedPAR file that we are using for this final rule for MS–LTC–DRG 61 (Acute Ischemic Stroke with Use of Thrombolytic Agent with MCC). We determined that MS–LTC–DRG 70 (Nonspecific Cerebrovascular Disorders with MCC) is similar clinically and based on resource use to MS–LTC–DRG 61. Therefore, we assigned the same relative weight (and average length of stay) of MS–LTC–DRG 70 of 0.9070 for FY 2016 to MS–LTC–DRG 61 (we refer readers to Table 11, which is listed in section VI. of the Addendum to this final rule and is available via the Internet on the CMS Web site).

Again, we note that, as this system is dynamic, it is entirely possible that the number of MS–LTC–DRGs with no volume will vary in the future. As proposed, we are using the most recent available claims data to identify the trimmed applicable LTCH cases from which we determined the relative weights in this final rule.

For FY 2016, consistent with our historical relative weight methodology, as we proposed, we are establishing a relative weight of 0.0000 for the following transplant MS–LTC–DRGs: Heart Transplant or Implant of Heart Assist System with MCC (MS–LTC–DRG 1); Heart Transplant or Implant of Heart Assist System without MCC (MS–LTC–DRG 2); Liver Transplant with MCC or Intestinal Transplant (MS–LTC–DRG 5); Liver Transplant without MCC (MS–LTC–DRG 6); Lung Transplant (MS–LTC–DRG 7); Simultaneous Pancreas/Kidney Transplant (MS–LTC–DRG 8); Pancreas Transplant (MS–LTC–DRG 10); and Kidney Transplant (MS–LTC–DRG 652). This is because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified. At the present time, we include these eight transplant MS–LTC–DRGs in the GROUPER program for administrative purposes only. Because we use the same GROUPER program for LTCHs as is used under the IPPS, removing these MS–LTC–DRGs would be administratively burdensome. (For additional information regarding our treatment of transplant MS–LTC–DRGs, we refer readers to the RY 2010 LTCH PPS final rule (74 FR 43964).) In addition, consistent with our historical policy and as we proposed, we are establishing a relative weight of 0.0000 for the 2 ''error'' MS–LTC–DRGs (that is, MS–LTC–DRG 998 (Principal Diagnosis Invalid as Discharge Diagnosis) and MS–LTC–DRG 999 (Ungroupable)) because applicable LTCH cases grouped to these MS–LTC–DRGs cannot be properly assigned to an MS–LTC–DRG according to the grouping logic.

In the proposed rule, for FY 2016, we proposed to establish a relative weight equal to the respective FY 2015 relative weight of the MS–LTC–DRGs for the following ''psychiatric or rehabilitation'' MS–LTC–DRGs: MS–LTC–DRG 876 (O.R. Procedure with Principal Diagnoses of Mental Illness); MS–LTC–DRG 880 (Acute Adjustment Reaction & Psychosocial Dysfunction); MS–LTC–DRG 881 (Depressive Neuroses); MS–LTC–DRG 882 (Neuroses Except Depressive); MS–LTC–DRG 883 (Disorders of Personality & Impulse Control); MS–LTC–DRG 884 (Organic Disturbances & Mental Retardation); MS–LTC–DRG 885 (Psychoses); MS–LTC–DRG 886 (Behavioral & Developmental Disorders); MS–LTC–DRG 887 (Other Mental Disorder Diagnoses); MS–LTC–DRG 894 (Alcohol/Drug Abuse or Dependence, Left Ama); MS–LTC–DRG 895 (Alcohol/Drug Abuse or Dependence, with Rehabilitation Therapy); MS–LTC–DRG 896 (Alcohol/Drug Abuse or Dependence, without Rehabilitation Therapy with MCC); MS–LTC–DRG 897 (Alcohol/Drug Abuse or Dependence, without Rehabilitation Therapy without MCC); MS–LTC–DRG 945 (Rehabilitation with CC/MCC); and MS–LTC–DRG 946 (Rehabilitation without CC/MCC). Under our proposed implementation of the new dual rate LTCH PPS payment structure, LTCH discharges that are grouped to these 15 ''psychiatric and rehabilitation'' MS–LTC–DRGs would not meet the criteria for exclusion from the site neutral payment rate. As such, under our proposed implementation of the criterion for a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation (which we are finalizing, as discussed in section VII.B.3.b. of the preamble of this final rule), there are no applicable LTCH cases to use in calculating a relative weight for the ''psychiatric and rehabilitation'' MS–LTC–DRGs. In other words, any LTCH PPS discharges grouped to any of the 15 ''psychiatric and rehabilitation'' MS–LTC–DRGs will always be paid at the site neutral payment rate, and, therefore, those MS–LTC–DRGs will never include any LTCH cases that meet the criteria for exclusion from the site neutral payment rate. However, section 1886(m)(6)(B) of the Act establishes a transitional payment method for cases that will be paid at the site neutral payment rate for LTCH discharges occurring in cost reporting periods beginning during FY 2016 or FY 2017. Under the transitional payment method

for cases for site neutral payment rate cases discussed in detail in section VII.B.4.b. of the preamble of this final rule, for LTCH discharges occurring in cost reporting periods beginning on or after October 1, 2015, and on or before September 30, 2017 (that is, discharges occurring in cost reporting periods beginning during FYs 2016 and 2017), site neutral payment rate cases will be paid a blended payment rate, calculated as 50 percent of the applicable site neutral payment rate amount for the discharge and 50 percent of the applicable LTCH PPS standard Federal payment rate. Because the LTCH PPS standard Federal payment rate is based on the relative weight of the MS–LTC–DRG, in order to determine the transitional blended payment for site neutral payment rate cases grouped to one of the ''psychiatric or rehabilitation'' MS–LTC–DRGs in FY 2016, in the proposed rule, we proposed to assign a relative weight to these MS–LTC–DRGs for FY 2016, that would be the same as the FY 2015 relative weight. We believe that using the respective FY 2015 relative weight for each of the ''psychiatric or rehabilitation'' MS–LTC–DRGs would result in appropriate payments for LTCH cases that will be paid at the site neutral payment rate under the transition policy provided by the statute because there are no clinically similar MS–LTC–DRGs for which we were able to determine relative weights based on applicable LTCH cases in the FY 2014 MedPAR file data using the steps described above. Furthermore, we believe that it would be administratively burdensome and introduce unnecessary complexity to the MS–LTC–DRG relative weight calculation to use the LTCH discharges in the MedPAR file data to calculate a relative weight for those 15 ''psychiatric and rehabilitation'' MS–LTC–DRGs to be used for the sole purpose of determining half of the transitional blended payment for site neutral payment rate cases during the transition period. (80 FR 24548 through 24549)

Comment: Some commenters requested that CMS provide more detail about how the GROUPER software will account for CCs and MCCs in grouping cases into one of the 15 ''psychiatric or rehabilitation'' MS–LTC–DRGs.

Response: When we proposed to adopt the severity-adjusted MS–DRGs (and by extension the MS–LTC–DRGs) as a replacement patient classification to the CMS DRG (and by extension the LTC–DRG) system, we present a detailed discussion on the development of the MCC, CC, and non-CC severity levels in the MS–DRGs and MS–LTC–DRGs (refer to the FY 2008 IPPS proposed rule (72 FR 24697 through 24706 and 24756 through 24757)). We also wish to point out that only two of the 15 ''psychiatric or rehabilitation'' MS–LTC–DRGs are grouped based on severity level. These are MS–LTC–DRG 945 (Rehabilitation with CC/MCC) and MS–LTC–DRG 946 (Rehabilitation without CC/MCC). The grouping of LTCH cases into these MS–LTC–DRGs will be in accordance with our established method for grouping discharges into MS–LTC–DRGs when those MS–LTC–DRGs are subdivided based on severity level; that is, cases with at least one code that is on the CC or MCC list are assigned to the ''with CC/MCC'' MS–LTC–DRG (MS–LTC–DRG 945) by the GROUPER software and LTCH cases without a CC or an MCC are assigned to the ''without CC/MCC'' MS–LTC–DRG (MS–LTC–DRG 946) by the GROUPER software. Because the other 13 ''psychiatric or rehabilitation'' MS–LTC–DRGs (that is, MS–LTC–DRGs 876, 880, 881, 882, 883, 884, 885, 886, 887, 894, 895, 896, and 897), by definition, are not subdivided based on severity level under our established method for grouping discharges into MS–LTC–DRGs, the presence of code that is on the CC or MCC list will not impact the MS–LTC–DRG grouping for such cases. For a full discussion of our method of grouping under the MS–DRGs (and by extension, the MS–LTC–DRGs) based on severity level, we refer readers to the discussion of the development of the severity-adjust MS–DRGs in the FY 2008 IPPS proposed rule (72 FR 24697–24706).

Comment: Commenters generally supported the proposal to adopt the FY 2015 relative weights for the ''psychiatric or rehabilitation'' MS–LTC–DRGs. However, some commenters pointed out a technical error in Table 11 of the proposed rule. The commenters noted that although CMS stated in the preamble that for the 15 MS–LTC–DRGs CMS identified as ''psychiatric or rehabilitation,'' CMS proposed to adopt the FY 2015 relative weights (and average length of stay thresholds) for FY 2016 to pay for cases grouped to those MS–LTC–DRGs from LTCHs whose FY 2016 cost reporting periods had not yet begun and under the transitional blended payment rate. However, they added, the proposed FY 2016 relative weights (and proposed average length of stay thresholds) listed in Table 11 of the proposed rule were not the FY 2015 relative weights for those MS–LTC–DRGs established in the FY 2015 IPPS/LTCH PPS final rule.

Response: We appreciate the commenters' support of our proposal to adopt the FY 2015 relative weights for the ''psychiatric or rehabilitation'' MS–LTC–DRGs for FY 2016. The commenters correctly pointed out that Table 11 of the proposed rule contained an inadvertent technical error in the proposed FY 2016 relative weights (and average length of stay thresholds in that table) for the ''psychiatric or rehabilitation'' MS–LTC–DRGs. We are correcting that technical error in Table 11 of this final rule, and after consideration of public comments we are adopting our proposal to assign the FY 2016 MS–LTC–DRG relative weights (and average length of stay thresholds) for the 15 ''psychiatric or rehabilitation'' MS–LTC–DRGs the FY 2015 relative weights for those respective MS–LTC–DRGs without further change.

In summary, in this final rule, for FY 2016, as we proposed, we are establishing a relative weight (and average length of stay thresholds) equal to the respective FY 2015 relative weight of the MS–LTC–DRGs for the 15 ''psychiatric or rehabilitation'' MS–LTC–DRGs listed above (that is, MS–LTC–DRGs 876, 880, 881, 882, 883, 884, 885, 886, 887, 894, 895, 896, 897, 945, and 946). Table 11, which is listed in section VI. of the Addendum to this final rule and is available via the Internet on the CMS Web site, reflects the correction of the technical error discussed above.

Step 6—Adjust the FY 2016 MS–LTC–DRG relative weights to account for nonmonotonically increasing relative weights.

As discussed earlier in this section, the MS–DRGs contain base DRGs that have been subdivided into one, two, or three severity of illness levels. Where there are three severity levels, the most severe level has at least one secondary diagnosis code that is referred to as an MCC (that is, major complication or comorbidity). The next lower severity level contains cases with at least one secondary diagnosis code that is a CC (that is, complication or comorbidity). Those cases without an MCC or a CC are referred to as ''without CC/MCC.'' When data do not support the creation of three severity levels, the base MS–DRG is subdivided into either two levels or the base MS–DRG is not subdivided. The two-level subdivisions could consist of the MS–DRG with CC/MCC and the MS–DRG without CC/MCC. Alternatively, the other type of two-level subdivision may consist of the MS–DRG with MCC and the MS–DRG without MCC.

In those base MS–LTC–DRGs that are split into either two or three severity levels, cases classified into the ''without CC/MCC'' MS–LTC–DRG are expected to have a lower resource use (and lower

costs) than the ''with CC/MCC'' MS–LTC–DRG (in the case of a two-level split) or both the ''with CC'' and the ''with MCC'' MS–LTC–DRGs (in the case of a three-level split). That is, theoretically, cases that are more severe typically require greater expenditure of medical care resources and will result in higher average charges. Therefore, in the three severity levels, relative weights should increase by severity, from lowest to highest. If the relative weights decrease as severity increases (that is, if within a base MS–LTC–DRG, an MS–LTC–DRG with CC has a higher relative weight than one with MCC, or the MS–LTC–DRG ''without CC/MCC'' has a higher relative weight than either of the others), they are nonmonotonic. We continue to believe that utilizing nonmonotonic relative weights to adjust Medicare payments would result in inappropriate payments because the payment for the cases in the higher severity level in a base MS–LTC–DRG (which are generally expected to have higher resource use and costs) would be lower than the payment for cases in a lower severity level within the same base MS–LTC–DRG (which are generally expected to have lower resource use and costs). Therefore, in determining the FY 2016 MS–LTC–DRG relative weights for LTCH PPS standard Federal payment rate payments in this final rule, consistent with our historical methodology, as proposed, we combined MS–LTC–DRG severity levels within a base MS–LTC–DRG for the purpose of computing a relative weight when necessary to ensure that monotonicity is maintained. For a comprehensive description of our existing methodology to adjust for nonmonotonicity, we refer readers to the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43964 through 43966). Any adjustments for nonmonotonicity that were made in determining the FY 2016 MS–LTC–DRG relative weights in this rule by applying this methodology are denoted in Table 11, which is listed in section VI. of the Addendum to this final rule and is available via the Internet on the CMS Web site.

Step 7— Calculate the FY 2016 MS–LTC–DRG reclassification and recalibration budget neutrality factor.

In accordance with the regulations at § 412.517(b) (in conjunction with § 412.503), the annual update to the MS–LTC–DRG classifications and relative weights is done in a budget neutral manner such that estimated aggregate LTCH PPS payments would be unaffected, that is, would be neither greater than nor less than the estimated aggregate LTCH PPS payments that would have been made without the MS–LTC–DRG classification and relative weight changes. (For a detailed discussion on the establishment of the budget neutrality requirement for the annual update of the MS–LTC–DRG classifications and relative weights, we refer readers to the RY 2008 LTCH PPS final rule (72 FR 26881 and 26882).)

The MS–LTC–DRG classifications and relative weights are updated annually based on the most recent available LTCH claims data to reflect changes in relative LTCH resource use (§ 412.517(a) in conjunction with § 412.503). Under the budget neutrality requirement at § 412.517(b), for each annual update, the MS–LTC–DRG relative weights are uniformly adjusted to ensure that estimated aggregate payments under the LTCH PPS would not be affected (that is, decreased or increased). Consistent with that provision, we are updating the FY 2016 MS–LTC–DRG classifications and relative weights for LTCH PPS standard Federal payment rate payments based on the most recent available LTCH data for applicable LTCH cases, and applying a budget neutrality adjustment in determining the FY 2016 MS–LTC–DRG relative weights.

To ensure budget neutrality in the update to the MS–LTC–DRG classifications and relative weights under § 412.517(b), as proposed, we are continuing to use our established two-step budget neutrality methodology. As discussed previously in this section, this approach is consistent with our general policies regarding the continued use of our existing methodologies, as presented in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50175 through 50176).

In this final rule, in the first step of our MS–LTC–DRG budget neutrality methodology, for FY 2016, we calculated and applied a normalization factor to the recalibrated relative weights (the result of Steps 1 through 6 above) to ensure that estimated payments were not affected by changes in the composition of case types or the changes to the classification system. That is, the normalization adjustment is intended to ensure that the recalibration of the MS–LTC–DRG relative weights (that is, the process itself) neither increases nor decreases the average case-mix index.

To calculate the normalization factor for FY 2016 (the first step of our budget neutrality methodology), we used the following three steps: (1.a.) We used the most recent available applicable LTCH cases from the most recent available data (that is, LTCH discharges from the FY 2014 MedPAR file) and grouped them using the FY 2016 GROUPER (that is, Version 33 for FY 2016) and the recalibrated FY 2016 MS–LTC–DRG relative weights (determined in Steps 1 through 6 above) to calculate the average case-mix index; (1.b.) we grouped the same applicable LTCH cases (as are used in Step 1.a.) using the FY 2015 GROUPER (Version 32) and FY 2015 MS–LTC–DRG relative weights and calculated the average case-mix index; and (1.c.) we computed the ratio of these average case-mix indexes by dividing the average CMI for FY 2015 (determined in Step 1.b.) by the average case-mix index for FY 2016 (determined in Step 1.a.). As a result, in determining the MS–LTC–DRG relative weights for FY 2016, each recalibrated MS–LTC–DRG relative weight was multiplied by 1.27929 (determined in Step 1.c.) in the first step of the budget neutrality methodology, which produces ''normalized relative weights.''

In the second step of our MS–LTC–DRG budget neutrality methodology, we calculated a second budget neutrality factor consisting of the ratio of estimated aggregate FY 2016 LTCH PPS standard Federal payment rate payments for applicable LTCH cases (the sum of all calculations under Step 1.a. above) after reclassification and recalibration to estimated aggregate payments for FY 2015 LTCH PPS standard Federal payment rate payments for applicable LTCH cases before reclassification and recalibration (that is, the sum of all calculations under Step 1.b. above).

That is, for this final rule, for FY 2016, under the second step of the budget neutrality methodology, we determined the budget neutrality adjustment factor using the following three steps: (2.a.) We simulated estimated total FY 2016 LTCH PPS standard Federal payment rate payments for applicable LTCH cases using the normalized relative weights for FY 2016 and GROUPER Version 33 (as described above); (2.b.) we simulated estimated total FY 2015 LTCH PPS standard Federal payment rate payments for applicable LTCH cases using the FY 2015 GROUPER (Version 32) and the FY 2015 MS–LTC–DRG relative weights in Table 11 of the FY 2015 IPPS/LTCH PPS final rule available on the Internet, as described in section VI. of the Addendum of that final rule (79 FR 5040 through 50402); and (2.c.) we calculated the ratio of these estimated total payments by dividing the value determined in Step 2.b. by the value determined in Step 2.a. In determining the FY 2016 MS–LTC–DRG relative weights, each normalized relative weight was then multiplied by a budget neutrality factor of 1.0033952

(the value determined in Step 2.c.) in the second step of the budget neutrality methodology to determine the budget neutral FY 2016 relative weight for each MS–LTC–DRG.

Accordingly, in determining the FY 2016 MS–LTC–DRG relative weights in this final rule, consistent with our existing methodology, we applied a normalization factor of 1.27929 and a budget neutrality factor of 1.0033952 (computed as described above). Table 11, which is listed in section VI. of the Addendum to this rule and is available via the Internet on the CMS Web site, lists the MS–LTC–DRGs and their respective relative weights, geometric mean length of stay, five-sixths of the geometric mean length of stay (used to identify SSO cases under § 412.529(a)), and the ''IPPS Comparable Thresholds'' (used in determining SSO payments under § 412.529(c)(3)), for FY 2016 (and reflect both the normalization factor of 1.27929 and the budget neutrality factor of 1.0033952).

We did not receive any public comments on our proposed methodology for calculating the FY 2016 MS–LTC–DRG reclassification and recalibration budget neutrality factor, and we are adopting it as final without modification. We note that the public comments we received, our responses to those comments, and our finalized policy of applying a budget neutrality requirement as part of the annual recalibration of the MS–LTC–DRG relative weights for FY 2016 are presented in section VII.B.7.a. of this preamble of this final rule.

D. Changes to the LTCH PPS Standard Federal Payment Rates for FY 2016

1. Overview of Development of the LTCH PPS Standard Federal Payment Rates

The basic methodology for determining LTCH PPS standard Federal prospective payment rates is set forth at § 412.515 through § 412.536. In this section, we discuss the factors that we used to update the LTCH PPS standard Federal payment rate for FY 2016, that is, effective for LTCH discharges occurring on or after October 1, 2015 through September 30, 2016. As previously discussed, under the dual rate LTCH PPS payment structure required by statute, we are establishing that, beginning with FY 2016, only LTCH discharges that meet the criteria for exclusion from the site neutral payment rate will be paid based on the LTCH PPS standard Federal payment rate specified at § 412.523. (For additional details on our finalized policies related to the dual rate LTCH PPS payment structure required by statute, we refer readers to section VII.C. of the preamble of this final rule.)

For details on the development of the initial FY 2003 standard Federal rate, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56037). For subsequent updates to the LTCH PPS standard Federal rate as implemented under § 412.523(c)(3), we refer readers to the following final rules: RY 2004 LTCH PPS final rule (68 FR 34134 through 34140); RY 2005 LTCH PPS final rule (68 FR 25682 through 25684); RY 2006 LTCH PPS final rule (70 FR 24179 through 24180); RY 2007 LTCH PPS final rule (71 FR 27819 through 27827); RY 2008 LTCH PPS final rule (72 FR 26870 through 27029); RY 2009 LTCH PPS final rule (73 FR 26800 through 26804); FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44021 through 44030); FY 2011 IPPS/LTCH PPS final rule (75 FR 50443 through 50444); FY 2012 IPPS/LTCH PPS final rule (76 FR 51769 through 51773); FY 2013 IPPS/LTCH PPS final rule (77 FR 53479 through 53481); FY 2014 IPPS/LTCH PPS final rule (78 FR 50760 through 50765); and FY 2015 IPPS/LTCH PPS final rule (79 FR 50176 through 50180).

In this FY 2016 final rule, we present our finalized policies related to the annual update to the LTCH PPS standard Federal payment rate for FY 2016, which includes the annual market basket update. Consistent with our historical practice of using the best data available, as proposed, we also used more recent data to determine the FY 2016 annual market basket update to the LTCH PPS standard Federal payment rate in this final rule.

The application of the update to the LTCH PPS standard Federal payment rate for FY 2016 is presented in section V.A. of the Addendum to this final rule. The components of the annual market basket update to the LTCH PPS standard Federal payment rate for FY 2016 are discussed below, including the reduction to the annual update for LTCHs that fail to submit quality reporting data for fiscal year FY 2016 as required by the statute (as discussed in section VII.D.2.c. of the preamble of this final rule). In addition, as discussed in section V.A. of the Addendum of this final rule, we made an adjustment to the LTCH PPS standard Federal payment rate to account for the estimated effect of the changes to the area wage level adjustment for FY 2016 on estimated aggregate LTCH PPS payments, in accordance with § 412.523(d)(4).

2. FY 2016 LTCH PPS Annual Market Basket Update

a. Overview

Historically, the Medicare program has used a market basket to account for price increases in the services furnished by providers. The market basket used for the LTCH PPS includes both operating and capital-related costs of LTCHs because the LTCH PPS uses a single payment rate for both operating and capital-related costs. As discussed in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53468 through 53476), we adopted the newly created FY 2009-based LTCH-specific market basket for use under the LTCH PPS beginning in FY 2013. For additional details on the historical development of the market basket used under the LTCH PPS, we refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53467 through 53468).

Section 3401(c) of the Affordable Care Act provides for certain adjustments to any annual update to the LTCH PPS standard Federal payment rate and refers to the timeframes associated with such adjustments as a ''rate year'' (which are discussed in more detail in section VII.C.2.b. of the preamble of this final rule.) We note that because the annual update to the LTCH PPS policies, rates, and factors now occurs on October 1, we adopted the term ''fiscal year'' (FY) rather than ''rate year'' (RY) under the LTCH PPS beginning October 1, 2010, to conform with the standard definition of the Federal fiscal year (October 1 through September 30) used by other PPSs, such as the IPPS (75 FR 50396 through 50397). Although the language of sections 3004(a) 3401(c), 10319, and 1105(b) of the Affordable Care Act refers to years 2010 and thereafter under the LTCH PPS as ''rate year,'' consistent with our change in the terminology used under the LTCH PPS from ''rate year'' to ''fiscal year,'' for purposes of clarity, when discussing the annual update for the LTCH PPS standard Federal payment rate, including the provisions of the Affordable Care Act, we use ''fiscal year'' rather than ''rate year'' for 2011 and subsequent years.

b. Revision of Certain Market Basket Updates as Required by the Affordable Care Act

Section 1886(m)(3)(A) of the Act, as added by section 3401(c) of the Affordable Care Act, specifies that, for rate year 2010 and each subsequent rate year through 2019, any annual update to the LTCH PPS standard Federal payment rate shall be reduced:

• For rate year 2010 through 2019, by the ''other adjustment'' specified in sections 1886(m)(3)(A)(ii) and (m)(4) of the Act; and

• For rate year 2012 and each subsequent year, by the productivity adjustment (which we refer to as ''the multifactor productivity (MFP) adjustment'') described in section 1886(b)(3)(B)(xi)(II) of the Act.

Section 1886(m)(3)(B) of the Act provides that the application of paragraph (3) of section 1886(m) of the Act may result in the annual update being less than zero for a rate year, and may result in payment rates for a rate year being less than such payment rates for the preceding rate year.

Section 1886(b)(3)(B)(xi)(II) of the Act defines the MFP adjustment as equal to the 10-year moving average of changes in annual economy-wide, private nonfarm business multifactor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, calendar year, cost reporting period, or other annual period). Under our methodology, the end of the 10-year moving average of changes in the MFP coincides with the end of the appropriate FY update period. In addition, the MFP adjustment that is applied in determining any annual update to the LTCH PPS standard Federal payment rate is the same adjustment that is required to be applied in determining the applicable percentage increase under the IPPS under section 1886(b)(3)(B)(i) of the Act as they are both based on a fiscal year. We refer readers to section IV.A.1. of the preamble of this final rule for more information on the FY 2016 MFP adjustment.

c. Adjustment to the Annual Update to the LTCH PPS Standard Federal Payment Rate Under the Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

In accordance with section 1886(m)(5) of the Act, as added by section 3004(a) of the Affordable Care Act, the Secretary established the Long-Term Care Hospital Quality Reporting Program (LTCH QRP). The reduction in the annual update to the LTCH PPS standard Federal payment rate for failure to report quality data under the LTCH QRP for FY 2014 and subsequent fiscal years is codified under § 412.523(c)(4) of the regulations. (As previously noted, although the language of section 3004(a) of the Affordable Care Act refers to years 2011 and thereafter under the LTCH PPS as ''rate year,'' consistent with our change in the terminology used under the LTCH PPS from ''rate year'' to ''fiscal year,'' for purposes of clarity, when discussing the annual update for the LTCH PPS, including the provisions of the Affordable Care Act, we use ''fiscal year'' rather than ''rate year'' for 2011 and subsequent years.) The LTCH QRP, as required for FY 2014 and beyond by section 1886(m)(5)(A)(i) of the Act, applies a 2.0 percentage point reduction to any update under § 412.523(c)(3) for an LTCH that does not submit quality reporting data to the Secretary in accordance with section 1886(m)(5)(C) of the Act with respect to such a year (that is, in the form and manner and at the time specified by the Secretary under the LTCH QRP) (§ 412.523(c)(4)(i)). Section 1886(m)(5)(A)(ii) of the Act provides that the application of the 2.0 percentage points reduction may result in an annual update that is less than 0.0 for a year, and may result in LTCH PPS payment rates for a year being less than such LTCH PPS payment rates for the preceding year (§ 412.523(c)(4)(iii)). Furthermore, section 1886(m)(5)(B) of the Act specifies that the 2.0 percentage points reduction is applied in a noncumulative manner, such that any reduction made under section 1886(m)(5)(A) of the Act shall apply only with respect to the year involved, and shall not be taken into account in computing the LTCH PPS payment amount for a subsequent year (§ 412.523(c)(4)(ii)). We discuss the application of the 2.0 percentage point reduction under § 412.523(c)(4)(i) in our discussion of the annual market basket update to the LTCH PPS standard Federal payment rate for FY 2016 in section VII.D.2.e. of the preamble of this final rule. (For additional information on the history of the LTCH QRP, including the statutory authority and the selected measures, we refer readers to section VII.C. of the preamble of this final rule.)

d. Market Basket Under the LTCH PPS for FY 2016

Under the authority of section 123 of the BBRA as amended by section 307(b) of the BIPA, we adopted a newly created FY 2009-based LTCH-specific market basket for use under the LTCH PPS beginning in FY 2013. The FY 2009-based LTCH-specific market basket is based solely on the Medicare cost report data submitted by LTCHs and, therefore, specifically reflects the cost structures of only LTCHs. For additional details on the development of the FY 2009-based LTCH-specific market basket, we refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53467 through 53476).

For FY 2016, as proposed, we are continuing to use the FY 2009-based LTCH-specific market basket to update the LTCH PPS for FY 2016. We continue to believe that the FY 2009-based LTCH-specific market basket appropriately reflects the cost structure of LTCHs for the reasons discussed when we adopted the FY 2009-based LTCH-specific market basket for use under the LTCH PPS in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53467 through 53476).

Comment: One commenter stated our proposal to use the FY 2009-based market basket update for FY 2016 is contradictory to our statements about the statutory change in the LTCH PPS payment structure, and the proposed rule contains language that states the FY 2009 LTCH-specific market basket is being used as the basis for FY 2016 update. The commenter referred our statement in the proposed rule that ''[w]e continue to believe that the FY 2009-based LTCH-specific market basket appropriately reflects the cost structure of LTCHs for the reasons discussed when we adopted the FY 2009-based LTCH-specific market basket for use under the LTCH PPS. . . '' (80 FR 24552). The commenter believed the market basket should reflect the most currently available data to update the LTCH PPS standard Federal payment rate that will be used to pay LTCH cases that meet the criteria for exclusion from the site neutral payment rate.

Response: The proposed LTCH market basket update reflects the most recent forecast of the 2009-based LTCH-specific market basket for FY 2016. Specifically, the update reflects the projected growth in the relative input prices LTCHs are expected to encounter for the period of October 1, 2015 through September 30, 2016. The Medicare Cost Report used to determine the base year weights for the FY 2009-based LTCH-specific market basket was the most up-to date data available at the time of the rebasing in FY 2013. We have performed sensitivity analysis for various market baskets and found that the cost share weights do not change substantially from year to year. For this reason, it has been our historical practice to rebase the market baskets about every 4 years. As such, we disagree with the commenter's assertion that the FY 2009-based LTCH-specific market basket does not reflect the most currently available data to update the annual payment rates. Rather the FY 2009-based LTCH-specific market basket reflects IGI's latest forecast on price inflation at this time, and for these reasons we believe that it is appropriate to continue to use the FY 2009-based LTCH-specific market basket to update the LTCH PPS standard Federal payment rate for FY 2016.

After consideration of the public comments we received, we are finalizing our proposal to continue to use the FY 2009-based LTCH-specific market basket to update the LTCH PPS standard Federal payment rate for FY 2016.

e. Annual Market Basket Update for LTCHs for FY 2016

Consistent with our historical practice and our proposal, we estimate the market basket update and the MFP adjustment based on IGI's forecast using the most recent available data. Based on IGI's second quarter 2015 forecast, the FY 2016 full market basket estimate for the LTCH PPS using the FY 2009-based LTCH-specific market basket is 2.4 percent. The current estimate of the MFP adjustment for FY 2016 based on IGI's second quarter 2015 forecast is 0.5 percent, as discussed in section IV.A. of the preamble of this final rule. In addition, consistent with our historical practice, we are using a more recent estimate of the market basket and the MFP adjustment) to determine the FY 2016 market basket update and the MFP adjustment in this final rule.

For FY 2016, section 1886(m)(3)(A)(i) of the Act requires that any annual update to the LTCH PPS standard Federal payment rate be reduced by the productivity adjustment (''the MFP adjustment'') described in section 1886(b)(3)(B)(xi)(II) of the Act. Consistent with the statute, we are reducing the full FY 2016 market basket update by the FY 2016 MFP adjustment. To determine the market basket update for LTCHs for FY 2016, as reduced by the MFP adjustment, consistent with our established methodology, we subtracted the FY 2016 MFP adjustment from the FY 2016 market basket update. Furthermore, sections 1886(m)(3)(A)(ii) and 1886(m)(4)(E) of the Act requires that any annual update to the LTCH PPS standard Federal payment rate for FY 2016 be reduced by the ''other adjustment'' described in paragraph (4), which is 0.2 percentage point for FY 2016. Therefore, following application of the productivity adjustment, as proposed, we are further reducing the adjusted market basket update (that is, the full market basket increase less the MFP adjustment) by the ''other adjustment'' specified by sections 1886(m)(3)(A)(ii) and 1886(m)(4) of the Act. (For additional details on our established methodology for adjusting the market basket increase by the MFP and the ''other adjustment'' required by the statute, we refer readers to the FY 2012 IPPS/LTCH PPS final rule (76 FR 51771).)

For FY 2016, section 1886(m)(5) of the Act requires that for LTCHs that do not submit quality reporting data as required under the LTCHQR Program, any annual update to an LTCH PPS standard Federal payment rate, after application of the adjustments required by section 1886(m)(3) of the Act, shall be further reduced by 2.0 percentage points. Therefore, the update to the LTCH PPS standard Federal payment rate for FY 2016 for LTCHs that fail to submit quality reporting data under the LTCH QRP, the full LTCH PPS market basket increase estimate, subject to an adjustment based on changes in economy-wide productivity (''the MFP adjustment'') as required under section 1886(m)(3)(A)(i) of the Act and an additional reduction required by sections 1886(m)(3)(A)(ii) and 1886(m)(4) of the Act, will also be further reduced by 2.0 percentage points.

In this final rule, in accordance with the statute, consistent with our proposal, we are reducing the FY 2016 full market basket estimate of 2.4 percent (based on IGI's second quarter 2015 forecast of the FY 2009-based LTCH-specific market basket) by the FY 2016 MFP adjustment of 0.5 percentage point (based on IGI's second quarter 2015 forecast). Following application of the productivity adjustment, the adjusted market basket update of 1.9 percent (2.4 percent minus 0.5 percentage point) was then reduced by 0.2 percentage point, as required by sections 1886(m)(3)(A)(ii) and 1886(m)(4)(E) of the Act. Therefore, in this final rule, under the authority of section 123 of the BBRA as amended by section 307(b) of the BIPA, we are establishing an annual market basket update under to the LTCH PPS standard Federal payment rate for FY 2016 of 1.7 percent (that is, the most recent estimate of the LTCH PPS market basket update of 2.4 percent, less the MFP adjustment of 0.5 percentage point, and less the 0.2 percentage point required under section 1886(m)(4)(E) of the Act). Accordingly, consistent with our finalized policy, we are revising § 412.523(c)(3) by adding a new paragraph (xii), which specifies that the LTCH PPS standard Federal payment rate for FY 2016 is the LTCH PPS standard Federal payment rate for the previous LTCH PPS year updated by 1.7 percent, and as further adjusted, as appropriate, as described in § 412.523(d). For LTCHs that fail to submit quality reporting data under the LTCH QRP, under § 412.523(c)(3)(xi) in conjunction with § 412.523(c)(4), we are further reducing the annual update to the LTCH PPS standard Federal payment rate by 2.0 percentage points in accordance with section 1886(m)(5) of the Act. Accordingly, consistent with our finalized policy, we are establishing an annual update to the LTCH PPS standard Federal payment rate of −0.3 percent (that is, 1.7 percent minus 2.0 percentage points) for FY 2016 for LTCHs that fail to submit quality reporting data as required under the LTCH QRP. As stated above, consistent with our historical practice, as proposed, we are using a more recent estimate of the market basket and the MFP adjustment to establish an annual update to the LTCH PPS standard Federal payment rate for FY 2016 under § 412.523(c)(3)(xii) in this final rule. (We note that we also are adjusting the FY 2016 LTCH PPS standard Federal payment rate by an area wage level budget neutrality factor in accordance with § 412.523(d)(4) (as discussed in section V.B.5. of the Addendum of this final rule).)

Comment: Based on its assessment of the adequacy of Medicare payments to LTCHs, which was presented in its March 2015 Report to the Congress, MedPAC concluded that no update to the LTCH PPS standard Federal payment rate for FY 2016 is warranted. MedPAC further stated that Medicare's current level of payments appears more than adequate to accommodate cost growth, even before any update, citing that Medicare margin for LTCHs for the past several years have exceeded five percent. For these reasons, MedPAC reiterated its recommendation that the Secretary eliminate the market basket update to the LTCH PPS standard Federal payment rate for FY 2016.

Response: We appreciate MedPAC's concerns about the necessity of a market basked update to the LTCH PPS standard Federal payment rate for FY 2016. However, as noted earlier, there is uncertainty surrounding of the LTCH patient universe under the new dual rate LTCH PPS payment structure, in particular the uncertainty as to what the costs of those cases will be during the transition to that revised system. Given this uncertainty, we do not believe that it is appropriate or prudent to eliminate the market basket update to the LTCH PPS standard Federal payment rate for FY 2016 at this time. For the reasons discussed above, we believe it is appropriate that the market basket update less the multi-factor productivity adjustment (and the ''other'' statutory adjustment) be applied in determining the LTCH PPS standard Federal payment rate for FY 2016 in order to keep pace with expected input price inflation. However, we will keep this recommendation in mind in developing

policies once we gain experience under the new system.

Comment: Some commenters requested that CMS clarify that the annual update established for IPPS excluded hospitals (that is, hospitals paid under the reasonable cost-based TEFRA payment system) for FY 2016, discussed in section VI of the Addendum to the proposed rule, is applicable to the target amount used to determine the LTCH PPS payment adjustment for ''subclause (II) LTCHs'' under existing § 412.526, and make any modifications to the regulations if needed.

Response: When we established the LTCH PPS payment adjustment for ''subclause (II) LTCHs'' at § 412.526, we established that for cost reporting periods beginning during FYs after FY 2015, the target amount (used to determine the adjusted payment for Medicare inpatient operating costs under reasonable cost-based reimbursement rules) will equal the hospital's target amount for the previous cost reporting period updated by the applicable annual rate-of-increase percentage specified in § 413.40(c)(3) for the subject cost reporting period (79 FR 50197). This provision is codified at § 412.526(c)(1)(ii) of the regulations, and, therefore, no modifications are needed to the existing regulations. However, in response to the commenters' request for clarification, we are taking the opportunity to specify that, for cost reporting periods beginning during FY 2016, the target amount for the payment adjustment for ''subclause (II) LTCHs'' is updated, consistent with the existing requirements of § 412.526(c)(1)(ii). As discussed in section IV. of the preamble of the proposed rule and the Addendum, the FY 2016 rate-of-increase percentage for updating the target amounts is equal to the estimated percentage increase in the FY 2016 IPPS operating market basket, in accordance with applicable regulations at § 413.40. Based on IHS Global Insight, Inc.'s 2015 second quarter forecast, with historical data through the 2015 first quarter, we estimate that the FY 2010-based IPPS operating market basket update for FY 2016 is 2.4 percent (that is, the estimate of the market basket rate of-increase). Therefore, the rate-of-increase percentage that will be applied to the FY 2015 target amounts in order to determine the FY 2016 target amounts for ''subclause (II) LTCHs'' under § 412.526(c)(1)(i) is 2.4 percent.

Comment: One commenter requested we rebase the LTCH PPS standard Federal payment rate (that is, recalculate the LTCH PPS standard Federal payment rate based on more recent cost report data). The commenter argued that LTCH cases that will receive an LTCH PPS standard Federal payment rate payment will be more resource intensive and thus warrant a higher base payment.

Response: While we consider this comment outside the scope of this proposed rule as we did not make any proposals to make such a recalculation of the LTCH PPS standard Federal rate beyond the annual market basked update (including any statutory adjustments), we do not believe that it is necessary or appropriate to rebase at this time. As we state several times throughout this preamble section, there is a good deal of uncertainty about the behavioral response of LTCHs to the new dual rate LTCH PPS payment structure as well as the nature of the future patient population in LTCHs. Furthermore, as we discuss in section VII.B.7.a. of this preamble, beginning with FY 2016, the annual update of the MS–LTC–DRG relative weights will be determined using only data from LTCH discharges that meet the criteria for exclusion from the site neutral payment rate (that is, LTCH PPS standard Federal payment rate cases), which will appropriately reflect the relative costliness and resource use of LTCH PPS standard Federal payment rate cases. For these reasons, we do not believe that rebasing is warranted at this time.

After consideration of the public comments we received, we are finalizing our of proposal to update the LTCH PPS standard Federal payment rate using the market basket update and the MFP adjustment based on IGI's forecast using the most recent available data (and the 'other' adjustments required by the statute). Accordingly, as stated above, consistent with our finalized policy, we are specifying at § 412.523(c)(3)(xii) that the LTCH PPS standard Federal payment rate for FY 2016 is the LTCH PPS standard Federal payment rate for the previous LTCH PPS year updated by 1.7 percent, and as further adjusted, as appropriate, as described in § 412.523(d).

E. Moratoria on the Establishment of LTCHs and LTCH Satellite Facilities and on the Increase in the Number of Beds in Existing LTCHs and LTCH Satellite Facilities

Section 1206(b)(2) of Public Law 113–67, as amended by section 112(b) of the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113–93), established ''new'' statutory moratoria on the establishment of new LTCHs and LTCH satellite facilities and on the increase in the number of hospital beds in existing LTCHs and LTCH satellite facilities. For a discussion on our implementation of these moratoria, we refer readers to the FY 2015 IPPS/LTCH PPS final rule (79 FR 50189 through 50193). Since the implementation of these LTCH PPS policy moratoria, we have been informed that some confusion may exist regarding the exceptions to the moratorium on the establishment of new LTCH and LTCH satellite facilities, as well as the application of the moratorium on an increase in the number of beds in existing LTCH and LTCH satellite facilities.

Under existing regulations at 42 CFR 412.23(e)(6), we specify that, to qualify for an exception under the moratorium to establish a new LTCH or LTCH satellite facility during the timeframe between April 1, 2014, and September 30, 2017, a hospital or entity must meet the following criteria:

- The hospital or entity must have begun its qualifying period for payment as an LTCH in accordance with § 412.23(e).
- The hospital or entity must have a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for an LTCH, and must have expended before April 1, 2014, at least 10 percent of the estimated cost of the project or, if less, $2,500,000.
- The hospital or entity must have obtained an approved certificate of need in a State where one is required.

As we stated in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24553), we believe that the existing regulation text regarding the moratorium on the establishment and classification of new LTCHs and LTCH satellite facilities could be misread as requiring fulfillment of all three conditions in order to qualify for an exception to the moratorium on the establishment of new LTCH and LTCH satellite facilities. This was not our intent, and we acknowledge that implementing the moratorium in that manner would have been directly contradictory to the statutory requirement. Technically, while we did not explicitly specify in the regulations text under § 412.23(e)(6) that only one of the listed criteria had to be met in order to qualify for an exception to the moratorium on the establishment of new LTCHs and LTCH satellite facilities (the language text states ''as applicable''), we clearly stated it in the preamble of the FY 2015 IPPS/LTCH PPS final rule. (We refer readers to the FY 2015 IPPS/LTCH PPS final rule (79 FR 50189 through 50193).) In addition, the requirement that one of the three exceptions had to be met in order to qualify for an

exception to the moratorium was also indicated in our proposal to implement the initial application of the moratorium during the FY 2009 rulemaking cycle. (We refer readers to the FY 2009 IPPS/LTCH PPS final rule (73 FR 29705).)

As we stated in the preamble of the FY 2015 IPPS/LTCH PPS final rule, the provisions in the new moratorium are nearly identical to the language in the prior ''expired'' moratorium under section 114(d) of MMSEA (Pub. L. 110–173). As also noted, the mechanics of exceptions to the new and expired moratoria on the establishment of new LTCHs and LTCH satellite facilities are analogous. Therefore, except as noted, to the extent that the new and expired moratoria were consistent, we proposed and adopted the identical implementation mechanisms. To minimize the confusion that may exist as a result of the existing regulations text, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24553), we proposed to revise the regulations under § 412.23(e)(6)(ii) to more clearly convey the established policy that only one of the statutory conditions needs to be met in order to qualify for the exception to the new moratorium on the establishment of new LTCH and LTCH satellite facilities.

We also have become aware of some confusion concerning what constitutes the ''estimated cost of the project'' with regard to the second exception. To alleviate confusion, we are further clarifying our longstanding policy on what constitutes the ''estimated cost of the project.'' In discussing this exception in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50189 through 50193), we noted that the ''cost of the project'' included the activities (plural) that were enumerated in the first prong of the exception. Those enumerated activities included ''the actual construction, renovation, lease, or demolition for a long-term care hospital.'' That is, our policy is that the sum total of any costs associated with any of the enumerated activities that comprised the project as a whole (with the project being the establishment of a new LTCH or a new LTCH satellite facility) would be considered in determining whether the facility met the amount specified in the statute. In using an ''or'' in this list of activities, we intended to acknowledge that any one project may or may not include every element listed (for example, new construction may not include any demolition), but if it does include an element, our policy is that the cost of that element and the costs of any other of the listed elements in the project are to be summed to determine the total cost of the project. Therefore, under our longstanding policy, when determining whether 10 percent of the estimated cost of the project had been expended prior to the start of the moratorium, the ''project'' is the establishment of a new LTCH or LTCH satellite facility, not any one element that, when combined with other elements listed in the first prong, would lead to the establishment of the LTCH or LTCH satellite facility. For example, if an entity has expended 10 percent of the costs of demolition, but that amount is less than both 10 percent of the estimated cost of the project, and less than the $2,500,000.00 ceiling amount, the entity would not qualify for this exception to the moratorium.

In the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24554), we also noted that we were taking that opportunity to provide additional clarification on our policy concerning the moratorium on increases in the number of beds in existing LTCH and LTCH satellite facilities. As we noted in the FY 2015 IPPS/LTCH PPS final rule, while the expired moratorium specifically included an exception to the moratorium on the increase in the number of beds in existing LTCHs and LTCH satellite facilities, the new moratorium under section 1206(b)(2)(B) of Public Law 113–67 expressly noted that the exceptions to the expired moratoria would not apply under the ''new'' moratoria. Further amendments made by section 112(b) of Public Law 113–93, created certain exceptions, but did not retract the prior statement regarding the express omission of any exceptions (79 FR 50189 through 50193). As the further amendments only provided exception to the moratorium on establishing new satellites, the express omission of any exceptions to the new moratorium on increasing the number of beds in an existing LTCH or LTCH satellite facility remained in place. As such, an LTCH may not increase the total number of Medicare certified beds beyond the number that existed prior to April 1, 2014, including when an existing LTCH meets one of the exceptions to the moratorium on the establishment of a new LTCH satellite facility. An LTCH satellite facility's beds historically have been, and continue to be, counted as the LTCH's beds. Therefore, under our existing regulation at § 412.23(e)(7)(iii), an existing LTCH cannot, through meeting the criteria for an exception to the new moratorium on the establishment of a new LTCH satellite facility, increase its total number of Medicare certified beds by establishing any number beds at the new LTCH satellite facility that would result in the total number of Medicare certified beds in that LTCH exceeding what existed prior to April 1, 2014. That is, if an existing LTCH meets one of the statutory exceptions for new satellite facilities and opens a new LTCH satellite facility during the moratorium, that new LTCH satellite facility's beds must come from the movement of beds in existence prior to April 1, 2014, from other locations of the existing LTCH to the new LTCH satellite facility. This requirement also applies to any remote locations that may be established by an existing LTCH during the moratorium on new beds.

Comment: Several commenters expressed concern with CMS' articulation of the existing policy. The commenters believed that CMS was proposing to change policy, rather than clarifying existing policy. The commenters urged CMS to adopt a final policy expressly inverse to its clarification.

Response: We disagree with any assertion that the clarification in the proposed rule represents a change in policy. When we implemented the current moratorium in the FY 2015 IPPS/LTCH PPS final rule, we stated that an existing LTCH may not increase the number of its hospital beds. This policy was not subject to any exceptions (79 FR 50190). We discussed in that final rule, in response to several comments received that urged us to create a regulatory exception to the bed moratorium, that we did not believe an exception was warranted and, therefore, did not establish one. We believe that our clear statement in the FY 2015 final rule, our decision not to provide for exceptions to the bed moratorium, and our longstanding policy to count a satellite facility's beds as an LTCH's beds were clear articulations of our policy. Nonetheless, as we were later informed that there was confusion regarding the moratorium, in the FY 2016 IPPS/LTCH PPS proposed rule, we reiterated our existing policy to alleviate that confusion.

In summary, without exception, an LTCH may not increase the total number of Medicare certified beds beyond the number that existed prior to April 1, 2014. The number of Medicare certified beds in an LTCH includes beds in all locations, including, as applicable, satellite facilities.

F. Changes to Average Length of Stay Criterion Under Public Law 113–67 (§ 412.23)

In the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24554), we proposed to revise § 412.23 to bring it into conformance with the self-

implementing statutory changes under section 1206(a)(3) of Public Law 113–67 regarding how the average length of stay for an LTCH is to be calculated. As required by section 1861(ccc) of the Act, in order for a hospital to be classified as an LTCH, it must maintain an average length of stay of greater than 25 days as calculated by the Secretary (or meet the requirements of clause (II) of section 1886(d)(1)(B)(iv) of the Act). Prior to the statutory change in Public Law 113–67, the Medicare average length of stay was calculated, in accordance with § 412.23(e)(3) of the regulations, by dividing the total number of covered and noncovered Medicare inpatient days by the total number of Medicare discharges. This calculation included Medicare inpatient days and discharges that were paid under a Medicare Advantage (MA) plan. (For a full discussion of the inclusion of MA days in the average length of stay calculation, we refer readers to the FY 2012 IPPS/LTCH PPS final rule (76 FR 51774).)

Section 1206(a)(3)(A) of Public Law 113–67 specified that, in general, for discharges occurring in cost reporting periods beginning on or after October 1, 2015, applicable total Medicare inpatient days and discharges that are paid at the site neutral payment rate (discussed in section VII.B. of the preamble of the proposed rule and this final rule with comment period), or for which payments are made under an MA plan, are to be excluded from the calculation of an LTCH's average length of stay. Section 1206(a)(3)(B) of Public Law 113–67 further required that this exclusion of site neutral and MA days would not apply to an LTCH that was classified as a ''subsection (d) hospital'' as of December 10, 2013. Therefore, in the FY 2016 IPPS/LTCH PPS proposed rule, we proposed to amend § 423.23 to conform with this self-implementing statutory exclusion and the self-implementing statutory exception to the exclusion, by revising paragraphs (e)(3)(ii) through (e)(3)(v), adding a new paragraph (e)(3)(vi), and revising the introductory text of paragraph (e)(6)(ii).

We did not receive any public comments on our proposals. However, upon further consideration, we realized that section 112(c)(2) of Public Law 113–93 altered the ''subsection (d) hospital'' language established by section 1206(a)(3)(B) of Public Law 113–67 to ''long-term care hospital.'' That is, section 112(c)(2) of Public Law 113–93 removed the phrase ''subsection (d) hospital'' in the provision regarding entities ''classified as a subsection (d) hospital as of December 10, 2013'' and in its place inserted ''long-term care hospital'', resulting in the combined statutory mandates providing ''classified as a long-term care hospital as of December 10, 2013''. While we initially mistakenly thought of this legislative language change as a technical change, we now recognize its substantive effect. As the change is statutorily mandated and self-implementing, we are making conforming changes to what we proposed in paragraph (e)(3)(vi) of § 412.23 (which specified that the provisions do not apply to a hospital classified as a ''subsection (d) hospital'' as of December 10, 2013). As the statute does not set forth any discretion on this provision, and as commenters did not object to the other content of our proposed text for § 412.23, using the authority noted below, we are waiving notice-and-comment rulemaking for this change (replacing ''subsection (d) hospital'' with ''long-term care hospital'') in our proposed rule's text, finalizing that change, and otherwise finalizing the remaining proposed regulation text changes in § 412.23 without modification.

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect. We can waive this procedure, however, if we find good cause that notice-and-comment procedures are impracticable, unnecessary, or contrary to the public interest and we incorporate a statement of finding and its reasons in the rule (5 U.S.C. 553(b)(B)). To that end, we find that it is unnecessary to undertake notice-and-comment rulemaking for the changes to the average length of stay calculation at 42 CFR 412.23(e)(3)(vi) (governing the exclusion of site neutral stays and MA days from the calculation) because those changes are statutorily required modifications to how the average length of stay is to be calculated. We find that notice-and-comment rulemaking is unnecessary to implement these statutory changes to the average length of stay calculation because they are self-implementing provisions of law, not requiring the exercise of any discretion on the part of the Secretary. As such, the changes in this final rule to the average length of stay calculation in § 412.23(e)(3)(vi) need not be published in a proposed rule prior to publication in this final rule, as such publication is unnecessary in the absence of any discretion regarding this aspect of the average length of stay calculation. Therefore, we find good cause to waive notice-and-comment procedures concerning the average length of stay calculation at § 412.23 (e)(3)(vi).

VIII. Quality Data Reporting Requirements for Specific Providers and Suppliers

We seek to promote higher quality and more efficient healthcare for Medicare beneficiaries. This effort is supported by the adoption of widely agreed-upon quality measures. We have worked with relevant stakeholders to define quality measures for most settings and to measure various aspects of care for most Medicare beneficiaries. These measures assess structural aspects of care, clinical processes, patient experiences with care, care coordination, and improving patient outcomes.

We have implemented quality reporting programs for multiple care settings, including:

- Hospital inpatient services under the Hospital Inpatient Quality Reporting (IQR) Program (formerly referred to as the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program);
- Hospital outpatient services under the Hospital Outpatient Quality Reporting (OQR) Program (formerly referred to as the Hospital Outpatient Quality Data Reporting Program (HOP QDRP));
- Care furnished by physicians and other eligible professionals under the Physician Quality Reporting System (PQRS, formerly referred to as the Physician Quality Reporting Program Initiative (PQRI));
- Inpatient rehabilitation facilities under the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP);
- Long-term care hospitals under the Long-Term Care Hospital Quality Reporting Program (LTCH QRP) (also referred to as the LTCHQR Program);
- PPS-exempt cancer hospitals under the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program;
- Ambulatory surgical centers under the Ambulatory Surgical Center Quality Reporting (ASCQR) Program;
- Inpatient psychiatric facilities under the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program;
- Home health agencies under the home health quality reporting program (HH QRP); and,
- Hospice facilities under the Hospice Quality Reporting Program.

We have also implemented the End-Stage Renal Disease Quality Incentive Program and Hospital VBP Program (described further below) that link payment to performance.

In implementing the Hospital IQR Program and other quality reporting

programs, we have focused on measures that have high impact and support CMS and HHS priorities for improved quality and efficiency of care for Medicare beneficiaries. Our goal for the future is to align the clinical quality measure requirements of the Hospital IQR Program with various other Medicare and Medicaid programs, including those authorized by the Health Information Technology for Economic and Clinical Health (HITECH) Act, so that the reporting burden on providers will be reduced. As appropriate, we will consider the adoption of clinical quality measures with electronic specifications so that the electronic collection of performance information is a seamless component of care delivery. Establishing such a system will require interoperability between EHRs and CMS data collection systems, additional infrastructure development on the part of hospitals and CMS, and adoption of standards for capturing, formatting, and transmitting the data elements that make up the measures. However, once these activities are accomplished, adoption of measures that rely on data obtained directly from EHRs will enable us to expand the Hospital IQR Program measure set with less cost and reporting burden to hospitals. We believe that in the near future, collection and reporting of data elements through EHRs will greatly simplify and streamline reporting for various CMS quality reporting programs, and that hospitals will be able to switch primarily to EHR-based data reporting for many measures that are currently manually chart-abstracted and submitted to CMS for the Hospital IQR Program.

We also have implemented a Hospital VBP Program under section 1886(o) of the Act, described in the Hospital Inpatient VBP Program final rule (76 FR 26490 through 26547). We most recently adopted additional policies for the Hospital VBP Program in section IV.I. of the FY 2015 IPPS/LTCH PPS final rule (79 FR 50048 through 50087). Under the Hospital VBP Program, hospitals receive value-based incentive payments based on their performance with respect to performance standards for a performance period for the fiscal year involved. The measures under the Hospital VBP Program must be selected from the measures (other than readmission measures) specified under the Hospital IQR Program as required by section 1886(o)(2)(A) of the Act.

In selecting measures for the Hospital IQR Program, we are mindful of the conceptual framework we have developed for the Hospital VBP Program. Because measures adopted for the Hospital VBP Program must first have been specified under the Hospital IQR Program, these two programs are linked and the reporting infrastructure for the programs overlap. We view the Hospital VBP Program as the next step in promoting higher quality care for Medicare beneficiaries by transforming Medicare from a passive payer of claims into an active purchaser of quality healthcare for its beneficiaries. Value-based purchasing is an important step to revamping how care and services are paid for, moving increasingly toward rewarding better value, outcomes, and innovations.

We also view the Hospital-Acquired Condition (HAC) payment adjustment program authorized by section 1886(p) of the Act, as added by section 3008 of the Affordable Care Act, and the Hospital VBP Program, as related but separate efforts to reduce HACs. The Hospital VBP Program is an incentive program that awards payments to hospitals based on quality performance on a wide variety of measures, while the HAC Reduction Program creates a payment adjustment resulting in payment reductions for poorly performing hospitals based on their rates of HACs.

In the preamble of the FY 2016 IPPS/LTCH PPS proposed rule, we proposed changes to the following Medicare quality reporting systems:

- In section VIII.A. (80 FR 24555 through 24590), the Hospital IQR Program.
- In section VIII.B. (80 FR 24590 through 24595), the PCHQR Program.
- In section VIII.C. (80 FR 24595 through 24611), the LTCH QRP.

In addition, in section VIII.D. of the preamble of the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24611 through 24615), we proposed changes to the Medicare EHR Incentive Program for eligible hospitals and CAHs.

A. Hospital Inpatient Quality Reporting (IQR) Program

1. Background

a. History of the Hospital IQR Program

We refer readers to the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43860 through 43861) and the FY 2011 IPPS/LTCH PPS final rule (75 FR 50180 through 50181) for detailed discussions of the history of the Hospital IQR Program, including the statutory history, and to the FY 2015 IPPS/LTCH PPS final rule (79 FR 50217 through 50249) for the measures we have adopted for the Hospital IQR measure set through the FY 2017 payment determination and subsequent years.

b. Maintenance of Technical Specifications for Quality Measures

The technical specifications for the Hospital IQR Program measures, or links to Web sites hosting technical specifications, are contained in the CMS/The Joint Commission (TJC) Specifications Manual for National Hospital Quality Measures (Specifications Manual). This Specifications Manual is posted on the QualityNet Web site at *http://www.qualitynet.org/*. We generally update the Specifications Manual on a semiannual basis and include in the updates detailed instructions and calculation algorithms for hospitals to use when collecting and submitting data on required measures. These semiannual updates are accompanied by notifications to users, providing sufficient time between the change and the effective date in order to allow users to incorporate changes and updates to the specifications into data collection systems.

The technical specifications for the HCAHPS patient experience of care survey are contained in the current HCAHPS *Quality Assurance Guidelines* manual available at the HCAHPS Web site, *http://www.hcahpsonline.org*. We maintain the HCAHPS technical specifications by updating the HCAHPS *Quality Assurance Guidelines* manual annually, and include detailed instructions on survey implementation, data collection, data submission and other relevant topics. As necessary, HCAHPS Bulletins are issued to provide notice of changes and updates to technical specifications in HCAHPS data collection systems.

Many of the quality measures used in different Medicare and Medicaid reporting programs are endorsed by the National Quality Forum (NQF). As part of its regular maintenance process for endorsed performance measures, the NQF requires measure stewards to submit annual measure maintenance updates and undergo maintenance of endorsement review every three years. We refer readers to the FY 2015 IPPS/LTCH PPS final rule (79 FR 50202 through 50203) for additional detail on the measure maintenance process.

We believe that it is important to have in place a subregulatory process to incorporate nonsubstantive updates to the measure specifications for measures we have adopted for the Hospital IQR Program so that these measures remain up-to-date. We refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53504 through 53505) and the FY 2015 IPPS/LTCH PPS final rule (79 FR 50203) for our policy for using the

subregulatory process to make non-substantive updates to measures used for the Hospital IQR Program. We recognize that some changes made to NQF-endorsed measures undergoing maintenance review are substantive in nature and might not be appropriate for adoption using a subregulatory process. We will continue to use rulemaking to adopt substantive updates made to measures we have adopted for the Hospital IQR Program.

c. Public Display of Quality Measures

Section 1886(b)(3)(B)(viii)(VII) of the Act was amended by the Deficit Reduction Act (DRA) of 2005. Section 5001(a) of the DRA requires that the Secretary establish procedures for making information regarding measures submitted available to the public after ensuring that a hospital has the opportunity to review its data before they are made public. We refer readers to the FY 2014 IPPS/LTCH PPS final rule (78 FR 50776 through 50778) for a more detailed discussion about public display of quality measures. We did not propose to change our current policy of reporting data from the Hospital IQR Program as soon as it is feasible on CMS Web sites such as the *Hospital Compare* Web site *http://www.medicare.gov/hospitalcompareand/* or the interactive *https://data.medicare.gov* Web site, after a preview period.

The *Hospital Compare* Web site is an interactive Web tool that assists beneficiaries by providing information on hospital quality of care to those who need to select a hospital. For more information on measures reported to *Hospital Compare,* we refer readers to the Web site at: *http://www.medicare.gov/hospitalcompare*. Other information not reported to *Hospital Compare* may be made available on other CMS Web sites such as *http://www.cms.hhs.gov/HospitalQualityInits/* or *https://data.medicare.gov*.

2. Process for Retaining Previously Adopted Hospital IQR Program Measures for Subsequent Payment Determinations

We refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53512 through 53513), for our finalized measure retention policy. When we adopt measures for the Hospital IQR Program beginning with a particular payment determination, these measures are automatically adopted for all subsequent payment determinations unless we propose to remove, suspend, or replace the measures.

In the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24556), we did not propose any changes to our policy for retaining previously adopted measures for subsequent payment determinations.

3. Removal and Suspension of Hospital IQR Program Measures

a. Considerations in Removing Quality Measures From the Hospital IQR Program

As discussed above, we generally retain measures from the previous year's Hospital IQR Program measure set for subsequent years' measure sets except when we specifically propose to remove, suspend, or replace a measure. We refer readers to the FY 2011 IPPS/LTCH PPS final rule (75 FR 50185) and the FY 2015 IPPS/LTCH PPS final rule (79 FR 50203 through 50204) for more information on the criteria we consider for removing quality measures. We also take into account the views of the Measure Applications Partnership (MAP) when determining when a measure should be removed, and we strive to eliminate redundancy of similar measures (77 FR 53505 through 53506). In the FY 2015 IPPS/LTCH PPS final rule (79 FR 50203 through 50204), we also finalized our proposal to clarify the criteria for determining when a measure is ''topped out.'' In the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24556), we did not propose any changes to the two criteria that we use to determine whether or not a measure is ''topped out.''

We use these previously adopted measure removal criteria to help evaluate when we should propose a measure for removal. However, we continue to believe that there are circumstances in which a measure that meets criteria for removal should be retained regardless, because the drawbacks of removing a measure could be outweighed by other benefits to retaining the measure. Therefore, because of the continued need to balance benefits and drawbacks as well as our desire to increase transparency, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24556 through 24557), we proposed additional factors to consider for measure removal and also include factors to consider in order to retain measures.

Specifically, we proposed to take into consideration the following additional factor in determining whether a measure should be removed:

- Feasibility to implement the measure specifications.

In addition, we proposed to remove one of the factors (''Availability of alternative measures with a stronger relationship to patient outcomes'') we take into consideration when determining whether to remove measures, because it is duplicates another factor (''The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic'').

We also proposed to take into consideration the following factors in determining whether a measure should be retained:

- Measure aligns with National Quality Strategy or CMS Quality Strategy goals;
- Measure aligns with other CMS programs, including other quality reporting programs, or the EHR Incentive Program; and
- Measure supports efforts to move facilities towards reporting electronic measures

For example, we may consider retaining a measure that is statistically ''topped-out'' in order to align with the Medicare EHR Incentive Program. Below is a table of newly proposed and previously adopted factors that we would take into consideration in removing or retaining measures:

FACTORS CMS CONSIDERS IN REMOVING OR RETAINING MEASURES

Measure Removal Factors
1. Measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (''topped-out'' measures).
2. A measure does not align with current clinical guidelines or practice.
3. The availability of a more broadly applicable measure (across settings, populations, or the availability of a measure that is more proximal in time to desired patient outcomes for the particular topic).
4. Performance or improvement on a measure does not result in better patient outcomes.
5. The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic.

FACTORS CMS CONSIDERS IN REMOVING OR RETAINING MEASURES—Continued

6. Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.
7. It is not feasible to implement the measure specifications.*
''Topped-Out'' Criteria
1. • Statistically indistinguishable performance at the 75th and 90th percentiles; and • Truncated coefficient of variation ≤ 0.10.
Measure Retention Factors
1. Measure aligns with other CMS and HHS policy goals.*
2. Measure aligns with other CMS programs, including other quality reporting programs, or the EHR Incentive Program.
3. Measure supports efforts to move facilities towards reporting electronic measures.

*Consideration proposed in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24556 through 24557).

We note that these removal/retention factors continue to be considerations taken into account when deciding whether or not to remove measures; but they are not firm requirements.

We invited public comments on our proposal.

Comment: Several commenters supported the considerations in removing/retaining quality measures and noted their appreciation for our efforts to align with other programs as well as the National Quality Strategy or CMS Quality Strategy goals, and to consider the feasibility of data collection and reporting. Several commenters specifically noted their support for CMS' efforts to transition to electronic clinical quality measures.

Response: We thank the commenters for their support.

Comment: Several commenters supported the addition of a measure retention criterion stating ''Measure supports efforts to move facilities towards reporting electronic measures.''

Response: We thank the commenters for their support.

Comment: Some commenters requested more detail on the measure removal criterion: ''feasibility to implement the measure specifications.'' A few commenters recommended that this measure removal criterion should include considerations of the difficulty of collection experienced by providers. The commenters also recommended that the assessment should evaluate the impact on clinical workflow, the degree of completeness, and the ease of related data collection requirements assumed to be derived from clinical workflow.

Response: In considering the ''feasibility to implement the measure specifications'' as proposed, we consider both our ability to receive the necessary data, as well as hospitals' ability to collect the measure data. Accordingly, when considering this measure removal criterion, we account for data collection challenges, including, but not limited to clinical workflow, the degree of completeness, and the ease of related data collection requirements, experienced by hospitals and providers.

Comment: One commenter encouraged CMS to consider approaches to improve hospital performance on measures that are slow to meet the ''topped-out'' criteria. Specifically, the commenter indicated that there is a need to put additional focus on the process measures that are tied to high quality data within IQR in order to support improvement of hospital quality and patient outcomes.

Response: We thank the commenter for its suggestion and note that we generally retain measures until they either become ''topped-out'' or meet one of the other measure removal criteria. We believe that the inclusion of these measures, whether they are process or outcomes measures, in the Hospital IQR Program will drive hospitals to improve performance. However, we will take the commenter's suggestion to put additional focus on process measures tied to high quality data under advisement for our plans for education and outreach on the Hospital IQR Program.

Comment: A few commenters opposed the proposed criterion ''measure aligns with other CMS and HHS policy goals'' as a factor to be considered for measure retention, noting that there may be reasons to remove a measure from one program, even though it is still appropriate in another.

Response: We would like to clarify that when we consider whether or not a ''measure aligns with other CMS and HHS policy goals,'' we evaluate whether a measure supports the CMS Quality Strategy goals or the National Quality Strategy, instead of alignment with other quality reporting programs. We are however, finalizing another criterion that allows retention of a measure that aligns with other quality reporting programs, such as the EHR Incentive Program, in order to enable hospitals to rely on the same measures to meet the requirements of multiple programs.

Comment: A few commenters opposed the addition of the measure removal criterion ''measure supports efforts to move facilities towards reporting electronic measures.'' Some commenters suggested that a measure-by-measure approach to accelerating/encouraging electronic reporting is not adequate.

Response: We clarify that we have added this criterion in acknowledgement that there may be instances when we may consider retaining an electronic version of a measure that is statistically ''topped out'' in its chart-abstracted mode specifically to align with the EHR Incentive Program. Accordingly, we make every effort to ensure an aligned set of electronic clinical quality measures across the Hospital IQR Program and the EHR Incentive Program.

Comment: One commenter supported the removal of topped out measures, noting that they provide little room for improvement, but recommended the creation of a system to monitor performance on retired measures to ensure that quality gains are sustained.

Response: We thank the commenter for its support and will take its suggestion under consideration.

After consideration of the public comments we received, we are finalizing factors that we would take into consideration in removing or retaining measures as proposed. Specifically, we are finalizing: (1) The addition of the removal factor ''feasibility to implement the measure specifications;'' (2) the removal of the factor ''availability of alternative measures with a stronger relationship to patient outcomes;'' and (3) the addition of the retention factors ''measure aligns with National Quality Strategy or CMS Quality Strategy goals,'' ''measure aligns with other CMS programs, including other quality reporting programs, or the

FYs 2014 and 2015, we also for FY 2016 allocated an estimated per-discharge uncompensated care payment amount to all cases for the hospitals eligible to receive the uncompensated care payment amount in the calculation of the outlier fixed-loss cost threshold methodology. We continue to believe that allocating an eligible hospital's estimated uncompensated care payment to all cases equally in the calculation of the outlier fixed-loss cost threshold best approximates the amount we will pay in uncompensated care payments during the year because, when we make claim payments to a hospital eligible for such payments, we will be making estimated per-discharge uncompensated care payments to all cases equally. Furthermore, we continue to believe that using the estimated per-claim uncompensated care payment amount to determine outlier estimates provides predictability as to the amount of uncompensated care payments included in the calculation of outlier payments. Therefore, consistent with the methodology used in FYs 2014 and 2015 to calculate the outlier fixed-loss cost threshold, for FY 2016, we included estimated FY 2016 uncompensated care payments in the computation of the outlier fixed-loss cost threshold. Specifically, we used the estimated per-discharge uncompensated care payments to hospitals eligible for the uncompensated care payment for all cases in the calculation of the outlier fixed-loss cost threshold methodology.

Using this methodology, we calculated a final outlier fixed-loss cost threshold for FY 2016 equal to the prospective payment rate for the MS–DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payments, and any add-on payments for new technology, plus $22,544.

(2) Other Changes Concerning Outliers

As stated in the FY 1994 IPPS final rule (58 FR 46348), we establish an outlier threshold that is applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common threshold resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2016 will result in outlier payments that will equal 5.1 percent of operating DRG payments and 6.35 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we reduced the FY 2016 standardized amount by the same percentage to account for the projected proportion of payments paid as outliers.

The outlier adjustment factors that were applied to the standardized amount based on the FY 2016 outlier threshold are as follows:

	Operating standardized amounts	Capital Federal rate
National	0.949000	0.936519
Puerto Rico	0.935042	0.919230

We applied the outlier adjustment factors to the FY 2016 payment rates after removing the effects of the FY 2015 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we apply hospital-specific CCRs to the total covered charges for the case. Estimated operating and capital costs for the case are calculated separately by applying separate operating and capital CCRs. These costs are then combined and compared with the outlier fixed-loss cost threshold.

Under our current policy at § 412.84, we calculate operating and capital CCR ceilings and assign a statewide average CCR for hospitals whose CCRs exceed 3.0 standard deviations from the mean of the log distribution of CCRs for all hospitals. Based on this calculation, for hospitals for which the MAC computes operating CCRs greater than 1.21 or capital CCRs greater than 0.175, or hospitals for which the MAC is unable to calculate a CCR (as described under § 412.84(i)(3) of our regulations), statewide average CCRs are used to determine whether a hospital qualifies for outlier payments. Table 8A listed in section VI. of this Addendum (and available only via the Internet on the CMS Web site) contains the statewide average operating CCRs for urban hospitals and for rural hospitals for which the MAC is unable to compute a hospital-specific CCR within the above range. Effective for discharges occurring on or after October 1, 2015, these statewide average ratios will replace the ratios posted on our Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Tables.html*. Table 8B listed in section VI. of this Addendum (and available via the Internet on the CMS Web site) contains the comparable statewide average capital CCRs. As previously stated, the CCRs in Tables 8A and 8B will be used during FY 2016 when hospital-specific CCRs based on the latest settled cost report either are not available or are outside the range noted above. Table 8C listed in section VI. of this Addendum (and available via the Internet on the CMS Web site) contains the statewide average total CCRs used under the LTCH PPS as discussed in section V. of this Addendum.

We finally note that we published a manual update (Change Request 3966) to our outlier policy on October 12, 2005, which updated Chapter 3, Section 20.1.2 of the Medicare Claims Processing Manual. The manual update covered an array of topics, including CCRs, reconciliation, and the time value of money. We encourage hospitals that are assigned the statewide average operating and/or capital CCRs to work with their MAC on a possible alternative operating and/or capital CCR as explained in Change Request 3966. Use of an alternative CCR developed by the hospital in conjunction with the MAC can avoid possible overpayments or underpayments at cost report settlement, thereby ensuring better accuracy when making outlier payments and negating the need for outlier reconciliation. We also note that a hospital may request an alternative operating or capital CCR ratio at any time as long as the guidelines of Change Request 3966 are followed. In addition, we published an additional manual update (Change Request 7192) to our outlier policy on December 3, 2010, which also updated Chapter 3, Section 20.1.2 of the Medicare Claims Processing Manual. The manual update outlines the outlier reconciliation process for hospitals and Medicare contractors. To download and view the manual instructions on outlier reconciliation, we refer readers to the CMS Web site: *http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf*.

(3) FY 2014 and FY 2015 Outlier Payments

In the FY 2015 IPPS/LTCH PPS final rule correction notice (79 FR 59681), we stated that, based on available data, we estimated that actual FY 2014 outlier payments would be approximately 5.68 percent of actual total MS–DRG payments. This estimate was computed based on simulations using the FY 2013 MedPAR file (discharge data for FY 2013 claims). That is, the estimate of actual outlier payments did not reflect actual FY 2014 claims, but instead reflected the application of FY 2014 payment rates and policies to available FY 2013 claims.

Our current estimate, using available FY 2014 claims data, is that actual outlier payments for FY 2014 were approximately 5.38 percent of actual total MS–DRG payments. Therefore, the data indicate that, for FY 2014, the percentage of actual outlier payments relative to actual total payments is higher than we projected for FY 2014. Consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2014 are equal to 5.1 percent of total MS–DRG payments.

We currently estimate that, using the latest CCRs from the March 2015 update of the PSF, actual outlier payments for FY 2015 will be approximately 4.65 percent of actual total MS–DRG payments, approximately 0.45 percentage point lower than the 5.1 percent we projected when setting the outlier policies for FY 2015. This estimate of 4.65 percent is based on simulations using the FY 2014 MedPAR file (discharge data for FY 2014 claims).

Comment: One commenter requested that CMS clarify its methodology used to calculate historical outlier payments. The commenter noted that CMS used FY 2014 claims data to model the total estimated actual outlier payments for FY 2014. The commenter stated that commenters have repeatedly noted that CMS' model overestimates the amount of total outlier payments, as compared to using actual claims data. The commenter further stated that in the FYs 2013 and 2014 IPPS/LTCH PPS final rules (77 FR 53698 and 78 FR 50983, respectively), one commenter used cost report data from the HCRIS to analyze the historical actual outlier payout from 2003 through 2010 and 2012 through 2014, which demonstrated that total outlier payments as a percentage of total MS–DRG payments are substantially lower than what CMS has ''modeled.''

The commenter stated that actual outlier payment estimates should be objectively calculated independent of HHS's ''modeling'' methodology. The commenter further stated that, in setting the fixed-loss cost threshold, CMS considers prior fiscal years' outlier payments and therefore it is important to have an accurate tally of those payments. The commenter concluded that CMS' estimates are unreliable and commenters have demonstrated far more reliable methods.

Response: As stated above, we do not rely upon historical actual outlier payments to determine the fixed-loss cost threshold. When we calculate the threshold, we use the latest data that are available at the time of the proposed and final rule in order to estimate that outlier payments are 5.1 percent of total payments. With regard to the remainder of the commenter's views, we have responded to similar comments in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51796) and refer readers to that final rule.

Comment: One commenter asked if CMS can confirm if calculations of historical actual outlier payments based on HCRIS data produce lower total outlier payments than CMS' methodology. The commenter stated that the correct calculation of actual outlier payments is important because CMS relies upon historical actual outlier payments to determine the fixed-loss cost threshold and general IPPS payments. The commenter noted that, in the proposed rule (80 FR 24665), CMS stated that ''The impact of moving from our estimate of FY 2015 outlier payments, 4.9 percent, to the proposed estimate of FY 2016 outlier payments, 5.1 percent, would result in an increase of 0.2 percent in FY 2016 payments relative to FY 2015.'' Based on this statement, the commenter stated that if the estimate of FY 2015 outlier payments was lower than 4.9 percent, CMS would need to make a corresponding upward adjustment in FY 2016 payments relative to FY 2015. The commenter further stated that if CMS' modeling efforts to calculate historical outlier payments have consistently underestimated actual outlier payments, CMS should adjust FY 2016 payments to compensate for the miscalculation of historical outlier payments. The commenter believed that such a correction would not be retroactive per se as CMS would simply be making the adjustment for upcoming fiscal year payments.

Response: Contrary to the commenter's statement, as stated above, we do not rely upon historical actual outlier payments to determine the fixed-loss cost threshold. When we calculate the threshold, we use the latest data that are available at the time of the proposed and final rule in order to estimate that outlier payments are 5.1 percent of total payments. For purposes of impacts and assessing whether or not potential changes to the outlier methodology may be warranted, we estimate outlier payments from the preceding fiscal year. However, this estimate does not impact the calculation of the fixed-loss threshold for the upcoming fiscal year. With regard to using HCRIS data to measure actual outlier payments, hospitals' cost reporting periods do not match the period of the Federal fiscal year. For example, many hospitals submit cost reports based on a calendar year (January 1 through December 31), while the Federal fiscal year runs from October 1 through September 30. Outlier payments are reported in the aggregate on the cost report, and it is currently not possible to break out outlier payments from the cost report to a Federal fiscal year if the cost report submitted by the provider is using a different reporting period.

5. FY 2016 Standardized Amount

The adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B listed and published in section VI. of this Addendum (and available via the Internet on the CMS Web site) contain the national standardized amounts that we are applying to all hospitals, except hospitals located in Puerto Rico, for FY 2016. The Puerto Rico-specific amounts are shown in Table 1C listed and published in section VI. of this Addendum (and available via the Internet on the CMS Web site). The amounts shown in Tables 1A and 1B differ only in that the labor-related share applied to the standardized amounts in Table 1A is 69.6 percent, and the labor-related share applied to the standardized amounts in Table 1B is 62 percent. In accordance with sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act, we are applying a labor-related share of 62 percent, unless application of that percentage will result in lower payments to a hospital than would otherwise be made. In effect, the statutory provision means that we will apply a labor-related share of 62 percent for all hospitals whose wage indexes are less than or equal to 1.0000.

In addition, Tables 1A and 1B include the standardized amounts reflecting the applicable percentage increases for FY 2016.

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the

Federal Register / Vol. 80, No. 158 / Monday, August 17, 2015 / Rules and Regulations 49787

discharge-weighted average of the national large urban standardized amount (this amount is set forth in Table 1A). The labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals for FY 2016 are set forth in Table 1C listed and published in section VI. of this Addendum (and available via the Internet on the CMS Web site). This table also includes the Puerto Rico-specific standardized amounts. The labor-related share applied to the Puerto Rico-specific standardized amount is the labor-related share of 63.2 percent, or 62 percent, depending on which provides higher payments to the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Public Law 108–173, provides that the labor-related share for hospitals located in Puerto Rico be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

The following table illustrates the changes from the FY 2015 national standardized amount to the FY 2016 national standardized amount. The second through fifth columns display the changes from the FY 2015 standardized amounts for each applicable FY 2016 standardized amount. The first row of the table shows the updated (through FY 2015) average standardized amount after restoring the FY 2015 offsets for outlier payments, demonstration budget neutrality, geographic reclassification budget neutrality, new labor market delineation wage Index transition budget neutrality and the retrospective documentation and coding adjustment under section 7(b)(1)(B) of Public Law 110–90. The MS–DRG reclassification and recalibration and wage index budget neutrality adjustment factors are cumulative. Therefore, those FY 2015 adjustment factors are not removed from this table.

COMPARISON OF FY 2015 STANDARDIZED AMOUNTS TO THE FY 2016 STANDARDIZED AMOUNTS

	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is NOT a meaningful EHR user	Hospital did NOT submit quality data and is a meaningful EHR user	Hospital did NOT submit quality data and is NOT a meaningful EHR user
FY 2015 Base Rate after removing: 1. FY 2015 Geographic Reclassification Budget Neutrality (0.990429). 2. FY 2015 Rural Community Hospital Demonstration Program Budget Neutrality (0.999313). 3. Cumulative FY 2008, FY 2009, FY 2012, FY 2013 and FY 2014, FY 2015 Documentation and Coding Adjustment as Required under Sections 7(b)(1)(A) and 7(b)(1)(B) of Public Law 110–90 and Documentation and Coding Recoupment Adjustment as required under Section 631 of the American Taxpayer Relief Act of 2012 (0.9329) 4. FY 2015 Operating Outlier Offset (0.948999) 5. FY 2015 New Labor Market Delineation Wage Index Transition Budget Neutrality Factor (0.998854)	If Wage Index is Greater Than 1.0000: Labor (69.6%): $4,324.23 Nonlabor (30.4%): $1,888.74. If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,852.04 Nonlabor (38%): $2,360.93.	If Wage Index is Greater Than 1.0000: Labor (69.6%): $4,324.23 Nonlabor (30.4%): $1,888.74. If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,852.04 Nonlabor (38%): $2,360.93.	If Wage Index is Greater Than 1.0000: Labor (69.6%): $4,324.23 Nonlabor (30.4%): $1,888.74. If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,852.04 Nonlabor (38%): $2,360.93.	If Wage Index is Greater Than 1.0000: Labor (69.6%): $4,324.23 Nonlabor (30.4%): $1,888.74. If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,852.04 Nonlabor (38%): $2,360.93.
FY 2016 Update Factor	1.017	1.005	1.011	0.999.
FY 2016 MS-DRG Recalibration and Wage Index Budget Neutrality Factor.	0.997150	0.997150	0.997150	0.997150.
FY 2016 Reclassification Budget Neutrality Factor.	0.987905	0.987905	0.987905	0.987905.
FY 2016 Rural Community Demonstration Program Budget Neutrality Factor.	0.999861	0.999861	0.999861	0.999861.
FY 2016 Operating Outlier Factor	0.949000	0.949000	0.949000	0.949000.
Cumulative Factor: FY 2008, FY 2009, FY 2012, FY 2013, FY 2014, FY 2015 and FY 2016 Documentation and Coding Adjustment as Required under Sections 7(b)(1)(A) and 7(b)(1)(B) of Public Law 110–90 and Documentation and Coding Recoupment Adjustment as required under Section 631 of the American Taxpayer Relief Act of 2012.	0.9255	0.9255	0.9255	0.9255.
FY 2016 New Labor Market Delineation Wage Index 3-Year Hold Harmless Transition Budget Neutrality Factor.	0.999996	0.999996	0.999996	0.999996.
National Standardized Amount for FY 2016 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (69.6/30.4).	Labor: $3,804.40 Nonlabor: $1,661.69	Labor: $3,759.51 Nonlabor: $1,642.08	Labor: $3,781.96 Nonlabor: $1,651.89	Labor: $3,737.07. Nonlabor: $1,632.28.

COMPARISON OF FY 2015 STANDARDIZED AMOUNTS TO THE FY 2016 STANDARDIZED AMOUNTS—Continued

	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is NOT a meaningful EHR user	Hospital did NOT submit quality data and is a meaningful EHR user	Hospital did NOT submit quality data and is NOT a meaningful EHR user
National Standardized Amount for FY 2016 if Wage Index is less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38).	Labor: $3,388.98 ..... Nonlabor: $2,077.11 ..	Labor: $3,348.99 ..... Nonlabor: $2,052.60 ..	Labor: $3,368.99 ..... Nonlabor: $2,064.86 ..	Labor: $3,329.00 Nonlabor: $2,040.35.

The following table illustrates the changes from the FY 2015 Puerto Rico-specific payment rate for hospitals located in Puerto Rico. The second column shows the changes from the FY 2015 Puerto Rico specific payment rate for hospitals with a Puerto Rico-specific wage index greater than 1.0000. The third column shows the changes from the FY 2015 Puerto Rico specific payment rate for hospitals with a Puerto Rico-specific wage index less than or equal to 1.0000. The first row of the table shows the updated (through FY 2015) Puerto Rico-specific payment rate after restoring the FY 2015 offsets for Puerto Rico-specific outlier payments, rural community hospital demonstration program budget neutrality, and the geographic reclassification budget neutrality. The MS–DRG recalibration budget neutrality adjustment factor is cumulative and is not removed from this table.

COMPARISON OF FY 2015 PUERTO RICO-SPECIFIC PAYMENT RATE TO THE FY 2016 PUERTO RICO-SPECIFIC PAYMENT RATE

	Update (1.7 percent); wage index is greater than 1.0000; labor/non-labor share percentage (63.2/36.8)	Update (1.7 percent); wage index is less than or equal to 1.0000; labor/non-labor share percentage (62/38)
FY 2015 Puerto Rico Base Rate, after removing: 1. FY 2015 Geographic Reclassification Budget Neutrality (0.990429). 2. FY 2015 Rural Community Hospital Demonstration Program Budget Neutrality (0.999313). 3. FY 2015 Puerto Rico Operating Outlier Offset (0.926334). 4. FY 2015 New Labor Market Delineation Wage Index Transition Budget Neutrality Factor (0.998854).	Labor: $1,758.02 ..... Nonlabor: $1,023.66 ..	Labor: $1,724.64. Nonlabor: $1,057.04.
FY 2016 Update Factor	1.017	1.017.
FY 2016 MS-DRG Recalibration Budget Neutrality Factor	0.998399	0.998399.
FY 2016 Reclassification Budget Neutrality Factor	0.987905	0.987905.
FY 2016 Rural Community Hospital Demonstration Program Budget Neutrality Factor	0.999861	0.999861.
FY 2016 New Labor Market Delineation Wage Index 3-Year Hold Harmless Transition Budget Neutrality Factor.	0.999996	0.999996.
FY 2016 Puerto Rico Operating Outlier Factor	0.935042	0.935042.
Puerto Rico-Specific Payment Rate for FY 2016	Labor: $1,648.66 ..... Nonlabor: $959.98	Labor: $1,617.36. Nonlabor: $991.28.

B. Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1C, as published in section VI. of this Addendum (and available via the Internet on the CMS Web site), contain the labor-related and nonlabor-related shares that we used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2016. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III of the preamble of this final rule, we discuss the data and methodology for the FY 2016 wage index.

2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act provides discretionary authority to the Secretary to make such adjustments as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. To account for higher nonlabor-related costs for these two States, we multiply the nonlabor-related portion of the standardized amount for hospitals located in Alaska and Hawaii by an adjustment factor.

In the FY 2013 IPPS/LTCH PPS final rule, we established a methodology to update the COLA factors for Alaska and Hawaii that were published by the U.S. Office of Personnel Management (OPM) every 4 years (at the same time as the update to the labor-related share of the IPPS market basket), beginning in FY 2014. We refer readers to the FY 2013 IPPS/LTCH PPS proposed and final rules for additional background and a detailed description of this methodology

payments for FY 2016. (We refer readers to MedPAC's Report to the Congress: Medicare Payment Policy, March 2015, Chapter 3, available on the Web site at: *http://www.medpac.gov*.)

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier payment methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital-related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating IPPS DRG payments.

For FY 2015, we estimated that outlier payments for capital would equal 6.18 percent of inpatient capital-related payments based on the capital Federal rate in FY 2015. Based on the thresholds as set forth in section II.A. of this Addendum, we estimate that outlier payments for capital-related costs will equal 6.35 percent for inpatient capital-related payments based on the capital Federal rate in FY 2016. Therefore, we are applying an outlier adjustment factor of 0.9365 in determining the capital Federal rate for FY 2016. Thus, we estimate that the percentage of capital outlier payments to total capital Federal rate payments for FY 2016 will be higher than the percentage for FY 2015.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. The FY 2016 outlier adjustment of 0.9365 is a − 0.18 percent change from the FY 2015 outlier adjustment of 0.9382. Therefore, the net change in the outlier adjustment to the capital Federal rate for FY 2016 is 0.9982 (0.9365/0.9382). Thus, the outlier adjustment will decrease the FY 2016 capital Federal rate by 0.18 percent compared to the FY 2015 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the GAF

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. Because we implemented a separate GAF for Puerto Rico, we apply separate budget neutrality adjustments for the national GAF and the Puerto Rico GAF. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier because the GAF for Puerto Rico was implemented in FY 1998.

To determine the factors for FY 2016, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2015 MS–DRG classifications and relative weights and the FY 2015 GAF to estimated aggregate capital Federal rate payments based on the FY 2015 MS–DRG classifications and relative weights and the FY 2016 GAFs. To achieve budget neutrality for the changes in the national GAFs, based on calculations using updated data, we are applying an incremental budget neutrality adjustment factor of 0.9979 for FY 2016 to the previous cumulative FY 2015 adjustment factor of 0.9884, yielding an adjustment factor of 0.9864 through FY 2016. For the Puerto Rico GAFs, we are applying an incremental budget neutrality adjustment factor of 0.9993 for FY 2016 to the previous cumulative FY 2015 adjustment factor of 1.0082, yielding a cumulative adjustment factor of 1.0075 through FY 2016.

We then compared estimated aggregate capital Federal rate payments based on the FY 2015 MS–DRG relative weights and the FY 2016 GAFs to estimated aggregate capital Federal rate payments based on the cumulative effects of the FY 2016 MS–DRG classifications and relative weights and the FY 2016 GAFs. The incremental adjustment factor for DRG classifications and changes in relative weights is 0.9994 both nationally and for Puerto Rico. The cumulative adjustment factors for MS–DRG classifications and changes in relative weights and for changes in the GAFs through FY 2016 are 0.9858 nationally and 1.0069 for Puerto Rico. (We note that all the values are calculated with unrounded numbers.) The GAF/DRG budget neutrality adjustment factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows the requirement under § 412.308(c)(4)(ii) that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAFs.

The methodology used to determine the recalibration and geographic adjustment factor (GAF/DRG) budget neutrality adjustment is similar to the methodology used in establishing budget neutrality adjustments under the IPPS for operating costs. One difference is that, under the operating IPPS, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the MS–DRG relative weights. Under the capital IPPS, there is a single GAF/DRG budget neutrality adjustment factor (the national capital rate and the Puerto Rico capital rate are determined separately) for changes in the GAF (including geographic reclassification) and the MS–DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for DSH or IME.

The cumulative adjustment factor of 0.9973 (the product of the incremental national GAF budget neutrality adjustment factor of 0.9979 and the incremental DRG budget neutrality adjustment factor of 0.9994) accounts for the MS–DRG reclassifications and recalibration and for changes in the GAFs. It also incorporates the effects on the GAFs of FY 2016 geographic reclassification decisions made by the MGCRB compared to FY 2015 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors.

4. Capital Federal Rate for FY 2016

For FY 2015, we established a capital Federal rate of $434.97 (79 FR 59684). We are establishing an update of 1.3 percent in determining the FY 2016 capital Federal rate for all hospitals. As a result of this update and the budget neutrality factors discussed above, we are establishing a national capital Federal rate of $438.65 for FY 2016. The national capital Federal rate for FY 2016 was calculated as follows:

- The FY 2016 update factor is 1.013, that is, the update is 1.3 percent.
- The FY 2016 budget neutrality adjustment factor that is applied to the capital Federal rate for changes in the MS–DRG classifications and relative weights and changes in the GAFs is 0.9973.
- The FY 2016 outlier adjustment factor is 0.9365.

(We note that, as discussed in section VI.C. of the preamble of this final rule,

we are not making an additional MS–DRG documentation and coding adjustment to the capital IPPS Federal rates for FY 2016.)

Because the FY 2016 capital Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we are not making additional adjustments in the capital Federal rate for these factors, other than the budget neutrality factor for changes in the MS–DRG classifications and relative weights and for changes in the GAFs.

We are providing the following chart that shows how each of the factors and adjustments for FY 2016 affects the computation of the FY 2016 national capital Federal rate in comparison to the FY 2015 national capital Federal rate. The FY 2016 update factor has the effect of increasing the capital Federal rate by 1.3 percent compared to the FY 2015 capital Federal rate. The GAF/DRG budget neutrality adjustment factor has the effect of decreasing the capital Federal rate by 0.27 percent. The FY 2016 outlier adjustment factor has the effect of decreasing the capital Federal rate by 0.18 percent compared to the FY 2015 capital Federal rate. The combined effect of all the changes will increase the national capital Federal rate by approximately 0.85 percent compared to the FY 2015 national capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2015 CAPITAL FEDERAL RATE AND FY 2016 CAPITAL FEDERAL RATE

	FY 2015	FY 2016	Change	Percent change
Update Factor [1]	1.0150	1.0130	1.0130	1.3
GAF/DRG Adjustment Factor [1]	0.9993	0.9973	0.9973	−0.27
Outlier Adjustment Factor [2]	0.9382	0.9365	0.9982	−0.18
Capital Federal Rate	$434.97	$438.65	1.0085	0.85

[1] The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rates. Thus, for example, the incremental change from FY 2015 to FY 2016 resulting from the application of the 0.9973 GAF/DRG budget neutrality adjustment factor for FY 2016 is a net change of 0.9973 (or −0.27 percent).

[2] The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the FY 2016 outlier adjustment factor is 0.9365/0.9382, or 0.9982 (or −0.18 percent).

In this final rule, we also are providing the following chart that shows how the final FY 2016 capital Federal rate differs from the proposed FY 2016 capital Federal rate as presented in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24640).

COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 2016 CAPITAL FEDERAL RATE AND FINAL FY 2016 CAPITAL FEDERAL RATE

	Proposed FY 2016	Final FY 2016	Change	Percent change
Update Factor	1.0130	1.0130	1.0000	0.00
GAF/DRG Adjustment Factor	0.9976	0.9973	0.9997	−0.30
Outlier Adjustment Factor	0.9357	0.9365	1.0008	0.08
Capital Federal Rate	438.40	438.65	1.0006	0.06

5. Special Capital Rate for Puerto Rico Hospitals

Section 412.374 provides for the use of a blended payment system for payments made to hospitals located in Puerto Rico under the PPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to hospitals located in Puerto Rico using the same methodology used to compute the national Federal rate for capital-related costs. Under the broad authority of section 1886(g) of the Act, beginning with discharges occurring on or after October 1, 2004, capital payments made to hospitals located in Puerto Rico are based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only, while the capital Federal rate is derived from the costs of all acute care hospitals participating in the IPPS (including Puerto Rico).

To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended capital rate. The GAF is calculated using the operating IPPS wage index, and varies depending on the labor market area or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended capital rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustment factors for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality adjustment factor for MS–DRG reclassifications and recalibration nationally and for Puerto Rico. The budget neutrality adjustment factors for the national GAF and for the Puerto Rico GAF and the budget neutrality factor for MS–DRG reclassifications and recalibration (which is the same nationally and for Puerto Rico) are discussed in section III.A.3. of this Addendum.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the capital rate (25 percent) is multiplied by the Puerto Rico-specific GAF for the labor market area in which the hospital is located, and the national portion of the capital rate (75 percent) is multiplied by the national GAF for the labor market area in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico).

For FY 2015, the special capital rate for hospitals located in Puerto Rico was $209.45 (79 FR 59683). With the changes we are making to the factors used to determine the capital Federal rate, the FY 2016 special capital rate for hospitals in Puerto Rico is $212.56.

B. Calculation of the Inpatient Capital-Related Prospective Payments for FY 2016

For purposes of calculating payments for each discharge during FY 2016, the capital Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (COLA for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted capital Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The outlier thresholds for FY 2016 are in section II.A. of this Addendum. For FY 2016, a case would qualify as a cost outlier if the cost for the case plus the (operating) IME and DSH payments (including both the empirically justified Medicare DSH payment and the estimated uncompensated care payment, as discussed in section II.A.4.g.(1) of this Addendum) is greater than the prospective payment rate for the MS–DRG plus the fixed-loss amount of $22,544.

Currently, as provided under § 412.304(c)(2), we pay a new hospital 85 percent of its reasonable costs during the first 2 years of operation unless it elects to receive payment based on 100 percent of the capital Federal rate. Effective with the third year of operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with capital costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input price indexes to reflect the changing composition of inputs for operating and capital expenses. In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50603 through 50607), we rebased and revised the CIPI to a FY 2010 base year to reflect the more current structure of capital costs in hospitals. For a complete discussion of this rebasing, we refer readers to the FY 2014 IPPS/LTCH PPS final rule.

2. Forecast of the CIPI for FY 2016

Based on the latest forecast by IHS Global Insight, Inc. (second quarter of 2015), we are forecasting the FY 2010-based CIPI to increase 1.3 percent in FY 2016. This reflects a projected 1.8 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment), and a projected 2.6 percent increase in other capital expense prices in FY 2016, partially offset by a projected 1.4 percent decline in vintage-weighted interest expense prices in FY 2016. The weighted average of these three factors produces the forecasted 1.3 percent increase for the FY 2010-based CIPI as a whole in FY 2016.

IV. Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2016

Payments for services furnished in children's hospitals, 11 cancer hospitals, and hospitals located outside the 50 States, the District of Columbia and Puerto Rico (that is, short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa) that are excluded from the IPPS are made on the basis of reasonable costs based on the hospital's own historical cost experience, subject to a rate-of-increase ceiling. A per discharge limit (the target amount as defined in § 413.40(a) of the regulations) is set for each hospital based on the hospital's own cost experience in its base year, and updated annually by a rate-of-increase percentage. (We note that, in accordance with § 403.752(a), RNHCIs are also subject to the rate-of-increase limits established under § 413.40 of the regulations.)

As discussed in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24641), the FY 2016 rate-of-increase percentage for updating the target amounts for the 11 cancer hospitals, children's hospitals, the short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, and RNHCIs is the estimated percentage increase in the IPPS operating market basket for FY 2016, in accordance with applicable regulations at § 413.40. Based on IHS Global Insight, Inc.'s 2015 first quarter forecast, we estimated that the FY 2010-based IPPS operating market basket update for FY 2016 would be 2.7 percent (that is, the estimate of the market basket rate-of-increase). However, we proposed that if more recent data became available for the final rule, we would use them to calculate the IPPS operating market basket update for FY 2016. Therefore, based on IHS Global Insight, Inc.'s 2015 second quarter forecast, with historical data through the first quarter of 2015, we estimate that the FY 2010-based IPPS operating market basket update for FY 2016 is 2.4 percent (that is, the estimate of the market basket rate-of-increase). For children's hospitals, the 11 cancer hospitals, hospitals located outside the 50 States, the District of Columbia and Puerto Rico (that is, short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa), and RNHCIs, the FY 2016 rate-of-increase percentage that will be applied to the FY 2015 target amounts in order to determine the final FY 2016 target amounts is 2.4 percent.

The IRF PPS, the IPF PPS, and the LTCH PPS are updated annually. We refer readers to section VII. of the preamble of this final rule and section V. of the Addendum to this final rule for the update changes to the Federal payment rates for LTCHs under the LTCH PPS for FY 2016. The annual updates for the IRF PPS and the IPF PPS are issued by the agency in separate **Federal Register** documents.

V. Updates to the Payment Rates for the LTCH PPS for FY 2016

A. LTCH PPS Standard Federal Payment Rate for FY 2016

1. Background

In section VII. of the preamble of this final rule, we discuss our annual updates to the payment rates, factors, and specific policies under the LTCH PPS for FY 2016.

Under § 412.523(c)(3)(ii) of the regulations, for LTCH PPS rate years beginning RY 2004 through RY 2006, we

neutrality factor for FY 2016 LTCH PPS standard Federal payment rate payments.

Step 4—We then applied the FY 2016 area wage level adjustment budget neutrality factor from Step 3 to determine the FY 2016 LTCH PPS standard Federal payment rate after the application of the FY 2016 annual update (discussed previously in section V.A.2. of this Addendum).

We note that, with the exception of cases subject to the transitional blend payment rate provisions in the first 2 years, under the dual rate LTCH PPS payment structure, only LTCH PPS cases that meet the statutory criteria to be excluded from the site neutral payment rate (that is, LTCH PPS standard Federal payment rate cases) will be paid based on the LTCH PPS standard Federal payment rate. Because the area wage level adjustment under § 412.525(c) is an adjustment to the LTCH PPS standard Federal payment rate, we only used data from claims that would have qualified for payment at the LTCH PPS standard Federal payment rate if such rate were in effect at the time of discharge to calculate the FY 2016 LTCH PPS standard Federal payment rate area wage level adjustment budget neutrality factor described above. (For additional information on our application of site neutral payment rate required under section 1886(m)(6) of the Act, we refer readers to section VII.B. of the preamble of this final rule.)

For this final rule, using the steps in the methodology described above, we determined a FY 2016 LTCH PPS standard Federal payment rate area wage level adjustment budget neutrality factor of 1.000513. Accordingly, in section V.A.2. of the Addendum to this final rule, to determine the FY 2016 LTCH PPS standard Federal payment rate, we are applying an area wage level adjustment budget neutrality factor of 1.000513, in accordance with § 412.523(d)(4). The FY 2016 LTCH PPS standard Federal payment rate shown in Table 1E of the Addendum to this final rule reflects this adjustment factor.

C. LTCH PPS Cost-of-Living Adjustment (COLA) for LTCHs Located in Alaska and Hawaii

Under § 412.525(b), a cost-of-living adjustment (COLA) is provided for LTCHs located in Alaska and Hawaii to account for the higher costs incurred in those States. Specifically, we apply a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the nonlabor-related portion of the standard Federal payment rate by the applicable COLA factors established annually by CMS. Higher labor-related costs for LTCHs located in Alaska and Hawaii are taken into account in the adjustment for area wage levels described above.

Under our current methodology, we update the COLA factors for Alaska and Hawaii every 4 years (at the same time as the update to the labor-related share of the IPPS market basket) (77 FR 53712 through 53713). This methodology is based on a comparison of the growth in the Consumer Price Indexes (CPIs) for Anchorage, Alaska, and Honolulu, Hawaii, relative to the growth in the CPI for the average U.S. city as published by the Bureau of Labor Statistics (BLS). It also includes a 25-percent cap on the CPI-updated COLA factors. (For additional details on our current methodology for updating the COLA factors for Alaska and Hawaii, we refer readers to section VII.D.3. of the preamble of the FY 2013 IPPS/LTCH PPS final rule (77 FR 53481 through 53482).)

We continue to believe that determining updated COLA factors using this methodology would appropriately adjust the nonlabor-related portion of the LTCH PPS standard Federal payment rate for LTCHs located in Alaska and Hawaii. Under our current policy, we update the COLA factors using the methodology described above every 4 years; the first year began in FY 2014 (77 FR 53482). Therefore, in this final rule, as we proposed, for FY 2016, under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of the BIPA, to determine appropriate payment adjustments under the LTCH PPS, we are continuing to use the COLA factors based on the 2009 OPM COLA factors updated through 2012 by the comparison of the growth in the CPIs for Anchorage, Alaska, and Honolulu, Hawaii, relative to the growth in the CPI for the average U.S. city as established in the FY 2014 IPPS/LTCH PPS final rule. (We refer readers to the FY 2014 IPPS/LTCH PPS final rule (78 FR 50998) for a discussion of the FY 2014 COLA factors.) Consistent with our historical practice and as we proposed, we are establishing that the COLA factors shown in the following table will be used to adjust the nonlabor-related portion of the LTCH PPS standard Federal payment rate for LTCHs located in Alaska and Hawaii under § 412.525(b).

COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII HOSPITALS UNDER THE LTCH PPS FOR FY 2016

Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
All other areas of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.19
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

D. Adjustment for LTCH PPS High-Cost Outlier (HCO) Cases

1. Overview

a. Background

Under the broad authority conferred upon the Secretary by section 123 of the BBRA as amended by section 307(b) of the BIPA, in the regulations at § 412.525(a), we established an adjustment for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. We refer to these cases as high cost outliers (HCOs). Providing additional payments for outliers strongly improves the accuracy of the LTCH PPS in determining resource costs at the patient and hospital level. These additional payments reduce the financial losses that would otherwise be incurred when treating patients who require more costly care and, therefore, reduce the incentives to underserve these patients. Under our current HCO policy at § 412.525(a), we set the outlier threshold before the beginning of the applicable rate year so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS.

Under the current HCO policy, we make outlier payments for any discharges if the estimated cost of a case exceeds the adjusted payment under the LTCH PPS standard Federal payment rate plus a fixed-loss amount. Specifically, in accordance with existing § 412.525(a)(3), we make an additional payment for an HCO case that is equal to 80 percent of the difference between the estimated cost of the patient case and the outlier threshold, which is the sum of the adjusted payment under the

LTCH PPS standard Federal payment rate and the fixed-loss amount. The fixed-loss amount is the amount used to limit the loss that a hospital incurs under the outlier policy for a case with unusually high costs before the LTCH will receive any additional payments. This results in Medicare and the LTCH sharing financial risk in the treatment of extraordinarily costly cases. Under the current LTCH PPS HCO policy, the LTCH's loss is limited to the fixed-loss amount and a fixed percentage of costs above the outlier threshold (the adjusted LTCH PPS standard Federal payment rate payment plus the fixed-loss amount). The fixed percentage of costs is called the marginal cost factor. We calculate the estimated cost of a case by multiplying the Medicare allowable covered charge by the hospital's overall hospital cost-to-charge ratio (CCR).

Under the current HCO policy at § 412.525(a), we determine a fixed-loss amount, that is, the maximum loss that an LTCH can incur under the LTCH PPS for a case with unusually high costs before the LTCH will receive any additional payments. We calculate the fixed-loss amount by estimating aggregate payments with and without an outlier policy. The fixed-loss amount results in estimated total outlier payments being projected to be equal to 8 percent of projected total LTCH PPS payments. Currently, MedPAR claims data and CCRs based on data from the most recent Provider-Specific File (PSF) (or from the applicable statewide average CCR if an LTCH's CCR data are faulty or unavailable) are used to establish a fixed-loss threshold amount under the LTCH PPS.

b. Application of the Site Neutral Payment Rate

Section 1206 of Public Law 113–67 establishes a new dual rate LTCH PPS payment structure with two distinct payment rates for LTCH discharges, beginning in FY 2016. To implement this statutory change, as discussed in section VII.B. of the preamble of this final rule, we will pay hospitals for LTCH discharges that meet the criteria for exclusion from site neutral payment rate (that is, LTCH PPS standard Federal payment rate cases) based on the LTCH PPS standard Federal payment rate, which includes HCO payments determined under existing § 412.525(a). Furthermore, we are establishing that the site neutral payment rate is the lower of the IPPS comparable per diem amount as determined under § 412.529(d)(4) (including any applicable adjustments, such as outlier payments), or 100 percent of the estimated cost of the case as determined under existing § 412.529(d)(2), consistent with the statute.

Under the new dual rate LTCH PPS payment structure, as discussed in section VII.B.7.b. of the preamble of this final rule, as we proposed, we are establishing two separate HCO targets—one for LTCH PPS standard Federal payment rate cases and one for site neutral payment rate cases. We are revising the regulations by making changes to the HCO policy to account for the new dual rate LTCH PPS payment structure by revising paragraphs (a)(1), (a)(2), and (a)(3), and adding a new paragraph (a)(4) to existing § 412.525 of the regulations. Under our HCO policy revised in accordance with the new dual rate LTCH PPS payment structure, we are establishing a fixed-loss amount and target for LTCH PPS standard Federal payment rate cases using the current LTCH PPS HCO policy, but limiting the data used under that policy to LTCH cases that would have been LTCH PPS standard Federal payment rate cases if the statutory changes had been in effect at the time of those discharges. Therefore, we are not making any modifications to the HCO methodology as it applies to LTCH PPS standard Federal payment rate cases other than determining a fixed-loss amount using only data from LTCH PPS standard Federal payment rate cases. Specifically, under our finalized policy, LTCH PPS standard Federal payment rate cases will receive an additional payment for an HCO case that is equal to 80 percent of the difference between the estimated cost of the case and the HCO threshold, which is the sum of the LTCH PPS payment for the LTCH PPS standard Federal payment rate case and the fixed-loss amount for such cases. The fixed-loss amount for LTCH PPS standard Federal payment rate cases will continue to be determined so that estimated HCO payments would be projected to be equal to 8 percent of estimated total LTCH PPS payments for LTCH PPS standard Federal payment rate cases.

Furthermore, as we proposed, we are revising the HCO policy under existing § 412.525(a) to provide for high-cost outlier payments under the site neutral payment rate. Specifically, we are establishing that site neutral payment rate cases will receive an additional payment for HCOs that is equal to 80 percent of the difference between the estimated cost of the case and the HCO threshold for site neutral payment rate discharges, which we are establishing as the sum of site neutral payment rate for the case and the IPPS fixed-loss amount. In addition, in order to maintain budget neutrality, as we proposed and as discussed in section VII.B.7.b. of the preamble of this final rule, we are making the HCO payments for site neutral payment rate cases budget neutral by applying a budget neutrality factor to the LTCH PPS payments for those site neutral payment rate cases. (Additional details on the calculation of the budget neutrality adjustment for HCO payments to site neutral payment rate cases is discussed subsequently in section V.D.4. of this Addendum.)

2. Determining LTCH CCRs Under the LTCH PPS

a. Background

The following is a discussion of CCRs that are used in determining payments for HCO cases under § 412.525(a), SSO cases paid under the LTCH PPS in accordance with § 412.529, and site neutral payment rate cases paid in accordance with proposed § 412.522(c) (as discussed in section VII.B.4. of the preamble of this final rule). Although this section is specific to HCO cases, because CCRs and the policies and methodologies pertaining to them are used in determining payments for HCO, SSO, and site neutral payment rate cases (to determine the estimated costs of these cases), we are discussing the determination of CCRs under the LTCH PPS for these three types of cases simultaneously in this section.

In determining HCO payments in accordance with § 412.525(a), SSO payments in accordance with § 412.529 and site neutral payment rate payments in accordance with § 412.522(c), we calculate the estimated cost of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case. In general, we use the LTCH's overall CCR, which is computed based on either the most recently settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period, in accordance with § 412.525(a)(4)(iv)(B), for HCOs, § 412.529(f)(4)(ii) for SSOs, and § 412.522(c)(1)(ii) for site neutral payment rate cases. (We note that, in some instances under the provisions of the regulations at § 412.525(a)(4)(iv) and § 412.529(f)(4), and § 412.522(c)(1)(ii), we may use an alternative CCR, such as the statewide average CCR, a CCR that is specified by CMS, or that is requested by the hospital.) Under the LTCH PPS, a single prospective payment per discharge is made for both inpatient operating and capital-related costs. Therefore, we compute a single ''overall'' or ''total'' LTCH-specific CCR based on the sum of LTCH operating and capital costs (as described in

Section 150.24, Chapter 3, of the Medicare Claims Processing Manual (Pub. 100–4)) as compared to total charges. Specifically, an LTCH's CCR is calculated by dividing an LTCH's total Medicare costs (that is, the sum of its operating and capital inpatient routine and ancillary costs) by its total Medicare charges (that is, the sum of its operating and capital inpatient routine and ancillary charges).

b. LTCH Total CCR Ceiling

Generally, an LTCH is assigned the applicable statewide average CCR if, among other things, an LTCH's CCR is found to be in excess of the applicable maximum CCR threshold (that is, the LTCH CCR ceiling). This is because CCRs above this threshold are most likely due to faulty data reporting or entry, and CCRs based on erroneous data should not be used to identify and make payments for outlier cases. Therefore, under our established policy, generally, if an LTCH's calculated CCR is above the applicable ceiling, the applicable LTCH PPS statewide average CCR is assigned to the LTCH instead of the CCR computed from its most recent (settled or tentatively settled) cost report data.

In this final rule, using our established methodology for determining the LTCH total CCR ceiling, based on IPPS total CCR data from the March 2015 update of the PSF, we are establishing a total CCR ceiling of 1.335 under the LTCH PPS for FY 2016 in accordance with § 412.525(a)(4)(iv)(C)(*2*) for HCOs, § 412.529(f)(4)(iii)(B) for SSOs, and § 412.522(c)(1)(ii) for site neutral payment rate cases. We also are, as proposed, using more recent data to determine the LTCH PPS CCR ceiling for this FY 2016 final rule.

c. LTCH Statewide Average CCRs

Our general methodology established for determining the statewide average CCRs used under the LTCH PPS is similar to our established methodology for determining the LTCH total CCR ceiling (described above) because it is based on ''total'' IPPS CCR data. Under the LTCH PPS HCO policy at § 412.525(a)(4)(iv)(C) the SSO policy at § 412.529(f)(4)(iii), and the site neutral payment rate policy at § 412.522(c)(1)(ii), the MAC may use a statewide average CCR, which is established annually by CMS, if it is unable to determine an accurate CCR for an LTCH in one of the following circumstances: (1) New LTCHs that have not yet submitted their first Medicare cost report (for this purpose, consistent with current policy, a new LTCH is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18); (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling; and (3) other LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the MAC may consider in determining an LTCH's CCR include data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as an LTCH (that is, the period of at least 6 months that it was paid as a short-term, acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

Consistent with our historical practice of using the best available data and as we proposed, in this final rule, using our established methodology for determining the LTCH statewide average CCRs, based on the most recent complete IPPS ''total CCR'' data from the March 2015 update of the PSF, we are establishing LTCH PPS statewide average total CCRs for urban and rural hospitals that will be effective for discharges occurring on or after October 1, 2015 through September 30, 2016, in Table 8C listed in section VI. of the Addendum to this final rule (and available via the Internet). We also, as proposed, are using more recent data to determine the LTCH PPS statewide average total CCRs for FY 2016.

Under the current LTCH PPS labor market areas, all areas in Delaware, the District of Columbia, New Jersey, and Rhode Island are classified as urban. Therefore, there are no rural statewide average total CCRs listed for those jurisdictions in Table 8C. This policy is consistent with the policy that we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48119 through 48121) and is the same as the policy applied under the IPPS. In addition, although Connecticut and Massachusetts have areas that are designated as rural, there are no short-term, acute care IPPS hospitals or LTCHs located in those areas as of March 2015. Therefore, consistent with our existing methodology and as we proposed, we are using the national average total CCR for rural IPPS hospitals for rural Connecticut and Massachusetts in Table 8C listed in section VI. of the Addendum to this final rule (and available via the Internet). In addition, consistent with our existing methodology as we proposed, in determining the urban and rural statewide average total CCRs for Maryland LTCHs paid under the LTCH PPS, we are continuing to use, as a proxy, the national average total CCR for urban IPPS hospitals and the national average total CCR for rural IPPS hospitals, respectively. We are using this proxy because we believe that the CCR data in the PSF for Maryland hospitals may not be entirely accurate (as discussed in greater detail in the FY 2007 IPPS final rule (71 FR 48120)).

d. Reconciliation of HCO and SSO Payments

Under the HCO policy at § 412.525(a)(4)(iv)(D) and the SSO policy at § 412.529(f)(4)(iv), the payments for HCO and SSO, cases are subject to reconciliation. Specifically, any reconciliation of payments is based on the CCR that is calculated based on a ratio of cost-to-charge data computed from the relevant cost report determined at the time the cost report coinciding with the discharge is settled. (As discussed section VII.B.4.a. of the preamble of this final rule, after consideration of public comments we received, we are not finalizing our proposal to establish a reconciliation process for site neutral payment rate payments. However, we are finalizing the portion of our proposal to apply the existing HCO reconciliation policy to the HCO payments made to site neutral payment rate cases. For additional information on the existing reconciliation policy, we refer readers to sections 150.26 through 150.28 of the Medicare Claims Processing Manual (Pub. 100–4) as added by Change Request 7192 (Transmittal 2111; December 3, 2010) and the RY 2009 LTCH PPS final rule (73 FR 26820 through 26821).

3. High-Cost Outlier Payments for LTCH PPS Standard Federal Payment Rate Cases

a. Establishment of the LTCH PPS Fixed-Loss Amount for LTCH PPS Standard Federal Payment Rate Cases for FY 2016

When we implemented the LTCH PPS, under the broad authority of section 123 of the BBRA as amended by section 307(b) of BIPA, we established a fixed-loss amount so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS (67 FR 56022 through 56026). To determine the fixed-loss amount, we estimate outlier payments and total LTCH PPS payments for each case using claims data from the MedPAR files. Specifically, we estimate the cost of the

case by multiplying the Medicare covered charges from the claim by the LTCH's CCR. Under the HCO policy at § 412.525(a), if the estimated cost of the case exceeds the outlier threshold, we make an outlier payment equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (that is, the sum of the adjusted standard Federal rate payment and the fixed-loss amount).

As noted above and as discussed in greater detail in section VII.B.7.b. of the preamble of this final rule, under the new dual rate LTCH PPS payment structure, we are establishing two separate HCO targets—one for LTCH PPS standard Federal payment rate cases and one for site neutral payment rate cases. Under this finalized policy, for LTCH PPS standard Federal payment rate cases, we are establishing a fixed-loss amount and target using the current LTCH PPS HCO policy, but to limit the data used under that policy to LTCH cases that would have been paid as LTCH PPS standard Federal payment rate cases, if that payment rate had been in effect at the time of those discharges. Therefore, as we proposed, we are not making any modifications to the existing LTCH PPS HCO payment methodology as it applies to LTCH PPS standard Federal payment rate cases, other than determining a fixed-loss amount using only data from LTCH PPS standard Federal payment rate cases (or cases that would have been LTCH PPS standard Federal payment rate cases had the new dual rate LTCH PPS payment structure been in effect at the time of those discharges). As such, LTCH PPS standard Federal payment rate cases will continue to receive an additional payment for any HCO case that is equal to 80 percent of the difference between the estimated cost of the case and the HCO threshold, which is the sum of the LTCH PPS payment for the LTCH PPS standard Federal payment rate case and the fixed-loss amount. The fixed-loss amount for LTCH PPS standard Federal payment rate cases will continue to be determined so that estimated HCO payments would be projected to equal 8 percent of estimated total LTCH PPS standard Federal payment rate cases, and a budget neutrality factor will continue to be applied to LTCH PPS standard Federal payment rate cases to offset that 8 percent so that HCO payments for LTCH PPS standard Federal payment rate cases will be budget neutral. Below we present our calculation of the LTCH PPS fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2016, which is consistent with the methodology used to establish the FY 2015 LTCH PPS fixed-loss amount. (Additional discussion of our HCO payment policy proposals for site neutral payment rate cases is discussed subsequently in section V.D.4. of this Addendum.)

In the FY 2015 IPPS/LTCH PPS final rule (79 FR 50399 through 50400), we presented our policies regarding the methodology and data we used to establish a fixed-loss amount of $14,972 for FY 2015, which was calculated using our existing methodology (based on the data and the rates and policies presented in that final rule) in order to maintain estimated HCO payments at the projected 8 percent of total estimated LTCH PPS payments. Consistent with our historical practice of using the best data available, in determining the fixed-loss amount for FY 2015, we used the most recent available LTCH claims data and CCR data, that is, LTCH claims data from the March 2014 update of the FY 2013 MedPAR file and CCRs from the March 2014 update of the PSF, as these data were the most recent complete LTCH data available at that time.

In this final rule, as we proposed, we are continuing to use our existing methodology to calculate a fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2016 using the best available data that will maintain estimated HCO payments at the projected 8 percent of total estimated LTCH PPS payments for LTCH PPS standard Federal payment rate cases (based on the rates and policies for these cases presented in this final rule). Specifically, based on the most recent complete LTCH data available (that is, LTCH claims data from the March 2015 update of the FY 2014 MedPAR file and CCRs from the March 2015 update of the PSF), we determined a fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2016 that will result in estimated outlier payments projected to be equal to 8 percent of estimated FY 2016 payments for such cases. Under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of the BIPA, we are establishing a fixed-loss amount of $16,423 for LTCH PPS standard Federal payment rate cases for FY 2016. We also will continue to make an additional HCO payment for the cost of an LTCH PPS standard Federal payment rate case that exceeds the HCO threshold amount that is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted LTCH PPS standard Federal payment rate payment and the fixed-loss amount for LTCH PPS standard Federal payment rate cases of $16,423).

We note that the fixed-loss amount of $16,423 for FY 2016 for LTCH PPS standard Federal payment rate cases is lower than the proposed FY 2016 fixed-loss amount for LTCH PPS standard Federal payment rate cases of $18,768. This decrease is primarily a result of updated data used to calculate the fixed-loss amount in this final rule, such as the most recent available LTCH claims data in the MedPAR file, CCRs in the PSF, and the estimate of the LTCH market basket increase. We also note that the fixed-loss amount of $16,423 for LTCH PPS standard Federal payment rate cases for FY 2016 is higher than the FY 2015 fixed-loss amount of $14,792. This increase is largely attributable to the implementation of the new dual rate LTCH PPS payment structure, under which we have established separate HCO target amounts for LTCH PPS standard Federal payment rate cases and site neutral payment rate cases. The FY 2015 fixed-loss amount was determined based on data from all LTCH cases—both those that would have been paid as site neutral payment rate cases and those that would have been paid as LTCH PPS standard Federal payment rate cases if the new dual rate LTCH PPS payment structure had been in effect at that time. However, under our finalized policy, the fixed-loss amount of $16,423 for FY 2016 will only be used to determine HCO payments made for LTCH PPS standard Federal payment rate cases. We currently estimate that the FY 2015 fixed-loss amount of $14,972 results in estimated HCO payments for LTCH PPS standard Federal payment rate cases of approximately 8.1 percent of total estimated FY 2015 LTCH PPS payments to those cases, which exceeds the 8 percent target. Therefore, we believe that it is necessary and appropriate to increase the fixed-loss amount to maintain that, for LTCH PPS standard Federal payment rate cases, estimated HCO payments would equal 8 percent of estimated total LTCH PPS payments for those cases as required under the revisions to § 412.525(a). (For further information on the existing 8 percent HCO ''target'' requirement, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 56022 through 56024).) Maintaining the fixed-loss amount at the current level would result in HCO payments that are more than the current regulatory 8-percent target that we are applying to total payments for LTCH PPS standard Federal payment rate cases because a lower fixed-loss amount would result in more cases

qualifying as outlier cases, as well as higher outlier payments for qualifying HCO cases because the maximum loss that an LTCH must incur before receiving an HCO payment (that is, the fixed-loss amount) would be smaller.

b. Application of the High-Cost Outlier Policy to SSO Cases

Under our finalized policies to implement the new dual rate LTCH PPS payment structure required by statute, we are establishing that LTCH PPS standard Federal payment rate cases (that is, LTCH discharges that meet the criteria for exclusion from the site neutral payment rate) will continue to be paid based on the LTCH PPS standard Federal payment rate, and will include all of the existing payment adjustments under § 412.525(d), such as the adjustments for SSO cases under § 412.529. (For additional information on our payments for LTCH PPS standard Federal payment rate cases, we refer readers to section VII.B.4.c. of the preamble of this final rule.) Under some rare circumstances, an LTCH discharge can qualify as an SSO case (as defined in the regulations at § 412.529 in conjunction with § 412.503) and also as an HCO case, as discussed in the August 30, 2002 final rule (67 FR 56026). In this scenario, a patient could be hospitalized for less than five-sixths of the geometric average length of stay for the specific MS–LTC–DRG, and yet incur extraordinarily high treatment costs. If the estimated costs exceeded the HCO threshold (that is, the SSO payment plus the fixed-loss amount), the discharge is eligible for payment as an HCO. Therefore, for an SSO case in FY 2016, the HCO payment will be 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the fixed-loss amount of $16,423 and the amount paid under the SSO policy as specified in § 412.529).

4. High-Cost Outlier Payments for Site Neutral Payment Rate Cases

Under the new dual rate LTCH PPS payment structure, the statute establishes two distinct payment rates for LTCH discharges beginning in FY 2016. Under this statutory change, as discussed in section VII.B. of the preamble of this final rule, we will pay for LTCH discharges that meet the criteria for exclusion from the site neutral payment rate (that is, LTCH PPS standard Federal payment rate cases) based on the LTCH PPS standard Federal payment rate. In addition, consistent with the statute, we are establishing that the site neutral payment rate is the lower of the IPPS comparable per diem amount as determined under § 412.529(d)(4), including any applicable outlier payments as specified in § 412.525(a); or 100 percent of the estimated cost of the case as determined under existing § 412.529(d)(2). Furthermore, we are establishing two separate HCO targets-one for LTCH PPS standard Federal payment rate cases and one for site neutral payment rate cases.

For site neutral payment rate cases, as we proposed, we are establishing that such cases will receive an additional HCO payment for costs that exceed the HCO threshold that is equal to 80 percent of the difference between the estimated cost of the case and the applicable HCO threshold. We are establishing that the applicable HCO threshold for site neutral payment rate cases is the sum of the site neutral payment rate for the case and the IPPS fixed-loss amount. As discussed in section II.A.4.g.(1) of this Addendum, we are establishing a fixed-loss amount of $22,544 under the IPPS for FY 2016. Accordingly, under our finalized policies, for FY 2016 we will calculate HCO payments for site neutral payment rate cases with costs that exceed the HCO threshold amount, which is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of site neutral payment rate payment and the fixed-loss amount for site neutral payment rate cases of $22,544). (We note that, as discussed in section VII.B.7.b. of the preamble of this final rule, in light of our HCO policies and in accordance with our implementation of the new dual rate LTCH PPS payment structure, any site neutral payment rate case that is paid 100 percent of the estimated cost of the case (because that amount is lower than the IPPS comparable per diem amount) will not be eligible to receive a HCO payment because, by definition, the estimated costs of such cases would never exceed the IPPS comparable per diem amount by any threshold.)

Furthermore, under our finalized policy, after consideration of public comments as discussed in section VII.B.7.b. of the preamble of this final rule, we are establishing that HCO payments for site neutral payment rate cases will be budget neutral, such that the site neutral payment rate HCO payments will not result in any change in estimated aggregate LTCH PPS payments (For additional details on our HCO policy for site neutral payment rate cases, we refer readers to section VII.B.7.b. of the preamble of this final rule.) In order to achieve this, in the proposed rule (80 FR 24648 through 24649), under proposed new § 412.522(c)(2)(i), we proposed to apply a budget neutrality factor to the payments for all site neutral payment rate cases, which would be established on an estimated basis. In addition, in order to estimate the magnitude a budget neutrality adjustment for HCO payments for site neutral payment rate cases, we relied on the assumption by our actuaries that site neutral payment rate cases would have lengths of stay and costs comparable to IPPS cases assigned to the same MS–DRG. Because site neutral payment rate cases are expected to have lengths of stay and costs comparable to IPPS cases assigned to the same MS DRG, we project that our policy to use the IPPS fixed-loss threshold for the site neutral payment rate cases will result in HCO payments for site neutral payment rate cases that are similar in proportion as is seen in IPPS cases assigned to the same MS–DRG; that is, 5.1 percent. Therefore, under new § 412.522(c)(2)(i), we proposed to adjust all payments for site neutral payment rate cases by a budget neutrality factor so that the estimated HCO payments payable for site neutral payment rate cases do not result in any increase in aggregate LTCH PPS payments. That is, for FY 2016 we proposed to apply a budget neutrality adjustment for estimated HCO payments for site neutral payment rate cases to *both* the site neutral payment rate and the LTCH PPS standard Federal payment rate portions of the FY 2016 transitional blended rate paid to site neutral payment rate cases. (We refer readers to section VII.B.7.b. of this preamble for our discussion of the public comments we received, our responses to those comments, and our finalized policy for a budget neutrality requirement for site neutral payment rate cases' HCO payments.) Because the statutory LTCH PPS payment changes required by section 1886(m)(6) of the Act (that is, the application of the site neutral payment rate) are effective for LTCH PPS discharges occurring in cost reporting periods beginning on or after October 1, 2015, in the proposed rule, our site neutral payment rate case HCO budget neutrality calculations also included a proposed approach to account for when LTCHs' first cost reporting period begins on or after October 1, 2015.

Under our proposed approach (summarized above and described in more detail in section V.D.4. of the Addendum of the proposed rule (80 FR 24649)) and based on the site neutral payment rate LTCH cases in our database from the FY 2014 MedPAR files (that is, cases that would have met

the new criteria had they been in effect at the time of the discharge), we estimated that site neutral payment rate HCO payments would be approximately 2.3 percent of total LTCH PPS payments for site neutral payment rate cases in FY 2016. Accordingly, we proposed to applying a budget neutrality factor of 0.976996 to all payments for site neutral payment rate cases in FY 2016 so that the estimated HCO payments payable to those cases would not result any increase in aggregate LTCH PPS payments.

Comment: Several commenters disagreed with our proposed approach of adjusting *all* payments for site neutral payment rate cases in FY 2016 (that is, *both* the site neutral payment rate and the LTCH PPS standard Federal payment rate portions of the transitional blended rate payment) by a budget neutrality factor for estimated HCO payments payable to site neutral payment rate cases. The reasons for the commenters' opposition to this proposal include: The LTCH PPS standard Federal payment rate portion under transitional blended rate would be lower than the LTCH PPS standard Federal payment rate used to pay cases that are excluded from the site neutral payment rate; and the comingling of site neutral payment rate and LTCH PPS standard Federal payment rate elements unnecessarily convolutes the proposed site neutral payment rate HCO calculations. Consequently, these commenters recommended that, if CMS finalizes its proposal to apply a budget neutrality factor to account for estimated site neutral payment case HCO payments, the site neutral payment rate and the LTCH PPS standard Federal payment rate portions of the transitional blended rate should be treated separately. That is, the budget neutrality adjustment for estimated HCO payments to site neutral payment rate cases should only be applied to the site neutral payment rate portion of the transitional blended rate payment (and not applied to the LTCH PPS standard Federal payment rate portion of the transitional blended rate payment).

Furthermore, some commenters stated that the description of the calculation of the estimated percentage of site neutral payment rate case HCO payments for FY 2016 was too brief, and requested that CMS provide additional details on the steps used to calculate the budget neutrality adjustment for estimated HCO payments to site neutral payment rate cases. In addition, commenters believed that our proposed calculation of our estimate in the proposed rule of HCO payments to site neutral payment rate cases includes a technical error. That is, the commenters stated that the calculation of the percentage of estimated site neutral payment rate case HCO payments for FY 2016 of 2.3 percent appears to be based on estimated HCO payments for site neutral payment rate cases *before* applying the transitional blended rate payment (rather than only 50 percent, consistent with the calculation of the transitional blended rate that is comprised of only 50 percent of the site neutral payment rate payment amount). Lastly, some commenters agreed with the proposed approach to account for when LTCHs' first cost reporting period begins on or after October 1, 2015 in estimating site neutral payment rate payments in FY 2016.

Response: We agree that the approach recommended by commenters would lessen the complexity and increase the transparency of the calculation of the site neutral payment rate HCO payment budget neutrality adjustment. Such an approach simplifies the calculation because the adjustment to account for additional HCO payments to site neutral payment rate cases would only be applied to the portion of the blended rate payment that is based on the site neutral payment rate calculation under new § 412.522(c)(1). Therefore, after consideration of public comments we received, we are modifying our proposal by adopting the commenters' recommended approach of applying the budget neutrality adjustment for estimated HCO payments for site neutral payment rate cases only to the site neutral payment rate portion of the transitional blended rate payment. As a result of this modification, we are making conforming changes to our proposed codification of this policy under new § 412.522(c)(2)(i) to specify that the site neutral payment rate HCO budget neutrality adjustment does not include the portion of the blended payment rate described in new § 412.522(c)(3)(ii).

This modification to our proposed approach for applying the budget neutrality adjustment to the site neutral payment rate portion of the transitional blended rate payment eliminates the need to perform any calculation of the site neutral payment rate cases HCO payment budget neutrality adjustment under our finalized policy. This is, as discussed above and in greater detail in section VII.B.7.b. of the preamble of this final rule, because based on our actuarial assumptions we project that our finalized policy to use the IPPS fixed-loss threshold for the site neutral payment rate cases will result in HCO payments for those cases that are similar in proportion as is seen in IPPS cases assigned to the same MS–DRG; that is, 5.1 percent. In other words, we estimated that HCO payments for site neutral payment rate cases will be 5.1 percent of the site neutral payment rate payments. As noted above, payments to site neutral payment rate cases in FY 2016 will be paid under the blended transitional rate. As such, estimated HCO payments for site neutral payment rate cases in FY 2016 under our finalized policies are equal to 5.1 percent of the portion of the blended rate payment that is based on the estimated site neutral payment rate payment amount (and does not include the LTCH PPS standard Federal payment rate payment amount, as we proposed). Therefore, to ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2016 do not result any increase in estimated aggregate FY 2016 LTCH PPS payments, it is necessary to reduce the site neutral payment rate portion of the blended rate payment by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2016. In order to achieve this, under § 412.522(c)(2)(i) for FY 2016, we are applying a budget neutrality factor of 0.949 (that is, the decimal equivalent of a 5.1 percent reduction, determined as 1.0–5.1/100 = 0.949). (We note, because this adjustment is intended to ensure that estimated HCO payments payable to site neutral payment rate cases are budget neutral (that is, do not result in any increase in aggregate LTCH PPS payments), the magnitude of the reduction is larger than it would be under our proposed approach as the adjustment is now only being applied to half of the transitional blended rate payment (rather than the whole transitional blended rate payment as it was under our proposal).

Upon review of our calculation in the proposed rule of the estimated percentage of site neutral payment rate case HCO payments for FY 2016, we determined that our calculation of the proposed budget neutrality adjustment for estimated HCO payments for site neutral payment rate cases inadvertently contained the technical error pointed out by the commenters. We appreciate the commenters bringing that inadvertent error to our attention, and we have included the necessary correction in the calculation of our estimate of HCO payments for site neutral payment rate cases, which we discuss in the regulatory impact analyses presented in section I.J. of Appendix A of this final rule. (We note, as explained above, the modification to the proposed approach for applying the

budget neutrality adjustment for estimated HCO payments for site neutral payment rate cases that we are adopting in this final rule eliminates the need for calculation of the budget neutrality adjustment under our finalized policy.)

We appreciate the commenters' support of our proposed approach to account for the fact that LTCHs whose cost reporting periods begin on or after October 1, 2015, will receive the LTCH PPS standard Federal payment rates for all of their LTCH PPS cases, including their cases that would be site neutral payment rate cases, until the start of their next cost reporting period when estimating site neutral payment rate payments in FY 2016. Because we are adopting a different, more direct approach in this final rule (as discussed above), in the applying the budget neutrality requirement for estimated HCO payments payable to site neutral payment rate cases in for FY 2016, it is no longer necessary to account for when LTCHs' first cost reporting period begins on or after October 1, 2015 (as we did to calculate the budget neutrality adjustment under our proposed approach). We note, however, for purposes of the impact analyses presented in section I.J. of Appendix A of this final rule, to estimate site neutral payment rate payments for FY 2016, it is still necessary to account for when LTCHs' first cost reporting period begins on or after October 1, 2015. Accordingly, in this final rule, when estimating total LTCH PPS site neutral payment rate payments in Federal FY 2016, as we proposed, we are applying an adjustment to account for the varying effective dates of the new dual rate LTCH PPS payment structure. We describe our application of this approach for purposes of the impact analyses presented in this final rule in section I.J. of Appendix A of this final rule. (For a description of our proposed approach to account for the statutory rolling effective date of the revisions to the LTCH PPS, we refer readers to section V.D.4. of the Addendum of the proposed rule (80 FR 24649).)

In summary, after consideration of public comments we received, for the reasons discussed above, we are modifying our proposed application of the site neutral payment rate HCO payment budget neutrality adjustment. In this final rule, we are adopting an approach under which the budget neutrality adjustment for estimated HCO payments to site neutral payment rate cases will be applied to the site neutral payment rate portion of the transitional blended rate payment in FY 2016 (and will not applied to the LTCH PPS standard Federal payment rate portion of the transitional blended rate payment). Accordingly, to ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2016 do not result any increase in estimated aggregate FY 2016 LTCH PPS payments, we are reducing the site neutral payment rate portion of the blended rate payment in FY 2016 by 5.1 percent. In order to achieve this, we are applying a budget neutrality factor of 0.949 to the site neutral payment rate portion of the blended rate payment in FY 2016, in accordance with new § 412.522(c)(2)(i).

E. Update to the IPPS Comparable/ Equivalent Amounts to Reflect the Statutory Changes to the IPPS DSH Payment Adjustment Methodology

In the FY 2014 IPPS/LTCH PPS final rule, we established a policy for reflecting the changes to the Medicare IPPS DSH payment adjustment methodology provided for by section 3133 of the Affordable Care Act in the calculation of the ''IPPS comparable amount'' under the SSO policy at § 412.529 and the ''IPPS equivalent amount'' under the 25-percent threshold payment adjustment policy at § 412.534 and § 412.536. Historically, the determination of both the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' includes an amount for inpatient operating costs ''for the costs of serving a disproportionate share of low-income patients.'' Under the statutory changes to the Medicare DSH payment adjustment methodology that began in FY 2014, in general, eligible IPPS hospitals receive an empirically justified Medicare DSH payment equal to 25 percent of the amount they otherwise would have received under the statutory formula for Medicare DSH payments prior to the amendments made by the Affordable Care Act. The remaining amount, equal to an estimate of 75 percent of the amount that otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under the age of 65 who are uninsured, is made available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. The additional uncompensated care payments are based on the hospital's amount of uncompensated care for a given time period relative to the total amount of uncompensated care for that same time period reported by all IPPS hospitals that receive Medicare DSH payments.

To reflect the statutory changes to the Medicare DSH payment adjustment methodology in the calculation of the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' under the LTCH PPS, we stated that we will include a reduced Medicare DSH payment amount that reflects the projected percentage of the payment amount calculated based on the statutory Medicare DSH payment formula prior to the amendments made by the Affordable Care Act that will be paid to eligible IPPS hospitals as empirically justified Medicare DSH payments and uncompensated care payments in that year (that is, a percentage of the operating DSH payment amount that has historically been reflected in the LTCH PPS payments that is based on IPPS rates). We also stated that the projected percentage will be updated annually, consistent with the annual determination of the amount of uncompensated care payments that will be made to eligible IPPS hospitals. As explained in the FY 2014 IPPS/LTCH PPS final rule (79 FR 50766 through 50767), we believe that this approach results in appropriate payments under the LTCH PPS and is consistent with our intention that the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' under the LTCH PPS closely resemble what an IPPS payment would have been for the same episode of care, while recognizing that some features of the IPPS cannot be translated directly into the LTCH PPS.

In the FY 2015 IPPS/LTCH PPS final rule (79 FR 50400 through 50401), we discussed that, for FY 2015, based on the latest data available at that time, we projected that the reduction in the amount of Medicare DSH payments pursuant to section 1886(r)(1) of the Act, along with the proposed payments for uncompensated care under section 1886(r)(2) of the Act, would result in overall Medicare DSH payments equaling 85.26 percent of the amount of Medicare DSH payments that would otherwise have been made in the absence of amendments made by the Affordable Care Act. Therefore, the calculation of the ''IPPS comparable amount'' under § 412.529 and the ''IPPS equivalent amount'' under § 412.534 and § 412.536 for FY 2015 includes an applicable operating Medicare DSH payment amount that would be equal to 85.26 percent of the operating Medicare DSH payment amount based on the statutory Medicare DSH payment formula prior to the amendments made by the Affordable Care Act.

For FY 2016, as discussed in greater detail in section IV.D.3.d.(2) of the preamble of this final rule, based on the most recent data available, our estimate of 75 percent of the amount that would otherwise have been paid as Medicare

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, 413, and 485

[CMS–1655–P]

RIN 0938–AS77

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports

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

ACTION: Proposed rule.

SUMMARY: We are proposing to revise 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 2017. Some of the proposed changes would implement certain statutory provisions contained in the Pathway for Sustainable Growth (SGR) Reform Act of 2013, the Improving Medicare Post-Acute Care Transformation Act of 2014, the Notice of Observation Treatment and Implications for Care Eligibility Act of 2015, and other legislation. We also are providing the estimated market basket update to apply to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits for FY 2017.

We are proposing to update the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for FY 2017.

In addition, we are proposing to make changes relating to direct graduate medical education (GME) and indirect medical education (IME) payments to hospitals with rural track training programs. We are proposing to establish new requirements or revise requirements for quality reporting by specific providers (acute care hospitals, PPS-exempt cancer hospitals, LTCHs, and inpatient psychiatric facilities) that are participating in Medicare, including related provisions for eligible hospitals and critical care hospitals (CAHs) participating in the Electronic Health Record (EHR) Incentive Program. We are proposing to update policies relating to the Hospital Value-Based Purchasing (VBP) Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition (HAC) Reduction Program. We also are proposing to: Implement statutory provisions that require hospitals and CAHs to furnish notification to Medicare beneficiaries, including Medicare Advantage enrollees, when the beneficiaries receive outpatient observation services for more than 24 hours; announce the implementation of the Frontier Community Health Integration Project Demonstration; and make technical corrections and changes to regulations relating to costs to organizations and Medicare cost reports.

DATES: To be assured consideration, comments must be received at one of the addresses provided in the **ADDRESSES** section, no later than 5 p.m. EDT on June 17, 2016.

ADDRESSES: In commenting, please refer to file code CMS–1655–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may (and we encourage you to) submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the instructions under the ''submit a comment'' tab.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1655–P, P.O. Box 8011, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments via express or overnight mail to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1655–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call the telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, we refer readers to the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Ing Jye Cheng, (410) 786–4548, and Donald Thompson, (410) 786–4487, Operating Prospective Payment, MS–DRGs, Wage Index, New Medical Service and Technology Add-On Payments, Hospital Geographic Reclassifications, Graduate Medical Education, Capital Prospective Payment, Excluded Hospitals, Medicare Disproportionate Share Hospital (DSH) Issues, Medicare-Dependent Small Rural Hospital (MDH) Program, and Low-Volume Hospital Payment Adjustment Issues.

Michele Hudson, (410) 786–4487, and Emily Lipkin, (410) 786–3633, Long-Term Care Hospital Prospective Payment System and MS–LTC–DRG Relative Weights Issues.

Mollie Knight (410) 786–7948, and Bridget Dickensheets, (410) 786–8670, Rebasing and Revising the LTCH Market Basket Issues.

Siddhartha Mazumdar, (410) 786–6673, Rural Community Hospital Demonstration Program Issues.

Jason Pteroski, (410) 786–4681, and Siddhartha Mazumdar, (410) 786–6673, Frontier Community Health Integration Project Demonstration Issues.

Kathryn McCann Smith, (410) 786–7623, Hospital Notification Procedures for Beneficiaries Receiving Outpatient Observation Services Issues; or

recent data to determine the LTCH total CCR ceiling for the FY 2017 final rule. (For additional information on our methodology for determining the LTCH total CCR ceiling, we refer readers to the FY 2007 IPPS final rule (71 FR 48118 through 48119).)

c. LTCH Statewide Average CCRs

Our general methodology for determining the statewide average CCRs used under the LTCH PPS is similar to our established methodology for determining the LTCH total CCR ceiling because it is based on ''total'' IPPS CCR data. (For additional information on our methodology for determining statewide average CCRs under the LTCH PPS, we refer readers to the FY 2007 IPPS final rule (71 FR 48119 through 48120).) Under the LTCH PPS HCO policy for cases paid under either payment rate at § 412.525(a)(4)(iv)(C), the SSO policy at § 412.529(f)(4)(iii), and the site neutral payment rate at § 412.522(c)(1)(ii), the MAC may use a statewide average CCR, which is established annually by CMS, if it is unable to determine an accurate CCR for an LTCH in one of the following circumstances: (1) New LTCHs that have not yet submitted their first Medicare cost report, a new LTCH is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18); (2) LTCHs whose calculated CCR is in excess of the LTCH total CCR ceiling; and (3) other LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the MAC may consider in determining an LTCH's CCR include data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as an LTCH (that is, the period of at least 6 months that it was paid as a short-term, acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

Consistent with our historical practice of using the best available data, in this proposed rule, using our established methodology for determining the LTCH statewide average CCRs, based on the most recent complete IPPS ''total CCR'' data from the December 2015 update of the PSF, we are proposing LTCH PPS statewide average total CCRs for urban and rural hospitals that would be effective for discharges occurring on or after October 1, 2016 through September 30, 2017, in Table 8C listed in section VI. of the Addendum to this proposed rule (and available via the Internet on the CMS Web site). Consistent with our historical practice, we are proposing to use more recent data to determine the LTCH PPS statewide average total CCRs for FY 2017 in the final rule.

Under the current LTCH PPS labor market areas, all areas in Delaware, the District of Columbia, New Jersey, and Rhode Island are classified as urban. Therefore, there are no rural statewide average total CCRs listed for those jurisdictions in Table 8C. This policy is consistent with the policy that we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48119 through 48121) and is the same as the policy applied under the IPPS. In addition, although Connecticut and North Dakota have areas that are designated as rural, in our calculation of the LTCH statewide average CCRs, there was no data available from short-term, acute care IPPS hospitals to compute a rural statewide average CCR or there were no short-term, acute care IPPS hospitals or LTCHs located in those areas as of December 2015. Therefore, consistent with our existing methodology, we are proposing to use the national average total CCR for rural IPPS hospitals for rural Connecticut and North Dakota in Table 8C listed in section VI. of the Addendum to this proposed rule (and available via the Internet on the CMS Web site). Furthermore, consistent with our existing methodology, in determining the urban and rural statewide average total CCRs for Maryland LTCHs paid under the LTCH PPS, we are proposing to continue to use, as a proxy, the national average total CCR for urban IPPS hospitals and the national average total CCR for rural IPPS hospitals, respectively. We use this proxy because we believe that the CCR data in the PSF for Maryland hospitals may not be entirely accurate (as discussed in greater detail in the FY 2007 IPPS final rule (71 FR 48120)).

d. Reconciliation of HCO and SSO Payments

Under the HCO policy for cases paid under either payment rate at § 412.525(a)(4)(iv)(D) and the SSO policy at § 412.529(f)(4)(iv), the payments for HCO and SSO cases are subject to reconciliation. Specifically, any such payments are reconciled at settlement based on the CCR that is calculated based on the cost report coinciding with the discharge. (We note the existing reconciliation process for HCO payments is also applicable to LTCH PPS payments for site neutral payment rate cases (80 FR 49610).) For additional information on the reconciliation policy, we refer readers to Sections 150.26 through 150.28 of the Medicare Claims Processing Manual (Pub. 100–4) as added by Change Request 7192 (Transmittal 2111; December 3, 2010) and the RY 2009 LTCH PPS final rule (73 FR 26820 through 26821).

e. Proposed Technical Change to the Definition of ''Outlier Payment''

The existing regulations at § 412.503 includes a definition of ''outlier payment,'' which was adopted when the LTCH PPS was implemented (67 FR 56049). This definition does not account for the dual rate LTCH PPS payment structure that began in FY 2016. Therefore, in this proposed rule, to account for our HCO policy for LTCH cases paid under either payment rate, we are proposing to revise the definition of ''outlier payment'' at § 412.503 to mean an additional payment beyond the LTCH PPS standard Federal payment rate or the site neutral payment rate (including, when applicable, the transitional blended rate), as applicable, for cases with unusually high costs.

3. Proposed High-Cost Outlier Payments for LTCH PPS Standard Federal Payment Rate Cases

a. Establishment of the Proposed Fixed-Loss Amount for LTCH PPS Standard Federal Payment Rate Cases for FY 2017

When we implemented the LTCH PPS, we established a fixed-loss amount so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS (67 FR 56022 through 56026). When we implemented the dual rate LTCH PPS payment structure beginning in FY 2016, we established that, in general, that the historical LTCH PPS HCO policy will continue to apply to LTCH PPS standard Federal payment rate cases. That is, the fixed-loss amount and target for LTCH PPS standard Federal payment rate cases is determined using the LTCH PPS HCO policy adopted when the LTCH PPS was first implemented, but we limited the data used under that policy to LTCH cases that would have been LTCH PPS standard Federal payment rate cases if the statutory changes had been in effect at the time of those discharges.

To determine the applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases, we estimate outlier payments and total LTCH PPS payments for each LTCH PPS standard Federal payment rate case (or for each case that would have been a LTCH PPS standard Federal payment rate case if the statutory changes had been in effect at the time of the discharge) using claims data from the MedPAR files. The applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases results in estimated total outlier payments being projected to be equal to 8 percent of projected total LTCH PPS payments for LTCH PPS standard Federal payment rate cases. We use MedPAR claims data and CCRs based on data from the most recent PSF (or from the applicable statewide average CCR if an LTCH's CCR data are faulty or unavailable) to establish an applicable fixed-loss threshold amount for LTCH PPS standard Federal payment rate cases.

For FY 2017, we are not proposing to make any modifications to the current LTCH PPS HCO payment methodology for LTCH PPS standard Federal payment rate cases. Therefore, for FY 2017, we are proposing to determine an applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases using data from LTCH PPS standard Federal payment rate cases (or cases that would have been LTCH PPS standard Federal payment rate cases had the dual rate LTCH PPS payment structure been in effect at the time of those discharges). The proposed fixed-loss amount for LTCH PPS standard Federal payment rate cases would continue to be determined so that estimated HCO payments would be projected to equal 8 percent of estimated total LTCH PPS standard Federal payment rate cases. Furthermore, in accordance with § 412.523(d)(1), a budget neutrality factor would continue to be applied to LTCH PPS standard Federal payment rate cases to offset that 8 percent so that HCO payments for LTCH PPS standard Federal payment rate

cases will be budget neutral. Below we present our calculation of the proposed fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017, which is consistent with the methodology used to establish the FY 2016 LTCH PPS fixed-loss amount.

In the FY 2016 IPPS/LTCH PPS final rule (80 FR 49803 through 49804), we presented our policies regarding the methodology and data we used to establish a fixed-loss amount of $16,432 for FY 2016 for LTCH PPS standard Federal payment rate cases, which was calculated based on the data and the rates and policies presented in that final rule in order to maintain estimated HCO payments at the projected 8 percent of total estimated LTCH PPS payments. Consistent with our historical practice of using the best data available, in determining the proposed fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017, we used the most recent available LTCH claims data and CCR data, that is, LTCH claims data from the December 2015 update of the FY 2015 MedPAR file and CCRs from the December 2015 update of the PSF, as these data were the most recent complete LTCH data available at that time.

For FY 2017, we are proposing to continue to use our current methodology to calculate an applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017 using the best available data that would maintain estimated HCO payments at the projected 8 percent of total estimated LTCH PPS payments for LTCH PPS standard Federal payment rate cases (based on the rates and policies for these cases presented in this proposed rule). Specifically, based on the most recent complete LTCH data available (that is, LTCH claims data from the December 2015 update of the FY 2015 MedPAR file and CCRs from the December 2015 update of the PSF), we determined a proposed fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017 that will result in estimated outlier payments projected to be equal to 8 percent of estimated FY 2017 payments for such cases. Under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of the BIPA, we are proposing a fixed-loss amount of $22,728 for LTCH PPS standard Federal payment rate cases for FY 2017. Under our proposal, we would continue to make an additional HCO payment for the cost of an LTCH PPS standard Federal payment rate case that exceeds the HCO threshold amount that is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted LTCH PPS standard Federal payment rate payment and the fixed-loss amount for LTCH PPS standard Federal payment rate cases of $22,728).

We note that the proposed fixed-loss amount of $22,728 for FY 2017 for LTCH PPS standard Federal payment rate cases is notably higher than the FY 2016 fixed-loss amount for LTCH PPS standard Federal payment rate cases of $16,423. The FY 2016 fixed-loss amount for LTCH PPS standard Federal payment rate cases was determined using LTCH claims data from the March 2015 update of the FY 2014 MedPAR file and CCRs from the March 2015 update of the PSF. Based on that data, the estimated outlier payments were projected to be equal to 8 percent of estimated FY 2016 payments for such cases (80 FR 49803). Using the more recent LTCH claims data (that is, FY 2015 LTCH discharges from the December 2015 update of the MedPAR file and CCRs from the December 2015 update of the PSF), we currently estimate that the FY 2016 fixed-loss amount of $16,423 results in estimated HCO payments for LTCH PPS standard Federal payment rate cases of approximately 9.1 percent of total estimated FY 2016 LTCH PPS payments to those cases, which exceeds the 8 percent target. While many factors contribute to this increase, we found that the rate-of-change in the Medicare allowable charges on the claims data in the MedPAR is a significant contributing factor. In the payment modeling used to estimate LTCH PPS payments for the FY 2016 IPPS/LTCH PPS final rule, for SSO and HCO cases paid as LTCH PPS standard Federal payment rate cases, we applied an inflation factor of 4.6 percent (determined by the Office of the Actuary) to update the 2014 costs of each case to 2016 (80 FR 49833). Upon examining the FY 2014 LTCH discharge data and the FY 2015 discharge data, we found that Medicare allowable charges for LTCH PPS standard Federal payment rate cases (had the dual rate LTCH PPS payment structure been in effect at the time of the discharges) increased approximately 7 percent. This higher inflation factor results in higher estimated costs for outlier cases and, therefore, more estimated outlier payments.

Fluctuations in the fixed-loss amount occurred in the first few years after the implementation of the LTCH PPS, due, in part, to the changes in LTCH behavior (such as Medicare beneficiary treatment patterns) in response to the new payment system and the lack of data and information available to predict how those changes would affect the estimate costs of LTCH cases. As we gained more experience with the effects and implementation of the LTCH PPS, the annual changes on the fixed-loss amount generally stabilized relative to the fluctuations that occurred in the early years of the LTCH PPS. At this time, we are not proposing any changes to our method for the inflation factor applied to update the costs of each case (that is, an inflation factor based on the most recent estimate of the proposed 2013-based LTCH market basket as determined by the Office of the Actuary) in determining the proposed fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017. We continue to believe that it is appropriate to continue to use our historical approach until we gain experience with the effects and implementation of the dual rate LTCH PPS payment structure that began with discharges occurring in cost reporting periods beginning on or after October 1, 2015, and the types of cases paid at the LTCH PPS standard Federal payment rate under this dual rate payment structure. We may revisit this issue in the future if data demonstrate such a change is warranted, and would propose any changes in the future through the notice-and-comment rulemaking process. However, we are inviting public comments on potential improvements to the determination of the fixed-loss amount for LTCH PPS standard Federal payment rate cases, including the most appropriate method of determining an inflation factor for projecting the costs of each case when determining the fixed-loss threshold.

For the reasons discussed above, we believe it is necessary and appropriate to propose an increase to the fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017 to maintain that, for LTCH PPS standard Federal payment rate cases, estimated HCO payments would equal 8 percent of estimated total LTCH PPS payments for those cases as required under § 412.525(a). (For further information on the existing 8 percent HCO ''target'' requirement, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 56022 through 56024).) Maintaining the fixed-loss amount at the current level would result in HCO payments that are substantially more than the current regulatory 8 percent target that we are applying to total payments for LTCH PPS standard Federal payment rate cases because a lower fixed-loss amount would result in more cases qualifying as outlier cases, as well as higher outlier payments for qualifying HCO cases because the maximum loss that an LTCH must incur before receiving an HCO payment (that is, the fixed-loss amount) would be smaller.

b. Application of the High-Cost Outlier Policy to SSO Cases

Under our implementation of the dual rate LTCH PPS payment structure required by statute, LTCH PPS standard Federal payment rate cases (that is, LTCH discharges that meet the criteria for exclusion from the site neutral payment rate) will continue to be paid based on the LTCH PPS standard Federal payment rate, and will include all of the existing payment adjustments under § 412.525(d), such as the adjustments for SSO cases under § 412.529. Under some rare circumstances, an LTCH discharge can qualify as an SSO case (as defined in the regulations at § 412.529 in conjunction with § 412.503) and also as an HCO case, as discussed in the August 30, 2002 final rule (67 FR 56026). In this scenario, a patient could be hospitalized for less than five-sixths of the geometric average length of stay for the specific MS–LTC–DRG, and yet incur extraordinarily high treatment costs. If the estimated costs exceeded the HCO threshold (that is, the SSO payment plus the applicable fixed-loss amount), the discharge is eligible for payment as an HCO. Therefore, for an SSO case in FY 2017, we are proposing the HCO payment would be 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the proposed fixed-loss amount of $22,728 and the amount paid under the SSO policy as specified in § 412.529).

4. Proposed High-Cost Outlier Payments for Site Neutral Payment Rate Cases

Under § 412.525(a), site neutral payment rate cases receive an additional HCO payment for costs that exceed the HCO threshold that is equal to 80 percent of the difference between the estimated cost of the case and the applicable HCO threshold (80

FR 49618 through 49629). In the FY 2016 IPPS/LTCH PPS final rule, in examining the appropriate fixed-loss amount for site neutral payment rate cases issue, we considered how LTCH discharges based on historical claims data would have been classified under the dual rate LTCH PPS payment structure and the CMS' Office of the Actuary (OACT) projections regarding how LTCHs would likely respond to our proposed implementation of policies resulting from the statutory payment changes. For FY 2016, at that time our actuaries projected that the proportion of cases that would qualify as LTCH PPS standard Federal payment rate cases versus site neutral payment rate cases under the statutory provisions would remain consistent with what is reflected in the historical LTCH PPS claims data. Although our actuaries did not project an immediate change in the proportions found in the historical data, they did project cost and resource changes to account for the lower payment rates. Our actuaries also projected that the costs and resource use for cases paid at the site neutral payment rate would likely be lower, on average, than the costs and resource use for cases paid at the LTCH PPS standard Federal payment rate and would likely mirror the costs and resource use for IPPS cases assigned to the same MS–DRG, regardless of whether the proportion of site neutral payment rate cases in the future remains similar to what is found based on the historical data. In light of these projections and expectations, we discussed that we believed that the use of a single fixed-loss amount and HCO target for all LTCH PPS cases would be problematic. In addition, we discussed that we did not believe that it would be appropriate for comparable LTCH PPS site neutral payment rate cases to receive dramatically different HCO payments from those cases that would be paid under the IPPS (80 FR 49618 through 49619). For those reasons, in the FY 2016 IPPS/LTCH PPS final rule (FR 80 49619), we stated that we believe that the most appropriate fixed-loss amount for site neutral payment rate cases for a given fiscal year, beginning with FY 2016, would be the IPPS fixed-loss amount for that fiscal year. Accordingly, we established that for FY 2016, a fixed-loss amount for site neutral payment rate cases of $22,544, which was the same as the FY 2016 IPPS fixed-loss amount. (We note that the FY 2016 fixed-loss amount under the IPPS was updated, applicable for discharges on or after January 1, 2016, as a conforming change to the implementation of section 601 of the Consolidated Appropriations Act, 2016, which modified the payment calculation with respect to operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges on or after January 1, 2016 (Change Request 9523, Transmittal 3449, dated February 4, 2016).) Consistent with this change, the FY 2016 fixed-loss amount for site neutral payment rate cases under the LTCH PPS was updated, applicable for discharges on or after January 1, 2016, to $22,538, which is the same as the updated IPPS outlier fixed-loss cost threshold for FY 2016. (We refer readers to Change Request 9527, Transmittal 3445, dated January 29, 2016, which also updated the IPPS comparable amount calculation, applicable to discharges occurring on or after January 1, 2016, consistent with the conforming changes made as a result of the new IPPS payment requirement.)

For this proposed rule, in developing a proposed fixed-loss amount for site neutral payment rate cases for FY 2017, we considered the same factors we did developing a fixed-loss amount for such cases for FY 2016. For FY 2017, our actuaries currently project that the proportion of cases that would qualify as LTCH PPS standard Federal payment rate cases versus site neutral payment rate cases under the dual rate LTCH PPS payment structure provisions would remain consistent with what is reflected in the historical LTCH PPS claims data. Based on FY 2014 LTCH claims data, LTCH claims data, we found that approximately 55 percent of LTCH cases would have been paid the LTCH PPS standard Federal payment rate and approximately 45 percent of LTCH cases would have been paid the site neutral payment rate if those rates had been in effect at that time.) At this time, our actuaries continue to project no immediate change in these proportions. However, they do continue to project that the costs and resource use for cases paid at the site neutral payment rate would likely be lower, on average, than the costs and resource use for cases paid at the LTCH PPS standard Federal payment rate and would likely mirror the costs and resource use for IPPS cases assigned to the same MS–DRG, regardless of whether the proportion of site neutral payment rate cases in the future remains similar to what is found based on the historical data. As discussed in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49619), this actuarial assumption is based on our expectation that site neutral payment rate cases would generally be paid based on an IPPS comparable per diem amount under the statutory LTCH PPS payment changes that began in FY 2016, which, in the majority of cases, is much lower than the payment that would have been paid if these statutory changes were not enacted. For these reasons, we continue to believe that the most appropriate fixed-loss amount for site neutral payment rate cases for FY 2017 is the IPPS fixed-loss amount for FY 2017.

Therefore, for FY 2017, we are proposing that the applicable HCO threshold for site neutral payment rate cases is the sum of the site neutral payment rate for the case and the IPPS fixed-loss amount. That is, we are proposing a fixed-loss amount for site neutral payment rate cases of $23,681, which is the same proposed FY 2017 IPPS fixed-loss amount discussed in section II.A.4.g.(1). of the Addendum to this proposed rule. We continue to believe that this policy will reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems. Accordingly, under this proposal, for FY 2017, we would calculate a HCO payment for site neutral payment rate cases with costs that exceed the HCO threshold amount, which is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of site neutral payment rate payment and the proposed fixed-loss amount for site neutral payment rate cases of $23,681). (We note that any site neutral payment rate case that is paid 100 percent of the estimated cost of the case (because that amount is lower than the IPPS comparable per diem amount) will not be eligible to receive a HCO payment because, by definition, the estimated costs of such cases would never exceed the IPPS comparable per diem amount by any threshold.)

In establishing a HCO policy for site neutral payment rate cases, we established a budget neutrality requirement at § 412.522(c)(2)(i). We established this requirement because we believe that the HCO policy for site neutral payment rate cases should be budget neutral, just as the HCO policy for LTCH PPS standard Federal payment rate cases are budget neutral, meaning that estimated site neutral payment rate HCO payments should not result in any change in estimated aggregate LTCH PPS payments. Under § 412.522(c)(2)(i), we adjust all payments for site neutral payment rate cases by a budget neutrality factor so that the estimated HCO payments payable for site neutral payment rate cases do not result in any increase in aggregate LTCH PPS payments. Specifically, under § 412.522(c)(2)(i), we apply a budget neutrality factor to the site neutral payment rate portion of the transitional blended rate payment (that is applicable to site neutral payment rate cases during the 2-year transition period provided by the statute) that is established based on an estimated basis. (We refer readers to 80 FR 49621 through 49622 and 49805.)

Under the approach adopted for applying the budget neutrality adjustment to the site neutral payment rate portion of the transitional blended rate payment in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49805), we explained that there is no need to perform any calculation of the site neutral payment rate case HCO payment budget neutrality adjustment under our finalized policy. This is because, as discussed previously, based on our actuarial assumptions we project that our proposal to use the IPPS fixed-loss threshold for the site neutral payment rate cases would result in HCO payments for those cases that are similar in proportion as is seen in IPPS cases assigned to the same MS–DRG; that is, 5.1 percent. In other words, we estimated that HCO payments for site neutral payment rate cases would be 5.1 percent of the site neutral payment rate payments. Under the statutory transition period, payments to site neutral payment rate cases in FY 2017 will be paid under the blended transitional rate. As such, estimated HCO payments for site neutral payment rate cases in the FY 2017 proposal would be projected to be 5.1 percent of the portion of the blended rate payment that is based on the estimated site neutral payment rate payment amount (and would not include the LTCH PPS standard Federal payment rate payment amount as specified in § 412.522(c)(2)(i)). To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2017 would not

result any increase in estimated aggregate FY 2017 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i), it is necessary to reduce the site neutral payment rate portion of the blended rate payment by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2017. In order to achieve this, for FY 2017, we are proposing to continue to apply a budget neutrality factor of 0.949 (that is, the decimal equivalent of a 5.1 percent reduction, determined as 1.0–5.1/100 = 0.949) to the site neutral payment rate portion of the blended rate payment (80 FR 49805). As stated previously, this adjustment is necessary so that the estimated HCO payments payable for site neutral payment rate cases do not result in any increase in aggregate LTCH PPS payments.

E. Proposed Update to the IPPS Comparable/Equivalent Amounts to Reflect the Statutory Changes to the IPPS DSH Payment Adjustment Methodology

In the FY 2014 IPPS/LTCH PPS final rule, we established a policy for reflecting the changes to the Medicare IPPS DSH payment adjustment methodology provided for by section 3133 of the Affordable Care Act in the calculation of the ''IPPS comparable amount'' under the SSO policy at § 412.529 and the ''IPPS equivalent amount'' under the 25-percent threshold payment adjustment policy at § 412.534 and § 412.536. Historically, the determination of both the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' includes an amount for inpatient operating costs ''for the costs of serving a disproportionate share of low-income patients.'' Under the statutory changes to the Medicare DSH payment adjustment methodology that began in FY 2014, in general, eligible IPPS hospitals receive an empirically justified Medicare DSH payment equal to 25 percent of the amount they otherwise would have received under the statutory formula for Medicare DSH payments prior to the amendments made by the Affordable Care Act. The remaining amount, equal to an estimate of 75 percent of the amount that otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under the age of 65 who are uninsured, is made available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. The additional uncompensated care payments are based on the hospital's amount of uncompensated care for a given time period relative to the total amount of uncompensated care for that same time period reported by all IPPS hospitals that receive Medicare DSH payments.

To reflect the statutory changes to the Medicare DSH payment adjustment methodology in the calculation of the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' under the LTCH PPS, we stated that we will include a reduced Medicare DSH payment amount that reflects the projected percentage of the payment amount calculated based on the statutory Medicare DSH payment formula prior to the amendments made by the Affordable Care Act that will be paid to eligible IPPS hospitals as empirically justified Medicare DSH payments and uncompensated care payments in that year (that is, a percentage of the operating DSH payment amount that has historically been reflected in the LTCH PPS payments that is based on IPPS rates). We also stated that the projected percentage will be updated annually, consistent with the annual determination of the amount of uncompensated care payments that will be made to eligible IPPS hospitals. We believe that this approach results in appropriate payments under the LTCH PPS and is consistent with our intention that the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' under the LTCH PPS closely resemble what an IPPS payment would have been for the same episode of care, while recognizing that some features of the IPPS cannot be translated directly into the LTCH PPS (79 FR 50766 through 50767).

For FY 2017, as discussed in greater detail in section IV.D.3.d.(2) of the preamble of this proposed rule, based on the most recent data available, our estimate of 75 percent of the amount that would otherwise have been paid as Medicare DSH payments (under the methodology outlined in section 1886(r)(2) of the Act) is adjusted to 56.74 percent of that amount to reflect the change in the percentage of individuals who are uninsured. The resulting amount is then used to determine the amount of uncompensated care payments that will be made to eligible IPPS hospitals in FY 2017. In other words, Medicare DSH payments prior to the amendments made by the Affordable Care Act would be adjusted to 42.56 percent (the product of 75 percent and 56.74 percent) and the resulting amount will be used to calculate the uncompensated care payments to eligible hospitals. As a result, for FY 2017, we project that the reduction in the amount of Medicare DSH payments pursuant to section 1886(r)(1) of the Act, along with the payments for uncompensated care under section 1886(r)(2) of the Act, would result in overall Medicare DSH payments of 67.56 percent of the amount of Medicare DSH payments that would otherwise have been made in the absence of amendments made by the Affordable Care Act (that is, 25 percent + 56.74 percent = 67.56 percent).

In this proposed rule, for FY 2017, we are proposing that the calculation of the ''IPPS comparable amount'' under § 412.529 and the ''IPPS equivalent amount'' under new § 412.538 would include an applicable operating Medicare DSH payment amount that is equal to 67.5677 percent of the operating Medicare DSH payment amount that would have been paid based on the statutory Medicare DSH payment formula but for the amendments made by the Affordable Care Act. Furthermore, consistent with our historical practice, we are proposing to use more recent data, if available, to determine this factor in the final rule.

F. Computing the Proposed Adjusted LTCH PPS Federal Prospective Payments for FY 2017

Section 412.525 sets forth the adjustments to the LTCH PPS standard Federal payment rate. Under the dual rate LTCH PPS payment structure, only LTCH PPS cases that meet the statutory criteria to be excluded from the site neutral payment rate are paid based on the LTCH PPS standard Federal payment rate. Under § 412.525(c), the LTCH PPS standard Federal payment rate is adjusted to account for differences in area wages by multiplying the labor-related share of the LTCH PPS standard Federal payment for a case by the applicable LTCH PPS wage index (the proposed FY 2017 values are shown in Tables 12A through 12B listed in section VI. of the Addendum of this proposed rule and are available via the Internet on the CMS Web site). The LTCH PPS standard Federal payment is also adjusted to account for the higher costs of LTCHs located in Alaska and Hawaii by the applicable COLA factors (the proposed FY 2017 factors are shown in the chart in section V.D. of this Addendum) in accordance with § 412.525(b). In this proposed rule, we are proposing an LTCH PPS standard Federal payment rate for FY 2017 of $42,314.31, as discussed in section V.A.2. of the Addendum to this proposed rule. We illustrate the methodology to adjust the proposed LTCH PPS standard Federal payment rate for FY 2017 in the following example:

Example: During FY 2017, a Medicare discharge that meets the criteria to be excluded from the site neutral payment rate, that is an LTCH PPS standard Federal payment rate case, is from an LTCH that is located in Chicago, Illinois (CBSA 16974). The FY 2017 LTCH PPS proposed wage index value for CBSA 16974 is 1.0486 (obtained from Table 12A listed in section VI. of the Addendum of this proposed rule and available via the Internet on the CMS Web site). The Medicare patient case is classified into MS–LTC–DRG 189 (Pulmonary Edema & Respiratory Failure), which has a proposed relative weight for FY 2017 of 0.9107 (obtained from Table 11 listed in section VI. of the Addendum of this proposed rule and available via the Internet on the CMS Web site). The LTCH submitted quality reporting data for FY 2017 in accordance with the LTCHQRP under section 1886(m)(5) of the Act.

To calculate the LTCH's total proposed adjusted Federal prospective payment for this Medicare patient case in FY 2017, we computed the wage-adjusted Federal prospective payment amount by multiplying the unadjusted proposed FY 2017 LTCH PPS standard Federal payment rate ($42,314.31) by the proposed labor-related share (66.6 percent) and the wage index value (1.0486). This wage-adjusted amount was then added to the proposed nonlabor-related portion of the unadjusted LTCH PPS standard Federal payment rate (33.4 percent; adjusted for cost of living, if applicable) to determine the adjusted proposed LTCH PPS standard Federal payment rate, which is then multiplied by the proposed MS–LTC–DRG relative weight (0.9107) to calculate the total proposed adjusted LTCH PPS standard Federal prospective payment for FY 2017 ($39,782.95). The table below illustrates the components of the calculations in this example.

MEDPAC Medicare Payment Advisory Commission

425 I Street, N.W. o Suite 701
Washington, DC 20001
202-220-3700 o Fax: 202-220-3759
www.medpac.gov

Francis J. Crosson, M.D., Chairman
Jon B. Christianson, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

May 31, 2016

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: File code CMS–1655–P

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Medicare proposed rule entitled *Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to costs to Organizations and Medicare costs Reports; Proposed rule* published in the *Federal Register* on April 27, 2016 and the interim final rule with comment period entitled *Medicare Program; Temporary Exception or Certain Severe Wound Discharges from Certain Long-Term Care Hospitals Required by the Consolidated Appropriations Act of 2016; Modification of Limitation on Redesignation by the Medicare Geographic Classification Review Board* published in the *Federal Register* on April 21, 2016. The rules revise the hospital inpatient prospective payment system, the long-term care hospital (LTCH) payment system, and quality reporting requirements for specific providers. In view of their competing demands, we especially appreciate your staff's efforts to improve these hospital payment systems.

In this letter we comment on five key issues:

- Support for the proposed changes to uncompensated care payments
- Agree that adjustments for documentation and coding are necessary and required by law
- Suggest changes to the hospital wage index
- Suggest changes in IPPS quality metrics and incentives
- Suggest changes in the LTCH payment system

Uncompensated care payments

Historically Medicare has adjusted inpatient payment rates to increase payments to hospitals with a "disproportionate share" (DSH) of low-income patients, as measured by the disproportionate patient percentage (DPP). The DPP is computed as the sum of two fractions: the "Medicare SSI fraction" and the "Medicaid fraction." The "Medicare SSI fraction" is the hospital's share of Medicare patients that are low-income; it is computed as the share of Medicare inpatient days attributable to patients entitled to supplemental security income (SSI). The Medicaid fraction is the hospital's share of total inpatient days attributable to Medicaid patients. The effect of the policy is to pay higher inpatient rates for low-income Medicare patients and indirectly subsidize hospitals serving Medicaid patients with supplemental Medicare inpatient dollars.

In 2010, Congress enacted several changes to DSH payment policy in the Patient Protection and Affordable Care Act (PPACA). Under the new DSH policy, CMS will determine the amount of Medicare dollars that are potentially available to be distributed as DSH and uncompensated care payments using the traditional DSH formula that is based on the DPP. However, rather than distribute the whole pool as traditional DSH payments, part of the pool will go toward uncompensated care payments and part will go toward savings for the treasury as the rate of uninsurance declines (and presumably the need for uncompensated care payments declines). CMS determined that the size of the pool of potential DSH and uncompensated care dollars will be $14.23 billion in FY 2017. CMS is proposing to allocate the potential pool of dollars as follows:

- CMS pays 25 percent of the pool ($3.56 billion) based on the traditional **DSH** formula.

- The remaining 75 percent of the pool ($10.67 billion) is further divided into two parts: savings for the treasury and payments for uncompensated care.
    - For every 1 percent decline in the rate of uninsurance, the share of the remaining pool allocated to trust fund savings increases by 1 percentage point. CMS estimated that the rate of unisurance has declined by 43 percent since the passage of PPACA. This means that 43 percent of the $10.67 billion ($4.6 billion) will be **savings for the Medicare Part A trust fund.**
    - The remaining $6 billion ($10.67 billion x .57 percent) will be distributed to partially pay for **uncompensated care** costs at hospitals in 2017. The distribution of these payments depends on each hospital's estimated share of uncompensated care. We expect a similar amount will be available in future years.
- On net hospitals will receive a total of **$9.6 billion in combined Medicare DSH and uncompensated care dollars**.

CMS has proposed to use Medicaid and SSI days as a proxy for a hospital's uncompensated care costs in FY 2017. Therefore, in FY 2017, each DSH hospital's share of the $6 billion in uncompensated care payments will purely be a function of the hospital's number of Medicaid and SSI days. However, in FY 2018, CMS proposes to estimate each hospital's level of uncompensated care using hospital reported uncompensated care costs reported on worksheet S-10 of the Medicare cost report. This will allow the approximately $6 billion in uncompensated care payments to be distributed using a direct measure of uncompensated care rather than using Medicaid days as a proxy for uncompensated care.

Comment: We support the proposal to start using worksheet S-10 to compute uncompensated care costs starting in 2018 with a three-year phase in. This is consistent with our March 2016 recommendation to phase in the use of S-10 data over three years. Using S-10 data coupled with selective auditing of cost reports submitted by hospitals reporting the highest levels of

uncompensated care, will lead to far better estimates of uncompensated care costs at DSH hospitals than using Medicaid and SSI days as a proxy for uncompensated care.

The use of the S-10 also will create more balance between Medicare support of Medicaid patients and Medicare support of the uninsured. The proposed rule shows that traditional Medicare DSH payments are estimated to be $3.56 billion in 2017. Because the DPP is dominated by the Medicaid share of patient days, the $3.56 billion will largely be distributed to hospitals with high Medicaid shares. In 2017, the $6 billion in "uncompensated care" payments again will be distributed using Medicaid and SSI days as a proxy for uncompensated care costs. Because Medicaid days are much more common than SSI days, most of the dollars (over $5 billion of the $6 billion) will be distributed as a per diem payment of approximately $160 for each Medicaid day. And the remaining $1 billion will be distributed as a per diem for Medicare SSI days. The net result is the Medicare Part A trust fund will provide significant payments for Medicaid patients. In contrast, there will be no direct payments for uncompensated care costs in 2017 because Medicaid and SSI days will continue to be used as proxies for uncompensated care.

In 2018, distributing uncompensated care dollars (the $6 billion) based on uncompensated care costs (not Medicaid days) coupled with distributing the $3.56 billion in traditional DSH payments based on the DPP formula will make Medicare support more proportional to the financial burdens of serving the uninsured and Medicaid patients. In the longer run, there are more fundamental questions regarding whether the Medicare Part A Trust Fund should be the source of support for the uninsured.

Defining uncompensated care

CMS proposes to define uncompensated care as the sum of the cost of charity care and the cost of non-Medicare bad debts. We agree with this proposal. It is inappropriate for Medicare to include "Medicaid shortfalls" when estimating uncompensated care costs for two reasons. First, the level of "shortfall" will depend on a specific hospital's cost structure and the Medicaid payments (including Medicaid DSH payments) it receives from state Medicaid programs. It would be

inappropriate for Medicare to signal to the states that it will increase Medicare payments to a hospital if the state reduces Medicaid payments to that hospital. Second, computing losses on Medicaid patients is operationally problematic for several reasons. One operational complexity stems from Medicaid paying hospitals a single DSH payment that in part covers costs of the uninsured and in part covers estimates of a hospital's Medicaid "shortfall." It is not clear how CMS would determine how much Medicaid "shortfall" is left after the Medicaid DSH payments are made. In addition, hospitals in some states return a portion of their Medicaid revenue to the state through provider taxes. It would be difficult for CMS to arrive at a net "shortfall" figure given the lack of reported data on the net value of Medicaid DSH payments less provider taxes. Finally, Medicare will still make $3.56 billion in traditional DSH payments in 2017. In many cases, Medicaid patients in fact may be profitable after considering Medicaid DSH payments and increases in Medicare DSH payments that occur with each additional Medicaid day. Therefore, for reasons of principle and operational complexity, the Medicaid "shortfall" should not be included when Medicare computes uncompensated care costs.

The current method of distributing uncompensated care payments distorts DRG prices

In FY 2014, CMS proposed to make uncompensated care payments directly to hospitals without tying the payments to the DRG pricing system. However, many hospital representatives objected because their contracts with managed care companies were (and still are) based on the price computed by the Medicare FFS "pricer." Thus, hospitals were concerned that if the uncompensated care payments were not in the "pricer" program that CMS uses to compute the FFS price for each discharge, managed care companies would not pay their share of uncompensated care costs. Managed care companies were only obligated to pay the negotiated rate, which is often the rate specified by the FFS pricer.

Because the uncompensated care payments are included in the Medicare Advantage (MA) plans' benchmarks, the MA plans should be expected to pay an amount of uncompensated care costs that is proportional to the amount paid under the FFS program. To accomplish this, the FY 2014 final

IPPS rule adjusted the "pricer" program to put an amount into each hospital's DRG payment rate that reflected its share of uncompensated care payments. In practice, this means that the rate MA plans paid hospitals was increased by a hospital-specific fixed add-on to reflect payments for uncompensated care. This method of putting a hospital-specific fixed add-on to the DRG payment rate was continued through 2016 and is proposed for 2017.

Comment: The problem is that the per discharge add-on payment varies widely from hospital to hospital. This distorts the basic DRG pricing system. Under the proposed system for 2017, one hospital may have an add-on of over $2,000 per discharge in the Medicare pricer and a competing hospital may have $0 add-on per discharge. Therefore, MA payment rates could differ by $2,000 for the same service in the same city. MA plans have an incentive to steer patients away from the hospital providing more uncompensated care (and having a higher add-on per discharge). MA plans may try to negotiate lower payment rates with hospitals providing high levels of uncompensated care or to simply not include these hospitals in their networks of providers.

There is a way to eliminate the distortion to the pricer. As we stated in our comment on the FY 2016 inpatient proposed rule, CMS could pay hospitals on a periodic basis for their FFS and MA patients (e.g., a quarterly lump sum payment at the start of each quarter) rather than include the uncompensated care payments as an add-on in the pricer. This could work as follows:

- CMS would first compute the aggregate FFS uncompensated care payments.
- Second CMS would compute the proportional uncompensated care payment that would be due from MA plans. For example, the implicit uncompensated care payments in MA plan benchmarks would be computed as a specific percentage of FFS uncompensated care payments. CMS then would increase the FFS uncompensated care pool by that percentage and reduce the MA benchmarks by an equal amount to reflect removing the uncompensated care payments from the benchmark in each county. In other words, CMS would pay the FFS and MA shares of uncompensated care costs directly, just as CMS directly pays the FFS and MA shares of direct graduate medical education costs.

- Therefore, uncompensated care payments would not be included in the MA benchmarks, just as the indirect medical education payments that CMS makes on behalf of MA plans are not included in the MA benchmarks.

- CMS would distribute this combined (FFS and MA) uncompensated care pool based on each hospital's share of historic uncompensated care costs. Unlike the current policy (that requires reconciliation due to not knowing the number of discharges that will take place during a year) this policy would eliminate the need for reconciliation.

This would allow uncompensated care payments to be distributed among hospitals more equitably. Providing uncompensated care would no longer disadvantage hospitals with respect to price negotiations with MA plans. As enrollment in MA plans expands, it becomes more important to not distort the price signals being sent to MA plans as they set up preferred provider networks.

Required adjustments for documentation and coding

The American Taxpayer Relief Act of 2012 (ATRA) requires the Secretary to recover $11 billion by 2017 to recoup past over payments that stem from changes in documentation and coding of inpatient claims following the introduction of MS-DRGs. OACT has estimated that this will require a 1.5 percent reduction to the standardized amount in 2017, bringing the full adjustment for documentation and coding (including three prior adjustments of 0.8 percent) to 3.9 percent for FY 2017. This means that 2017 inpatient rates are expected to be 3.9 percent lower than they would have been without the temporary adjustment. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) mandates that this adjustment will partially continue past 2017. Instead of fully offsetting the 3.9 percent reduction with a 3.9 percent increase in FY 2018 as would have taken place under prior law, MACRA requires that CMS only make a 0.5 percent positive adjustment for six years from FY 2018 through FY 2023. The six mandated adjustments of 0.5 percent will eventually offset 3 percent of the 3.9 percent documentation and coding adjustment.

Comment: As we have stated in the past, we support recovery of past over payments due to changes in documentation and coding. The law stipulates the amount of the recovery and the

timing of the recovery. In addition, MACRA stipulates the degree to which the recovery adjustments will be phased out. CMS has little discretion and is proceeding as required by law. However, when making update recommendations to Congress for 2018 and beyond, the Commission will consider the net effect of the mandated changes in ATRA and MACRA on the adequacy of Medicare payment rates to hospitals.

Proposed changes in quality metrics and incentives

We support CMS's proposal to decrease the number of process measures and increase the number of outcome measures for quality reporting and value-based purchasing programs, but have concerns about proposed condition-specific efficiency/cost measures.

Inpatient quality reporting

CMS proposes to decrease the total number of measures required for the Inpatient Quality Reporting (IQR) program from 68 measures in FY 2018 to 55 measures in FY 2019. The proposed changes would:

- Remove 13 electronic clinical quality measures (eCQM). This will reduce the number of eCQMs reported from 28 to 15.
- Remove 2 structural measures.
- Remove 2 chart-abstracted measures.
- Add 3 condition-specific episodes cost measures rather than only use the all-condition measure currently being computed.
- Add a measure for excess days in acute care after hospitalization for pneumonia

Value-based purchasing programs

In FY 2017 the hospital VBP program will be based on 22 measures spread across 4 domains of care: clinical care, safety, efficiency and cost reduction, and patient- and caregiver-centered experience of care. In FY 2018 it will use 20 measures, as 2 process of care measures are being

removed. The program will be funded from 2 percent of base operating payments, all of which will be redistributed back to hospitals. CMS is not proposing any changes to either the FY 2017 or FY 2018 VBP program in this year's rule. Compared to FY 2016, there will be fewer process of care measures in FY 2017 and FY 2018 and there will be more uniform weighting across the four dimensions of the VBP.

Comment: For several years, the Commission has urged CMS to move Medicare's quality measurement system away from the use of clinical process measures and toward the use of outcome measures, and therefore we appreciate and strongly support CMS's proposals to reduce the number of process measures that use medical chart-abstracted data as well as the reduction in the number of electronic clinical quality measures being reported.

With respect to episode spending measures, we strongly object to the use of the proposed condition-specific cost measures in the IQR or VBP programs. We believe hospitals should be provided actionable service-line specific relative cost information, but be rewarded or penalized based on a broad all-condition 30-day cost measure. We supported adding the all-condition Medicare Spending per Beneficiary (MSPB) measure to the IQR and VBP programs, because we agree that hospital performance should be evaluated both on the quality of care and the cost of care. However, the proposed condition-specific cost measures would have smaller numbers of hospital-specific observations than the current all-condition measure which pools information from all inpatient conditions. Splitting the pool of information on costs into condition-specific measures would result in more random variation without providing clear additional information about the average costliness of the hospitals' care. It is likely that there will be substantial variability in hospitals' ability to report statistically reliable information on all of the proposed measures, given variation in volume. To ensure reliability and provide a broad incentive to reduce costs across all types of services, we believe it is important that the cost measures used should be as broadly based as possible. Each provider could be given condition-specific costs of care to understand what may be driving their aggregate MSPB performance, but we do not think Medicare should base financial incentives on condition-specific cost measures.

The hospital readmissions reduction program can be improved with certain statutory changes

The Commission maintains that the hospital readmission reduction program (HRRP) has been a success as hospitals have worked to improve care transitions which has helped to lower hospital readmission rates. The program has protected beneficiaries from the risks of adverse outcomes inherent in institutional transitions as well as generated savings for the Medicare program and beneficiaries. The Commission strongly supports having a hospital readmission reduction program as part of the Medicare hospital payment system.

CMS is making no substantive changes to the readmission reduction program in this years proposed rule. Most of the changes CMS made to the program were made in the FY 2016 final rule which affects policies going into place in FY 2017. The main changes going into place in FY 2017 include:

- Modification to the pneumonia readmission measure to include readmission for patients with a primary discharge diagnosis of aspiration pneumonia or sepsis with pneumonia as a secondary condition.
- Adding Coronary Artery Bypass Graft (CABG) surgery to the readmission reduction program.

Comment: With the addition of the CABG readmission measure to the readmission reduction program we are concerned about the potential double counting of cases covered under the program. Twenty-six percent of CABG cases are also AMI cases. This will potentially result in cases being counted under both the AMI and CABG readmission measures. Cases should only count under either AMI or CABG to prevent double counting.

While CMS implemented the hospital readmissions reduction program (HRRP) according to statute, the Commission continues to believe that the law could be changed to permit use of an all-condition readmission measure with a fixed target as discussed in our June 2013 Report to the

Congress.[1] Given a fixed target, penalties would decline if hospitals' collective performance improves. In addition, our June 2013 report discussed evaluating hospital readmission rates against a group of peer hospitals with a similar share of low-income Medicare beneficiaries as a way to adjust readmission penalties for socioeconomic status. These changes could be made in a budget neutral manner with the savings from moving to an all-condition measure offsetting the cost of fixing the current payment formula. These actions would require legislative changes because the current formula used to compute the readmission penalty is set in law.

The star rating program

CMS is also developing a star rating program whereby hospitals will be given overall star ratings. We suggest this system of star ratings should reflect the variables used in value-based purchasing and highlight patient outcomes rather than process measures. In cases where the volume of Medicare cases is too few to reasonably measure quality CMS should explicitly state that the small number of observations does not allow it to accurately assess a hospital's quality. To overcome this limitation, CMS could move toward using all-condition measures rather than measuring cost and outcomes on specific conditions. This is similar to our proposal to stay with all-condition episode cost measures (as discussed above for VBP) and similar to the move toward an all-condition readmission measures as discussed in the prior paragraph.

Proposed changes to the hospital wage index for acute-care hospitals

The 2017 IPPS proposed rule requests comments on a variety of detailed hospital wage index issues. We wish to reiterate our recommendations on wage index reform, included in the Commission's 2007 Report to Congress. We recommended Congress repeal the existing hospital wage index statute and replace it with a new wage index system described below. The repeal should include removing the more than 1,000 individual hospital reclassifications that occur each

[1] Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

year, which are either stipulated in law or implemented through regulation. The repeal also would give the Secretary the authority to establish a new wage index system. Our 2007 recommendations stated that the law should be changed to establish a new hospital compensation index so that it:

- Uses compensation data from all employers together with hospital industry-specific occupational weights;
- Is adjusted for geographic differences in the ratio of benefits to wages;
- Is adjusted at the county level to smooth large differences between counties; and
- Is implemented so that large changes in wage index values are phased in over a transition period.

The system we proposed is similar to recommendations made by the Institute of Medicine. Both sets of recommendations would eliminate the need for the system of geographic reclassification and exceptions that is currently in place.[2]

Changes to the long-term care hospital (LTCH) prospective payment system (PPS)

Medicare makes substantially different payments for patients with similar conditions depending on whether they are treated in an acute-care hospital (ACH) or a LTCH. The Pathway for SGR Reform Act of 2013 established "site-neutral" payments for specified cases in LTCHs, beginning in fiscal year (FY) 2016. Under the law, Medicare will pay the LTCH PPS standard federal

[2] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare.* Washington, DC: MedPAC. Institute of Medicine. 2011. *Geographic adjustment in Medicare payment, Phase I: Improving accuracy. Second edition.* Washington, DC: The National Academies Press.

payment rate (LTCH standard payment rate) for LTCH discharges that had an immediately preceding ACH stay and:

- the ACH stay included at least three days in an intensive care unit (ICU), or
- the discharge receives an LTCH principal diagnosis indicating the receipt of mechanical ventilation services for at least 96 hours.

All other LTCH discharges—including any psychiatric or rehabilitation discharges, regardless of ICU use—will be paid an amount based on Medicare's ACH payment rates under the inpatient prospective payment system (IPPS) (including outlier payments) or 100 percent of the costs of the case, whichever is lower. These site-neutral payments will be phased in over multiple years based on each LTCH's cost reporting period.

In the April 27, 2016 rule, CMS proposes a -1.1 percent adjustment for high-cost outlier (HCO) payments, alignment of the limitation on beneficiary charges for "subclause (II)" LTCHs, revisions to the 25-percent threshold policy, and quality measures to meet the requirements of the IMPACT Act of 2014. In the interim final rule released April 21, 2016, CMS implements a provision of the Consolidated Appropriations Act of 2016 that exempts certain discharges from certain LTCHs from receiving the site-neutral payment rate. Our comments below address each of these elements of the recently released proposed and interim final rules.

High-cost outlier (HCO) adjustment

CMS estimates that the FY 2016 fixed-loss amount will result in HCO payments equal to 9.1 percent of estimated LTCH standard payment rate payments, which is higher than the estimate used in setting FY 2016 payment rates. CMS proposes to set the fixed-loss amount for cases paid under the LTCH standard payment rate such the HCO pool would equal 8.0 percent of estimated payments in FY 2017. This year's proposed HCO amount results in a 1.1 percent estimated decrease in HCO payments from FY 2016.

Comment: The Commission expects large fluctuations to occur in the fixed-loss amount following implementation of major policy changes, similar to those that occurred following the implementation of the LTCH PPS. In this context, the Commission supports CMS' proposal to set the fixed-loss amount so that outlier payments equal 8.0 percent of payments for cases paid under the LTCH standard payment rate.

Revising the 25-percent threshold

In fiscal year 2005, CMS established the 25-percent threshold in an attempt to prevent LTCHs from functioning as units of ACHs by decreasing payments for discharges from LTCHs that admit a large share of their patients from a single ACH. The 25-percent threshold initially applied only to LTCH hospitals-within-hospitals (HWHs) and LTCH satellites with a less restrictive threshold specified for LTCHs located in rural areas or in an area with an MSA-dominant hospital. In July 2007, CMS extended the rule to freestanding LTCHs. However, the Congress subsequently delayed full implementation of the 25-percent threshold so that most HWHs and satellites are paid standard LTCH rates for eligible patients admitted from their host hospitals as long as the percentage of Medicare admissions from the host hospital does not exceed a 50 percent threshold. In addition, the Secretary is prohibited from applying the 25-percent threshold to freestanding LTCHs before July 1, 2016 and permanently prohibited from applying the 25-percent threshold policy to certain co-located facilities. For FY 2017, CMS proposes to implement the 25-percent threshold policy across LTCH cases paid under the LTCH standard payment rate and the site-neutral rate. CMS also proposes to revise the policy in several ways including: aligning the implementation dates for cost-reporting periods starting on or after October 1, 2016; and evaluating the threshold on the basis of the provider's CMS certification number (CCN). To qualify for a less-restrictive threshold, CMS proposes to require that all LTCH locations within a single CCN to be classified as rural or as located in an area with an MSA-dominant hospital.[3]

[3] An MSA-dominant hospital is an acute-care hospital that has discharged more than 25-percent of the total hospital Medicare discharges in the MSA where it is located. CMS proposes that LTCHs located in these MSAs qualify for a less-restrictive threshold.

Comment: The Commission supports CMS's proposal to apply the 25-percent rule to all LTCH discharges, including those paid under the site-neutral rate. Some may argue that with the implementation of the Pathway for SGR Reform Act's provisions reforming the LTCH PPS, the 25-percent rule is no longer necessary, as many cases previously paid a higher LTCH standard payment rate will now be paid a lower site-neutral rate. Thus, the argument would go, the financial incentives for an LTCH to admit cases that could be effectively treated in a lower-cost setting have been rendered moot, and it is no longer necessary control an LTCH's source of admissions through the 25-percent rule.

The Commission disagrees with such arguments for two reasons. First, we note that the Pathway for SGR Reform Act of 2013 used a broader definition of cases eligible for the LTCH standard payment rates than MedPAC modeled in our analytic work and our 2014 recommendation to the Congress. Therefore, there are still cases that could be treated in a lower-cost setting that would receive LTCH standard payment rates if admitted to an LTCH. Second, the impacts of payment system revisions on LTCHs and their admitting practices are not yet fully understood. LTCHs may respond to the new payment changes in ways not contemplated by the policy that could have adverse effects on the Medicare program and its beneficiaries. Therefore, we believe there is still at least a short-term need to maintain the 25-percent rule and apply it to all LTCH discharges, as CMS proposes in this rule.

Calculating high-cost outlier payment for cases paid a "site-neutral" rate

The Pathway for SGR Reform Act of 2013 mandates that cases that do not qualify to receive the full LTCH PPS payment rate receive the lesser of an IPPS-comparable rate (plus applicable outlier payment) or an amount equal to the estimated cost of the case, as described previously. The IPPS-comparable rate uses the IPPS standardized payment amounts finalized through the annual rulemaking which includes an adjustment for budget neutrality to account for cases that are HCOs. In the FY 2016 final rule, CMS finalized that HCO payments for LTCH cases paid under the site-neutral payment rate would be calculated based on the IPPS fixed-loss amount. CMS assumed that these cases would likely mirror the costs and resource use for IPPS cases assigned to the same

MS–DRG. CMS proposes to use the IPPS fixed-loss amount for LTCH site-neutral cases again in FY 2017. As in FY 2016, CMS proposes to reduce payment for site-neutral cases by 5.1 percent (or an adjustment of 0.949) to account for the estimated LTCH HCO payments for those cases in FY 2017.

Comment: The Commission has long held that payments to providers should be properly aligned with the resource needs of beneficiaries and, subject to risk differentials, payment for the same services should be comparable regardless of where the services are provided (Medicare Payment Advisory Commission 2009). Such "site neutrality" helps to ensure that beneficiaries receive appropriate, high-quality care in the least costly setting for their clinical conditions. The Commission recognizes that the establishment of site-neutral payments under the Pathway for SGR Reform Act of 2013 leaves the Secretary little discretion in setting the amount CMS pays for site-neutral cases defined by law as the lesser of either an IPPS-comparable rate or 100 percent of the cost of the case. This "lesser of" mechanism does not equalize payments across provider types; instead, it could result in the LTCH receiving a lower payment than what it would have received for a similar IPPS discharge.

CMS proposes to use the IPPS fixed-loss amount to determine if a discharge paid under the site-neutral rate qualifies to receive an HCO payment again for FY 2017. CMS sets the IPPS fixed-loss amount each year at a level that it estimates will result in aggregate HCO payments equal 5.1 percent of total IPPS payment. To account for the spending attributed to these outlier payments, CMS reduces the IPPS base payment rates to maintain budget neutrality in the IPPS. The IPPS-comparable rate used to pay for site-neutral cases in LTCHs includes an adjustment for budget neutrality to account for spending associated with HCOs.

With the Commission's payment principles in mind, MedPAC urges CMS to eliminate the proposed payment adjustment for discharges paid the site-neutral rate to account for outlier payments under this payment methodology. Given that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates

the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.

LTCH Quality reporting

The IMPACT Act of 2014 requires the implementation of several quality and resource use measures that are standardized and interoperable across post-acute care settings including measures of: function and cognition, skin integrity, medication reconciliation, incidence of major falls, the transfer of health information and care preferences, readmissions, discharge to community, and resource use. The LTCH proposed rule discusses four measures for adoption in the LTCH quality reporting program: drug regimen review with follow up, the resource use measure (Medicare spending per beneficiary–Post Acute Care LTCH), discharge to community, and potentially preventable readmissions within 30 days after discharge from the LTCH. CMS invited comments on how socioeconomic (SES) factors should be used in the resource use and quality measures.

Comment: Because the goal of cross-cutting measures is to gauge and compare care provided across PAC settings, it is critical that each measure use uniform definitions, specifications (such as inclusions and exclusions), and risk-adjustment methods. Otherwise, differences in rates across settings could reflect differences in the way the rates were constructed rather than underlying differences in the quality of care. Our work on the design of a unified PAC payment system and the work of others indicate considerable overlap in where beneficiaries are treated for similar PAC needs. These results indicate it is imperative that quality and resource use measures are directly comparable across settings so that Medicare can evaluate the value of its purchases and beneficiaries can make informed choices about where to seek care. Separate measures will continue to be used to evaluate each PAC setting in isolation rather than support cross-setting comparisons of PAC providers. We emphasize this principle in our discussion of the MSPB measure, but note that the principle applies to all four of the IMPACT measures discussed here.

The Commission recognizes that socio-economic status (SES) factors can play a role in the outcomes for quality and resource use measures. One way to consider SES factors is to include

them in the risk adjustment method. The Commission does not support this approach because it results in adjusted rates (or spending) that hide the actual disparities in care, and could reduce pressure on providers to improve care for the poor. The Commission believes that a better way to address any differences in outcomes is to compare rates (or spending) that have not been adjusted for SES across "peer" providers that have similar shares of, for example, low-income, beneficiaries. This way, the outcome rates remain intact but the comparisons are "fair" because providers are compared with other providers with similar shares of low-income beneficiaries.

To promote transparency for beneficiaries and competition across providers, the Commission supports the public reporting of the cross-cutting quality measures. CMS should move towards reporting the cross-cutting measures quality measures for all providers in each setting.

Drug regimen review conducted with follow-up for identified issues—CMS is proposing to adopt a drug regimen review measure that reports the percentage of resident stays in which a drug regimen review was conducted at the time of admission and timely follow-up with a physician each time potentially clinically significant medication issues were identified. The purpose of the measure is to encourage PAC providers to perform a review of all medications a patient uses to identify and resolve any potential adverse effects and drug reactions (including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy).

Comment: The Commission supports CMS's proposed medication reconciliation measure. The medication and reconciliation and follow-up process can help reduce medication errors that are especially common among patients who have multiple health care providers and multiple comorbidities. In addition to the measure proposed, MedPAC encourages CMS to assess whether PAC providers conduct medication reconciliation when discharging their patients. For example, CMS could also measure whether a PAC provider sends discharge medication lists to either the next PAC provider or, if being discharged home, to the patient's primary care provider.

Medicare spending per beneficiary (MSPB)–Post-acute care LTCH—CMS proposes a measure of resource use that includes the average risk-adjusted total Medicare spending per beneficiary

during the LTCH stay and the 30 days after discharge from the LTCH. By holding LTCHs accountable for resource use over episodes of care, the measure will increase a provider's responsibility for care furnished during their own "watch," a safe transition to the next setting or home, and for care during the next 30 days. CMS is developing separate MSPB measures for each of the four PAC settings; the proposed rule describes the MSPB–PAC LTCH measure.

Comment: The Commission supports the adoption of a resource use measure that promotes providers' responsibility for episodes of care. By reporting provider's performance regarding resource use during their patients' stays plus 30 days after discharge, the measure will ready providers for broader payment reforms that extend providers' responsibility for episodes of care, such as bundled payments. However, the Commission does not support the development of setting-specific measures. We believe a uniformly defined resource use measure for all four PAC settings, rather than separate measures for each PAC setting (such as the MSPB–PAC LTCH), will better meet the intent of the IMPACT Act and enable comparisons across PAC settings. Under a single measure, the episode definitions, service inclusions/exclusions, and risk adjustment methods would be the same across all PAC settings.

Until there is a uniform PAC PPS and payment differences between settings are eliminated, the Commission appreciates that a single measure would, without other adjustment, consistently advantage lower-cost settings and disadvantage higher-cost settings due to the large spending differences associated with the initial PAC stay across the settings. Therefore, to assess providers' performance in the near term, CMS should use a single measure and compare providers within each setting (i.e. a LTCH's spending would be compared with other LTCHs' spending, an IRF's spending would be compared with other IRFs, et cetera). In the future, comparisons of the single measure could be made across all PAC settings.

Discharge to community—This measure is a risk-adjusted rate of FFS beneficiaries who are discharged to the community following a PAC stay and do not have unplanned hospital readmissions during the 31 days following discharge to the community. CMS proposes to gather the discharge status from the PAC claim.

Comment: The Commission supports this measure; it has used a similar measure to track the quality of SNFs and IRFs for several years. However, the Commission urges CMS to confirm discharge status by matching claims between the discharging PAC provider and any subsequent institutional provider (a hospital, IRF, SNF, or LTCH). CMS evaluated the accuracy of the discharge status field on the PAC claim by examining the agreement between the "discharge status" on the PAC claim and the presence of a subsequent acute hospital claim. The agreement between the PAC claim and hospital claim was high (about 90 percent) but the agreement between PAC claims (for example, an LTCH claim indicated the beneficiary was discharged to a SNF and there was a subsequent SNF claim) was not reported. To ensure that rates reflect actual performance, "discharged to the community" should be confirmed with the absence of a subsequent claim to a hospital, an IRF, SNF, or a LTCH.

***Potentially preventable 30-day post-discharge readmission*—**This measure assesses a facility's risk-adjusted rate of unplanned, potentially preventable hospital readmissions for Medicare FFS beneficiaries in the 30 days after discharge from the LTCH.

Comment: The Commission supports this measure, believing that LTCHs should be held accountable for safe transitions to the next setting (including home). MedPAC has tracked a post-discharge readmission measure over multiple years for SNFs and IRFs. As noted above, the measure definition and risk adjustment should be identical across the four PAC settings so the post-discharge rates can be meaningfully compared.

Rural reclassification of LTCHs

The Consolidated Appropriations Act of 2016 (CAA) establishes a temporary exception from the site-neutral payment rate for certain wound care discharges from certain LTCHs. In order to qualify for this exemption, the LTCH must have participated in Medicare as an LTCH, been co-located with another hospital as of September 30, 1995, meet certain other operating requirements, and be located in a rural area. The CAA defines a "rural" LTCH as being either located in a rural area or "treated" as a rural hospital based on reclassification. The rural reclassification historically has only applied to subsection (d) hospitals, which excludes LTCHs by definition. CMS proposes

to apply the existing rural reclassification process for subsection (d) hospitals to certain LTCHs for the sole purpose of qualifying for this temporary exception. CMS further specifies that these facilities would not be treated as rural for any other provision including, but not limited to, the 25-percent threshold policy and wage index.

Comment: The Commission strongly opposes this temporary exception from the site-neutral payment rate. While statute requires CMS to provide an exception for certain discharges involving wound care in certain LTCHs, the Commission urges CMS to apply this exception as narrowly as possible. The Commission does not understand the basis for CMS' proposal to apply the subsection (d) hospital reclassification policy to LTCHs for purposes of this exception and requests that CMS provide a detailed explanation of the rationale for proposing this reclassification. Geographic reclassification distorts wage indexes for subsection (d) hospitals which the Commission discussed in its 2007 Report to Congress. The Commission has long held that the existing hospital wage index should be repealed and replaced eliminating the need for the distorting geographic reclassification policies of IPPS hospitals. Given that LTCHs have not previously qualified for any geographic reclassification, introducing this concept in the LTCH setting creates a precedent against the Commission's principles and previous recommendations.

If you have questions about any of the issues raised in our comments, please contact Mark Miller, MedPAC's Executive Director, at (202) 220-3700.

Sincerely,

Francis J. Crosson, M.D.
Chairman

LIFECARE HOSPITALS

June 15, 2016

Filed Electronically

Andrew M. Slavitt
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-1655-P
P.O. Box 8011
Baltimore, MD 21244-1850

***Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports*; 81 Federal Register 24,946 (April 27, 2016).**

Dear Mr. Slavitt:

This letter presents the comments and recommendations of LifeCare Hospitals ("LifeCare") on the above-referenced Proposed Rule. LifeCare operates a network of 24 long-term acute care hospitals ("LTCHs") in 9 states that care for medically-complex patients who require acute care hospital services for an extended period of time. We appreciate the opportunity to express our concerns with the proposed changes to the fiscal year ("FY") 2017 LTCH prospective payment system ("LTCH PPS") and related policies, and we trust that CMS will carefully consider each of the issues raised in this letter.

THE 25% RULE SHOULD BE RETIRED BECAUSE THE NEW PATIENT CRITERIA MAKE IT UNNECESSARY, BUT UNTIL IT IS RETIRED CMS SHOULD EXTEND THE STATUTORY MORATORIUM THAT FROZE THE 25% RULE AT CURRENT PERCENTAGE THRESHOLDS

Issue. CMS is proposing to continue to apply the 25-percent patient threshold payment adjustment policies at 42 C.F.R. §§ 412.534 and 412.536 (*i.e.*, the "25% Rule") to all traditional Medicare discharges from LTCHs that qualify for the ICU criterion or the ventilator criterion. In addition, CMS is proposing to continue to apply these 25% Rule payment adjustment policies to LTCH discharges that are site neutral cases under the regulation at 42 C.F.R. § 412.522(c)(2)(iii),(iv). However, effective for LTCH discharges on or after October 1, 2016, CMS would apply a new 25% Rule regulation at 42 C.F.R. § 412.538. This regulation would only apply to a LTCH's traditional Medicare patients, not Medicare Advantage patients.

Comment. **We have consistently objected to the 25% Rule payment policies in comments to CMS. The 25% Rule applies an arbitrary cap on the number of patients who are admitted from any one hospital and paid a full MS-LTC-DRG payment. The 25% Rule policies fail to**

CMS adds that fluctuations in the fixed-loss amount also occurred in the first few years of the LTCH PPS, but later stabilized as CMS "gained more experience with the effects and implementation of the LTCH PPS."[13] Our review of the rulemaking record found that the largest change in the HCO fixed-loss amount during the first few years of the LTCH PPS was a 24.8 percent *decrease* in the second year of the LTCH PPS (*i.e.*, RY 2004). A larger *decrease* of 41.2 percent occurred in the fourth year of the LTCH PPS (*i.e.*, RY 2006). It was not until the fifth year of the LTCH PPS (*i.e.*, RY 2007) that the HCO fixed-loss amount *increased*. At that time, it increased by more than 41%. However, CMS also showed a willingness to explore policy changes in these years and reevaluate the quality, accuracy and age of the data they used for HCO and short-stay outlier ("SSO") payments. Therefore, in addition to using the most recent LTCH claims data from the MedPAR file and the latest CCRs from the PSF, CMS should consider whether the new dual rate payment system warrants the use of other relevant data, consistent with statute, or a change in the inflation factor for projecting the costs of each case when determining the fixed-loss threshold. More could be done to mitigate instability in the HCO fixed-loss amount for LTCH PPS standard Federal payment rate cases.

Recommendations. **CMS should recalculate the proposed fixed-loss amount for FY 2017 HCO cases paid under the LTCH PPS standard Federal payment rate after using the most recent LTCH claims data from the MedPAR file and the latest CCRs from the PSF. If this does not significantly reduce the proposed $22,728 HCO fixed-loss amount for LTCH PPS standard Federal payment rate cases, CMS should consider whether the new dual rate payment system warrants the use of other relevant data, consistent with statute, or a change in the inflation factor for projecting the costs of each case when determining the fixed-loss threshold.**

CMS SHOULD NOT APPLY AN ADDITIONAL BUDGET NEUTRALITY ADJUSTMENT TO SITE NEUTRAL PAYMENTS FOR HIGH-COST OUTLIERS

Issue. CMS is proposing to continue to apply a budget neutrality adjustment ("BNA") factor under section 412.522(c)(2)(i) to all cases paid at the site neutral payment rate (including the site neutral payment rate portion of blended rate payments during the transition period) so that HCO payments for site neutral cases will not result in any change in estimated aggregate LTCH PPS payments. CMS says that "[w]e established this requirement because we believe that the HCO policy for site neutral payment rate cases should be budget neutral, just as the HCO policy for LTCH PPS standard Federal payment rate cases are budget neutral."[14] "To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2017 would not result [in] any increase in estimated aggregate FY 2017 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i)" CMS says that "it is necessary to reduce the site neutral payment rate portion of the blended rate payment by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2017."[15] For FY 2017, CMS is proposing to continue to apply a budget neutrality factor of 0.949 (the decimal equivalent of a 5.1% reduction) to the site neutral payment rate portion of the blended rate payment.

Comment. **We *strongly disagree* with CMS' proposal to apply an *additional* 5.1% budget neutrality adjustment for site neutral cases that qualify as high-cost outliers.** CMS is proposing to apply a second BNA to all LTCH payments for site neutral rate cases to offset LTCH payments for HCO site neutral rate cases. **This BNA is duplicative and unwarranted because**

[13] 81 Fed. Reg. 24,946, 25,287 (April 27, 2016).
[14] Id.
[15] Id. at 25,288-89.

CMS has *already* applied budget neutrality adjustments to reduce the operating and capital portions of the IPPS standard Federal payment rate by the same 5.1%, before using that rate to determine the IPPS comparable per diem amount for site neutral payment cases. MedPAC agrees.

In MedPAC's May 31, 2016 comment letter to CMS on the Proposed Rule, MedPAC states that CMS should not apply a separate budget neutrality adjustment to site neutral high-cost outliers because "the IPPS standard payment amount is already adjusted to account for HCO payments."[16] As MedPAC explains:

> CMS proposes to use the IPPS fixed-loss amount to determine if a discharge paid under the site-neutral rate qualifies to receive an HCO payment again for FY 2017. CMS sets the IPPS fixed-loss amount each year at a level that it estimates will result in aggregate HCO payments equal 5.1 percent of total IPPS payment. **To account for the spending attributed to these outlier payments, CMS reduces the IPPS base payment rates to maintain budget neutrality in the IPPS. The IPPS-comparable rate used to pay for site-neutral cases in LTCHs includes an adjustment for budget neutrality to account for spending associated with HCOs.**
>
> With the Commission's payment principles in mind, **MedPAC urges CMS to eliminate the proposed payment adjustment for discharges paid the site-neutral rate to account for outlier payments under this payment methodology. Given that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.**[17]

CMS addressed this issue to some extent in the FY 2016 IPPS/LTCH PPS final rule, but the agency did not see the duplication that MedPAC now agrees is problematic. First, CMS confirmed that the IPPS base rates used to calculate LTCH site neutral payments already include the budget neutrality adjustment discussed above for HCO payments.[18] CMS referred to this BNA as "one of the inputs" used to calculate the LTCH site neutral payment rate.[19] CMS then tried to distinguish this BNA from the LTCH site neutral HCO BNA by stating that these adjustments fund different outlier payments—the former funds outlier payments for IPPS hospitals and the latter funds site neutral outlier payments for LTCHs.[20] This is *not correct*, as MedPAC points out. Since "the IPPS standard payment amount is already adjusted to account for HCO payments, CMS'

---

[16] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 16 (May 31, 2016).
[17] Id. at 16-17 (emphasis added).
[18] See 80 Fed. Reg. at 49,622 ("While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments . . .").
[19] See id. (". . . that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate.").
[20] See id. ("The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS.").

proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative."[21] **Stated another way, the budget neutrality adjustment for LTCH site neutral HCOs should not fund site neutral high cost outliers at LTCHs *and* high cost outliers at IPPS hospitals. In FY 2016, and as proposed for FY 2017, multiple outlier BNAs mean that all LTCHs are effectively paying for outliers at LTCH and IPPS hospitals.**

To ensure that LTCHs are only paying for high cost outliers at LTCHs, and not IPPS hospitals, CMS must not apply the separate 5.1% adjustment for LTCH site neural cases. This is illustrated in **Table 1** below using information from the Proposed Rule.

TABLE 1

FY 2017 LTCH Site Neutral Payment Amount Comparison – With and Without Proposed Budget Neutrality Adjustment to Site Neutral Payments

Duplicate BNAs in Proposed Rule		**Apply BNA Once by Not Applying LTCH Site Neutral HCO BNA**
IPPS Standardized Amount (before adjustments)[1]		
Labor	$4,394.09	$4,394.09
Non-Labor	$1,919.26	$1,919.26
Subtotal	$6,313.35	$6,313.35
IPPS HCO Outlier Factor (0.94899)[2]	**$(281.10)**	**$(281.10)**
Other Adjustments[3]	$(520.46)	$(520.46)
IPPS Standardized Amount (after adjustments)[4]		
Labor	$3,836.20	$3,836.20
Non-Labor	$1,675.59	$1,675.59
Subtotal	$5,511.79	$5,511.79
Capital PPS Rate (before adjustments)[5]	$438.75	$438.75
Capital PPS Outlier Factor (0.937400)[6]	**$(43.87)**	**$(43.87)**
Other Adjustments[7]	$51.47	$51.47
Capital PPS Rate (after adjustments)[8]	$446.35	$446.35
Subtotal	$5,958.14	$5,958.14
LTCH Site Neutral Outlier Factor (0.949)[9]	**$(303.87)**	**N/A**
Total	$5,654.27	$5,958.14

[1] 81 Fed. Reg. at 25,274-75 (assuming full update and wage index greater than 1.0).
[2] Id. at 25,274.
[3] Id. at 25,274-75.

[21] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 17.

[4] Id. at 25,275.
[5] Id. at 25,280.
[6] Id. (net change of this factor is 1.0010 or 0.10%).
[7] Id.
[8] Id.
[9] Id. at 25,289.

As **Table 1** shows, CMS is proposing to adjust LTCH site neutral payments *twice* to keep the LTCH PPS budget neutral for the estimated 5.1% of LTCH payments for site neutral HCO cases. The payment reduction is actually larger for site neutral cases that receive a HCO payment. Consistent with MedPAC's recommendation, CMS should only adjust LTCH site neutral payments *once* for outlier budget neutrality. This can be achieved under what we have labelled "Apply BNA Once" in the third column of the table. MedPAC's comments align with this approach. By eliminating the additional BNA for site neutral HCOs, CMS still has "a budget neutrality adjustment when determining payment for a case under the LTCH PPS" to avoid the situation where "any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases."[22] Moreover, this "approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases."[23] Without making this change, the duplicative BNA not only "exaggerates the disparity in payment rates across provider settings," as MedPAC states, but it is also purely punitive.

Therefore, it would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed 5.1% site neutral HCO BNA to LTCH site neutral payments. This would be the case because the IPPS comparable per diem amount is based on the IPPS and capital PPS payment rates, which have already been reduced by 5.1% for IPPS outlier payments and 6.26% for capital PPS outlier payments. Since CMS has already made these adjustments for budget neutrality, it would be inappropriate for CMS to reduce LTCH site neutral payments that are based on the IPPS and capital PPS rates by *another 5.1%* for HCOs. Accordingly, we object to CMS' proposal to apply a separate HCO BNA to LTCH site neutral payments. CMS should not make a second BNA to LTCH site neutral payments.

For the same reasons, it was incorrect for CMS to apply the 5.1% (0.949) site neutral HCO BNA to FY 2016 site neutral rate cases. CMS is underpaying LTCHs for site neutral rate cases in FY 2016 by 5.1%. CMS must reverse this adjustment to all FY 2016 payments, or make an equivalent prospective increase in payments to FY 2017 site neutral rate cases to account for this underpayment.

Recommendations. **Consistent with MedPAC's comments, we *strongly disagree* with the proposed 0.949 budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. There is no precedent for such an adjustment to the annual payment rate determination for the LTCH PPS. Moreover, CMS already reduced the FY 2017 site neutral payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor. CMS should *not* reduce LTCH site neutral payments by *another 5.1%*.**

[22] 80 Fed. Reg. at 49,622.
[23] Id.

For the same reason, it was incorrect for CMS to apply the 5.1% site neutral HCO BNA to FY 2016 payments for site neutral rate cases. CMS must reverse this adjustment to all FY 2016 payments, or make an equivalent prospective increase in payments to FY 2017 site neutral rate cases to account for this underpayment.

LTCH DISCHARGE PAYMENT PERCENTAGE PROPOSALS

Issue. Pursuant to section 1886(m)(6)(C)(iv) of the Social Security Act, as amended by the PSRA, CMS promulgated the regulation at 42 C.F.R. § 412.522(d)(1) to define an LTCH's discharge payment percentage. The regulation states that this is a ratio, expressed as a percentage, of Medicare discharges excluded from the site neutral payment rate (as described under section 412.522(a)(2), *i.e.*, standard Federal payment rate cases) to total Medicare discharges paid under the LTCH PPS in accordance with 42 C.F.R. Part 412, Subpart O (*i.e.*, standard Federal payment rate cases plus site neutral cases) during the cost reporting period. As required by section 1886(m)(6)(C)(i) of the Social Security Act, for cost reporting periods beginning on or after October 1, 2015, CMS will inform each LTCH of their discharge payment percentage. CMS says that they plan to develop such a notification process through sub-regulatory guidance.

Section 1886(m)(6)(C)(ii) of the Social Security Act requires, for cost reporting periods beginning on or after October 1, 2020, that any LTCH whose discharge payment percentage for the period is not at least 50% will be informed by CMS and all of the LTCH's discharges in each successive cost reporting period will be paid the subsection (d) hospital payment amount, subject to the process for reinstatement under section 1886(m)(6)(C)(iii) of the Act. Congress left it to CMS to establish a process for reinstatement of payments to the hospital at the LTCH PPS rates. To date, CMS has not made any proposals related to this 50% limitation requirement or the process for reinstatement. In the FY 2016 IPPS/LTCH PPS final rule, CMS said that the agency appreciates commenters' input on these issues, including suggestions for "cure periods" for LTCHs who fall below the 50% discharge patient percentage. However, CMS said that they would develop these processes through "operational guidance" instead of by rulemaking.

Comment. CMS should use the rulemaking process to develop: (i) the process to notify LTCHs when their discharge payment percentage under section 412.522(d) is below 50%; (ii) a cure period to continue to receive payments at LTCH PPS rates; and (iii) the process for reinstatement of a LTCH's payment at LTCH PPS rates. For LTCHs that do not maintain a discharge payment percentage of at least 50 percent in a cost reporting period beginning on or after October 1, 2020, CMS should establish a "cure period" similar to the one that is used to confirm compliance with the average length of stay ("ALOS") requirement.[24] Specifically, CMS should establish a "cure period" for LTCHs to demonstrate that they have a discharge payment percentage of at least 50 percent. If the Medicare payment contractor notifies an LTCH that it did not have a discharge payment percentage of at least 50 percent for a cost reporting period that began on or after October 1, 2020, the payment contractor would be required to evaluate the LTCH's discharge payment percentage for at least 5 of the 6 months immediately preceding the date the payment contractor conducts the cure period evaluation. LTCHs should be allowed to choose which months the payment contractor will evaluate, provided that at least 5 months of data are included. If the LTCH has a discharge payment percentage of at least 50 percent for this cure period, the LTCH would continue to be paid under the LTCH PPS. If, however, the LTCH does not have a discharge payment percentage of at least 50 percent for this cure period, the LTCH would no longer be paid under the LTCH PPS effective at the start of the LTCH's next cost reporting period

[24] See 42 C.F.R. § 412.23(e)(3)(iii).

June 17, 2016

Filed Electronically

Andrew M. Slavitt
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-1655-P
P.O. Box 8011
Baltimore, MD 21244-1850

***Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports*; 81 Federal Register 24,946 (April 27, 2016)**

Dear Mr. Slavitt:

This letter presents the comments and recommendations of Vibra Healthcare on the above-referenced Proposed Rule. Vibra Healthcare operates a network of 27 long-term acute care hospitals ("LTCHs") that care for medically-complex patients who require acute care hospital services for an extended period of time. We appreciate the opportunity to express our concerns with the proposed changes to the fiscal year ("FY") 2017 LTCH prospective payment system ("LTCH PPS") and related policies, and we trust that CMS will carefully consider each of the issues raised in this letter.

LTCH 25% Rule Payment Adjustment Policies

1. The 25% Rule Regulations Should Be Retired Because They Are Inconsistent With the New Patient Criteria and No Longer Needed

Issue. The "25% Rule" is a set of payment adjustment policies under the LTCH PPS, originally established at 42 C.F.R. § 412.534 for LTCH hospitals-within-hospitals ("HwHs") and LTCH satellite facilities and their co-located referring hospitals in the FY 2005 IPPS final rule,[1] and at 42 C.F.R. § 412.536 for all other LTCHs and referring hospitals in the RY 2007 LTCH PPS final rule.[2] CMS applies the 25% Rule payment

1 69 Fed. Reg. 48,916, 49,191 (Aug. 11, 2004).

2 71 Fed. Reg. 27,798, 27,875 (May 12, 2006).

will need to calculate a different fixed-loss amount and target amount for site neutral HCO cases. Until that time, using the IPPS fixed-loss amount and target amount is a reasonable place to start.

Recommendations. We are concerned about the significant increase in the proposed FY 2017 fixed-loss amount of $22,728 for LTCH PPS standard Federal payment rate cases. We expect that the fixed-loss amount will change in the final rule after CMS uses the most recent LTCH claims data from the MedPAR file and the latest CCRs from the PSF. But if this does not significantly reduce the increase in the fixed-loss amount for FY 2017, CMS should reassess the 8% target for standard Federal payment rate cases to see if a modest change to the target results in a more manageable increase in the fixed-loss amount. At a minimum, CMS should be more transparent about why there are such large year-to-year changes in the fixed-loss amount and how much of this variability is attributable to the new dual-rate payment system.

It is reasonable for CMS to use the proposed FY 2017 IPPS fixed-loss amount of $23,681 for cases paid at the site neutral payment rate in FY 2017, and the same 5.1% target as the IPPS for HCO payments for these cases in FY 2017. However, as we commented last year, CMS should *not* automatically use the IPPS fixed-loss amount and target for site neutral HCO cases every year.

2. Budget Neutrality Adjustment for Site Neutral HCO Cases

Issue. CMS also is proposing to continue to apply a budget neutrality adjustment ("BNA") factor under section 412.522(c)(2)(i) to all cases paid at the site neutral payment rate (including the site neutral payment rate portion of blended rate payments during the transition period) so that HCO payments for site neutral cases will not result in any change in estimated aggregate LTCH PPS payments. CMS says that "[w]e established this requirement because we believe that the HCO policy for site neutral payment rate cases should be budget neutral, just as the HCO policy for LTCH PPS standard Federal payment rate cases are budget neutral."[17] "To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2017 would not result [in] any increase in estimated aggregate FY 2017 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i)" CMS says that "it is necessary to reduce the site neutral payment rate portion of the blended rate payment by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2017."[18] For FY 2017, CMS is proposing to continue to apply a budget neutrality factor of 0.949 (the decimal equivalent of a 5.1% reduction) to the site neutral payment rate portion of the blended rate payment.

Comment. **We *strongly disagree* with CMS' proposal to apply an *additional* 5.1% budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. CMS is proposing to apply a second BNA to all LTCH payments for site**

[17] Id.
[18] Id. at 25,288-89.

neutral rate cases to offset LTCH payments for HCO site neutral rate cases. As we explained in comments last year, this BNA is duplicative and unwarranted because CMS has *already* applied budget neutrality adjustments to reduce the operating and capital portions of the IPPS standard Federal payment rate by the same 5.1%, before using that rate to determine the IPPS comparable per diem amount for site neutral payment cases. MedPAC agrees that this BNA is duplicative and should not be used to further adjust site neutral payments. Moreover, we found no precedent in the LTCH PPS for an annual BNA for high-cost outlier payments. We address each of these points in more detail below.

a. The Proposed BNA to Site Neutral Payments is Duplicative

CMS already accounted for site neutral HCO payments by using the IPPS and Capital PPS payment rates for the IPPS comparable per diem amount. As discussed above, HCO payments for LTCH site neutral cases will be 80% of the difference between the estimated cost of the case and the proposed IPPS HCO threshold, which is $23,681 for FY 2017. The proposed IPPS HCO threshold for cases paid at the site neutral payment rate would be the sum of the site neutral payment and the proposed IPPS fixed-loss amount of $23,681. Because cases paid at the site neutral payment rate that are paid 100% of the estimated cost of the case would never be eligible for HCO payments, only site neutral cases based on the IPPS comparable per diem amount will be eligible for HCO payments.[19] The IPPS comparable per diem amount, as determined under section 412.529(d)(4), is "based on the sum of the applicable operating inpatient prospective payment system standardized amount and the capital inpatient prospective payment system Federal rate in effect at the time of the LTCH discharge."[20] Congress required calculation of the IPPS comparable per diem amount in this way because it is based on the existing regulation at section 412.529(d)(4) for LTCH short-stay outlier payments.[21] We note that this statute and this regulation do not require a budget neutrality adjustment.

CMS continues to believe that a separate BNA for LTCH site neutral HCO cases will "reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems."[22] However, by aligning this proposed policy with the IPPS payment system—and making the IPPS comparable per diem amount and the IPPS fixed-loss amount the primary components—CMS needs to consider the adjustments that it has already made to the proposed IPPS and capital PPS payment rates to account for outlier payments. Like MedPAC, we do not believe CMS had done this in the Proposed Rule.

[19] 81 Fed. Reg. at 25,288.
[20] 42 C.F.R. §§ 412.522(c)(1)(i),412.529(d)(4)(i)(A).
[21] See Social Security Act (SSA) § 1886(m)(6)(B)(ii)(I).
[22] 81 Fed. Reg. at 25,288.

Specifically, CMS already reduced the operating standardized payment amount under the IPPS and the capital federal rate under the capital PPS for outliers.[23] In determining these payment rates for FY 2017, CMS reduced the IPPS payment rate by a factor of 0.948999 and CMS reduced the capital PPS payment rate by a factor of 0.937400. As CMS explains, these 5.1% and 6.26% outlier adjustment factors, respectively, reduce the IPPS and capital PPS payment rates.[24]

b. MedPAC Agrees that the Proposed BNA to Site Neutral Payments is Duplicative and Should Not Be Applied

In MedPAC's May 31, 2016 comment letter to CMS on the Proposed Rule, MedPAC states that **CMS should not apply a separate budget neutrality adjustment to site neutral high-cost outliers because "the IPPS standard payment amount is already adjusted to account for HCO payments."[25]** As MedPAC explains:

> CMS proposes to use the IPPS fixed-loss amount to determine if a discharge paid under the site-neutral rate qualifies to receive an HCO payment again for FY 2017. CMS sets the IPPS fixed-loss amount each year at a level that it estimates will result in aggregate HCO payments equal 5.1 percent of total IPPS payment. **To account for the spending attributed to these outlier payments, CMS reduces the IPPS base payment rates to maintain budget neutrality in the IPPS. The IPPS-comparable rate used to pay for site-neutral cases in LTCHs includes an adjustment for budget neutrality to account for spending associated with HCOs.**
>
> With the Commission's payment principles in mind, **MedPAC urges CMS to eliminate the proposed payment adjustment for discharges paid the site-neutral rate to account for outlier payments under this payment methodology. Given that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.**[26]

MedPAC is generally critical of the site neutral payment rate established by Congress because the "lesser of" mechanism results in LTCH payments *below* IPPS hospital payments, thereby failing to "equalize payments" across LTCH and IPPS provider types for such cases.[27] Specifically, MedPAC comments that the LTCH site neutral payment rate "could result in the LTCH receiving a lower payment than what it would have

[23] See id. at 25,273.
[24] See id. at 25,273-74, 25,277, 25,280.
[25] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 16 (May 31, 2016).
[26] Id. at 16-17 (emphasis added).
[27] Id. at 16.

received for a similar discharge."[28] If CMS were to impose a second BNA to reduce LTCH site neutral payments by an additional 5.1%, it would exaggerate this disparity even further. This is contrary to the principle of site neutrality in payments.

c. CMS Should Not Apply the Proposed BNA to Site Neutral Payments

To ensure that LTCHs are only paying for high cost outliers at LTCHs, and not IPPS hospitals, CMS must not apply the separate 5.1% adjustment for LTCH site neural cases. This is illustrated in **Table 1** below using information from the Proposed Rule.

TABLE 1

FY 2017 LTCH Site Neutral Payment Amount Comparison – With and Without Proposed Budget Neutrality Adjustment to Site Neutral Payments

Duplicate BNAs in Proposed Rule		**Apply BNA Once by Not Applying LTCH Site Neutral HCO BNA**
IPPS Standardized Amount (before adjustments)[1]		
Labor	$4,394.09	$4,394.09
Non-Labor	$1,919.26	$1,919.26
Subtotal	$6,313.35	$6,313.35
IPPS HCO Outlier Factor (0.94899)[2]	**$(281.10)**	**$(281.10)**
Other Adjustments[3]	$(520.46)	$(520.46)
IPPS Standardized Amount (after adjustments)[4]		
Labor	$3,836.20	$3,836.20
Non-Labor	$1,675.59	$1,675.59
Subtotal	$5,511.79	$5,511.79
Capital PPS Rate (before adjustments)[5]	$438.75	$438.75
Capital PPS Outlier Factor (0.937400)[6]	**$(43.87)**	**$(43.87)**
Other Adjustments[7]	$51.47	$51.47
Capital PPS Rate (after adjustments)[8]	$446.35	$446.35

[28] Id.

Subtotal	$5,958.14	$5,958.14
LTCH Site Neutral Outlier Factor (0.949)[9]	**$(303.87)**	**N/A**
Total	$5,654.27	$5,958.14

[1] 81 Fed. Reg. at 25,274-75 (assuming full update and wage index greater than 1.0).
[2] Id. at 25,274.
[3] Id. at 25,274-75.
[4] Id. at 25,275.
[5] Id. at 25,280.
[6] Id. (net change of this factor is 1.0010 or 0.10%).
[7] Id.
[8] Id.
[9] Id. at 25,289.

As **Table 1** shows, CMS is proposing to adjust LTCH site neutral payments *twice* to keep the LTCH PPS budget neutral for the estimated 5.1% of LTCH payments for site neutral HCO cases. The payment reduction is actually larger for site neutral cases that receive a HCO payment. Consistent with MedPAC's recommendation, CMS should only adjust LTCH site neutral payments *once* for outlier budget neutrality. This can be achieved under what we have labelled "Apply BNA Once" in the third column of the table. MedPAC's comments align with this approach. By eliminating the additional BNA for site neutral HCOs, CMS still has "a budget neutrality adjustment when determining payment for a case under the LTCH PPS" to avoid the situation where "any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases."[29] Moreover, this "approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases."[30] Without making this change, the duplicative BNA not only "exaggerates the disparity in payment rates across provider settings," as MedPAC states, but it is also purely punitive.

Therefore, it would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed 5.1% site neutral HCO BNA to LTCH site neutral payments. This would be the case because the IPPS comparable per diem amount is based on the IPPS and capital PPS payment rates, which have already been reduced by 5.1% for IPPS outlier payments and 6.26% for capital PPS outlier payments. Since CMS has already made these adjustments for budget neutrality, it would be inappropriate for CMS to reduce LTCH site neutral payments that are based on the IPPS and capital PPS rates by *another 5.1%* for HCOs. Accordingly, we object to CMS' proposal to apply a separate HCO BNA to LTCH site neutral payments. CMS should not make a second BNA to LTCH site neutral payments.

[29] 80 Fed. Reg. at 49,622.
[30] Id.

d. Based Upon MedPAC's Comments, CMS Also Should Not Have Finalized This BNA In FY 2016

CMS addressed this issue to some extent in the FY 2016 IPPS/LTCH PPS final rule, but the agency failed to see the duplication that we identified and that MedPAC now agrees is problematic. First, CMS confirmed that the IPPS base rates used to calculate LTCH site neutral payments already include the budget neutrality adjustment discussed above for HCO payments.[31] CMS referred to this BNA as "one of the inputs" used to calculate the LTCH site neutral payment rate.[32] CMS then tried to distinguish this BNA from the LTCH site neutral HCO BNA by stating that these adjustments fund different outlier payments—the former funds outlier payments for IPPS hospitals and the latter funds site neutral outlier payments for LTCHs.[33] This is *not correct*, as MedPAC points out. Since "the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative."[34] **Stated another way, the budget neutrality adjustment for LTCH site neutral HCOs should not fund site neutral high cost outliers at LTCHs *and* high cost outliers at IPPS hospitals. In FY 2016, and as proposed for FY 2017, multiple outlier BNAs mean that all LTCHs are effectively paying for outliers at LTCH and IPPS hospitals.**

Therefore, it was incorrect for CMS to apply the 5.1% (0.949) site neutral HCO BNA to FY 2016 site neutral payments for the same reasons that CMS should not apply this BNA to FY 2017 site neutral payments. CMS is underpaying LTCHs for site neutral rate cases in FY 2016 by 5.1%. CMS must reverse this adjustment to all FY 2016 payments, or make an equivalent prospective increase in payments to FY 2017 site neutral rate cases to account for this underpayment.

e. The Proposed Rule Does Not Include a HCO BNA Factor for Standard Federal Payment Rate Cases

In the FY 2016 IPPS/LTCH PPS proposed rule, CMS stated that "a budget neutrality factor will *continue* to be applied to LTCH PPS *standard Federal payment rate* cases to offset that 8 percent [target] so that HCO payments for LTCH PPS standard Federal

[31] See 80 Fed. Reg. at 49,622 ("While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments . . .").
[32] See id. (". . . that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate.").
[33] See id. ("The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS.").
[34] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 17.

payment rate cases would be budget neutral."[35] CMS pointed to this budget neutrality factor as precedent for a BNA factor to offset LTCH *site neutral* payments by the 5.1% target for site neutral HCO cases.[36] As CMS explained in the preamble:

> The current LTCH PPS HCO policy has a budget neutrality requirement in which the LTCH PPS standard Federal payment rate is reduced by an adjustment factor to account for the estimated proportion of HCO payments to total estimated LTCH PPS payments, that is, 8 percent. (We refer readers to § 412.523(d)(1) of the regulations.) This budget neutrality requirement is intended to ensure that the HCO policy would not result in any change in estimated aggregate LTCH PPS payments. Under our proposal to continue to apply the current HCO methodology as it relates to LTCH PPS standard Federal payment rate cases (other than determining a fixed-loss amount using only data from LTCH PPS standard Federal payment rate cases), we also would continue to apply the current budget neutrality requirement (described above). In accordance with the current LTCH PPS HCO policy budget neutrality requirement, we believe that the HCO policy for site neutral payment rate cases should also be budget neutral, meaning that the proposed site neutral payment rate HCO payments should not result in any change in estimated aggregate LTCH PPS payments. In order to achieve this, under proposed new § 412.522(c)(2)(i), we are proposing to apply a budget neutrality factor to the payment for all site neutral payment rate cases described under proposed new § 412.522(a)(1), which would also be established on an estimated basis. This approach is consistent with the HCO policy proposed for LTCH PPS standard Federal payment rate cases, which is budget neutral within the universe of LTCH PPS standard Federal payment rate cases. We are inviting public comments on this proposed approach and the alternative approach of applying a single budget neutrality factor to all LTCH PPS cases, irrespective of the site neutral payment rate.[37]

However, we found no budget neutrality factor in the Proposed Rule for HCO payments to LTCH PPS *standard Federal payment rate* cases. In addition, the regulation at § 412.523(d)(1) only says that "CMS adjusts the standard Federal rate by a reduction factor of 8 percent, the estimated proportion of outlier payments under the long-term care hospital prospective payment system, as described in § 412.525(a)." The regulation at § 412.525(a) does *not* address budget neutrality—it determines the amount of the HCO payment, when an HCO payment is made, the cost-to-charge ratio that is used and reconciliation of outlier payments. Moreover, in the same parts of the preamble to the LTCH PPS rate update in previous years, CMS does *not* mention a

[35] 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; Proposed Rule, 80 Fed. Reg. 24,324, 24,647-48 (April 30, 2015) (emphasis added).
[36] See 80 Fed. Reg. at 24539-40, 24647-48.
[37] Id. at 24,539-40.

budget neutrality adjustment for LTCH HCO cases. In the current Proposed Rule, CMS explains how it computes the proposed adjusted LTCH PPS Federal prospective payments for FY 2017, but nowhere does CMS mention a BNA factor for HCOs.[38]

Based upon our review of the rulemaking record, there does *not* appear to be an existing budget neutrality adjustment for LTCH HCO payments that is applied during the update to the LTCH PPS standard Federal payment rate each fiscal year. Rather, it appears that CMS may have considered the HCO target and its effect on overall LTCH HCO payments when setting the payment rate *in the first year of the LTCH PPS only*. This was done to comply with the statutory requirement that the LTCH PPS be budget neutral *in the first year only*, compared to the previous TEFRA payment system—not each year as CMS implies in the Proposed Rule.[39] Therefore, the 0.949 BNA factor that CMS applies to FY 2016 site neutral payments, and is proposing to apply to FY 2017 site neutral payments, to offset the 5.1% target for site neutral HCO cases has no precedent in the LTCH PPS and is not required by the PSRA, the PAMA, or the Social Security Act. We raised this in comments to CMS last year, but **CMS did not respond to this comment in the FY 2016 IPPS/LTCH PPS final rule. Yet, CMS repeats the same fallacy in the current Proposed Rule**, stating "[i]n order to maintain budget neutrality, consistent with the budget neutrality requirement for HCO payments to LTCH PPS standard Federal rate payment cases, we also adopted a budget neutrality requirement for HCO payments to site neutral payment rate cases by applying a budget neutrality factor to the LTCH PPS payment for those site neutral payment rate cases."[40]

Recommendations. **Consistent with MedPAC's comments, we *strongly disagree* with the proposed 0.949 budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. There is no precedent for such an adjustment to the annual payment rate determination for the LTCH PPS. Moreover, CMS already reduced the FY 2017 site neutral payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor. CMS should *not* reduce LTCH site neutral payments by *another 5.1%*.**

For the same reason, it was incorrect for CMS to apply the 5.1% site neutral HCO BNA to FY 2016 payments for site neutral rate cases. CMS must reverse this adjustment to all FY 2016 payments, or make an equivalent prospective increase in payments to FY 2017 site neutral rate cases to account for this underpayment.

[38] See 81 Fed. Reg. 24,946, 25,289 (April 27, 2016).
[39] See Section 123(a)(1) of Public Law 106-113; 42 C.F.R. § 412.523(d)(2) ("*Budget neutrality.* CMS adjusts the Federal prospective payment rates for FY 2003 so that aggregate payments under the prospective payment system are estimated to equal the amount that would have been made to long-term care hospitals under Part 413 of this subchapter without regard to the prospective payment system implemented under this subpart.").
[40] 81 Fed. Reg. at 25,285.

June 17, 2016

Filed Electronically

Andrew M. Slavitt
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-1655-P
P.O. Box 8011
Baltimore, MD 21244-1850

***Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports*; 81 Federal Register 24,946 (April 27, 2016)**

Dear Mr. Slavitt:

This letter presents the comments and recommendations of Kindred Healthcare, Inc. ("Kindred") and Select Medical Holdings Corp. ("Select Medical") on the above-referenced Proposed Rule. Kindred and Select Medical collectively operate 204 hospitals that are certified by Medicare as long-term acute care hospitals ("LTCHs")—almost half of the LTCHs operating across the United States. These hospitals care for medically-complex patients who require acute care hospital services for an extended period of time. We appreciate the opportunity to express our concerns with the proposed changes to the fiscal year ("FY") 2017 LTCH prospective payment system ("LTCH PPS") and related policies, and we trust that CMS will carefully consider each of the issues raised in this letter.

EXECUTIVE SUMMARY

Now that specific patient criteria have been implemented for the LTCH PPS, CMS should retire the 25% Rule regulations entirely. If CMS does not retire the 25% Rule

amount and how much of this variability is attributable to the new dual-rate payment system.

It is reasonable for CMS to use the proposed FY 2017 IPPS fixed-loss amount of $23,681 for cases paid at the site neutral payment rate in FY 2017, and the same 5.1% target as the IPPS for HCO payments for these cases in FY 2017. However, as we commented last year, CMS should *not* automatically use the IPPS fixed-loss amount and target for site neutral HCO cases every year.

2. Budget Neutrality Adjustment for Site Neutral HCO Cases

Issue. CMS also is proposing to continue to apply a budget neutrality adjustment factor under section 412.522(c)(2)(i) to all cases paid at the site neutral payment rate (including the site neutral payment rate portion of blended rate payments during the transition period) so that HCO payments for site neutral cases will not result in any change in estimated aggregate LTCH PPS payments. CMS says that "[w]e established this requirement because we believe that the HCO policy for site neutral payment rate cases should be budget neutral, just as the HCO policy for LTCH PPS standard Federal payment rate cases are budget neutral."[20] "To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2017 would not result [in] any increase in estimated aggregate FY 2017 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i)" CMS says that "it is necessary to reduce the site neutral payment rate portion of the blended rate payment by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2017."[21] For FY 2017, CMS is proposing to continue to apply a budget neutrality factor of 0.949 (the decimal equivalent of a 5.1% reduction) to the site neutral payment rate portion of the blended rate payment.

Comment. **We *strongly disagree* with CMS' proposal to apply an *additional* 5.1% budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. CMS is proposing to apply a second BNA to all LTCH payments for site neutral rate cases to offset LTCH payments for HCO site neutral rate cases. As we explained in comments last year, this BNA is duplicative and unwarranted because CMS has *already* applied budget neutrality adjustments to reduce the operating and capital portions of the IPPS standard Federal payment rate by the same 5.1%, before using that rate to determine the IPPS comparable per diem amount for site neutral payment cases. MedPAC agrees that this BNA is duplicative and should not be used to further adjust site neutral payments. Moreover, we found no precedent in the LTCH PPS for an annual BNA for high-cost outlier payments. We address each of these points in more detail below.**

a. The Proposed BNA to Site Neutral Payments is Duplicative

[20] Id.
[21] Id. at 25,288-89.

CMS already accounted for site neutral HCO payments by using the IPPS and Capital PPS payment rates for the IPPS comparable per diem amount. As discussed above, HCO payments for LTCH site neutral cases will be 80% of the difference between the estimated cost of the case and the proposed IPPS HCO threshold, which is $23,681 for FY 2017. The proposed IPPS HCO threshold for cases paid at the site neutral payment rate would be the sum of the site neutral payment and the proposed IPPS fixed-loss amount of $23,681. Because cases paid at the site neutral payment rate that are paid 100% of the estimated cost of the case would never be eligible for HCO payments, only site neutral cases based on the IPPS comparable per diem amount will be eligible for HCO payments.[22] The IPPS comparable per diem amount, as determined under section 412.529(d)(4), is "based on the sum of the applicable operating inpatient prospective payment system standardized amount and the capital inpatient prospective payment system Federal rate in effect at the time of the LTCH discharge."[23] Congress required calculation of the IPPS comparable per diem amount in this way because it is based on the existing regulation at section 412.529(d)(4) for LTCH short-stay outlier payments.[24] We note that this statute and this regulation do not require a budget neutrality adjustment.

CMS continues to believe that a separate BNA for LTCH site neutral HCO cases will "reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems."[25] However, by aligning this proposed policy with the IPPS payment system—and making the IPPS comparable per diem amount and the IPPS fixed-loss amount the primary components—CMS needs to consider the adjustments that it has already made to the proposed IPPS and capital PPS payment rates to account for outlier payments. Like MedPAC, we do not believe CMS had done this in the Proposed Rule.

Specifically, CMS already reduced the operating standardized payment amount under the IPPS and the capital federal rate under the capital PPS for outliers.[26] In determining these payment rates for FY 2017, CMS reduced the IPPS payment rate by a factor of 0.948999 and CMS reduced the capital PPS payment rate by a factor of 0.937400. As CMS explains, these 5.1% and 6.26% outlier adjustment factors, respectively, reduce the IPPS and capital PPS payment rates.[27]

b. MedPAC Agrees that the Proposed BNA to Site Neutral Payments is Duplicative and Should Not Be Applied

In MedPAC's May 31, 2016 comment letter to CMS on the Proposed Rule, MedPAC states that **CMS should <u>not</u> apply a separate budget neutrality adjustment to site**

[22] Id. at 25,288.
[23] 42 C.F.R. §§ 412.522(c)(1)(i),412.529(d)(4)(i)(A).
[24] See Social Security Act (SSA) § 1886(m)(6)(B)(ii)(I).
[25] 81 Fed. Reg. at 25,288.
[26] See id. at 25,273.
[27] See id. at 25,273-74, 25,277, 25,280.

neutral high-cost outliers because "the IPPS standard payment amount is already adjusted to account for HCO payments."[28] As MedPAC explains:

> CMS proposes to use the IPPS fixed-loss amount to determine if a discharge paid under the site-neutral rate qualifies to receive an HCO payment again for FY 2017. CMS sets the IPPS fixed-loss amount each year at a level that it estimates will result in aggregate HCO payments equal 5.1 percent of total IPPS payment. **To account for the spending attributed to these outlier payments, CMS reduces the IPPS base payment rates to maintain budget neutrality in the IPPS. The IPPS-comparable rate used to pay for site-neutral cases in LTCHs includes an adjustment for budget neutrality to account for spending associated with HCOs.**
>
> With the Commission's payment principles in mind, **MedPAC urges CMS to eliminate the proposed payment adjustment for discharges paid the site-neutral rate to account for outlier payments under this payment methodology. Given that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.**[29]

MedPAC is generally critical of the site neutral payment rate established by Congress because the "lesser of" mechanism results in LTCH payments *below* IPPS hospital payments, thereby failing to "equalize payments" across LTCH and IPPS provider types for such cases.[30] Specifically, MedPAC comments that the LTCH site neutral payment rate "could result in the LTCH receiving a lower payment than what it would have received for a similar discharge."[31] If CMS were to impose a second BNA to reduce LTCH site neutral payments by an additional 5.1%, it would exaggerate this disparity even further. This is contrary to the principle of site neutrality in payments.

c. CMS Should Not Apply the Proposed BNA to Site Neutral Payments

To ensure that LTCHs are only paying for high cost outliers at LTCHs, and not IPPS hospitals, CMS must not apply the separate 5.1% adjustment for LTCH site neural cases. This is illustrated in **Table 1** below using information from the Proposed Rule.

[28] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 16 (May 31, 2016).
[29] Id. at 16-17 (emphasis added).
[30] Id. at 16.
[31] Id.

TABLE 1

FY 2017 LTCH Site Neutral Payment Amount Comparison – With and Without Proposed Budget Neutrality Adjustment to Site Neutral Payments

Duplicate BNAs in Proposed Rule		**Apply BNA Once by Not Applying LTCH Site Neutral HCO BNA**
IPPS Standardized Amount (before adjustments)[1]		
Labor	$4,394.09	$4,394.09
Non-Labor	$1,919.26	$1,919.26
Subtotal	$6,313.35	$6,313.35
IPPS HCO Outlier Factor (0.94899)[2]	**$(281.10)**	**$(281.10)**
Other Adjustments[3]	$(520.46)	$(520.46)
IPPS Standardized Amount (after adjustments)[4]		
Labor	$3,836.20	$3,836.20
Non-Labor	$1,675.59	$1,675.59
Subtotal	$5,511.79	$5,511.79
Capital PPS Rate (before adjustments)[5]	$438.75	$438.75
Capital PPS Outlier Factor (0.937400)[6]	**$(43.87)**	**$(43.87)**
Other Adjustments[7]	$51.47	$51.47
Capital PPS Rate (after adjustments)[8]	$446.35	$446.35
Subtotal	$5,958.14	$5,958.14
LTCH Site Neutral Outlier Factor (0.949)[9]	**$(303.87)**	**N/A**
Total	$5,654.27	$5,958.14

[1] 81 Fed. Reg. at 25,274-75 (assuming full update and wage index greater than 1.0).
[2] Id. at 25,274.
[3] Id. at 25,274-75.
[4] Id. at 25,275.
[5] Id. at 25,280.
[6] Id. (net change of this factor is 1.0010 or 0.10%).
[7] Id.
[8] Id.

[9] Id. at 25,289.

As **Table 1** shows, CMS is proposing to adjust LTCH site neutral payments *twice* to keep the LTCH PPS budget neutral for the estimated 5.1% of LTCH payments for site neutral HCO cases. The payment reduction is actually larger for site neutral cases that receive a HCO payment. Consistent with MedPAC's recommendation, CMS should only adjust LTCH site neutral payments *once* for outlier budget neutrality. This can be achieved under what we have labelled "Apply BNA Once" in the third column of the table. MedPAC's comments align with this approach. By eliminating the additional BNA for site neutral HCOs, CMS still has "a budget neutrality adjustment when determining payment for a case under the LTCH PPS" to avoid the situation where "any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases."[32] Moreover, this "approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases."[33] Without making this change, the duplicative BNA not only "exaggerates the disparity in payment rates across provider settings," as MedPAC states, but it is also purely punitive.

Therefore, it would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed 5.1% site neutral HCO BNA to LTCH site neutral payments. This would be the case because the IPPS comparable per diem amount is based on the IPPS and capital PPS payment rates, which have already been reduced by 5.1% for IPPS outlier payments and 6.26% for capital PPS outlier payments. Since CMS has already made these adjustments for budget neutrality, it would be inappropriate for CMS to reduce LTCH site neutral payments that are based on the IPPS and capital PPS rates by *another 5.1%* for HCOs. Accordingly, we object to CMS' proposal to apply a separate HCO BNA to LTCH site neutral payments. CMS should not make a second BNA to LTCH site neutral payments.

d. Based Upon MedPAC's Comments, CMS Also Should Not Have Finalized This BNA In FY 2016

CMS addressed this issue to some extent in the FY 2016 IPPS/LTCH PPS final rule, but the agency failed to see the duplication that we identified and that MedPAC now agrees is problematic. First, CMS confirmed that the IPPS base rates used to calculate LTCH site neutral payments already include the budget neutrality adjustment discussed above for HCO payments.[34] CMS referred to this BNA as "one of the inputs" used to calculate

[32] 80 Fed. Reg. at 49,622.
[33] Id.
[34] See 80 Fed. Reg. at 49,622 ("While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments . . .").

the LTCH site neutral payment rate.[35] CMS then tried to distinguish this BNA from the LTCH site neutral HCO BNA by stating that these adjustments fund different outlier payments—the former funds outlier payments for IPPS hospitals and the latter funds site neutral outlier payments for LTCHs.[36] This is *not correct*, as MedPAC points out. Since "the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative."[37] **Stated another way, the budget neutrality adjustment for LTCH site neutral HCOs should not fund site neutral high cost outliers at LTCHs *and* high cost outliers at IPPS hospitals. In FY 2016, and as proposed for FY 2017, multiple outlier BNAs mean that all LTCHs are effectively paying for outliers at LTCH and IPPS hospitals.**

Therefore, it was incorrect for CMS to apply the 5.1% (0.949) site neutral HCO BNA to FY 2016 site neutral payments for the same reasons that CMS should not apply this BNA to FY 2017 site neutral payments. CMS is underpaying LTCHs for site neutral rate cases in FY 2016 by 5.1%. CMS must reverse this adjustment to all FY 2016 payments, or make an equivalent prospective increase in payments to FY 2017 site neutral rate cases to account for this underpayment.

e. The Proposed Rule Does Not Include a HCO BNA Factor for Standard Federal Payment Rate Cases

In the FY 2016 IPPS/LTCH PPS proposed rule, CMS stated that "a budget neutrality factor will *continue* to be applied to LTCH PPS *standard Federal payment rate* cases to offset that 8 percent [target] so that HCO payments for LTCH PPS standard Federal payment rate cases would be budget neutral."[38] CMS pointed to this budget neutrality factor as precedent for a BNA factor to offset LTCH *site neutral* payments by the 5.1% target for site neutral HCO cases.[39] As CMS explained in the preamble:

> The current LTCH PPS HCO policy has a budget neutrality requirement in which the LTCH PPS standard Federal payment rate is reduced by an adjustment factor to account for the estimated proportion of HCO payments to total estimated LTCH PPS payments, that is, 8 percent. (We refer readers to § 412.523(d)(1) of the regulations.) This budget neutrality requirement is intended to ensure that the HCO policy would not result in

[35] See id. (". . . that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate.").
[36] See id. ("The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS.").
[37] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 17.
[38] 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; Proposed Rule, 80 Fed. Reg. 24,324, 24,647-48 (April 30, 2015) (emphasis added).
[39] See 80 Fed. Reg. at 24539-40, 24647-48.

> any change in estimated aggregate LTCH PPS payments. Under our proposal to continue to apply the current HCO methodology as it relates to LTCH PPS standard Federal payment rate cases (other than determining a fixed-loss amount using only data from LTCH PPS standard Federal payment rate cases), we also would continue to apply the current budget neutrality requirement (described above). In accordance with the current LTCH PPS HCO policy budget neutrality requirement, we believe that the HCO policy for site neutral payment rate cases should also be budget neutral, meaning that the proposed site neutral payment rate HCO payments should not result in any change in estimated aggregate LTCH PPS payments. In order to achieve this, under proposed new § 412.522(c)(2)(i), we are proposing to apply a budget neutrality factor to the payment for all site neutral payment rate cases described under proposed new § 412.522(a)(1), which would also be established on an estimated basis. This approach is consistent with the HCO policy proposed for LTCH PPS standard Federal payment rate cases, which is budget neutral within the universe of LTCH PPS standard Federal payment rate cases. We are inviting public comments on this proposed approach and the alternative approach of applying a single budget neutrality factor to all LTCH PPS cases, irrespective of the site neutral payment rate.[40]

However, we found no budget neutrality factor in the Proposed Rule for HCO payments to LTCH PPS *standard Federal payment rate* cases. In addition, the regulation at § 412.523(d)(1) only says that "CMS adjusts the standard Federal rate by a reduction factor of 8 percent, the estimated proportion of outlier payments under the long-term care hospital prospective payment system, as described in § 412.525(a)." The regulation at § 412.525(a) does *not* address budget neutrality—it determines the amount of the HCO payment, when an HCO payment is made, the cost-to-charge ratio that is used and reconciliation of outlier payments. Moreover, in the same parts of the preamble to the LTCH PPS rate update in previous years, CMS does *not* mention a budget neutrality adjustment for LTCH HCO cases. In the current Proposed Rule, CMS explains how it computes the proposed adjusted LTCH PPS Federal prospective payments for FY 2017, but nowhere does CMS mention a BNA factor for HCOs.[41]

Based upon our review of the rulemaking record, there does *not* appear to be an existing budget neutrality adjustment for LTCH HCO payments that is applied during the update to the LTCH PPS standard Federal payment rate each fiscal year. Rather, it appears that CMS may have considered the HCO target and its effect on overall LTCH HCO payments when setting the payment rate *in the first year of the LTCH PPS only*. This was done to comply with the statutory requirement that the LTCH PPS be budget neutral *in the first year only*, compared to the previous TEFRA payment system—not

[40] Id. at 24,539-40.
[41] See 81 Fed. Reg. 24,946, 25,289 (April 27, 2016).

each year as CMS implies in the Proposed Rule.[42] Therefore, the 0.949 BNA factor that CMS applies to FY 2016 site neutral payments, and is proposing to apply to FY 2017 site neutral payments, to offset the 5.1% target for site neutral HCO cases has no precedent in the LTCH PPS and is not required by the PSRA, the PAMA, or the Social Security Act. We raised this in comments to CMS last year, but **CMS did not respond to this comment in the FY 2016 IPPS/LTCH PPS final rule. Yet, CMS repeats the same fallacy in the current Proposed Rule**, stating "[i]n order to maintain budget neutrality, consistent with the budget neutrality requirement for HCO payments to LTCH PPS standard Federal rate payment cases, we also adopted a budget neutrality requirement for HCO payments to site neutral payment rate cases by applying a budget neutrality factor to the LTCH PPS payment for those site neutral payment rate cases."[43]

Recommendations. **Consistent with MedPAC's comments, we *strongly disagree* with the proposed 0.949 budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. There is no precedent for such an adjustment to the annual payment rate determination for the LTCH PPS. Moreover, CMS already reduced the FY 2017 site neutral payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor. CMS should *not* reduce LTCH site neutral payments by *another 5.1%*.**

For the same reason, it was incorrect for CMS to apply the 5.1% site neutral HCO BNA to FY 2016 payments for site neutral rate cases. CMS must reverse this adjustment to all FY 2016 payments, or make an equivalent prospective increase in payments to FY 2017 site neutral rate cases to account for this underpayment.

LTCH PATIENT CRITERIA & SITE-NEUTRAL PAYMENT

1. CMS Should Clarify the Regulations On When a LTCH Stay Was Immediately Preceded By a Discharge From a Subsection (d) Hospital

Issue. Section 1886(m)(6)(A)(iii)(I) of the Social Security Act specifies that in order to qualify for the intensive care unit ("ICU") criterion, the LTCH admission must be immediately preceded by a discharge from a subsection (d) hospital that included at least 3 days in an ICU, as determined by the Secretary. Section 1886(m)(6)(A)(iv)(I) of the Social Security Act specifies that in order to qualify for the ventilator criterion, the LTCH admission must be immediately preceded by a discharge from a subsection (d) hospital, and the LTCH discharge must be assigned to an MS-LTC-DRG based on the beneficiary's receipt of at least 96 hours of ventilator services. Both the ICU criterion and the ventilator criterion require that the LTCH admission be immediately preceded by a discharge from a subsection (d) hospital. CMS interpreted the phrase "immediately

[42] See Section 123(a)(1) of Public Law 106-113; 42 C.F.R. § 412.523(d)(2) ("*Budget neutrality.* CMS adjusts the Federal prospective payment rates for FY 2003 so that aggregate payments under the prospective payment system are estimated to equal the amount that would have been made to long-term care hospitals under Part 413 of this subchapter without regard to the prospective payment system implemented under this subpart.").
[43] 81 Fed. Reg. at 25,285.

Charles N. Kahn III
President and CEO

June 17, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

SUBJECT: CMS-1655-P. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports; April 27, 2016

Dear Administrator Slavitt:

The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural parts of America, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. The FAH appreciates the opportunity to comment to the Centers for Medicare & Medicaid Services ("CMS") about the referenced Notice of Proposed Rulemaking on the Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports; April 27, 2016 ("Proposed Rule").

The FAH agrees with CMS's proposal to exclude Medicare Advantage (Part C) cases from the 25% Rule policies, consistent with current CMS policy.

Addendum—Proposed Schedule of Standardized Amounts, Update Factors, Rate-of-Increase Percentages Effective with Cost Reporting Periods Beginning on or after October 1, 2016 and Payment Rates for LTCHs Effective for Discharges occurring on or after October 1, 2016

V. Proposed Changes to the Payment Rates for LTCH PPS for FY 2017

D. Proposed Adjustment for LTCH PPS High-Cost Outlier ("HCO") Cases

CMS has made a number of proposals relative to high-cost outlier ("HCO") cases. First, as in FY 2016, CMS is proposing to maintain separate FY 2017 fixed-loss amounts for the two categories of LTCH cases. For LTCH PPS standard Federal payment rate cases CMS is proposing a fixed-loss amount of $22,728, while it is proposing a fixed-loss amount of $23,681 for cases paid at the site neutral payment rate. In addition, as in FY 2016, CMS is proposing to maintain two separate HCO targets, one for long term acute care hospitals ("LTCHs") paid at the LTCH PPS standard Federal payment and one for cases paid at the site neutral rate. In FY 2017, CMS is proposing to continue to use an 8 % target for HCO payments for LTCH standard Federal payment rate cases and to use the IPPS HCO payment target of 5.1% for HCO payments for site neutral cases. Finally, CMS is proposing to continue to apply a budget neutrality adjustment ("BNA") factor of .949 to all cases paid at the site neutral rate.

Although the FAH generally supports using a target amount of 8% for HCOs paid at the LTCH PPS standard Federal payment rate, it is concerned about the proposed, significant increase in the fixed-loss amount for these cases for FY 2017. CMS recognizes that the proposed fixed-loss amount of $22,728 for FY 2017 for LTCH PPS standard Federal payment rate cases is "notably higher" than the fixed-loss amount in FY 2016 - nearly a 40% increase from FY 2016. The FAH is concerned that such a substantial increase is inconsistent with CMS' stated policy goal of mitigating instability in the HCO fixed-loss amounts for LTCH PPS standard Federal payment rate cases. CMS has indicated that it expects the annual changes in the fixed-loss amount to stabilize over time as it gains more experience with the effects and implementation of the new dual-rate LTCH PPS payment system. Notwithstanding, the FAH believes it is important for CMS to be more transparent about the year-to-year fluctuations in the fixed-loss amounts.

The FAH supports CMS' proposals to use the FY 2017 IPPS fixed-loss amount of $23,681 for site neutral payment rate cases, and the same 5.1% target as the IPPS for HCO payments to these cases. The FAH does not believe, however, that CMS should automatically use the IPPS fixed-loss amount and target for site neutral HCO cases every year. Instead, the FAH suggests that once data becomes available following the transition to the new two-tiered LTCH payment system, CMS should calculate the fixed-loss amount and target amount for site neutral HCO cases independently. Until then, the FAH finds the use of the IPPS fixed-loss amount and target amount to be a reasonable proxy.

The FAH strongly disagrees, however, with CMS' proposal to apply a .949 budget neutrality factor to LTCH site neutral cases that qualify for HCO payments. First, there is

no precedent in the LTCH PPS for an annual budget neutrality adjustment to the LTCH site neutral payments. Furthermore, perhaps more importantly, CMS has already accounted for site neutral HCO budget neutrality by using the IPPS and Capital PPS payment rates for the IPPS comparable per diem amounts. **Because only site neutral cases paid based on the IPPS comparable per diem amount will be eligible for HCO payments, the budget neutrality factor is duplicative because these cases are paid based on an IPPS comparable per diem amount that is comprised of IPPS and capital PPS rates that have already been reduced for budget neutrality.** Importantly, MedPAC agrees. Specifically, in its May 31, 2016 comment letter to CMS, MedPAC stated that CMS should not apply a separate budget neutrality adjustment to site neutral high-cost outliers because "the IPPS standard payment amount is already adjusted to account for HCO payments." *See* MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 16 (May 16, 2016). MedPAC further suggested that applying this budget neutrality factor to site neutral cases was "duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further." *Id.* at 16-17.

As such, the FAH believes that **CMS should withdraw the proposed .949 budget neutrality adjustment for site neutral cases that qualify as HCOs**. This adjustment is not supported in LTCH PPS and CMS has already reduced the FY 2017 site neutral payment amount for estimated outlier payments through the IPPS HCO outlier factor and the capital PPS outlier factor. Applying the budget neutrality adjustment for the site neutral cases is an improper duplicative hit for the site neutral cases that qualify for HCO. In addition, since this budget neutrality adjustment has already been applied to site neutral HCO cases in FY 2016, the FAH also urges CMS to reverse this adjustment to all FY 2016 payments.

Other Comments/Considerations

A. Technical Correction of Definition of "Subsection (d) Hospital" for Site Neutral Payment Rate

Under the new two-tiered LTCH payment system, in order for a stay to qualify for payment under the LTCH PPS standard Federal payment rate under either the ICU criterion or the ventilator criterion, the LTCH admission must be immediately preceded by a discharge from a subsection (d) hospital. In the FY 2016 IPPS/LTCH PPS final rule, CMS adopted a definition of "subsection (d) hospital" in the regulation at 42 C.F.R. § 412.503: "*Subsection (d) hospital* means, for purposes of § 412.526, a hospital defined in section 1886(d)(1)(B) of the Social Security Act and includes any hospital that is located in Puerto Rico and that would be a subsection (d) hospital as defined in section 1886(d)(1)(B) of the Social Security Act if it were located in one of the 50 States." CMS now proposes to amend this definition so that it applies to the site-neutral payment rate regulation at section 412.522 instead of the payment provisions for "subclause II" LTCHs at section 412.526. CMS states that this is being done to correct an "inadvertent cross-reference error."

The FAH agrees that CMS should correct the definition of "subsection (d) hospital" at section 412.503 to refer to the site-neutral payment rate regulation. In addition, the FAH believes CMS should make two additional changes to clarify that (i) a subsection (d) hospital is not required to submit a Medicare claim, and (ii) a subsection (d) hospital is not required to be enrolled in Medicare as an IPPS hospital. These changes are necessary so that Medicare payment contractors will pay LTCH claims correctly for cases that meet LTCH patient criteria.

June 17, 2016

Filed Electronically

Andrew M. Slavitt
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-1655-P
P.O. Box 8011
Baltimore, MD 21244-1850

***Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports*; 81 Federal Register 24,946 (April 27, 2016)**

Dear Mr. Slavitt:

This letter presents the comments and recommendations of Post Acute Medical on the above-referenced Proposed Rule. Post Acute Medical operates a network of 16 long-term acute care hospitals ("LTCHs") that care for medically-complex patients who require acute care hospital services for an extended period of time. We appreciate the opportunity to express our concerns with the proposed changes to the fiscal year ("FY") 2017 LTCH prospective payment system ("LTCH PPS") and related policies, and we trust that CMS will carefully consider each of the issues raised in this letter.

LTCH 25% RULE PAYMENT ADJUSTMENT POLICIES

1. The 25% Rule Regulations Should Be Retired Because They Are Inconsistent With the New Patient Criteria and No Longer Needed

Issue. The "25% Rule" is a set of payment adjustment policies under the LTCH PPS, originally established at 42 C.F.R. § 412.534 for LTCH hospitals-within-hospitals ("HwHs") and LTCH satellite facilities and their co-located referring hospitals in the FY

target amount are appropriate for site neutral HCO cases. **As claims data become available from the transition to the new dual-rate LTCH PPS, we expect that CMS will need to calculate a different fixed-loss amount and target amount for site neutral HCO cases.** Until that time, using the IPPS fixed-loss amount and target amount is a reasonable place to start.

Recommendations. We are generally in favor of continuing to use a target amount of 8% for HCOs paid using the LTCH PPS standard Federal payment rate, but we are concerned about the significant increase in the proposed FY 2017 fixed-loss amount of $22,728 for LTCH PPS standard Federal payment rate cases. We expect that the fixed-loss amount will change in the final rule after CMS uses the most recent LTCH claims data from the MedPAR file and the latest CCRs from the PSF. But CMS should be more transparent about why there are such large year-to-year changes in the fixed-loss amount and how much of this variability is attributable to the new dual-rate payment system.

It is reasonable for CMS to use the proposed FY 2017 IPPS fixed-loss amount of $23,681 for cases paid at the site neutral payment rate in FY 2017, and the same 5.1% target as the IPPS for HCO payments for these cases in FY 2017. However, as we commented last year, CMS should *not* automatically use the IPPS fixed-loss amount and target for site neutral HCO cases every year.

2. Budget Neutrality Adjustment for Site Neutral HCO Cases

Issue. CMS also is proposing to continue to apply a budget neutrality adjustment ("BNA") factor under section 412.522(c)(2)(i) to all cases paid at the site neutral payment rate (including the site neutral payment rate portion of blended rate payments during the transition period) so that HCO payments for site neutral cases will not result in any change in estimated aggregate LTCH PPS payments. CMS says that "[w]e established this requirement because we believe that the HCO policy for site neutral payment rate cases should be budget neutral, just as the HCO policy for LTCH PPS standard Federal payment rate cases are budget neutral."[17] "To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2017 would not result [in] any increase in estimated aggregate FY 2017 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i)" CMS says that "it is necessary to reduce the site neutral payment rate portion of the blended rate payment by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2017."[18] For FY 2017, CMS is proposing to continue to apply a budget neutrality factor of 0.949 (the decimal equivalent of a 5.1% reduction) to the site neutral payment rate portion of the blended rate payment.

Comment. **We *strongly disagree* with CMS' proposal to apply an *additional* 5.1% budget neutrality adjustment for site neutral cases that qualify as high-cost**

[17] Id.
[18] Id. at 25,288-89.

outliers. CMS is proposing to apply a second BNA to all LTCH payments for site neutral rate cases to offset LTCH payments for HCO site neutral rate cases. As we explained in comments last year, this BNA is duplicative and unwarranted because CMS has *already* applied budget neutrality adjustments to reduce the operating and capital portions of the IPPS standard Federal payment rate by the same 5.1%, before using that rate to determine the IPPS comparable per diem amount for site neutral payment cases. MedPAC agrees that this BNA is duplicative and should not be used to further adjust site neutral payments. Moreover, we found no precedent in the LTCH PPS for an annual BNA for high-cost outlier payments. We address each of these points in more detail below.

a. The Proposed BNA to Site Neutral Payments is Duplicative

CMS already accounted for site neutral HCO payments by using the IPPS and Capital PPS payment rates for the IPPS comparable per diem amount. As discussed above, HCO payments for LTCH site neutral cases will be 80% of the difference between the estimated cost of the case and the proposed IPPS HCO threshold, which is $23,681 for FY 2017. The proposed IPPS HCO threshold for cases paid at the site neutral payment rate would be the sum of the site neutral payment and the proposed IPPS fixed-loss amount of $23,681. Because cases paid at the site neutral payment rate that are paid 100% of the estimated cost of the case would never be eligible for HCO payments, only site neutral cases based on the IPPS comparable per diem amount will be eligible for HCO payments.[19] The IPPS comparable per diem amount, as determined under section 412.529(d)(4), is "based on the sum of the applicable operating inpatient prospective payment system standardized amount and the capital inpatient prospective payment system Federal rate in effect at the time of the LTCH discharge."[20] Congress required calculation of the IPPS comparable per diem amount in this way because it is based on the existing regulation at section 412.529(d)(4) for LTCH short-stay outlier payments.[21] We note that this statute and this regulation do not require a budget neutrality adjustment.

CMS continues to believe that a separate BNA for LTCH site neutral HCO cases will "reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems."[22] However, by aligning this proposed policy with the IPPS payment system—and making the IPPS comparable per diem amount and the IPPS fixed-loss amount the primary components—CMS needs to consider the adjustments that it has already made to the proposed IPPS and capital PPS payment rates to account for outlier payments. Like MedPAC, we do not believe CMS had done this in the Proposed Rule.

[19] 81 Fed. Reg. at 25,288.
[20] 42 C.F.R. §§ 412.522(c)(1)(i),412.529(d)(4)(i)(A).
[21] See Social Security Act (SSA) § 1886(m)(6)(B)(ii)(I).
[22] 81 Fed. Reg. at 25,288.

Specifically, CMS already reduced the operating standardized payment amount under the IPPS and the capital federal rate under the capital PPS for outliers.[23] In determining these payment rates for FY 2017, CMS reduced the IPPS payment rate by a factor of 0.948999 and CMS reduced the capital PPS payment rate by a factor of 0.937400. As CMS explains, these 5.1% and 6.26% outlier adjustment factors, respectively, reduce the IPPS and capital PPS payment rates.[24]

b. MedPAC Agrees that the Proposed BNA to Site Neutral Payments is Duplicative and Should Not Be Applied

In MedPAC's May 31, 2016 comment letter to CMS on the Proposed Rule, MedPAC states that **CMS should not apply a separate budget neutrality adjustment to site neutral high-cost outliers because "the IPPS standard payment amount is already adjusted to account for HCO payments."[25]** As MedPAC explains:

> CMS proposes to use the IPPS fixed-loss amount to determine if a discharge paid under the site-neutral rate qualifies to receive an HCO payment again for FY 2017. CMS sets the IPPS fixed-loss amount each year at a level that it estimates will result in aggregate HCO payments equal 5.1 percent of total IPPS payment. **To account for the spending attributed to these outlier payments, CMS reduces the IPPS base payment rates to maintain budget neutrality in the IPPS. The IPPS-comparable rate used to pay for site-neutral cases in LTCHs includes an adjustment for budget neutrality to account for spending associated with HCOs.**
>
> With the Commission's payment principles in mind, **MedPAC urges CMS to eliminate the proposed payment adjustment for discharges paid the site-neutral rate to account for outlier payments under this payment methodology. Given that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.**[26]

MedPAC is generally critical of the site neutral payment rate established by Congress because the "lesser of" mechanism results in LTCH payments *below* IPPS hospital payments, thereby failing to "equalize payments" across LTCH and IPPS provider types for such cases.[27] Specifically, MedPAC comments that the LTCH site neutral payment rate "could result in the LTCH receiving a lower payment than what it would have

[23] See id. at 25,273.
[24] See id. at 25,273-74, 25,277, 25,280.
[25] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 16 (May 31, 2016).
[26] Id. at 16-17 (emphasis added).
[27] Id. at 16.

received for a similar discharge."[28] If CMS were to impose a second BNA to reduce LTCH site neutral payments by an additional 5.1%, it would exaggerate this disparity even further. This is contrary to the principle of site neutrality in payments.

c. CMS Should Not Apply the Proposed BNA to Site Neutral Payments

To ensure that LTCHs are only paying for high cost outliers at LTCHs, and not IPPS hospitals, CMS must not apply the separate 5.1% adjustment for LTCH site neural cases. This is illustrated in **Table 1** below using information from the Proposed Rule.

TABLE 1

FY 2017 LTCH Site Neutral Payment Amount Comparison – With and Without Proposed Budget Neutrality Adjustment to Site Neutral Payments

Duplicate BNAs in Proposed Rule		**Apply BNA Once by Not Applying LTCH Site Neutral HCO BNA**
IPPS Standardized Amount (before adjustments)[1]		
Labor	$4,394.09	$4,394.09
Non-Labor	$1,919.26	$1,919.26
Subtotal	$6,313.35	$6,313.35
IPPS HCO Outlier Factor (0.94899)[2]	**$(281.10)**	**$(281.10)**
Other Adjustments[3]	$(520.46)	$(520.46)
IPPS Standardized Amount (after adjustments)[4]		
Labor	$3,836.20	$3,836.20
Non-Labor	$1,675.59	$1,675.59
Subtotal	$5,511.79	$5,511.79
Capital PPS Rate (before adjustments)[5]	$438.75	$438.75
Capital PPS Outlier Factor (0.937400)[6]	**$(43.87)**	**$(43.87)**
Other Adjustments[7]	$51.47	$51.47
Capital PPS Rate (after adjustments)[8]	$446.35	$446.35

[28] Id.

Subtotal	$5,958.14	$5,958.14
LTCH Site Neutral Outlier Factor (0.949)[9]	**$(303.87)**	**N/A**
Total	$5,654.27	$5,958.14

[1] 81 Fed. Reg. at 25,274-75 (assuming full update and wage index greater than 1.0).
[2] Id. at 25,274.
[3] Id. at 25,274-75.
[4] Id. at 25,275.
[5] Id. at 25,280.
[6] Id. (net change of this factor is 1.0010 or 0.10%).
[7] Id.
[8] Id.
[9] Id. at 25,289.

As **Table 1** shows, CMS is proposing to adjust LTCH site neutral payments *twice* to keep the LTCH PPS budget neutral for the estimated 5.1% of LTCH payments for site neutral HCO cases. The payment reduction is actually larger for site neutral cases that receive a HCO payment. Consistent with MedPAC's recommendation, CMS should only adjust LTCH site neutral payments *once* for outlier budget neutrality. This can be achieved under what we have labelled "Apply BNA Once" in the third column of the table. MedPAC's comments align with this approach. By eliminating the additional BNA for site neutral HCOs, CMS still has "a budget neutrality adjustment when determining payment for a case under the LTCH PPS" to avoid the situation where "any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases."[29] Moreover, this "approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases."[30] Without making this change, the duplicative BNA not only "exaggerates the disparity in payment rates across provider settings," as MedPAC states, but it is also purely punitive.

Therefore, it would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed 5.1% site neutral HCO BNA to LTCH site neutral payments. This would be the case because the IPPS comparable per diem amount is based on the IPPS and capital PPS payment rates, which have already been reduced by 5.1% for IPPS outlier payments and 6.26% for capital PPS outlier payments. Since CMS has already made these adjustments for budget neutrality, it would be inappropriate for CMS to reduce LTCH site neutral payments that are based on the IPPS and capital PPS rates by *another 5.1%* for HCOs. Accordingly, we object to CMS' proposal to apply a separate HCO BNA to LTCH site neutral payments. CMS should not make a second BNA to LTCH site neutral payments.

[29] 80 Fed. Reg. at 49,622.
[30] Id.

d. Based Upon MedPAC's Comments, CMS Also Should Not Have Finalized This BNA In FY 2016

CMS addressed this issue to some extent in the FY 2016 IPPS/LTCH PPS final rule, but the agency failed to see the duplication that we identified and that MedPAC now agrees is problematic. First, CMS confirmed that the IPPS base rates used to calculate LTCH site neutral payments already include the budget neutrality adjustment discussed above for HCO payments.[31] CMS referred to this BNA as "one of the inputs" used to calculate the LTCH site neutral payment rate.[32] CMS then tried to distinguish this BNA from the LTCH site neutral HCO BNA by stating that these adjustments fund different outlier payments—the former funds outlier payments for IPPS hospitals and the latter funds site neutral outlier payments for LTCHs.[33] This is *not correct*, as MedPAC points out. Since "the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative."[34] **Stated another way, the budget neutrality adjustment for LTCH site neutral HCOs should not fund site neutral high cost outliers at LTCHs *and* high cost outliers at IPPS hospitals. In FY 2016, and as proposed for FY 2017, multiple outlier BNAs mean that all LTCHs are effectively paying for outliers at LTCH and IPPS hospitals.**

Therefore, it was incorrect for CMS to apply the 5.1% (0.949) site neutral HCO BNA to FY 2016 site neutral payments for the same reasons that CMS should not apply this BNA to FY 2017 site neutral payments. CMS is underpaying LTCHs for site neutral rate cases in FY 2016 by 5.1%. CMS must reverse this adjustment to all FY 2016 payments, or make an equivalent prospective increase in payments to FY 2017 site neutral rate cases to account for this underpayment.

e. The Proposed Rule Does Not Include a HCO BNA Factor for Standard Federal Payment Rate Cases

In the FY 2016 IPPS/LTCH PPS proposed rule, CMS stated that "a budget neutrality factor will *continue* to be applied to LTCH PPS *standard Federal payment rate* cases to offset that 8 percent [target] so that HCO payments for LTCH PPS standard Federal

[31] See 80 Fed. Reg. at 49,622 ("While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments . . .").
[32] See id. (". . . that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate.").
[33] See id. ("The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS.").
[34] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 17.

payment rate cases would be budget neutral."[35] CMS pointed to this budget neutrality factor as precedent for a BNA factor to offset LTCH *site neutral* payments by the 5.1% target for site neutral HCO cases.[36] As CMS explained in the preamble:

> The current LTCH PPS HCO policy has a budget neutrality requirement in which the LTCH PPS standard Federal payment rate is reduced by an adjustment factor to account for the estimated proportion of HCO payments to total estimated LTCH PPS payments, that is, 8 percent. (We refer readers to § 412.523(d)(1) of the regulations.) This budget neutrality requirement is intended to ensure that the HCO policy would not result in any change in estimated aggregate LTCH PPS payments. Under our proposal to continue to apply the current HCO methodology as it relates to LTCH PPS standard Federal payment rate cases (other than determining a fixed-loss amount using only data from LTCH PPS standard Federal payment rate cases), we also would continue to apply the current budget neutrality requirement (described above). In accordance with the current LTCH PPS HCO policy budget neutrality requirement, we believe that the HCO policy for site neutral payment rate cases should also be budget neutral, meaning that the proposed site neutral payment rate HCO payments should not result in any change in estimated aggregate LTCH PPS payments. In order to achieve this, under proposed new § 412.522(c)(2)(i), we are proposing to apply a budget neutrality factor to the payment for all site neutral payment rate cases described under proposed new § 412.522(a)(1), which would also be established on an estimated basis. This approach is consistent with the HCO policy proposed for LTCH PPS standard Federal payment rate cases, which is budget neutral within the universe of LTCH PPS standard Federal payment rate cases. We are inviting public comments on this proposed approach and the alternative approach of applying a single budget neutrality factor to all LTCH PPS cases, irrespective of the site neutral payment rate.[37]

However, we found no budget neutrality factor in the Proposed Rule for HCO payments to LTCH PPS *standard Federal payment rate* cases. In addition, the regulation at § 412.523(d)(1) only says that "CMS adjusts the standard Federal rate by a reduction factor of 8 percent, the estimated proportion of outlier payments under the long-term care hospital prospective payment system, as described in § 412.525(a)." The regulation at § 412.525(a) does *not* address budget neutrality—it determines the amount of the HCO payment, when an HCO payment is made, the cost-to-charge ratio that is used and reconciliation of outlier payments. Moreover, in the same parts of the preamble to the LTCH PPS rate update in previous years, CMS does *not* mention a

[35] 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; Proposed Rule, 80 Fed. Reg. 24,324, 24,647-48 (April 30, 2015) (emphasis added).
[36] See 80 Fed. Reg. at 24539-40, 24647-48.
[37] Id. at 24,539-40.

budget neutrality adjustment for LTCH HCO cases. In the current Proposed Rule, CMS explains how it computes the proposed adjusted LTCH PPS Federal prospective payments for FY 2017, but nowhere does CMS mention a BNA factor for HCOs.[38]

Based upon our review of the rulemaking record, there does *not* appear to be an existing budget neutrality adjustment for LTCH HCO payments that is applied during the update to the LTCH PPS standard Federal payment rate each fiscal year. Rather, it appears that CMS may have considered the HCO target and its effect on overall LTCH HCO payments when setting the payment rate *in the first year of the LTCH PPS only*. This was done to comply with the statutory requirement that the LTCH PPS be budget neutral *in the first year only*, compared to the previous TEFRA payment system—not each year as CMS implies in the Proposed Rule.[39] Therefore, the 0.949 BNA factor that CMS applies to FY 2016 site neutral payments, and is proposing to apply to FY 2017 site neutral payments, to offset the 5.1% target for site neutral HCO cases has no precedent in the LTCH PPS and is not required by the PSRA, the PAMA, or the Social Security Act. We raised this in comments to CMS last year, but **CMS did not respond to this comment in the FY 2016 IPPS/LTCH PPS final rule. Yet, CMS repeats the same fallacy in the current Proposed Rule**, stating "[i]n order to maintain budget neutrality, consistent with the budget neutrality requirement for HCO payments to LTCH PPS standard Federal rate payment cases, we also adopted a budget neutrality requirement for HCO payments to site neutral payment rate cases by applying a budget neutrality factor to the LTCH PPS payment for those site neutral payment rate cases."[40]

Recommendations. **Consistent with MedPAC's comments, we *strongly disagree* with the proposed 0.949 budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. There is no precedent for such an adjustment to the annual payment rate determination for the LTCH PPS. Moreover, CMS already reduced the FY 2017 site neutral payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor. CMS should *not* reduce LTCH site neutral payments by *another 5.1%*.**

For the same reason, it was incorrect for CMS to apply the 5.1% site neutral HCO BNA to FY 2016 payments for site neutral rate cases. CMS must reverse this adjustment to all FY 2016 payments, or make an equivalent prospective increase in payments to FY 2017 site neutral rate cases to account for this underpayment.

[38] See 81 Fed. Reg. 24,946, 25,289 (April 27, 2016).
[39] See Section 123(a)(1) of Public Law 106-113; 42 C.F.R. § 412.523(d)(2) ("*Budget neutrality.* CMS adjusts the Federal prospective payment rates for FY 2003 so that aggregate payments under the prospective payment system are estimated to equal the amount that would have been made to long-term care hospitals under Part 413 of this subchapter without regard to the prospective payment system implemented under this subpart.").
[40] 81 Fed. Reg. at 25,285.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, 413, and 489

[CMS–1655–F; CMS–16644–F; CMS–1632–F2]

RIN 0938–AS77; 0938–AS88; 0938–AS41

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; Technical Changes Relating to Costs to Organizations and Medicare Cost Reports; Finalization of Interim Final Rules With Comment Period on LTCH PPS Payments for Severe Wounds, Modifications of Limitations on Redesignation by the Medicare Geographic Classification Review Board, and Extensions of Payments to MDHs and Low-Volume Hospitals

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

ACTION: Final rule.

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 2017. Some of these changes will implement certain statutory provisions contained in the Pathway for Sustainable Growth Reform Act of 2013, the Improving Medicare Post-Acute Care Transformation Act of 2014, the Notice of Observation Treatment and Implications for Care Eligibility Act of 2015, and other legislation. We also are providing the estimated market basket update to apply to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits for FY 2017.

We are updating the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for FY 2017.

In addition, we are making changes relating to direct graduate medical education (GME) and indirect medical education payments; establishing new requirements or revising existing requirements for quality reporting by specific Medicare providers (acute care hospitals, PPS-exempt cancer hospitals, LTCHs, and inpatient psychiatric facilities), including related provisions for eligible hospitals and critical access hospitals (CAHs) participating in the Electronic Health Record Incentive Program; updating policies relating to the Hospital Value-Based Purchasing Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition Reduction Program; implementing statutory provisions that require hospitals and CAHs to furnish notification to Medicare beneficiaries, including Medicare Advantage enrollees, when the beneficiaries receive outpatient observation services for more than 24 hours; announcing the implementation of the Frontier Community Health Integration Project Demonstration; and making technical corrections and changes to regulations relating to costs to related organizations and Medicare cost reports; we are providing notice of the closure of three teaching hospitals and the opportunity to apply for available GME resident slots under section 5506 of the Affordable Care Act.

We are finalizing the provisions of interim final rules with comment period that relate to a temporary exception for certain wound care discharges from the application of the site neutral payment rate under the LTCH PPS for certain LTCHs; application of two judicial decisions relating to modifications of limitations on redesignation by the Medicare Geographic Classification Review Board; and legislative extensions of the Medicare-dependent, small rural hospital program and changes to the payment adjustment for low-volume hospitals.

DATES: *Effective Date:* These final rules are effective on October 1, 2016.

FOR FURTHER INFORMATION CONTACT: Ing Jye Cheng, (410) 786–4548, and Donald Thompson, (410) 786–44487, Operating Prospective Payment, MS–DRGs, Wage Index, New Medical Service and Technology Add-On Payments, Hospital Geographic Reclassifications, Graduate Medical Education, Capital Prospective Payment, Excluded Hospitals, Medicare Disproportionate Share Hospital (DSH) Issues, Medicare-Dependent Small Rural Hospital (MDH) Program, and Low-Volume Hospital Payment Adjustment Issues.

Michele Hudson, (410) 786–4487, and Emily Lipkin, (410) 786–3633, Long-Term Care Hospital Prospective Payment System and MS–LTC–DRG Relative Weights Issues.

Mollie Knight (410) 786–7948, and Bridget Dickensheets, (410) 786–8670, Rebasing and Revising the LTCH Market Basket Issues.

Siddhartha Mazumdar, (410) 786–6673, Rural Community Hospital Demonstration Program Issues.

Jason Pteroski, (410) 786–4681, and Siddhartha Mazumdar, (410) 786–6673, Frontier Community Health Integration Project Demonstration Issues.

Kathryn McCann Smith, (410) 786–7623, Hospital Notification Procedures for Beneficiaries Receiving Outpatient Observation Services Issues; or Stephanie Simons, (206) 615–2420, only for Related Medicare Health Plans Issues.

Lein Han, (617) 879–0129, Hospital Readmissions Reduction Program—Readmission Measures for Hospitals Issues.

Delia Houseal, (410) 786–2724, Hospital-Acquired Condition Reduction Program and Hospital Readmissions Reduction Program—Administration Issues.

Joseph Clift, (410) 786–4165, Hospital-Acquired Condition Reduction Program—Measures Issues.

James Poyer, (410) 786–2261, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing—Program Administration, Validation, and Reconsideration Issues.

Cindy Tourison, (410) 786–1093, Hospital Inpatient Quality Reporting—Measures Issues Except Hospital Consumer Assessment of Healthcare Providers and Systems Issues; and Readmission Measures for Hospitals Issues.

Kim Spaulding Bush, (410) 786–3232, Hospital Value-Based Purchasing Efficiency Measures Issues.

Elizabeth Goldstein, (410) 786–6665, Hospital Inpatient Quality Reporting—Hospital Consumer Assessment of Healthcare Providers and Systems Measures Issues.

James Poyer, (410) 786–2261, PPS-Exempt Cancer Hospital Quality Reporting Issues.

Mary Pratt, (410) 786–6867, Long-Term Care Hospital Quality Data Reporting Issues.

Jeffrey Buck, (410) 786–0407 and Cindy Tourison (410) 786–1093, Inpatient Psychiatric Facilities Quality Data Reporting Issues.

Deborah Krauss, (410) 786–5264, and Lisa Marie Gomez, (410) 786–1175, EHR Incentive Program Clinical Quality Measure Related Issues.

Elizabeth Myers, (410) 786–4751, EHR Incentive Program Nonclinical Quality Measure Related Issues.

Lauren Wu, (202) 690–7151, Certified EHR Technology Related Issues.

in a rural area'' in section 1886(m)(6)(E)(i)(I)(bb) of the Act refers to LTCHs which are currently located in a rural area as defined under § 412.503 (81 FR 23432). As discussed in the April 21, 2016 IFC, the phrase ''treated as being so located pursuant to subsection (d)(8)(E)'' required interpretation as section 1886(d)(8)(E) of the Act only applies to subsection (d) hospitals, and LTCHs, by definition at section 1886(b)(1) of the Act, are not subsection (d) hospitals.

Section 1886(d)(8)(B) of the Act, as applied to urban subsection (d) hospitals is implemented at § 412.103, and establishes the procedures by which an urban IPPS hospital may apply for reclassification as a rural hospital, the process for reviewing such applications, and the conditions under which applications will be approved (81 FR 23432). To apply these policies and procedures to LTCHs in the context of the temporary exception, we revised our LTCH regulations at § 412.522(b)(2) to—

- Limit reclassification applications under the LTCH PPS to grandfathered HwHs.
- Limit the application and effect of any reclassifications granted to grandfathered HwHs to the eligibility determination for the temporary exception, and
- Adopt the existing rural IPPS reclassification process and procedures as stated under § 412.103 for the LTCH PPS.

Furthermore, in adopting these policies and procedures, we highlighted that a reclassified grandfathered HwH LTCH will not be treated as rural for any other reason, including, but not limited to, the 25-percent threshold policy and wage index, and that any rural treatment under these LTCH PPS policies and procedures will expire at the same time as the temporary exception (that is, December 31, 2016).

Comment: MedPAC opposed allowing LTCHs to seek rural ''reclassification'' based on the Commission's general opposition to the current wage index system.

Response: As we explained in the April 21, 2016 IFC, we were required to give meaning to an LTCH being ''treated as being so located'' under section 1886(d)(8)(E) of the Act. We achieved this by allowing limited reclassification in the LTCH PPS context, by having it apply solely for the purpose of eligibility for the temporary exception established under section 231 of Public Law 114–113. As implemented, we believe that our policy had no effect on the MedPAC's wage index related reclassification concerns. It merely allows eligible LTCHs to reclassify as rural for the purposes of qualifying for the temporary exception to the site neutral payment rate under the LTCH PPS for certain severe wound care discharges from certain LTCHs. It is not applicable in the LTCH PPS for any other purpose, including but not limited to, the 25-percent threshold policy and the wage index, and such treatment is effective only until the expiration of the temporary exception (that is, December 31, 2016).

Furthermore, as MedPAC offered no alternative that would give meaning to the phrase ''treated as being so located'' under section 1886(d)(8)(E) of the Act, we continue to believe our interpretation to be the most appropriate way to interpret ''treated as being so located'' in this context.

Comment: One commenter supported our interpretation of ''treated as being so located'' under section 1886(d)(8)(E) of the Act in relation to section 231 of Public Law 114–113. Other commenters requested that CMS expand the scope of the temporary exception to either allow additional hospitals or discharges to be excluded from the site neutral payment rate.

Response: We appreciate the commenter's support for our implementation of the phrase ''treated as being so located'' under section 1886(d)(8)(E) of the Act in relation to section 231 of Public Law 114–113. In response to the commenters who requested expansion of the temporary exception beyond the LTCHs and discharges defined in section 231 of Public Law 114–113, as we stated in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49602), we do not have the authority to pay LTCH discharges that fail to meet the patient-level criteria for payment at the LTCH PPS standard Federal payment rate at a rate other than the site neutral payment rate unless the discharge meets the eligibility criteria for the temporary exception for certain severe wound discharges. Therefore, we lack the authority to implement additional exceptions as the commenters suggested.

After consideration of the public comments we received, we are finalizing our implementation of the meaning of the phrases ''located in a rural area'' under section 1886(d)(2)(D) of the Act and ''treated as being so located'' under section 1886(d)(8)(E) of the Act, without change.

d. Interpretation of the Phrase ''Individual Discharged Has a Severe Wound''

Section 1886(m)(6)(E)(i)(II) of the Act, as added by section 231 of Public Law 114–113, provides that the temporary exception for certain discharges from the application of the payment policy for site neutral payment rate cases discharged from certain LTCHs is applicable when the ''individual discharged has a severe wound.'' We stated in the April 21, 2016 IFC (81 FR 23433) that the use of the present tense in regard to the word ''has'' when addressing a severe wound is internally inconsistent. A strict and literal read of the statute would require temporary exception from the application of the payment policies for site neutral payment rate cases only representing an individual who, presently, ''has severe a wound'' at the time of his or her discharge from the LTCH and, therefore, payments for cases representing patients whose wounds are either healed or no longer severe at the time of discharge would be made under our existing regulations (that is, the LTCH would receive payment for the case discharge at the site neutral payment rate unless the discharge met the existing exclusion criteria). As we stated in the April 21, 2016 IFC (81 FR 23433), we interpreted this phrase in the provision of the statute to include discharges for cases representing patients who received treatment for a ''severe wound'' at the LTCH, regardless of whether the wound was present and severe at the time of discharge.

Comment: One commenter supported the interpretation.

Response: We appreciate the commenter's support and are finalizing our interpretation of a patient who ''has'' a severe wound as a patient who ''had'' a severe wound, without modification.

e. Statutory Definition of the Term ''Severe Wound''

Section 1886(m)(6)(E)(ii) of the Act, as added by section 231 of Public Law 114–113, defines a ''severe wound'' as a Stage 3 wound, Stage 4 wound, unstageable wound, non-healing surgical wound, infected wound, fistula, osteomyelitis or wound with morbid obesity as identified in the claim from the LTCH. For purposes of implementing this statutory definition in the April 21, 2016 IFC (81 FR 23433), after consultation with our clinical advisors, we interpreted the term ''wound'' as: An injury, usually involving division of tissue or rupture of the integument or mucous membrane with exposure to the external environment. In that same IFC, we also established that the phase ''as identified in the claim'' to mean as identified based on the ICD–10–CM diagnosis codes reported on the claim where—

Quarter	Covered charges (April 1, 2014, through March 31, 2015)	Cases (April 1, 2014, through March 31, 2015)	Covered charges (April 1, 2015, through March 31, 2016)	Cases (April 1, 2015, through March 31, 2016)
4	125,106,133,072	2,441,645	126,979,101,227	2,343,069
Total	502,567,787,353	9,821,348	479,546,875,755	8,941,661

Under our current methodology, to compute the 1-year average annualized rate-of-change in charges per case for FY 2017, we compared the average covered charge per case of $51,171 ($502,567,787,353/9,821,348) from the third quarter of FY 2014 through the second quarter of FY 2015 (April 1, 2014, through March 31, 2015) to the average covered charge per case of $56,361 ($479,546,875,755/8,941,661) from the third quarter of FY 2015 through the second quarter of FY 2016 (April 1, 2015, through March 31, 2016). This rate-of-change is 4.8 percent (1.048067) or 9.8 percent (1.098446) over 2 years.

As we have done in the past, we are establishing the FY 2017 outlier threshold using hospital CCRs from the March 2016 update to the Provider-Specific File (PSF)—the most recent available data at the time of development of this final rule. For FY 2017, we also are continuing to apply an adjustment factor to the CCRs to account for cost and charge inflation (as explained below).

Therefore, as we did for the last 3 fiscal years, we are adjusting the CCRs from the March 2016 update of the PSF by comparing the percentage change in the national average case-weighted operating CCR and capital CCR from the March 2015 update of the PSF to the national average case-weighted operating CCR and capital CCR from the March 2016 update of the PSF. We note that we used total transfer-adjusted cases from FY 2015 to determine the national average case-weighted CCRs for both sides of the comparison.

Using the methodology above, we calculated a March 2015 operating national average case-weighted CCR of 0.278734 and a March 2016 operating national average case-weighted CCR of 0.270034. We then calculated the percentage change between the two national operating case-weighted CCRs by subtracting the March 2015 operating national average case-weighted CCR from the March 2016 operating national average case-weighted CCR and then dividing the result by the March 2015 national operating average case-weighted CCR. This resulted in a national operating CCR adjustment factor of 0.96879.

We also used the same methodology above to adjust the capital CCRs. Specifically, we calculated a March 2015 capital national average case-weighted CCR of 0.024375 and a March 2016 capital national average case-weighted CCR of 0.023688. We then calculated the percentage change between the two national capital case-weighted CCRs by subtracting the March 2015 capital national average case-weighted CCR from the March 2016 capital national average case-weighted CCR and then dividing the result by the March 2015 capital national average case-weighted CCR. This resulted in a national capital CCR adjustment factor of 0.971819.

As discussed above, similar to the proposed rule, for FY 2017 we applied the following policies (see discussion above for more details):

- The final year of the 3-year transitional wage index because of the adoption of the new OMB labor market area delineations.
- In accordance with section 10324(a) of the Affordable Care Act, we created a wage index floor of 1.0000 for all hospitals located in States determined to be frontier States.
- As we did in establishing the FY 2009 outlier threshold (73 FR 57891), in our projection of FY 2017 outlier payments, we did not make any adjustments for the possibility that hospitals' CCRs and outlier payments may be reconciled upon cost report settlement.
- We excluded the hospital VBP payment adjustments and the hospital readmissions payment adjustments from the calculation of the outlier fixed-loss cost threshold.
- We used the estimated per-discharge uncompensated care payments to hospitals eligible for the uncompensated care payment for all cases in the calculation of the outlier fixed-loss cost threshold methodology.

Using this methodology, we used the formula described in section I.C.1. of this Addendum to simulate and calculate the Federal payment rate and outlier payments for all claims. We calculated a threshold of $23,570 and calculated total operating Federal payments of $83,347,416,971 and total outlier payments of $4,479,256,519. We then divided total outlier payments by total operating Federal payments plus total outlier payments and determined that this threshold met the 5.1 percent target. As a result, we are finalizing an outlier fixed-loss cost threshold for FY 2017 equal to the prospective payment rate for the MS–DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus $23,570.

(2) Other Changes Concerning Outliers

As stated in the FY 1994 IPPS final rule (58 FR 46348), we establish an outlier threshold that is applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common threshold resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2017 will result in outlier payments that will equal 5.1 percent of operating DRG payments and 6.14 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we reduced the FY 2017 standardized amount by the same percentage to account for the projected proportion of payments paid as outliers.

The outlier adjustment factors that were applied to the standardized amount based on the FY 2017 outlier threshold are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948999	0.938575

We applied the outlier adjustment factors to the FY 2017 payment rates after removing the effects of the FY 2016 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we apply hospital-specific CCRs to the total covered charges for the case. Estimated operating and capital costs for the case are calculated separately by applying separate operating and capital CCRs. These costs are then combined and compared with the outlier fixed-loss cost threshold.

Under our current policy at § 412.84, we calculate operating and capital CCR ceilings and assign a statewide average CCR for hospitals whose CCRs exceed 3.0 standard deviations from the mean of the log distribution of CCRs for all hospitals. Based on this calculation, for hospitals for which the MAC computes operating CCRs greater than 1.183 or capital CCRs greater than 0.17, or hospitals for which the MAC is unable to calculate a CCR (as described under § 412.84(i)(3) of our regulations), statewide average CCRs are used to determine whether a hospital qualifies for outlier payments. Table 8A listed in section VI. of this Addendum (and available only via the Internet on the CMS Web site) contains the statewide average operating CCRs for urban hospitals and for rural hospitals for which the MAC is unable to compute a hospital-specific CCR within the above range. Effective for discharges occurring on or after October 1, 2016, these statewide average ratios will replace the ratios posted on our Web site at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page-Items/FY2016-IPPS-Final-Rule-Tables.html*. Table 8B listed in section VI. of this Addendum (and available via the Internet on the CMS Web site) contains the comparable statewide average capital CCRs. As previously stated, the CCRs in Tables 8A and 8B will be used during FY 2017 when hospital-specific CCRs based on the latest settled cost report either are not available or are outside the range noted above. Table 8C listed in section VI. of this Addendum (and available via the Internet on the CMS Web site) contains the statewide average total CCRs used under the LTCH PPS as discussed in section V. of this Addendum.

We finally note that we published a manual update (Change Request 3966) to our outlier policy on October 12, 2005, which updated Chapter 3, Section 20.1.2 of the Medicare Claims Processing Manual. The manual update covered an array of topics, including CCRs, reconciliation, and the time value of money. We encourage hospitals that are assigned the statewide average operating and/or capital CCRs to work with their MAC on a possible alternative operating and/or capital CCR as explained in Change Request 3966. Use of an alternative CCR developed by the hospital in conjunction with the MAC can avoid possible overpayments or underpayments at cost report settlement, thereby ensuring better accuracy when making outlier payments and negating the need for outlier reconciliation. We also note that a hospital may request an alternative operating or capital CCR ratio at any time as long as the guidelines of Change Request 3966 are followed. In addition, as mentioned above, we published an additional manual update (Change Request 7192) to our outlier policy on December 3, 2010, which also updated Chapter 3, Section 20.1.2 of the Medicare Claims Processing Manual. The manual update outlines the outlier reconciliation process for hospitals and Medicare contractors. To download and view the manual instructions on outlier reconciliation, we refer readers to the CMS Web site: *http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf*.

(3) FY 2015 Outlier Payments

Our current estimate, using available FY 2015 claims data, is that actual outlier payments for FY 2015 were approximately 4.68 percent of actual total MS–DRG payments. Therefore, the data indicate that, for FY 2015, the percentage of actual outlier payments relative to actual total payments is lower than we projected for FY 2015. Consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2015 are equal to 5.1 percent of total MS–DRG payments. As explained in the FY 2003 Outlier Final Rule (68 FR 34502), if we were to make retroactive adjustments to all outlier payments to ensure total payments are 5.1 percent of MS–DRG payments (by retroactively adjusting outlier payments), we would be removing the important aspect of the prospective nature of the IPPS. Because such an across-the-board adjustment would either lead to more or less outlier payments for all hospitals, hospitals would no longer be able to reliably approximate their payment for a patient while the patient is still hospitalized. We believe that it would be neither necessary nor appropriate to make such an aggregate retroactive adjustment. Furthermore, we believe it is consistent with the intent of the language at section 1886(d)(5)(A)(iv) of the Act not to make retroactive adjustments to outlier payments. This section calls for the Secretary to ensure that outlier payments are equal to or greater than 5 percent and less than or equal to 6 percent of projected or estimated (not actual) MS–DRG payments. We believe this language reflects the intent of Congress regarding the prospectivity of the IPPS. We believe that an important goal of a PPS is predictability. Therefore, we believe that the fixed-loss outlier threshold should be projected based on the best available historical data and should not be adjusted retroactively. A retroactive change to the fixed-loss outlier threshold would affect all hospitals subject to the IPPS, thereby undercutting the predictability of the system as a whole.

We note that because the MedPAR claims data for the entire FY 2016 will not be available until after September 30, 2016, we are unable to provide an estimate of actual outlier payments for FY 2016 based on FY 2016 claims data in this final rule. We will provide an estimate of actual FY 2016 outlier payments in the FY 2018 IPPS/LTCH PPS proposed rule.

5. FY 2017 Standardized Amount

The adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B listed and published in section VI. of this Addendum (and available via the Internet on the CMS Web site) contain the national standardized amounts that we are applying to all hospitals, except hospitals located in Puerto Rico, for FY 2017. The standardized amount for hospitals in Puerto Rico is shown in Table 1C listed and published in section VI. of this Addendum (and available via the Internet on the CMS Web site). The amounts shown in Tables 1A and 1B differ only in that the labor-related share applied to the standardized amounts in Table 1A is 69.6 percent, and the labor-related share applied to the standardized amounts in Table 1B is 62 percent. In accordance with sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act, we are applying a labor-related share of 62 percent, unless application of that percentage will result in lower payments to a hospital than would otherwise be made. In effect, the statutory provision means that we will apply a labor-related share of 62 percent for all hospitals whose wage indexes are less than or equal to 1.0000.

In addition, Tables 1A and 1B include the standardized amounts reflecting the applicable percentage increases for FY 2017.

The labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals for FY 2017 are set forth in Table 1C listed and published in section VI. of this Addendum (and available via the Internet on the CMS Web site). Similar to above, section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Public Law 108–173, provides that the labor-related share for hospitals located in Puerto Rico be 62 percent, unless the

application of that percentage would result in lower payments to the hospital.

The following table illustrates the changes from the FY 2016 national standardized amount to the FY 2017 national standardized amount. The second through fifth columns display the changes from the FY 2016 standardized amounts for each applicable FY 2017 standardized amount. The first row of the table shows the updated (through FY 2016) average standardized amount after restoring the FY 2016 offsets for outlier payments, demonstration budget neutrality, geographic reclassification budget neutrality, new labor market delineation wage index transition budget neutrality, retrospective documentation and coding adjustment under section 7(b)(1)(B) of Public Law 110–90 and an adjustment to the standardized amount using our authority under section 1886(d)(5)(I)(i) of the Act to permanently prospectively remove the 0.2 percent reduction to the payment rate established in FY 2014 to offset the estimated increase in IPPS expenditures as a result of the 2-midnight policy. The MS–DRG reclassification and recalibration and wage index budget neutrality adjustment factors are cumulative. Therefore, those FY 2016 adjustment factors were not removed from this table.

CHANGE OF FY 2016 STANDARDIZED AMOUNTS TO THE FY 2017 STANDARDIZED AMOUNTS

	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is NOT a meaningful EHR user	Hospital did NOT submit quality data and is a meaningful EHR user	Hospital did NOT submit quality data and is NOT a meaningful EHR user
FY 2016 Base Rate after removing: 1. FY 2016 Geographic Reclassification Budget Neutrality (0.988169) 2. FY 2016 Rural Community Hospital Demonstration Program Budget Neutrality (0.999837) 3. Cumulative FY 2008, FY 2009, FY 2012, FY 2013, FY 2014, FY 2015 and FY 2016 Documentation and Coding Adjustments as Required under Sections 7(b)(1)(A) and 7(b)(1)(B) of Pub. L. 110–90 and Documentation and Coding Recoupment Adjustment as required under Section 631 of the American Taxpayer Relief Act of 2012 (0.9255) 4. FY 2016 Operating Outlier Offset (0.948998).. 5. FY 2016 New Labor Market Delineation Wage Index Transition Budget Neutrality Factor (0.999998).. 6. FY 2017 2-Midnight Rule Permanent Adjustment (1/0.998)..	If Wage Index is Greater Than 1.0000: Labor (69.6 percent): $4,394.09; Nonlabor (30.4 percent): $1,919.26. If Wage Index is less Than or Equal to 1.0000: Labor (62 percent): $3,914.28; Nonlabor (38 percent): $2,399.07.	If Wage Index is Greater Than 1.0000: Labor (69.6 percent): $4,394.09; Nonlabor (30.4 percent): $1,919.26. If Wage Index is less Than or Equal to 1.0000: Labor (62 percent): $3,914.28; Nonlabor (38 percent): $2,399.07.	If Wage Index is Greater Than 1.0000: Labor (69.6 percent): $4,394.09; Nonlabor (30.4 percent): $1,919.26. If Wage Index is less Than or Equal to 1.0000: Labor (62 percent): $3,914.28; Nonlabor (38 percent): $2,399.07.	If Wage Index is Greater Than 1.0000: Labor (69.6 percent): $4,394.09; Nonlabor (30.4 percent): $1,919.26. If Wage Index is less Than or Equal to 1.0000: Labor (62 percent): $3,914.28; Nonlabor (38 percent): $2,399.07.
FY 2017 Update Factor	1.0165	0.99625	1.00975	0.9895
FY 2017 MS–DRG Recalibration Budget Neutrality Factor.	0.999079	0.999079	0.999079	0.999079
FY 2017 Wage Index Budget Neutrality Factor.	1.000209	1.000209	1.000209	1.000209
FY 2017 Reclassification Budget Neutrality Factor.	0.988224	0.988224	0.988224	0.988224
FY 2017 Operating Outlier Factor	0.948999	0.948999	0.948999	0.98999
Cumulative Factor: FY 2008, FY 2009, FY 2012, FY 2013, FY 2014, FY 2015, FY 2016 and FY 2017 Documentation and Coding Adjustment as Required under Sections 7(b)(1)(A) and 7(b)(1)(B) of Pub. L. 110–90 and Documentation and Coding Recoupment Adjustment as required under Section 631 of the American Taxpayer Relief Act of 2012.	0.9118	0.9118	0.9118	0.9118
FY 2017 New Labor Market Delineation Wage Index 3-Year Hold Harmless Transition Budget Neutrality Factor.	0.999994	0.999994	0.999994	0.999994
FY 2017 2–Midnight Rule One-Time Prospective Increase.	1.006	1.006	1.006	1.006
National Standardized Amount for FY 2017 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (69.6/30.4).	Labor: $3,839.57; Nonlabor: $1,677.06.	Labor: $3,763.08; Nonlabor: $1,643.65.	Labor: $3,814.07; Nonlabor: $1,665.92.	Labor: $3,737.58; Nonlabor: $1,632.51.
National Standardized Amount for FY 2017 if Wage Index is less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38).	Labor: $3,420.31; Nonlabor: $2,096.32.	Labor: $3,352.17; Nonlabor: $2,054.56.	Labor: $3,397.59; Nonlabor: $2,082.40.	Labor: $3,329.46; Nonlabor: $2,040.63.

approach, because we estimate that intensity declined during that 5-year period, we believe it is appropriate to continue to apply a zero intensity adjustment for FY 2017. Therefore, we are making a 0.0 percentage point adjustment for intensity in the update for FY 2017.

Above, we described the basis of the components used to develop the 0.9 percent capital update factor under the capital update framework for FY 2017 as shown in the following table.

CMS FY 2017 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index*	1.2
Intensity	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	0.5
Projected Case-Mix Change	0.5
Subtotal	1.2
Effect of FY 2015 Reclassification and Recalibration	0.0
Forecast Error Correction	−0.3
Total Update	0.9

*The capital input price index represents the FY 2010-based CIPI.

b. Comparison of CMS and MedPAC Update Recommendation

In its March 2016 Report to Congress, MedPAC did not make a specific update recommendation for capital IPPS payments for FY 2017. (We refer readers to MedPAC's Report to the Congress: Medicare Payment Policy, March 2016, Chapter 3, available on the Web site at: *http://www.medpac.gov*.)

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier payment methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital-related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating IPPS DRG payments.

For FY 2016, we estimated that outlier payments for capital would equal 6.35 percent of inpatient capital-related payments based on the capital Federal rate in FY 2016. Based on the thresholds as set forth in section II.A. of this Addendum, we estimate that outlier payments for capital-related costs will equal 6.14 percent for inpatient capital-related payments based on the capital Federal rate in FY 2017. Therefore, we are applying an outlier adjustment factor of 0.9386 in determining the capital Federal rate for FY 2017. Thus, we estimate that the percentage of capital outlier payments to total capital Federal rate payments for FY 2017 will be lower than the percentage for FY 2016.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. The FY 2017 outlier adjustment of 0.9386 is a 0.22 percent change from the FY 2016 outlier adjustment of 0.9365. Therefore, the net change in the outlier adjustment to the capital Federal rate for FY 2017 is 1.0022 (0.9386/0.9365). Thus, the outlier adjustment will increase the FY 2017 capital Federal rate by 0.22 percent compared to the FY 2016 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the GAF

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. Because we are determining capital IPPS payments to hospitals located in Puerto Rico based on 100 percent of the capital Federal rate beginning in FY 2017, we have not calculated a separate GAF for Puerto Rico, and therefore, we are not applying a separate budget neutrality adjustment for the Puerto Rico GAF. Similarly, the budget neutrality factor for DRG reclassifications and recalibration nationally is applied in determining the capital IPPS Federal rate, and is applicable for all hospitals, including those hospitals located in Puerto Rico.

To determine the national capital rate factors for FY 2017, we compared estimated aggregate capital Federal rate payments based on the FY 2016 MS–DRG classifications and relative weights and the FY 2016 GAF to estimated aggregate capital Federal rate payments based on the FY 2016 MS–DRG classifications and relative weights and the FY 2017 GAFs. To achieve budget neutrality for the changes in the national GAFs, based on calculations using updated data, we are applying an incremental budget neutrality adjustment factor of 0.9995 for FY 2017 to the previous cumulative FY 2016 adjustment factor of 0.9860, yielding an adjustment factor of 0.9855 through FY 2017.

We then compared estimated aggregate capital Federal rate payments based on the FY 2016 MS–DRG relative weights and the FY 2017 GAFs to estimated aggregate capital Federal rate payments based on the cumulative effects of the FY 2017 MS–DRG classifications and relative weights and the FY 2017 GAFs. The incremental adjustment factor for DRG classifications and changes in relative weights is 0.9996. The cumulative adjustment factor for MS–DRG classifications and changes in relative weights and for changes in the GAFs through FY 2017 is 0.9851. (We note that all the values are calculated with unrounded numbers.)

The GAF/DRG budget neutrality adjustment factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows the requirement under § 412.308(c)(4)(ii) that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAFs.

The methodology used to determine the recalibration and geographic adjustment factor (GAF/DRG) budget neutrality adjustment is similar to the methodology used in establishing budget neutrality adjustments under the IPPS for operating costs. One difference is that, under the operating IPPS, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the MS–DRG relative weights. Under the capital IPPS, there is a single GAF/DRG budget neutrality adjustment factor for changes in the GAF (including geographic reclassification) and the MS–DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for DSH or IME.

The cumulative adjustment factor of 0.9991 (the product of the incremental national GAF budget neutrality adjustment factor of 0.9995 and the incremental DRG budget neutrality adjustment factor of 0.9996) accounts for the MS–DRG reclassifications and recalibration and for changes in the GAFs. It also incorporates the effects on the GAFs of FY 2017 geographic reclassification decisions made by the MGCRB compared to FY 2016 decisions. However, it does not account for

changes in payments due to changes in the DSH and IME adjustment factors.

As discussed in section V.C. of the preamble of this final rule, we are making an adjustment of (1/0.998) to the national capital Federal rate to remove the 0.2 percent reduction (an adjustment factor of 0.998) to the national capital Federal rate to offset the estimated increase in capital IPPS expenditures associated with the 2-midnight policy. This is consistent with the adjustment to the operating IPPS standardized amount and the hospital-specific payment rates. In addition, consistent with the approach for the operating IPPS standardized amount and hospital-specific payment rates and for the reasons discussed in sections IV.P. and V.C. of the preamble of this final rule, we are making a one-time prospective adjustment of 1.006 in FY 2017 to the national capital Federal rate to address the effect of the 0.2 percent reduction to the national capital Federal rates in effect for FY 2014, FY 2015, and FY 2016. We also are removing this one-time prospective adjustment through an adjustment of (1/1.006) to the national capital Federal rate in FY 2018, consistent with the approach for the operating IPPS standardized amount and hospital-specific payment rates (as discussed in section IV.P. of the preamble of this final rule). We refer readers to sections IV.P. and V.C. of the preamble of this final rule for a complete discussion of these issues.

4. Capital Federal Rate for FY 2017

For FY 2016, we established a capital Federal rate of $438.75 (as revised, in the FY 2016 IPPS/LTCH PPS correction notice CMS–1632–CN2 (80 FR 60060 and 60061)). We are establishing an update of 0.9 percent in determining the FY 2017 capital Federal rate for all hospitals. As a result of this update, the budget neutrality factors discussed earlier, and the adjustments to remove the 0.2 percent reductions (both the (1/0.998) adjustment to permanently remove the 0.2 percent reduction and the one-time 0.6 percent adjustment) resulting from the 2-midnight policy, we are establishing a national capital Federal rate of $446.81 for FY 2017. The national capital Federal rate for FY 2017 was calculated as follows:

- The FY 2017 update factor is 1.009, that is, the update is 0.9 percent.
- The FY 2017 budget neutrality adjustment factor that is applied to the capital Federal rate for changes in the MS–DRG classifications and relative weights and changes in the GAFs is 0.9991.
- The FY 2017 outlier adjustment factor is 0.9386.
- The 2-midnight policy adjustment to permanently remove the 0.2 percent reduction is (1/0.998).
- The 2-midnight one-time policy adjustment is 1.006.

(We note that, as discussed in section V.C. of the preamble of this final rule, we are not making an additional MS–DRG documentation and coding adjustment to the capital IPPS Federal rate for FY 2017.)

Because the FY 2017 capital Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we are not making additional adjustments in the capital Federal rate for these factors, other than the budget neutrality factor for changes in the MS–DRG classifications and relative weights and for changes in the GAFs.

We are providing the following chart that shows how each of the factors and adjustments for FY 2017 affects the computation of the FY 2017 national capital Federal rate in comparison to the FY 2016 national capital Federal rate. The FY 2017 update factor has the effect of increasing the capital Federal rate by 0.9 percent compared to the FY 2016 capital Federal rate. The GAF/DRG budget neutrality adjustment factor has the effect of decreasing the capital Federal rate by 0.09 percent. The FY 2017 outlier adjustment factor has the effect of increasing the capital Federal rate by 0.22 percent compared to the FY 2016 capital Federal rate. The permanent 2-midnight policy adjustment has the effect of increasing the capital Federal rate by 0.2 percent and the temporary 2-midnight policy adjustment has the effect of increasing the capital Federal rate by 0.6 percent. The combined effect of all the changes would increase the national capital Federal rate by approximately 1.84 percent compared to the FY 2016 national capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2016 CAPITAL FEDERAL RATE AND FY 2017 CAPITAL FEDERAL RATE

	FY 2016	FY 2017	Change	Percent change
Update Factor [1]	$1.0130	$1.009	1.009	0.9
GAF/DRG Adjustment Factor [1]	0.9976	0.9991	0.9991	−0.09
Outlier Adjustment Factor [2]	0.9365	0.9386	1.0022	0.22
Permanent 2-midnight Policy Adjustment Factor	N/A	1.002	1.002	0.2
One-Time 2-midnight Policy Adjustment Factor	N/A	1.006	1.006	0.6
Capital Federal Rate	438.75	446.81	1.0184	1.84

[1] The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rates. Thus, for example, the incremental change from FY 2016 to FY 2017 resulting from the application of the 0.9991 GAF/DRG budget neutrality adjustment factor for FY 2017 is a net change of 0.9991 (or −0.09 percent).

[2] The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the FY 2017 outlier adjustment factor is 0.9386/0.9365, or 1.0022 (or 0.22 percent).

In this final rule, we also are providing the following chart that shows how the final FY 2017 capital Federal rate differs from the proposed FY 2017 capital Federal rate as presented in the FY 2017 IPPS/LTCH PPS proposed rule (81 FR 25280).

COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 2017 CAPITAL FEDERAL RATE AND FINAL FY 2017 CAPITAL FEDERAL RATE

	Proposed FY 2017	Final FY 2017	Change	Percent change
Update Factor [1]	$1.0090	$1.0090	1.0000	0.00
GAF/DRG Adjustment Factor [1]	0.9993	0.9991	0.9998	−0.02
Outlier Adjustment Factor [2]	0.9374	0.9386	1.0013	0.13
Permanent 2-midnight Policy Adjustment Factor	1.002	1.002	1.000	0.00
One-Time 2-midnight Policy Adjustment Factor	1.006	1.006	1.000	0.00
Capital Federal Rate	446.35	446.81	1.0010	0.10

B. Calculation of the Inpatient Capital-Related Prospective Payments for FY 2017

For purposes of calculating payments for each discharge during FY 2017, the capital Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (COLA for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted capital Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The outlier thresholds for FY 2017 are in section II.A. of this Addendum. For FY 2017, a case would qualify as a cost outlier if the cost for the case plus the (operating) IME and DSH payments (including both the empirically justified Medicare DSH payment and the estimated uncompensated care payment, as discussed in section II.A.4.g.(1) of this Addendum) is greater than the prospective payment rate for the MS–DRG plus the fixed-loss amount of $23,570.

Currently, as provided under § 412.304(c)(2), we pay a new hospital 85 percent of its reasonable costs during the first 2 years of operation unless it elects to receive payment based on 100 percent of the capital Federal rate. Effective with the third year of operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with capital costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input price indexes to reflect the changing composition of inputs for operating and capital expenses. In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50603 through 50607), we rebased and revised the CIPI to a FY 2010 base year to reflect the more current structure of capital costs in hospitals. For a complete discussion of this rebasing, we refer readers to the FY 2014 IPPS/LTCH PPS final rule.

2. Forecast of the CIPI for FY 2017

Based on the latest forecast by IHS Global Insight, Inc. (second quarter of 2016), we are forecasting the FY 2010-based CIPI to increase 1.2 percent in FY 2017. This reflects a projected 1.6 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment), and a projected 2.7 percent increase in other capital expense prices in FY 2017, partially offset by a projected 1.6 percent decline in vintage-weighted interest expense prices in FY 2017. The weighted average of these three factors produces the forecasted 1.2 percent increase for the FY 2010-based CIPI as a whole in FY 2017.

IV. Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2017

Payments for services furnished in children's hospitals, 11 cancer hospitals, and hospitals located outside the 50 States, the District of Columbia and Puerto Rico (that is, short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa) that are excluded from the IPPS are made on the basis of reasonable costs based on the hospital's own historical cost experience, subject to a rate-of-increase ceiling. A per discharge limit (the target amount as defined in § 413.40(a) of the regulations) is set for each hospital based on the hospital's own cost experience in its base year, and updated annually by a rate-of-increase percentage. (We note that, in accordance with § 403.752(a), RNHCIs are also subject to the rate-of-increase limits established under § 413.40 of the regulations.)

As discussed in the FY 2017 IPPS/LTCH PPS proposed rule (81 FR 25281), the FY 2017 rate-of-increase percentage for updating the target amounts for the 11 cancer hospitals, children's hospitals, the short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, and RNHCIs is the estimated percentage increase in the IPPS operating market basket for FY 2017, in accordance with applicable regulations at § 413.40. Based on IHS Global Insight, Inc.'s 2016 first quarter forecast, we estimated that the FY 2010-based IPPS operating market basket update for FY 2017 would be 2.8 percent (that is, the estimate of the market basket rate-of-increase). However, we proposed that if more recent data became available for the final rule, we would use them to calculate the IPPS operating market basket update for FY 2017. Therefore, based on IHS Global Insight, Inc.'s 2016 second quarter forecast, with historical data through 2016 first quarter, we estimate that the FY 2010-based IPPS operating market basket update for FY 2017 is 2.7 percent (that is, the estimate of the market basket rate-of-increase). For children's hospitals, the 11 cancer hospitals, hospitals located outside the 50 States, the District of Columbia and Puerto Rico (that is, short-term acute

would have qualified for payment at the LTCH PPS standard Federal payment rate if such rate were in effect at the time of discharge to calculate the FY 2017 LTCH PPS standard Federal payment rate area wage level adjustment budget neutrality factor described above.

For this final rule, using the steps in the methodology previously described, we determined a FY 2017 LTCH PPS standard Federal payment rate area wage level adjustment budget neutrality factor of 0.999593. Accordingly, in section V.A.2. of the Addendum to this final rule, to determine the FY 2017 LTCH PPS standard Federal payment rate, we applied an area wage level adjustment budget neutrality factor of 0.999593, in accordance with § 412.523(d)(4). The FY 2017 LTCH PPS standard Federal payment rate shown in Table 1E of the Addendum to this final rule reflects this adjustment factor.

C. Cost-of-Living Adjustment (COLA) for LTCHs Located in Alaska and Hawaii

Under § 412.525(b), a cost-of-living adjustment (COLA) is provided for LTCHs located in Alaska and Hawaii to account for the higher costs incurred in those States. Specifically, we apply a COLA to payments to LTCHs located in Alaska and Hawaii by multiplying the nonlabor-related portion of the standard Federal payment rate by the applicable COLA factors established annually by CMS. Higher labor-related costs for LTCHs located in Alaska and Hawaii are taken into account in the adjustment for area wage levels previously described.

Under our current methodology, we update the COLA factors for Alaska and Hawaii every 4 years (at the same time as the update to the labor-related share of the IPPS market basket) (77 FR 53712 through 53713). This methodology is based on a comparison of the growth in the Consumer Price Indexes (CPIs) for Anchorage, Alaska, and Honolulu, Hawaii, relative to the growth in the CPI for the average U.S. city as published by the Bureau of Labor Statistics (BLS). It also includes a 25-percent cap on the CPI-updated COLA factors. (For additional details on our current methodology for updating the COLA factors for Alaska and Hawaii, we refer readers to section VII.D.3. of the preamble of the FY 2013 IPPS/LTCH PPS final rule (77 FR 53481 through 53482).)

As discussed in the FY 2017 IPPS/LTCH proposed rule (81 FR 25284 through 25285), we continue to believe that determining updated COLA factors using this methodology will appropriately adjust the nonlabor-related portion of the LTCH PPS standard Federal payment rate for LTCHs located in Alaska and Hawaii. Under our current policy, we update the COLA factors using the methodology described above every 4 years; the first year began in FY 2014 (77 FR 53482). Therefore, in this final rule for FY 2017, under the broad authority conferred upon the Secretary by section 123 of the BBRA, as amended by section 307(b) of the BIPA, to determine appropriate payment adjustments under the LTCH PPS, as we proposed, we are continuing to use the COLA factors based on the 2009 OPM COLA factors updated through 2012 by the comparison of the growth in the CPIs for Anchorage, Alaska, and Honolulu, Hawaii, relative to the growth in the CPI for the average U.S. city as established in the FY 2014 IPPS/LTCH PPS final rule. (We refer readers to the FY 2014 IPPS/LTCH PPS final rule (78 FR 50998) for a discussion of the FY 2014 COLA factors.) Consistent with our historical practice, as we proposed, we are establishing that the COLA factors shown in the following table will be used to adjust the nonlabor-related portion of the LTCH PPS standard Federal payment rate for LTCHs located in Alaska and Hawaii under § 412.525(b).

COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII HOSPITALS UNDER THE LTCH PPS FOR FY 2017

Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
All other areas of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.19
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

D. Adjustment for LTCH PPS High-Cost Outlier (HCO) Cases

1. HCO Background

From the beginning of the LTCH PPS, we have included an adjustment to account for cases in which there are extraordinarily high costs relative to the costs of most discharges. Under this policy, additional payments are made based on the degree to which the estimated cost of a case (which is calculated by multiplying the Medicare allowable covered charge by the hospital's overall hospital CCR) exceeds a fixed-loss amount. This policy results in greater payment accuracy under the LTCH PPS and the Medicare program, and the LTCH sharing the financial risk for the treatment of extraordinarily high-cost cases.

We retained the basic tenets of our HCO policy in FY 2016 when we implemented the dual rate LTCH PPS payment structure under section 1206 of Public Law 113–67. LTCH discharges that meet the criteria for exclusion from site neutral payment rate (that is, LTCH PPS standard Federal payment rate cases) are paid at the LTCH PPS standard Federal payment rate, which includes, as applicable, HCO payments under § 412.523(e). LTCH discharges that do not meet the criteria for exclusion are paid at the site neutral payment rate, which includes, as applicable, HCO payments under § 412.522(c)(2)(i). In the same rule, we established separate fixed-loss amounts and targets for the two different LTCH PPS payment rates. Under this bifurcated policy, the historic 8 percent HCO target was retained for LTCH PPS standard Federal payment rate cases, with the fixed-loss amount calculated using only data from LTCH cases which would have been paid at the LTCH PPS standard Federal payment rate if that rate had been in effect at the time of those discharges. For site neutral payment rate cases, we adopted the operating IPPS HCO target (currently 5.1 percent) and set the fixed-loss amount for site neutral payment rate cases at the value of the IPPS fixed-loss amount. Under the HCO policy for both payment rates, an LTCH receives 80 percent of the difference between the estimated cost of the case and the applicable HCO

threshold, which is the sum of the LTCH PPS payment for the case and the applicable fixed-loss amount for such case.

In order to maintain budget neutrality, consistent with the budget neutrality requirement for HCO payments to LTCH PPS standard Federal rate payment cases, we also adopted a budget neutrality requirement for HCO payments to site neutral payment rate cases by applying a budget neutrality factor to the LTCH PPS payment for those site neutral payment rate cases. (We refer readers to § 412.522(c)(2)(i) of the regulation for further details). We note during the 2-year transitional period, the site neutral payment rate HCO budget neutrality factor does not apply to the LTCH PPS standard Federal payment rate portion of the blended rate at § 412.522(c)(3) payable to site neutral payment rate cases. (For additional details on the HCO policy adopted for site neutral payment rate cases under the dual rate LTCH PPS payment structure, including the budget neutrality adjustment for HCO payments to site neutral payment rate cases, we refer readers to the FY 2016 IPPS/LTCH PPS final rule (80 FR 49617 through 49623).)

2. Determining LTCH CCRs Under the LTCH PPS

a. Background

As noted above, CCRs are used to determine payments for HCO adjustments for both payment rates under the LTCH PPS, and are also used to determine payments for SSO cases under § 412.529 as well as payments for site neutral payment rate cases. (We note that the provisions of § 412.529 are only applicable to LTCH PPS standard Federal payment rate cases.) Therefore, this discussion is relevant to all HCO, SSO, and site neutral payment rate calculations.

As noted earlier, in determining HCO, SSO, and the site neutral payment rate (regardless of whether the case is also an HCO) payments, we generally calculate the estimated cost of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case. An overall CCR is used because the LTCH PPS uses a single prospective payment per discharge that covers both inpatient operating and capital-related costs. The LTCH's overall CCR is generally computed based on the sum of LTCH operating and capital costs (as described in Section 150.24, Chapter 3, of the Medicare Claims Processing Manual (Pub. 100–4)) as compared to total Medicare charges (that is, the sum of its operating and capital inpatient routine and ancillary charges), with those values determined from either the most recently settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period. However, in certain instances, we use an alternative CCR, such as the statewide average CCR, a CCR that is specified by CMS, or one that is requested by the hospital. (We refer readers to § 412.525(a)(4)(iv) of the regulations for further details regarding HCO adjustments for either LTCH PPS payment rate, § 412.529(f)(4) for SSO adjustments, and § 412.522(c)(1)(ii) for the site neutral payment rate, respectively.)

The LTCH's calculated CCR is then compared to the LTCH total CCR ceiling. Under our established policy, an LTCH with a calculated CCR in excess of the applicable maximum CCR threshold (that is, the LTCH total CCR ceiling, which is calculated as 3 standard deviations from the national geometric average CCR) is generally assigned the applicable statewide CCR. This policy is premised on a belief that calculated CCRs above the LTCH total CCR ceiling are most likely due to faulty data reporting or entry, and CCRs based on erroneous data should not be used to identify and make payments for outlier cases.

b. LTCH Total CCR Ceiling

Consistent with our historical practice, we used more recent data to determine the LTCH total CCR ceiling for this FY 2017 in this final rule. Specifically, in this final rule, using our established methodology for determining the LTCH total CCR ceiling based on IPPS total CCR data from the March 2016 update of the Provider Specific File (PSF), which is the most recent data available, we are establishing a LTCH total CCR ceiling of 1.297 under the LTCH PPS for FY 2017 in accordance with § 412.525(a)(4)(iv)(C)(*2*) for HCO cases under either payment rate, § 412.529(f)(4)(iii)(B) for SSOs, and § 412.522(c)(1)(ii) for the site neutral payment rate. (For additional information on our methodology for determining the LTCH total CCR ceiling, we refer readers to the FY 2007 IPPS final rule (71 FR 48118 through 48119).)

c. LTCH Statewide Average CCRs

Our general methodology for determining the statewide average CCRs used under the LTCH PPS is similar to our established methodology for determining the LTCH total CCR ceiling because it is based on ''total'' IPPS CCR data. (For additional information on our methodology for determining statewide average CCRs under the LTCH PPS, we refer readers to the FY 2007 IPPS final rule (71 FR 48119 through 48120).) Under the LTCH PPS HCO policy for cases paid under either payment rate at § 412.525(a)(4)(iv)(C)(2), the SSO policy at § 412.529(f)(4)(iii)(B), and the site neutral payment rate at § 412.522(c)(1)(ii), the MAC may use a statewide average CCR, which is established annually by CMS, if it is unable to determine an accurate CCR for an LTCH in one of the following circumstances: (1) New LTCHs that have not yet submitted their first Medicare cost report (a new LTCH is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18); (2) LTCHs whose calculated CCR is in excess of the LTCH total CCR ceiling; and (3) other LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the MAC may consider in determining an LTCH's CCR include data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as an LTCH (that is, the period of at least 6 months that it was paid as a short-term, acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

Consistent with our historical practice of using the best available data and as we proposed, in this final rule, using our established methodology for determining the LTCH statewide average CCRs, based on the most recent complete IPPS ''total CCR'' data from the March 2016 update of the PSF, we are establishing LTCH PPS statewide average total CCRs for urban and rural hospitals that will be effective for discharges occurring on or after October 1, 2016 through September 30, 2017, in Table 8C listed in section VI. of the Addendum to this final rule (and available via the Internet on the CMS Web site). Consistent with our historical practice, as we proposed, we used more recent data to determine the LTCH PPS statewide average total CCRs for FY 2017 in this final rule.

Under the current LTCH PPS labor market areas, all areas in Delaware, the District of Columbia, New Jersey, and Rhode Island are classified as urban. Therefore, there are no rural statewide average total CCRs listed for those jurisdictions in Table 8C. This policy is consistent with the policy that we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71

FR 48119 through 48121) and is the same as the policy applied under the IPPS. In addition, although Connecticut has areas that are designated as rural, in our calculation of the LTCH statewide average CCRs, there was no data available from short-term, acute care IPPS hospitals to compute a rural statewide average CCR or there were no short-term, acute care IPPS hospitals or LTCHs located in that area as of March 2016. (We note that, based on the best available data at the time of the proposed rule, there were no data available from short-term acute care IPPS hospitals (or LTCHs) located in the rural areas of North Dakota. However, based on the more recent data available for this final rule, there is now data available from short-term acute care IPPS hospitals in the rural areas of North Dakota from which to compute a rural statewide average CCR. Therefore, it is no longer necessary to use the national average total CCR for rural IPPS hospitals for rural North Dakota in Table 8C associated with this final rule, which is available via the Internet on the CMS Web site.) Therefore, consistent with our existing methodology, as we proposed, we used the national average total CCR for rural IPPS hospitals for rural Connecticut in Table 8C listed in section VI. of the Addendum to this final rule (and available via the Internet on the CMS Web site). Furthermore, consistent with our existing methodology, in determining the urban and rural statewide average total CCRs for Maryland LTCHs paid under the LTCH PPS, as we proposed, we are continuing to use, as a proxy, the national average total CCR for urban IPPS hospitals and the national average total CCR for rural IPPS hospitals, respectively. We used this proxy because we believe that the CCR data in the PSF for Maryland hospitals may not be entirely accurate (as discussed in greater detail in the FY 2007 IPPS final rule (71 FR 48120)).

d. Reconciliation of HCO and SSO Payments

Under the HCO policy for cases paid under either payment rate at § 412.525(a)(4)(iv)(D) and the SSO policy at § 412.529(f)(4)(iv), the payments for HCO and SSO cases are subject to reconciliation. Specifically, any such payments are reconciled at settlement based on the CCR that is calculated based on the cost report coinciding with the discharge. (We note the existing reconciliation process for HCO payments is also applicable to LTCH PPS payments for site neutral payment rate cases (80 FR 49610).) For additional information on the reconciliation policy, we refer readers to Sections 150.26 through 150.28 of the Medicare Claims Processing Manual (Pub. 100–4) as added by Change Request 7192 (Transmittal 2111; December 3, 2010) and the RY 2009 LTCH PPS final rule (73 FR 26820 through 26821).

e. Technical Change to the Definition of ''Outlier Payment''

The existing regulations at § 412.503 includes a definition of ''outlier payment,'' which was adopted when the LTCH PPS was implemented (67 FR 56049). This definition does not account for the dual rate LTCH PPS payment structure that began in FY 2016. Therefore, in this final rule, to account for our HCO policy for LTCH cases paid under either payment rate, as we proposed, we are revising the definition of ''outlier payment'' at § 412.503 to mean an additional payment beyond the LTCH PPS standard Federal payment rate or the site neutral payment rate (including, when applicable, the transitional blended rate), as applicable, for cases with unusually high costs.

We did not receive any public comments on our proposed technical revisions to the definition of ''outlier payment'' at § 412.503 to account for the dual rate LTCH PPS payment structure that began in FY 2016. Therefore, we are adopting this revision as final, without modification.

3. High-Cost Outlier Payments for LTCH PPS Standard Federal Payment Rate Cases

a. Establishment of the Fixed-Loss Amount for LTCH PPS Standard Federal Payment Rate Cases for FY 2017

When we implemented the LTCH PPS, we established a fixed-loss amount so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS (67 FR 56022 through 56026). When we implemented the dual rate LTCH PPS payment structure beginning in FY 2016, we established that, in general, that the historical LTCH PPS HCO policy will continue to apply to LTCH PPS standard Federal payment rate cases. That is, the fixed-loss amount and target for LTCH PPS standard Federal payment rate cases is determined using the LTCH PPS HCO policy adopted when the LTCH PPS was first implemented, but we limited the data used under that policy to LTCH cases that would have been LTCH PPS standard Federal payment rate cases if the statutory changes had been in effect at the time of those discharges.

To determine the applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases, we estimate outlier payments and total LTCH PPS payments for each LTCH PPS standard Federal payment rate case (or for each case that would have been a LTCH PPS standard Federal payment rate case if the statutory changes had been in effect at the time of the discharge) using claims data from the MedPAR files. The applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases results in estimated total outlier payments being projected to be equal to 8 percent of projected total LTCH PPS payments for LTCH PPS standard Federal payment rate cases. We use MedPAR claims data and CCRs based on data from the most recent PSF (or from the applicable statewide average CCR if an LTCH's CCR data are faulty or unavailable) to establish an applicable fixed-loss threshold amount for LTCH PPS standard Federal payment rate cases.

In the FY 2017 IPS/LTCH PPS proposed rule (81 FR 25286 through 25287), we proposed to continue to use our current methodology to calculate an applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017 using the best available data that would maintain estimated HCO payments at the projected 8 percent of total estimated LTCH PPS payments for LTCH PPS standard Federal payment rate cases (based on the payment rates and policies for these cases presented in that proposed rule). Specifically, based on the most recent complete LTCH data available (that is, LTCH claims data from the December 2015 update of the FY 2015 MedPAR file and CCRs from the December 2015 update of the PSF), we determined that a proposed fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017 of $22,728 would result in estimated outlier payments projected to be equal to 8 percent of estimated FY 2017 payments for such cases. Under this proposal, we would continue to make an additional HCO payment for the cost of an LTCH PPS standard Federal payment rate case that exceeds the HCO threshold amount that is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted LTCH PPS standard Federal payment rate payment and the fixed-loss amount for LTCH PPS standard Federal payment rate cases of $22,728). We also noted that the proposed fixed-loss amount for HCO cases paid under the LTCH PPS standard Federal payment rate in FY 2017 of $22,728 is notably higher than the FY 2016 fixed-

loss amount for LTCH PPS standard Federal payment rate cases of $16,423, and explains that the increase is largely attributable to rate-of-change in the Medicare allowable charges on the claims data in the MedPAR file. Based on the most recent available data at the time of the proposed rule, we found that the current FY 2016 HCO threshold of $16,423 results in estimated HCO payments for LTCH PPS standard Federal payment rate cases of approximately 9.1 percent of the estimated total LTCH PPS payments in FY 2016, which exceeds the 8 percent target by 1.1 percentage points. We also noted that fluctuations in the fixed-loss amount occurred in the first few years after the implementation of the LTCH PPS, due, in part, to the changes in LTCH behavior (such as Medicare beneficiary treatment patterns) in response to the new payment system and the lack of data and information available to predict how those changes would affect the estimate costs of LTCH cases. As we gained more experience with the effects and implementation of the LTCH PPS, the annual changes on the fixed-loss amount generally stabilized relative to the fluctuations that occurred in the early years of the LTCH PPS. Therefore, we did not propose any changes to our method for the inflation factor applied to update the costs of each case (that is, an inflation factor based on the most recent estimate of the proposed 2013-based LTCH market basket as determined by the Office of the Actuary) in determining the proposed fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017. We stated our continued belief that it is appropriate to continue to use our historical approach until we gain experience with the effects and implementation of the dual rate LTCH PPS payment structure that began with discharges occurring in cost reporting periods beginning on or after October 1, 2015, and the types of cases paid at the LTCH PPS standard Federal payment rate under this dual rate payment structure. We stated that we may revisit this issue in the future if data demonstrate such a change is warranted, and would propose any changes in the future through the notice-and-comment rulemaking process. Furthermore, we invited public comments on potential improvements to the determination of the fixed-loss amount for LTCH PPS standard Federal payment rate cases, including the most appropriate method of determining an inflation factor for projecting the costs of each case when determining the fixed-loss threshold.

Comment: A few commenters expressed concern with the notable increase in the proposed FY 2017 fixed-loss amount for LTCH PPS standard Federal payment rate cases as compared to the current fixed-loss amount for such cases. Some of these commenters expressed general support for continuing to use a target amount of 8 percent for HCO payments for LTCH PPS standard Federal payment rate cases. Some commenters stated that they are concerned about the potential instability in the fixed-loss amount from year to year and requested that CMS continue to be transparent about the possible causes for such large year-to-year changes in the fixed-loss amount and how much of this variability may be attributable to the new dual rate LTCH PPS payment structure. Some commenters also expected that the fixed-loss amount would change in the final rule based on the use of more recent LTCH claims data from the MedPAR file and the latest CCRs from the PSF. In addition to using the most recent LTCH claims data and CCRs, some commenters suggested that CMS consider whether the new dual rate LTCH PPS payment structure warrants the use of other relevant data or a change in the inflation factor for projecting the costs of each case when determining the fixed-loss amount. One commenter stated that it is not reasonable for the HCO fixed-loss amount for LTCH PPS standard Federal payment rate cases to increase to such a high level, and suggested that the increase in the HCO fixed-loss amount be established at 7 percent, which would reflect the LTCH industry's average increase in charges.

Response: We understand the commenters' concern with the proposed increase to the fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017, and we appreciate the commenters' support for our proposed continued use of a HCO target amount of 8 percent for LTCH PPS standard Federal payment rate cases. (For information on the rationale for the existing 8 percent HCO ''target'' requirement, we refer readers to the August 30, 2002 LTCH PPS final rule (67 FR 56022 through 56024).) As we discussed in the proposed rule, based on the best available data at that time, we estimated that the current FY 2016 HCO fixed-loss amount of $16,423 results in estimated HCO payments for LTCH PPS standard Federal payment rate cases in excess of the 8 percent target by 1.1 percentage points. Similarly, based on the most recent available data for this final rule (discussed below), we found that the current FY 2016 HCO threshold of $16,423 results in estimated HCO payments for LTCH PPS standard Federal payment rate cases of approximately 9.0 percent of the estimated total LTCH PPS payments in FY 2016, which exceeds the 8 percent target by 1.0 percentage point. Maintaining the fixed-loss amount at the current level would result in HCO payments that are substantially more than the current regulatory 8 percent target that we apply to total payments for LTCH PPS standard Federal payment rate cases because a lower fixed-loss amount results in more cases qualifying as outlier cases, as well as higher HCO payments for qualifying cases because the maximum loss that an LTCH must incur before receiving an HCO payment (that is, the fixed-loss amount) would be smaller. For these reasons, we continue to believe it is necessary and appropriate to increase to the fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017 to maintain estimated HCO payments equal to 8 percent of estimated total LTCH PPS payments for such cases as required under § 412.525(a). In addition, for these reasons, we are not adopting the commenter's suggestion to only increase the fixed-loss amount for LTCH PPS standard Federal payment rate cases by the average increase in LTCHs' charges because the resulting fixed-loss amount would not maintain estimated HCO payments to equal 8 percent of estimated total LTCH PPS payments for such cases, as required under current policy.

As discussed in the proposed rule, fluctuations in the fixed-loss amount have occurred previously under the LTCH PPS, due, in part, to the changes in LTCH behavior in response to the changes in Medicare payments and the lack of data and information available to predict how those changes affect the estimate costs of LTCH cases. As was the case when there were fluctuations in the fixed-loss amount in the early years of the LTCH PPS, we expect annual changes to the fixed-loss amount to generally stabilize as experience is gained under the new dual rate LTCH PPS payment structure. We intend to continue to monitor annual changes in the HCO fixed-loss amount, including factors that cause any such changes. We appreciate the commenters' suggestions for potential improvements to the determination of the fixed-loss amount for LTCH PPS standard Federal payment rate cases, including the use of other relevant data or a change in the inflation factor for projecting the costs of each

case when determining the fixed-loss amount. As we indicated in the proposed rule, we may revisit this issue in the future if data demonstrate such a change is warranted, and would propose any changes in the future through the notice-and-comment rulemaking process. We note, as in greater detail discussed below, the fixed-loss amount for FY 2017 for LTCH PPS standard Federal payment rate cases we are establishing in this final rule, after consideration of public comments and based on the most recent LTCH claims data from the MedPAR file and the latest CCRs from the PSF, does result in a fixed-loss amount for such cases that is lower than the proposed fixed-loss amount, consistent with commenters' expectations.

After consideration of the public comments we received, for the reasons discussed above, we are finalizing our proposal to continue to use the current LTCH PPS HCO payment methodology for LTCH PPS standard Federal payment rate cases for FY 2017 without modification. Therefore, in this final rule, for FY 2017, we determined an applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases using data from LTCH PPS standard Federal payment rate cases (or cases that would have been LTCH PPS standard Federal payment rate cases had the dual rate LTCH PPS payment structure been in effect at the time of those discharges). The fixed-loss amount for LTCH PPS standard Federal payment rate cases will continue to be determined so that estimated HCO payments will be projected to equal 8 percent of estimated total LTCH PPS standard Federal payment rate cases. Furthermore, in accordance with § 412.523(d)(1), a budget neutrality factor will continue to be applied to LTCH PPS standard Federal payment rate cases to offset that 8 percent so that HCO payments for LTCH PPS standard Federal payment rate cases will be budget neutral. Below we present our calculation of the fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017, which is consistent with the methodology used to establish the FY 2016 LTCH PPS fixed-loss amount, as we proposed.

In the FY 2016 IPPS/LTCH PPS final rule (80 FR 49803 through 49804), we presented our policies regarding the methodology and data we used to establish a fixed-loss amount of $16,423 for FY 2016 for LTCH PPS standard Federal payment rate cases, which was calculated based on the data and the rates and policies presented in that final rule in order to maintain estimated HCO payments at the projected 8 percent of total estimated LTCH PPS payments. Consistent with our historical practice of using the best data available, as we proposed, in determining the fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017, we used the most recent available LTCH claims data and CCR data, that is, LTCH claims data from the March 2016 update of the FY 2015 MedPAR file and CCRs from the March 2016 update of the PSF, as these data were the most recent complete LTCH data available at that time.

For FY 2017, as we proposed, we are continuing to use our current methodology to calculate an applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017 using the best available data that will maintain estimated HCO payments at the projected 8 percent of total estimated LTCH PPS payments for LTCH PPS standard Federal payment rate cases (based on the rates and policies for these cases presented in this final rule). Specifically, based on the most recent complete LTCH data available (that is, LTCH claims data from the March 2016 update of the FY 2015 MedPAR file and CCRs from the March 2016 update of the PSF), we determined a fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017 that will result in estimated outlier payments projected to be equal to 8 percent of estimated FY 2017 payments for such cases. Under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of the BIPA, we are establishing a fixed-loss amount of $21,943 for LTCH PPS standard Federal payment rate cases for FY 2017. Under our policy, we will continue to make an additional HCO payment for the cost of an LTCH PPS standard Federal payment rate case that exceeds the HCO threshold amount that is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted LTCH PPS standard Federal payment rate payment and the fixed-loss amount for LTCH PPS standard Federal payment rate cases of $21,943).

We note that the fixed-loss amount of $21,943 for FY 2017 for LTCH PPS standard Federal payment rate cases is somewhat lower than the proposed FY 2017 fixed-loss amount of $22,728 for FY 2017 for such cases, but notably higher than the FY 2016 fixed-loss amount for LTCH PPS standard Federal payment rate cases of $16,423. As discussed in the FY 2017 IPPS/LTCH PPS proposed rule (81 FR 25287), the FY 2016 fixed-loss amount for LTCH PPS standard Federal payment rate cases was determined using LTCH claims data from the March 2015 update of the FY 2014 MedPAR file and CCRs from the March 2015 update of the PSF. Based on that data, the estimated outlier payments were projected to be equal to 8 percent of estimated FY 2016 payments for such cases (80 FR 49803). Using the more recent LTCH claims data (that is, FY 2015 LTCH discharges from the March 2016 update of the MedPAR file and CCRs from the March 2016 update of the PSF), we currently estimate that the FY 2016 fixed-loss amount of $16,423 results in estimated HCO payments for LTCH PPS standard Federal payment rate cases of approximately 9.0 percent of total estimated FY 2016 LTCH PPS payments to those cases, which exceeds the 8 percent target. While many factors contribute to this increase, we found that the rate-of-change in the Medicare allowable charges on the claims data in the MedPAR is a significant contributing factor. In the payment modeling used to estimate LTCH PPS payments for the FY 2016 IPPS/LTCH PPS final rule, for SSO and HCO cases paid as LTCH PPS standard Federal payment rate cases, we applied an inflation factor of 4.6 percent (determined by the Office of the Actuary) to update the 2014 costs of each case to 2016 (80 FR 49833). Upon examining FY 2014 LTCH and FY 2015 LTCH discharge data, we found that Medicare allowable charges for LTCH PPS standard Federal payment rate cases (had the dual rate LTCH PPS payment structure been in effect at the time of the discharges) increased approximately 7 percent. This higher inflation factor results in higher estimated costs for outlier cases and, therefore, more estimated outlier payments. For the reasons discussed above, we believe that it is necessary and appropriate to apply an increase to the fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017 to ensure that, for LTCH PPS standard Federal payment rate cases, estimated HCO payments will equal 8 percent of estimated total LTCH PPS payments for those cases as required under § 412.525(a).

b. Application of the High-Cost Outlier Policy to SSO Cases

Under our implementation of the dual rate LTCH PPS payment structure required by statute, LTCH PPS standard Federal payment rate cases (that is, LTCH discharges that meet the criteria for exclusion from the site neutral payment rate) will continue to be paid based on the LTCH PPS standard Federal payment rate, and will include all of the existing payment adjustments

under § 412.525(d), such as the adjustments for SSO cases under § 412.529. Under some rare circumstances, an LTCH discharge can qualify as an SSO case (as defined in the regulations at § 412.529 in conjunction with § 412.503) and also as an HCO case, as discussed in the August 30, 2002 final rule (67 FR 56026). In this scenario, a patient could be hospitalized for less than five-sixths of the geometric average length of stay for the specific MS–LTC–DRG, and yet incur extraordinarily high treatment costs. If the estimated costs exceeded the HCO threshold (that is, the SSO payment plus the applicable fixed-loss amount), the discharge is eligible for payment as an HCO. Therefore, for an SSO case in FY 2017, as we proposed, we are establishing that the HCO payment will be 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the fixed-loss amount of $21,943 and the amount paid under the SSO policy as specified in § 412.529).

4. High-Cost Outlier Payments for Site Neutral Payment Rate Cases

Under § 412.525(a), site neutral payment rate cases receive an additional HCO payment for costs that exceed the HCO threshold that is equal to 80 percent of the difference between the estimated cost of the case and the applicable HCO threshold (80 FR 49618 through 49629). In the FY 2016 IPPS/LTCH PPS final rule, in examining the appropriate fixed-loss amount for site neutral payment rate cases issue, we considered how LTCH discharges based on historical claims data would have been classified under the dual rate LTCH PPS payment structure and the CMS' Office of the Actuary (OACT) projections regarding how LTCHs will likely respond to our implementation of policies resulting from the statutory payment changes. For FY 2016, at that time our actuaries projected that the proportion of cases that would qualify as LTCH PPS standard Federal payment rate cases versus site neutral payment rate cases under the statutory provisions would remain consistent with what is reflected in the historical LTCH PPS claims data. Although our actuaries did not project an immediate change in the proportions found in the historical data, they did project cost and resource changes to account for the lower payment rates. Our actuaries also projected that the costs and resource use for cases paid at the site neutral payment rate would likely be lower, on average, than the costs and resource use for cases paid at the LTCH PPS standard Federal payment rate and would likely mirror the costs and resource use for IPPS cases assigned to the same MS–DRG, regardless of whether the proportion of site neutral payment rate cases in the future remains similar to what is found based on the historical data. In light of these projections and expectations, we discussed that we believed that the use of a single fixed-loss amount and HCO target for all LTCH PPS cases would be problematic. In addition, we discussed that we did not believe that it would be appropriate for comparable LTCH PPS site neutral payment rate cases to receive dramatically different HCO payments from those cases that would be paid under the IPPS (80 FR 49618 through 49619). For those reasons, in the FY 2016 IPPS/LTCH PPS final rule (FR 80 49619), we stated that we believe that the most appropriate fixed-loss amount for site neutral payment rate cases for a given fiscal year, beginning with FY 2016, would be the IPPS fixed-loss amount for that fiscal year. Accordingly, we established that for FY 2016, a fixed-loss amount for site neutral payment rate cases of $22,544, which was the same as the FY 2016 IPPS fixed-loss amount. (We note that the FY 2016 fixed-loss amount under the IPPS was updated, applicable for discharges on or after January 1, 2016, as a conforming change to the implementation of section 601 of the Consolidated Appropriations Act, 2016, which modified the payment calculation with respect to operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges on or after January 1, 2016 (Change Request 9523, Transmittal 3449, dated February 4, 2016).) Consistent with this change, the FY 2016 fixed-loss amount for site neutral payment rate cases under the LTCH PPS was updated, applicable for discharges on or after January 1, 2016, to $22,538, which is the same as the updated IPPS outlier fixed-loss cost threshold for FY 2016. (We refer readers to Change Request 9527, Transmittal 3445, dated January 29, 2016, which also updated the IPPS comparable amount calculation, applicable to discharges occurring on or after January 1, 2016, consistent with the conforming changes made as a result of the new IPPS payment requirement.)

In developing a fixed-loss amount for site neutral payment rate cases for FY 2017, as discussed in the FY 2017 IPPS/LTCH proposed rule (81 FR 25288), we considered the same factors we did developing a fixed-loss amount for such cases for FY 2016. For FY 2017, our actuaries currently project that the proportion of cases that will qualify as LTCH PPS standard Federal payment rate cases versus site neutral payment rate cases under the dual rate LTCH PPS payment structure provisions will remain consistent with what is reflected in the historical LTCH PPS claims data. Based on FY 2014 LTCH claims data, LTCH claims data, we found that approximately 55 percent of LTCH cases would have been paid the LTCH PPS standard Federal payment rate and approximately 45 percent of LTCH cases would have been paid the site neutral payment rate if those rates had been in effect at that time.) At this time, our actuaries continue to project no immediate change in these proportions. However, they do continue to project that the costs and resource use for cases paid at the site neutral payment rate would likely be lower, on average, than the costs and resource use for cases paid at the LTCH PPS standard Federal payment rate and will likely mirror the costs and resource use for IPPS cases assigned to the same MS–DRG, regardless of whether the proportion of site neutral payment rate cases in the future remains similar to what is found based on the historical data. As discussed in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49619), this actuarial assumption is based on our expectation that site neutral payment rate cases would generally be paid based on an IPPS comparable per diem amount under the statutory LTCH PPS payment changes that began in FY 2016, which, in the majority of cases, is much lower than the payment that would have been paid if these statutory changes were not enacted. For these reasons, we continue to believe that the most appropriate fixed-loss amount for site neutral payment rate cases for FY 2017 is the IPPS fixed-loss amount for FY 2017.

Therefore, for FY 2017, we proposed that the applicable HCO threshold for site neutral payment rate cases is the sum of the site neutral payment rate for the case and the IPPS fixed-loss amount. That is, we proposed a fixed-loss amount for site neutral payment rate cases of $23,681, which is the same FY 2017 IPPS fixed-loss amount discussed in section II.A.4.g.(1) of the Addendum to that proposed rule. We stated that we continued to believe that this policy will reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems. Accordingly, for FY 2017, we proposed to calculate a HCO payment for site neutral payment rate cases with costs that exceed the HCO threshold amount,

which is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of site neutral payment rate payment and the fixed-loss amount for site neutral payment rate cases of $23,681).

Comment: Some commenters expressed support for our proposal to continue to use the FY 2017 IPPS fixed-loss amount and 5.1 percent HCO target for LTCH discharges paid at the site neutral payment rate in FY 2017. However, some commenters suggested that the IPPS fixed-loss amount and 5.1 percent HCO target not be used automatically for site neutral payment rate cases every year.

Response: We appreciate the commenters support for our proposal to continue to use the FY 2017 IPPS fixed-loss amount and 5.1 percent HCO target for LTCH discharges paid at the site neutral payment rate in FY 2017. Given the current expectation that cases paid at the site neutral payment rate would likely be similar to IPPS cases assigned to the same MS–DRG, we continue to believe the most appropriate fixed-loss amount for site neutral payment rate cases is the IPPS fixed-loss amount for that fiscal year. As we indicated in the FY 2016 IPPS/LTCH PS final rule (80 FR 49619), to the extent experience under the revised LTCH PPS indicates site neutral payment rate cases differ sufficiently from these expectations, we agree it would be appropriate to revisit in future rulemaking the most appropriate fixed-loss amount used to determine HCO payments for site neutral payment rate cases.

Comment: One commenter recommended that CMS apply geographic adjustments (that is, the wage index and COLA) to the fixed-loss amount when determining the HCO threshold for site neutral payment rate cases, consistent with the approach used under the IPPS.

Response: The LTCH PPS HCO policy does not include the application of geographic adjustments when determining the HCO threshold, and therefore, our current policy for determining the HCO threshold for site neutral payment rate cases, which we proposed to continue to use for FY 2017, is consistent with our longstanding LTCH PPS HCO policy. The LTCH PPS and IPPS HCO policies have historically differed with regard to this aspect of the HCO payment policy calculation. Moreover, the commenter offered little support to demonstrate that its recommended change, which we did not propose and are not accepting, would result in more appropriate HCO payments to site neutral payment rate cases paid under the LTCH PPS. We will keep this recommended change in mind as we consider potential refinements to the LTCH PPS HCO policy, including the HCO threshold for site neutral payment rate cases, in the future.

After consideration of the public comments we received, we are finalizing, without modification, our proposals to use the FY 2017 IPPS fixed-loss amount and 5.1 percent HCO target for LTCH discharges paid at the site neutral payment rate in FY 2017. Therefore, for FY 2017, as we proposed, we are establishing that the applicable HCO threshold for site neutral payment rate cases is the sum of the site neutral payment rate for the case and the IPPS fixed-loss amount. That is, we are establishing a fixed-loss amount for site neutral payment rate cases of $23,570, which is the same FY 2017 IPPS fixed-loss amount discussed in section II.A.4.g.(1) of the Addendum to this final rule. We continue to believe that this policy will reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems. Accordingly, under this policy, for FY 2017, we are calculating a HCO payment for site neutral payment rate cases with costs that exceed the HCO threshold amount, which is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of site neutral payment rate payment and the fixed-loss amount for site neutral payment rate cases of $23,570). (We note that any site neutral payment rate case that is paid 100 percent of the estimated cost of the case (because that amount is lower than the IPPS comparable per diem amount) will not be eligible to receive a HCO payment because, by definition, the estimated costs of such cases will never exceed the IPPS comparable per diem amount by any threshold.)

In establishing a HCO policy for site neutral payment rate cases, we established a budget neutrality requirement at § 412.522(c)(2)(i). We established this requirement because we believe that the HCO policy for site neutral payment rate cases should be budget neutral, just as the HCO policy for LTCH PPS standard Federal payment rate cases are budget neutral, meaning that estimated site neutral payment rate HCO payments should not result in any change in estimated aggregate LTCH PPS payments. Under § 412.522(c)(2)(i), we adjust all payments for site neutral payment rate cases by a budget neutrality factor so that the estimated HCO payments payable for site neutral payment rate cases do not result in any increase in aggregate LTCH PPS payments. Specifically, under § 412.522(c)(2)(i), we apply a budget neutrality factor to the site neutral payment rate portion of the transitional blended rate payment (that is applicable to site neutral payment rate cases during the 2-year transition period provided by the statute) that is established based on an estimated basis. (We refer readers to 80 FR 49621 through 49622 and 49805.)

Under the approach adopted for applying the budget neutrality adjustment to the site neutral payment rate portion of the transitional blended rate payment in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49805), we explained that there is no need to perform any calculation of the site neutral payment rate case HCO payment budget neutrality adjustment under our finalized policy. This is because, as discussed in the proposed rule (81 FR 25288), based on our actuarial assumptions we project that our proposal to use the IPPS fixed-loss threshold for the site neutral payment rate cases would result in HCO payments for those cases that are similar in proportion as is seen in IPPS cases assigned to the same MS–DRG; that is, 5.1 percent. In other words, we estimated that HCO payments for site neutral payment rate cases would be 5.1 percent of the site neutral payment rate payments. Under the statutory transition period, payments to site neutral payment rate cases in FY 2017 will be paid under the blended transitional rate. As such, we stated that estimated HCO payments for site neutral payment rate cases in the FY 2017 policy will be projected to be 5.1 percent of the portion of the blended rate payment that is based on the estimated site neutral payment rate payment amount (and will not include the LTCH PPS standard Federal payment rate payment amount as specified in § 412.522(c)(2)(i)). To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2017 will not result any increase in estimated aggregate FY 2017 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i), we explained it is necessary to reduce the site neutral payment rate portion of the blended rate payment by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2017. In order to achieve this, for FY 2017, we proposed to continue to apply a budget neutrality factor of 0.949 (that is, the decimal equivalent of a 5.1 percent reduction, determined as 1.0 − 5.1/100 =

0.949) to the site neutral payment rate portion of the blended rate payment (81 FR 25289). As stated previously, this adjustment is necessary so that the estimated HCO payments payable for site neutral payment rate cases do not result in any increase in aggregate LTCH PPS payments.

Comment: As was the case in the FY 2016 rulemaking cycle, commenters again objected to the proposed application of a high-cost outlier (HCO) budget neutrality adjustment to site neutral payment rate cases, stating that it results in savings to the Medicare program instead of being budget neutral. The commenters' primary objection was again based on their belief that, because the IPPS base rates used in the IPPS comparable per diem amount calculation of the site neutral payment rate include a budget neutrality adjustment for IPPS HCO payments (that is, a 5.1 percent adjustment on the operating IPPS standardized amount), an ''additional'' budget neutrality factor is not necessary and is, in fact, duplicative. Some of these commenters stated that, in addition to not applying a HCO budget neutrality adjustment to site neutral payment rate payments, its application in FY 2016 should be discontinued, and that a retroactive adjustment to the FY 2016 site neutral payment rate payments that have already occurred should be made to address this perceived error. In addition, some commenters also indicated that the HCO budget neutrality payment adjustment is inappropriate because it increases the payment difference between the IPPS payment amount for a case and the ''LTCH PPS payment amount'' (which we took to mean cases paid the IPPS comparable per diem amount under the site neutral payment rate) for similar cases. Other commenters stated that there is no statutory requirement for budget neutrality for HCO payments, and that any HCO budget neutrality adjustment for site neutral payment rate cases is therefore unwarranted. These commenters stated that there was nothing in their review of the rulemaking record that they read to mean that CMS would apply a HCO budget neutrality adjustment on an ongoing basis, and that they believed that a budget neutrality adjustment was only required for the first year of the LTCH PPS. A few other commenters stated that if CMS finalizes its proposal to apply a HCO budget neutrality adjustment for site neutral payment rate cases, then that budget neutrality adjustment should not be applied to site neutral payment rate cases that are paid at 100 percent of the estimated cost because they believed that doing so would violate the statute, which they understood to require payment at ''100 percent of the estimated cost for the services involved,'' without adjustment.

Response: We continue to disagree with the commenters who assert that a HCO budget neutrality adjustment for site neutral payment rate cases is inappropriate, unnecessary, or duplicative. We have made a budget neutrality adjustment for estimated HCO payments under the LTCH PPS under § 412.525 every year since its inception in FY 2003. Specifically, at § 412.523(d)(1), under the broad authority provided by section 123 of Public Law 106–113 and section 307 of Public Law 106–554, which includes the authority to establish adjustments, we established that the standard Federal rate (now termed the LTCH PPS standard Federal payment rate under the new dual rate system) would be adjusted by a reduction factor of 8 percent, the estimated proportion of outlier payments under the LTCH PPS (67 FR 56052). Thus, Congress was well aware of how we had implemented our HCO policy under the LTCH PPS under § 412.525 at the time of the enactment of section 1206 of Public Law 113–67.

Section 1206 of Public Law 113–67 defined the site neutral payment rate as the lower of the estimated cost of the case or the IPPS comparable per diem amount determined under paragraph (d)(4) of § 412.529, including any applicable outlier payments under § 412.525. The term ''IPPS comparable per diem amount'' was not new at the time of enactment. That term had already previously been defined under § 412.529(d)(4), which has been in effect since July 1, 2006, and used as a component of the payment adjustment formula for LTCH PPS SSO cases. From the July 1, 2006 inception of the IPPS comparable component of the LTCH PPS' SSO payment formula, we have budget neutralized the estimated HCO payments that we expected to pay to SSO cases including those paid based on the IPPS comparable per diem amount. Congress was also well aware of how we had implemented our ''IPPS comparable per diem amount'' concept in the SSO context at the time of the enactment of section 1206 of Public Law 113–67. As such, we believe Congress left us with the discretion to continue to treat the ''IPPS comparable per diem amount'' in the site neutral payment rate context as we have historically done with respect to LTCH PPS HCO payments made to discharges paid using the ''IPPS comparable per diem amount,'' that is, to adopt a policy in the site neutral context to budget neutralize HCO payments made to LTCH PPS discharges including those paid using the ''IPPS comparable per diem amount.''

In response to the commenters who believe that budget neutrality was only required in the first year of the LTCH PPS, we suspect that they are referencing the budget neutrality adjustment that was made to the LTCH PPS relative to the reasonable cost-based TEFRA payment system that preceded it. That initial budget neutrality adjustment is unrelated to our ongoing authority to make annual HCO budget neutrality adjustments for payments under the LTCH PPS, adjustments we adopted through prior notice-and-comment rulemaking using the broad authority provided by section 123 of Public Law 106–113 and section 307 of Public Law 106–554.

In response to commenters who stated that there is no statutory requirement to apply a budget neutrality adjustment for HCO payments, as discussed previously, the authorizing statutes grant the Secretary broad authority to determine appropriate adjustments under the LTCH PPS, and that although the statute did not ''require'' that a HCO policy be implemented in a budget neutral manner, we adopted such an approach through notice-and comment rulemaking when we initially implemented the LTCH PPS. As such, we have made a budget neutrality adjustment for estimated HCO payments under the LTCH PPS every year since its inception in FY 2003 under § 412.523(d)(1), where we established that the standard Federal rate is adjusted by a reduction factor of 8 percent, the estimated proportion of outlier payments under the LTCH PPS (67 FR 56052).

In response to commenters who indicated that the adjustment is inappropriate because it increases the payment difference between the IPPS comparable payment amount for a case and the LTCH PPS payment amount (that is, the site neutral payment rate) for similar cases, we note that the statutory requirement to take into account the estimated cost of the case if lower already creates a differential. In addition, the statute also specifies that the IPPS comparable amount is calculated as a per diem capped at the full amount as set forth under § 412.529(d)(4), which also creates a differential. Thus, the statute does not require or allow exact payment neutrality.

Finally, we disagree with the comment that applying the HCO budget neutrality adjustment to site neutral

payment rate payments that are paid at 100 percent of the estimated cost violates the statute. As noted above, CMS regularly uses its broad authorities under the authorizing statutes for the LTCH PPS to apply additional adjustments, where appropriate, to base payment amounts. For this reason, we are not adopting the commenter's request, and for FY 2017 we will apply a HCO budget neutrality adjustment factor to all site neutral payment rate cases (or the site neutral payment rate portion of the blended payment rate for all such cases), as proposed.

In summary, we continue to disagree with commenters that a HCO budget neutrality adjustment for site neutral payment rate cases is inappropriate, unnecessary or duplicative. As such, we will continue to use the IPPS comparable per diem amount (calculated in accordance with our historical practices, which predates enactment of section 1206 of Pub. L. 113–67), and we will continue to apply a HCO budget neutrality adjustment to all site neutral payment rate payments (or portion thereof in the blended payment rate context). For these reasons, we are not adopting the commenter's recommendation to discontinue the application of the HCO budget neutrality adjustment for site neutral payment rate cases in FY 2016, or their suggestion that we make a retroactive adjustment to the FY 2016 site neutral payment rate case payments that have already occurred.

Comment: One commenter noted that the HCO payment amount itself is being reduced under our proposed application of a budget neutrality factor to the site neutral payment rate portion of the blended payment rate, which is inconsistent with high-cost outlier payments for other LTCH PPS and IPPS cases, and requested that we treat all cases in the same manner.

Response: On review, we agree that our proposed application would be inconsistent with our budget neutrality treatment of HCO payments for other LTCH PPS and IPPS cases, and we agree with the commenter that we should remove this variance. As such, we are adopting a policy of not applying the 0.949 budget neutrality adjustment factor to any applicable HCO payment for the site neutral payment rate (or, during the transition, the site neutral payment rate portion of the blended payment rate).

After consideration of the public comments we received, we are finalizing our proposal to apply a budget neutrality adjustment for HCO payments made to site neutral payment rate cases, with one modification. That is, we will not apply the HCO budget neutrality adjustment to the HCO portion of the payment amount. To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2017 will not result any increase in estimated aggregate FY 2017 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i), it is necessary to reduce the site neutral payment rate (or portion thereof in the blended payment rate context) by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2017. To effectuate this policy, for FY 2017, in this final rule we have adopted a budget neutrality policy under which we will apply a budget neutrality factor of 0.949 (that is, the decimal equivalent of a 5.1 percent reduction, determined as 1.0 − 5.1/100 = 0.949) to the site neutral payment rate (or portion thereof in the blended payment rate context). This policy will be applied to cases paid at the IPPS comparable per diem amount and cases paid at 100 percent of the estimated cost.

E. Update to the IPPS Comparable/Equivalent Amounts to Reflect the Statutory Changes to the IPPS DSH Payment Adjustment Methodology

In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50766), we established a policy for reflecting the changes to the Medicare IPPS DSH payment adjustment methodology provided for by section 3133 of the Affordable Care Act in the calculation of the ''IPPS comparable amount'' under the SSO policy at § 412.529 and the ''IPPS equivalent amount'' under the 25-percent threshold payment adjustment policy at § 412.534 and § 412.536. Historically, the determination of both the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' includes an amount for inpatient operating costs ''for the costs of serving a disproportionate share of low-income patients.'' Under the statutory changes to the Medicare DSH payment adjustment methodology that began in FY 2014, in general, eligible IPPS hospitals receive an empirically justified Medicare DSH payment equal to 25 percent of the amount they otherwise would have received under the statutory formula for Medicare DSH payments prior to the amendments made by the Affordable Care Act. The remaining amount, equal to an estimate of 75 percent of the amount that otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under the age of 65 who are uninsured, is made available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. The additional uncompensated care payments are based on the hospital's amount of uncompensated care for a given time period relative to the total amount of uncompensated care for that same time period reported by all IPPS hospitals that receive Medicare DSH payments.

To reflect the statutory changes to the Medicare DSH payment adjustment methodology in the calculation of the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' under the LTCH PPS, we stated that we will include a reduced Medicare DSH payment amount that reflects the projected percentage of the payment amount calculated based on the statutory Medicare DSH payment formula prior to the amendments made by the Affordable Care Act that will be paid to eligible IPPS hospitals as empirically justified Medicare DSH payments and uncompensated care payments in that year (that is, a percentage of the operating DSH payment amount that has historically been reflected in the LTCH PPS payments that is based on IPPS rates). We also stated that the projected percentage will be updated annually, consistent with the annual determination of the amount of uncompensated care payments that will be made to eligible IPPS hospitals. We believe that this approach results in appropriate payments under the LTCH PPS and is consistent with our intention that the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' under the LTCH PPS closely resemble what an IPPS payment would have been for the same episode of care, while recognizing that some features of the IPPS cannot be translated directly into the LTCH PPS (79 FR 50766 through 50767).

For FY 2017, as discussed in greater detail in section IV.D.3.d.(2) of the preamble of this final rule, based on the most recent data available, our estimate of 75 percent of the amount that would otherwise have been paid as Medicare DSH payments (under the methodology outlined in section 1886(r)(2) of the Act) is adjusted to 55.36 percent of that amount to reflect the change in the percentage of individuals who are uninsured. The resulting amount was then used to determine the amount of uncompensated care payments that will be made to eligible IPPS hospitals in FY 2017. In other words, Medicare DSH payments prior to the amendments made by the Affordable Care Act will be adjusted to 41.52 percent (the product of 75 percent and 55.36 percent) and the

POST ACUTE MEDICAL™

June 12, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8011
Baltimore, MD 21244-1850

Subject: 42 CRF Parts 405, 412, 413, 414, 416, 486, 488, 489, and 495 [CMS-1777-P], RIN 0938-AS98, Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices

Attention: File Code CMS-1677-P

Dear Administrator Verma:

I am writing on behalf of Post Acute Medical, LLC (PAM) to convey to the Centers for Medicare & Medicaid Services (CMS) our views on the proposed Medicare regulation governing payments to long-term acute-care hospitals (LTACHs) for FY 2018 that was published in the Federal Register on April 28, 2017 (Vol. 82, No. 81, pp. 19796-20231).

We would like to address four specific aspects of the proposed rule:

- the continued transition to site-neutral payments for post-acute providers
- the 25 percent rule
- proposed rate reductions
- high-cost outliers

We address each of these considerations individually below.

The Continued Transition to Site-Neutral Payments for Post-Acute Providers

FY 2018 is scheduled to be the third year of the three-year transition toward full site-neutral payments for long-term acute care. PAM urges CMS to suspend this transition and keep the blended payments at their current, second-year level for another year.

suited to meet their needs. It would be especially inappropriate in regions that are relatively isolated geographically and sparsely populated where there may be only two or three or four hospitals in a large geographic area and just one LTACH within reasonable distance to serve them. There would be nothing untoward, or unusual, about such an LTACH receiving the vast majority of its patients from just a few acute-care hospitals, but the 25 percent rule would penalize that LTACH for this. It also, in effect, would penalize the communities served by such LTACHs and such acute-care hospitals. Resolving this matter once and for all would free LTACHs from the now-13-year threat of implementation this potentially damaging regulation has posed. **PAM therefore supports CMS's proposal to delay implementation of this rule for another year and further encourages CMS to eliminate this rule permanently.**

Proposed Rate Reductions

As noted above, PAM opposes CMS's proposal to continue onto the third year of the three-year process for establishing site-neutral payments. In addition, we believe the proposed increase of 0.4 percent for standard cases is too modest and the proposed net cut of 22 percent for site-neutral payments is much too large. These reductions are proposed at a time when payments to LTACH are already declining precipitously because of both the phased transition to site-neutral payments and CMS's application of a 5.1 percent budget neutrality adjustment. It is worth noting that the Medicare Payment Advisory Commission (MedPAC) believes this budget neutrality adjustment "…is duplicative and exaggerates the disparity in payment rates across provider settings…" and for this reason concluded that "CMS should not adjust the site-neutral rate for them."

PAM believes that together with the continued implementation of the site-neutral payment system, the overly restrictive criteria for what constitutes a case of high medical acuity, and the proposed increase in the high-cost outlier threshold (addressed below), this is all too much and has the potential to jeopardize providers and jeopardize access to care. For these reasons, we urge CMS to reduce the impact of payment reductions that are not mandated by Congress. CMS is attempting to do a great deal at this time: move toward site-neutral payments, establish a unified post-acute-care payment system, encourage innovation, and more. LTACHs cannot participate in all of these changes and continue to serve their patients effectively if they are systematically deprived of the resources they need to care for those patients. **Consequently, PAM urges CMS to delay the transition to site-neutral payments for another year by remaining at the current blended level of payments, increasing the annual update, and reducing the size of the proposed 22 percent reduction for site-neutral payments.**

High-Cost Outliers

In its proposed FY 2018 rule CMS calls for raising the high-cost outlier threshold from the current $21,943 to $30,081. The underlying rationale for such a drastic change is the combination of the 21st Century Cures Act reducing the outlier proportion from eight percent to 7.95 percent and the current year's projected level of 8.6 percent for outlier spending.

June 13, 2017

Filed Electronically

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-1677-P
P.O. Box 8011
Baltimore, MD 21244-1850

***Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices*; 82 Federal Register 19,796 (April 28, 2017)**

Dear Administrator Verma:

This letter presents the comments and recommendations of Vibra Healthcare on the above-referenced Proposed Rule. Vibra Healthcare operates a network of 27 long-term acute care hospitals ("LTCHs") that care for medically-complex patients who require acute care hospital services for an extended period of time. We appreciate the opportunity to express our concerns with the proposed changes to the fiscal year ("FY") 2018 LTCH prospective payment system ("LTCH PPS") and related policies, and we trust that CMS will carefully consider each of the issues raised in this letter.

CMS SHOULD REEVALUATE THE ACCURACY OF THE PAYMENT UPDATE AND RELATED POLICIES BECAUSE WE ARE PROJECTING A BIGGER NEGATIVE IMPACT

Issue. As proposed for FY 2018, CMS projects a 3.75% decrease in payments under the LTCH PPS, which is expected to result in a decrease of approximately $173 million in payments compared to FY 2017. Total FY 2018 LTCH PPS payments would be

instability in the HCO fixed-loss amount for LTCH PPS standard Federal payment rate cases.

Recommendations. **CMS should recalculate the proposed fixed-loss amount for FY 2018 HCO cases paid under the LTCH PPS standard Federal payment rate after using the most recent LTCH claims data from the MedPAR file and the latest CCRs from the PSF. If this does not significantly reduce the proposed $30,081 HCO fixed-loss amount for LTCH PPS standard Federal payment rate cases, CMS should consider whether it is using the correct percentage of standard Federal payment rate cases, whether the new dual rate payment system warrants the use of other relevant data, consistent with statute, or a change in the inflation factor for projecting the costs of each case when determining the fixed-loss threshold.**

CMS SHOULD NOT APPLY AN ADDITIONAL BUDGET NEUTRALITY ADJUSTMENT TO SITE NEUTRAL PAYMENTS FOR HIGH-COST OUTLIERS

Issue. CMS is proposing to continue to apply a budget neutrality adjustment ("BNA") factor under section 412.522(c)(2)(i) to all cases paid at the site neutral payment rate (including the site neutral payment rate portion of blended rate payments during the transition period) so that HCO payments for site neutral cases will not result in any change in estimated aggregate LTCH PPS payments. CMS says that "[w]e established this requirement because we believed, and continue to believe, that the HCO policy for site neutral payment rate cases should be budget neutral, just as the HCO policy for LTCH PPS standard Federal payment rate cases are budget neutral."[28] "To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2018 would not result in any increase in estimated aggregate FY 2018 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i)" CMS says that "it is necessary to reduce site neutral payment rate payments (or the portion of the blended payment rate payment for FY 2018 discharges occurring in LTCH cost reporting periods beginning before October 1, 2017) by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2018."[29] For FY 2018, CMS is proposing to continue to apply a budget neutrality factor of 0.949 (the decimal equivalent of a 5.1% reduction) to the site neutral payment rate cases paid under § 412.522(c)(1)(i).

Comment. **We *strongly disagree* with CMS' proposal to apply an *additional* 5.1% budget neutrality adjustment for site neutral cases that qualify as high-cost outliers.** CMS is proposing to apply a second BNA to all LTCH payments for site neutral rate cases to offset LTCH payments for HCO site neutral rate cases. **As we explained in our comments to the FY 2017 IPPS/LTCH PPS final rule, this BNA is duplicative and unwarranted because CMS has *already* applied budget neutrality adjustments to reduce the operating and capital portions of the IPPS standard Federal payment rate by the same 5.1%, before using that rate to determine the IPPS comparable per diem amount for site neutral payment cases. MedPAC agreed.**

[28] Id. at 20,191.
[29] Id.

In MedPAC's May 31, 2016 comment letter to CMS on the Proposed Rule, MedPAC states that CMS should not apply a separate budget neutrality adjustment to site neutral high-cost outliers because "the IPPS standard payment amount is already adjusted to account for HCO payments."[30] As MedPAC explains:

> CMS proposes to use the IPPS fixed-loss amount to determine if a discharge paid under the site-neutral rate qualifies to receive an HCO payment again for FY 2017. CMS sets the IPPS fixed-loss amount each year at a level that it estimates will result in aggregate HCO payments equal 5.1 percent of total IPPS payment. **To account for the spending attributed to these outlier payments, CMS reduces the IPPS base payment rates to maintain budget neutrality in the IPPS. The IPPS-comparable rate used to pay for site-neutral cases in LTCHs includes an adjustment for budget neutrality to account for spending associated with HCOs.**
>
> With the Commission's payment principles in mind, **MedPAC urges CMS to eliminate the proposed payment adjustment for discharges paid the site-neutral rate to account for outlier payments under this payment methodology. Given that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.**[31]

CMS addressed this issue to some extent in the FY 2016 IPPS/LTCH PPS final rule, but the agency did not see the duplication that MedPAC now agrees is problematic. First, CMS confirmed that the IPPS base rates used to calculate LTCH site neutral payments already include the budget neutrality adjustment discussed above for HCO payments.[32] CMS referred to this BNA as "one of the inputs" used to calculate the LTCH site neutral payment rate.[33] CMS then tried to distinguish this BNA from the LTCH site neutral HCO BNA by stating that these adjustments fund different outlier payments—the former funds outlier payments for IPPS hospitals and the latter funds site neutral outlier payments for LTCHs.[34] This is *not correct*, as MedPAC points out. Since "the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to

[30] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 16 (May 31, 2016).
[31] Id. at 16-17 (emphasis added).
[32] See 80 Fed. Reg. at 49,622 ("While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments . . .").
[33] See id. (". . . that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate.").
[34] See id. ("The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS.").

reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative."[35] **Stated another way, the budget neutrality adjustment for LTCH site neutral HCOs should not fund site neutral high cost outliers at LTCHs *and* high cost outliers at IPPS hospitals. In FY 2016 and FY 2017, and as proposed for FY 2018, multiple outlier BNAs mean that all LTCHs are effectively paying for outliers at LTCH and IPPS hospitals.**

CMS briefly responded to this issue again in the FY 2017 IPPS/LTCH PPS final rule, but CMS did not address the duplication directly. Instead, CMS speculated that Congress knew when passing the PSRA that CMS reduces LTCH PPS payments each year by estimated HCO payments, and that CMS "budget neutralized" LTCH very short-stay outlier payments since 2006 based on the same IPPS comparable per diem amount. Unfortunately, the regulation CMS refers to (42 C.F.R. § 412.529(d)(4)) does not specify a separate budget neutrality adjustment for HCO or SSO payments based upon the IPPS comparable per diem amount, and CMS does not state any other authority for this assertion. Therefore, it is difficult to see how Congress was "well aware" of this policy when it passed the PSRA. More importantly, CMS avoided responding to the basic criticism that the IPPS and Capital PPS base rates already have budget neutrality adjustments calculated upon the same 5.1% target amount for HCO payments (higher for Capital PPS HCO payments).

To ensure that LTCHs are only paying for high cost outliers at LTCHs, and not IPPS hospitals, CMS must not apply the separate 5.1% adjustment for LTCH site neural cases. CMS is proposing to adjust LTCH site neutral payments *twice* to keep the LTCH PPS budget neutral for the estimated 5.1% of LTCH payments for site neutral HCO cases. The payment reduction is actually larger for site neutral cases that receive a HCO payment. Consistent with MedPAC's recommendation, CMS should only adjust LTCH site neutral payments *once* for outlier budget neutrality. By eliminating the additional BNA for site neutral HCOs, CMS still has "a budget neutrality adjustment when determining payment for a case under the LTCH PPS" to avoid the situation where "any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases."[36] Moreover, this "approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases."[37] Without making this change, the duplicative BNA not only "exaggerates the disparity in payment rates across provider settings," as MedPAC states, but it is also purely punitive.

Therefore, it would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed 5.1% site neutral HCO BNA to LTCH site neutral payments. This would be the case because the IPPS comparable per diem amount is based on the IPPS and capital PPS payment rates, which have already been reduced

[35] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 17.
[36] 80 Fed. Reg. at 49,622.
[37] Id.

by 5.1% for IPPS outlier payments and 5.66% for capital PPS outlier payments. Since CMS has already made these adjustments for budget neutrality, it would be inappropriate for CMS to reduce LTCH site neutral payments that are based on the IPPS and capital PPS rates by *another 5.1%* for HCOs. Accordingly, we object to CMS' proposal to apply a separate HCO BNA to LTCH site neutral payments. CMS should not make a second BNA to LTCH site neutral payments.

For the same reasons, it was incorrect for CMS to apply the 5.1% (0.949) site neutral HCO BNA to FY 2017 and FY 2016 site neutral rate cases. CMS is underpaying LTCHs for site neutral rate cases in FY 2017 and FY 2016 by 5.1%. CMS should reverse this adjustment to all FY 2017 and FY 2016 payments, or make an equivalent prospective increase in payments to FY 2018 site neutral rate cases to account for this underpayment.

Recommendations. **Consistent with MedPAC's prior comments, we *strongly disagree* with the proposed 0.949 budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. There is no precedent for such an adjustment to the annual payment rate determination for the LTCH PPS. Moreover, CMS already reduced the FY 2018 site neutral payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor. CMS should *not* reduce LTCH site neutral payments by *another 5.1%*. For the same reason, CMS should reverse this duplicative adjustment to all FY 2017 and FY 2016 payments, or make an equivalent prospective increase in payments to FY 2018 site neutral rate cases to account for this underpayment.**

CMS SHOULD MAKE THE PROPOSED CHANGE TO THE SHORT-STAY OUTLIER POLICY AND RECONSIDER THE BUDGET NEUTRALITY ADJUSTMENT

Issue. CMS is proposing to eliminate all but the "blended" option at section 412.529(c)(2)(iv) to pay LTCH short-stay outlier cases. Under this option, a SSO case is paid based on a blend of the IPPS comparable amount (determined under section 412.529(d)(4)(i)) and the MS-LTC-DRG per diem amount (determined under section 412.529(d)(1) in conjunction with section 412.503). As the patient's length of stay increases, more of the blended payment would be comprised of the LTCH PPS amount. This change would be effective for LTCH discharges on or after October 1, 2017.

In addition, CMS is proposing to adjust FY 2018 LTCH PPS payments by a one-time, permanent budget neutrality factor of 0.9672 (*i.e.*, -3.28%) to ensure that the change in SSO payment policy at 42 C.F.R. § 412.529 does not increase aggregate LTCH PPS payments.

Comment. **We agree with the proposal to pay all SSO cases using the "blended" option at § 412.529(c)(2)(iv) effective for discharges on or after October 1, 2017.** This should eliminate the payment cliff at the SSO threshold (five-sixths the geometric average length of stay for the MS-LTC-DRG). It should also provide a more gradual increase in payment as the patient's length of stay increases.

LIFECARE HOSPITALS

June 13, 2017

Filed Electronically

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-1677-P
P.O. Box 8011
Baltimore, MD 21244-1850

***Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices*; 82 Federal Register 19,796 (April 28, 2017)**

Dear Administrator Verma:

This letter presents the comments and recommendations of LifeCare Hospitals ("LifeCare") on the above-referenced Proposed Rule. LifeCare operates a network of 24 long-term acute care hospitals ("LTCHs") in 9 states that care for medically-complex patients who require acute care hospital services for an extended period of time. We appreciate the opportunity to express our concerns with the proposed changes to the fiscal year ("FY") 2018 LTCH prospective payment system ("LTCH PPS") and related policies, and we trust that CMS will carefully consider each of the issues raised in this letter.

THE 25% RULE SHOULD BE RETIRED BECAUSE THE NEW PATIENT CRITERIA MAKE IT UNNECESSARY, BUT UNTIL IT IS RETIRED CMS SHOULD DELAY THE EFFECTIVE DATE OF THE 25% RULE REGULATION, AS PROPOSED

Issue. The *Medicare, Medicaid and SCHIP Extension Act of 2007* ("MMSEA") (Pub. L. 110-173), as amended, temporarily froze the implementation of the 25% Rule regulations at 42 C.F.R. §§ 412.534 and 412.536 (*i.e.*, the "25% Rule"). This regulatory relief has been extended a number of times to create a "statutory moratorium" until cost

increases in the fixed-loss amount will prevent LTCHs from being fairly reimbursed for the increased costs of caring for Medicare beneficiaries who would otherwise qualify as HCO cases this year. Moreover, this would not be consistent with CMS' goals to (1) reduce financial risk, (2) reduce incentives to underserve costly beneficiaries, and (3) improve the overall fairness of the system. In fact, financial risk would sharply increase, LTCHs would be incentivized to underserve costly beneficiaries, and the overall fairness of the system would plummet. Instead of increased stability with respect to HCO payments, CMS will create significant *instability*.

CMS adds that fluctuations in the fixed-loss amount also occurred in the first few years of the LTCH PPS, but later stabilized as CMS "gained more experience with the effects and implementation of the LTCH PPS."[27] Our review of the rulemaking record found that the largest change in the HCO fixed-loss amount during the first few years of the LTCH PPS was a 24.8 percent *decrease* in the second year of the LTCH PPS (*i.e.*, RY 2004). A larger *decrease* of 41.2 percent occurred in the fourth year of the LTCH PPS (*i.e.*, RY 2006). It was not until the fifth year of the LTCH PPS (*i.e.*, RY 2007) that the HCO fixed-loss amount *increased*. At that time, it increased by more than 41%, but generally returned to previous levels. However, CMS also showed a willingness to explore policy changes in these years and reevaluate the quality, accuracy and age of the data they used for HCO and short-stay outlier ("SSO") payments. Therefore, in addition to using the most recent LTCH claims data from the MedPAR file and the latest cost-to-charge ratios ("CCRs") from the Provider Specific File ("PSF"), CMS should consider whether the new dual rate payment system warrants the use of other relevant data, consistent with statute, or a change in the inflation factor for projecting the costs of each case when determining the fixed-loss threshold. More could be done to mitigate instability in the HCO fixed-loss amount for LTCH PPS standard Federal payment rate cases.

Recommendations. **CMS should recalculate the proposed fixed-loss amount for FY 2018 HCO cases paid under the LTCH PPS standard Federal payment rate after using the most recent LTCH claims data from the MedPAR file and the latest CCRs from the PSF. If this does not significantly reduce the proposed $30,081 HCO fixed-loss amount for LTCH PPS standard Federal payment rate cases, CMS should consider whether it is using the correct percentage of standard Federal payment rate cases, whether the new dual rate payment system warrants the use of other relevant data, consistent with statute, or a change in the inflation factor for projecting the costs of each case when determining the fixed-loss threshold.**

CMS SHOULD NOT APPLY AN ADDITIONAL BUDGET NEUTRALITY ADJUSTMENT TO SITE NEUTRAL PAYMENTS FOR HIGH-COST OUTLIERS

Issue. CMS is proposing to continue to apply a budget neutrality adjustment ("BNA") factor under section 412.522(c)(2)(i) to all cases paid at the site neutral payment rate (including the site neutral payment rate portion of blended rate payments during the transition period) so that HCO payments for site neutral cases will not result in any

[27] 81 Fed. Reg. 24,946, 25,287 (April 27, 2016).

change in estimated aggregate LTCH PPS payments. CMS says that "[w]e established this requirement because we believed, and continue to believe, that the HCO policy for site neutral payment rate cases should be budget neutral, just as the HCO policy for LTCH PPS standard Federal payment rate cases are budget neutral."[28] "To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2018 would not result in any increase in estimated aggregate FY 2018 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i)" CMS says that "it is necessary to reduce site neutral payment rate payments (or the portion of the blended payment rate payment for FY 2018 discharges occurring in LTCH cost reporting periods beginning before October 1, 2017) by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2018."[29] For FY 2018, CMS is proposing to continue to apply a budget neutrality factor of 0.949 (the decimal equivalent of a 5.1% reduction) to the site neutral payment rate cases paid under § 412.522(c)(1)(i).

Comment. **We *strongly disagree* with CMS' proposal to apply an *additional* 5.1% budget neutrality adjustment for site neutral cases that qualify as high-cost outliers.** CMS is proposing to apply a second BNA to all LTCH payments for site neutral rate cases to offset LTCH payments for HCO site neutral rate cases. **As we explained in our comments to the FY 2017 IPPS/LTCH PPS final rule, this BNA is duplicative and unwarranted because CMS has *already* applied budget neutrality adjustments to reduce the operating and capital portions of the IPPS standard Federal payment rate by the same 5.1%, before using that rate to determine the IPPS comparable per diem amount for site neutral payment cases. MedPAC agreed.**

In MedPAC's May 31, 2016 comment letter to CMS on the Proposed Rule, MedPAC states that CMS should <u>not</u> apply a separate budget neutrality adjustment to site neutral high-cost outliers because "the IPPS standard payment amount is already adjusted to account for HCO payments."[30] As MedPAC explains:

> CMS proposes to use the IPPS fixed-loss amount to determine if a discharge paid under the site-neutral rate qualifies to receive an HCO payment again for FY 2017. CMS sets the IPPS fixed-loss amount each year at a level that it estimates will result in aggregate HCO payments equal 5.1 percent of total IPPS payment. **To account for the spending attributed to these outlier payments, CMS reduces the IPPS base payment rates to maintain budget neutrality in the IPPS. <u>The IPPS-comparable rate used to pay for site-neutral cases in LTCHs includes an adjustment for budget neutrality to account for spending associated with HCOs.</u>**
>
> With the Commission's payment principles in mind, **<u>MedPAC urges CMS to eliminate the proposed payment adjustment for discharges paid</u>**

[28] <u>Id.</u> at 20,191.
[29] <u>Id.</u>
[30] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 16 (May 31, 2016).

> **the site-neutral rate to account for outlier payments under this payment methodology. Given that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.**[31]

CMS addressed this issue to some extent in the FY 2016 IPPS/LTCH PPS final rule, but the agency did not see the duplication that MedPAC now agrees is problematic. First, CMS confirmed that the IPPS base rates used to calculate LTCH site neutral payments already include the budget neutrality adjustment discussed above for HCO payments.[32] CMS referred to this BNA as "one of the inputs" used to calculate the LTCH site neutral payment rate.[33] CMS then tried to distinguish this BNA from the LTCH site neutral HCO BNA by stating that these adjustments fund different outlier payments—the former funds outlier payments for IPPS hospitals and the latter funds site neutral outlier payments for LTCHs.[34] This is *not correct*, as MedPAC points out. Since "the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative."[35] **Stated another way, the budget neutrality adjustment for LTCH site neutral HCOs should not fund site neutral high cost outliers at LTCHs *and* high cost outliers at IPPS hospitals. In FY 2016 and FY 2017, and as proposed for FY 2018, multiple outlier BNAs mean that all LTCHs are effectively paying for outliers at LTCH and IPPS hospitals.**

CMS briefly responded to this issue again in the FY 2017 IPPS/LTCH PPS final rule, but CMS did not address the duplication directly. Instead, CMS speculated that Congress knew when passing the PSRA that CMS reduces LTCH PPS payments each year by estimated HCO payments, and that CMS "budget neutralized" LTCH very short-stay outlier payments since 2006 based on the same IPPS comparable per diem amount. Unfortunately, the regulation CMS refers to (42 C.F.R. § 412.529(d)(4)) does not specify a separate budget neutrality adjustment for HCO or SSO payments based upon the IPPS comparable per diem amount, and CMS does not state any other authority for this assertion. Therefore, it is difficult to see how Congress was "well aware" of this policy when it passed the PSRA. More importantly, CMS avoided responding to the basic criticism that the IPPS and Capital PPS base rates already have budget neutrality

---

[31] Id. at 16-17 (emphasis added).
[32] See 80 Fed. Reg. at 49,622 ("While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments . . .").
[33] See id. (". . . that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate.").
[34] See id. ("The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS.").
[35] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 17.

adjustments calculated upon the same 5.1% target amount for HCO payments (higher for Capital PPS HCO payments).

To ensure that LTCHs are only paying for high cost outliers at LTCHs, and not IPPS hospitals, CMS must not apply the separate 5.1% adjustment for LTCH site neutral cases. CMS is proposing to adjust LTCH site neutral payments *twice* to keep the LTCH PPS budget neutral for the estimated 5.1% of LTCH payments for site neutral HCO cases. The payment reduction is actually larger for site neutral cases that receive a HCO payment. Consistent with MedPAC's recommendation, CMS should only adjust LTCH site neutral payments *once* for outlier budget neutrality. By eliminating the additional BNA for site neutral HCOs, CMS still has "a budget neutrality adjustment when determining payment for a case under the LTCH PPS" to avoid the situation where "any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases."[36] Moreover, this "approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases."[37] Without making this change, the duplicative BNA not only "exaggerates the disparity in payment rates across provider settings," as MedPAC states, but it is also purely punitive.

Therefore, it would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed 5.1% site neutral HCO BNA to LTCH site neutral payments. This would be the case because the IPPS comparable per diem amount is based on the IPPS and capital PPS payment rates, which have already been reduced by 5.1% for IPPS outlier payments and 5.66% for capital PPS outlier payments. Since CMS has already made these adjustments for budget neutrality, it would be inappropriate for CMS to reduce LTCH site neutral payments that are based on the IPPS and capital PPS rates by *another 5.1%* for HCOs. Accordingly, we object to CMS' proposal to apply a separate HCO BNA to LTCH site neutral payments. CMS should not make a second BNA to LTCH site neutral payments.

For the same reasons, it was incorrect for CMS to apply the 5.1% (0.949) site neutral HCO BNA to FY 2017 and FY 2016 site neutral rate cases. CMS is underpaying LTCHs for site neutral rate cases in FY 2017 and FY 2016 by 5.1%. CMS should reverse this adjustment to all FY 2017 and FY 2016 payments, or make an equivalent prospective increase in payments to FY 2018 site neutral rate cases to account for this underpayment.

Recommendations. **Consistent with MedPAC's prior comments, we *strongly disagree* with the proposed 0.949 budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. There is no precedent for such an adjustment to the annual payment rate determination for the LTCH PPS. Moreover, CMS already reduced the FY 2018 site neutral payment amount for**

[36] 80 Fed. Reg. at 49,622.
[37] Id.

estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor. CMS should *not* reduce LTCH site neutral payments by *another 5.1%*. For the same reason, CMS should reverse this duplicative adjustment to all FY 2017 and FY 2016 payments, or make an equivalent prospective increase in payments to FY 2018 site neutral rate cases to account for this underpayment.

CMS SHOULD MAKE THE PROPOSED CHANGE TO THE SHORT-STAY OUTLIER POLICY AND RECONSIDER THE BUDGET NEUTRALITY ADJUSTMENT

Issue. CMS is proposing to eliminate all but the "blended" option at section 412.529(c)(2)(iv) to pay LTCH short-stay outlier cases. Under this option, a SSO case is paid based on a blend of the IPPS comparable amount (determined under section 412.529(d)(4)(i)) and the MS-LTC-DRG per diem amount (determined under section 412.529(d)(1) in conjunction with section 412.503). As the patient's length of stay increases, more of the blended payment would be comprised of the LTCH PPS amount. This change would be effective for LTCH discharges on or after October 1, 2017.

In addition, CMS is proposing to adjust FY 2018 LTCH PPS payments by a one-time, permanent budget neutrality factor of 0.9672 (*i.e.*, -3.28%) to ensure that the change in SSO payment policy at 42 C.F.R. § 412.529 does not increase aggregate LTCH PPS payments.

Comment. **We agree with the proposal to pay all SSO cases using the "blended" option at § 412.529(c)(2)(iv) effective for discharges on or after October 1, 2017.** This should eliminate the payment cliff at the SSO threshold (five-sixths the geometric average length of stay for the MS-LTC-DRG). It should also provide a more gradual increase in payment as the patient's length of stay increases.

We question the proposed budget neutrality adjustment related to this change in SSO policy. A permanent reduction of the standard Federal payment rate by 3.28% is very significant. It will put additional financial pressure on LTCHs when they are already doing everything they can to adjust to a dual-rate payment system. It also results in less predictability in the LTCH PPS, which is not consistent with congressional intent. CMS has stated many times how important stability and predictability is for LTCH payments.[38] The original legislation authorizing the LTCH PPS,[39] and the PSRA creating the dual-rate LTCH PPS, do not require a budget neutrality adjustment for SSO payments. Indeed, CMS did not apply a budget neutrality adjustment when it made

[38] See, e.g., 80 Fed. Reg. at 24537 (stating that using only data from LTCH PPS standard Federal payment rate cases to compute the MS-LTC-DRG relative payment weights "would result in the most appropriate payments under the new statutory structure required by section 1206(a) of Public Law 113–67, and would provide **stability and predictability** in MS-LTC-DRG payments for LTCH PPS standard Federal payment rate cases compared to current LTCH PPS payments.") (emphasis added).

[39] Section 4422 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33), Section 123 of the Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106-113), and section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554).

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

June 13, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: CMS-1677-P Medicare Program; Hospital Inpatient Prospective Payment Systems (PPS) for Acute Care Hospitals and the Long-Term Care Hospital PPS and Proposed Policy Changes and FY 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices; Proposed Rule (Vol. 82, No 81), April 28, 2017

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 312 long-term care hospitals (LTCHs) and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the LTCH provisions in the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2018 proposed rule for the inpatient and LTCH prospective payment systems (PPS). This letter addresses only the LTCH payment and quality-reporting provisions in the proposed rule. We have submitted separate comments on the agency's proposed changes to the inpatient PPS (IPPS) as well as its request for information related to regulatory burden.

The AHA supports a number of the proposed rule's LTCH's provisions. **In particular, we appreciate the proposal to extend the current pause on full implementation of the 25%**

mandated payment for some cases that qualify for a standard rate due to the origin of their referral, directly contradicting the payment requirements in BiBA.

- The New Criteria for LTCH PPS Standard Rate Cases Address CMS's Concerns Regarding LTCH Medical Necessity. The BiBA criteria also directly address another CMS rationale for the 25% Rule that LTCHs provide medically unnecessary care when functioning as "step-down units" for hosting or nearby general acute-care hospitals. However, by identifying the cases that qualify for an LTCH PPS standard rate, the BiBA criteria serve as de facto medical necessity criteria, effectively eliminating the agency's concern regarding LTCHs serving as step-down units.

- The 25% Rule is Arbitrary. The 25% Rule is non-clinical in nature, targeting patients based on their referral source rather than clinical needs. This is a flawed and arbitrary manner in which to create a policy. As a result, it presents an access barrier for patients who are clinically appropriate for the LTCH setting. In fact, the Medicare Payment Advisory Commission (MedPAC) March 2011 report to Congress described this aspect of the policy as "blunt" and "flawed."

- CMS has the Authority to Rescind the 25% Rule. The 25% Rule was established through regulation in the FY 2004 LTCH PPS final rule. While multiple congressional bills have temporarily blocked full implementation of the 25% Rule, the resulting statutory language did not mandate implementation of the policy. Thus, CMS has the authority to rescind the policy.

SITE-NEUTRAL CASES ARE BEING UNDERPAID DUE TO DUPLICATIVE BUDGET-NEUTRAL ADJUSTMENTS

The AHA appreciates CMS's decision in the FY 2017 final rule to remove the second budget neutral adjustment (BNA) it had been applying to the high-cost outlier (HCO) portion of site-neutral payments. However, we remain very concerned that the agency continues to apply the duplicative BNA to the non-HCO portion of site-neutral payments. In its FY 2016 through FY 2018 rulemaking, CMS stated that its rationale for applying a 5.1 percent reduction (hereafter "5.1 percent BNA") to the site-neutral portion of the blended payment was to avoid any "increase in aggregate LTCH PPS payments." **However, as we have stated in the past, CMS's decision to apply two BNAs is yielding a material, unwarranted payment reduction to LTCH site-neutral cases. We strongly urge the agency to withdraw the duplicative BNA.**

Specifically, as discussed in our FYs 2016 and 2017 comment letters and in other communications with CMS, these site-neutral cases are inappropriately subject to two BNAs:

- The first 5.1 percent BNA is applied when CMS sets the IPPS rates used to calculate the IPPS comparable per diem amount paid to site-neutral cases;[1]
- The second BNA occurs within the LTCH PPS framework, when a second 5.1 percent BNA is applied to the non-HCO portion of the site-neutral payment.

In addition to its unwarranted duplication, we encourage CMS to consider these other reasons that support withdrawing the second BNA:

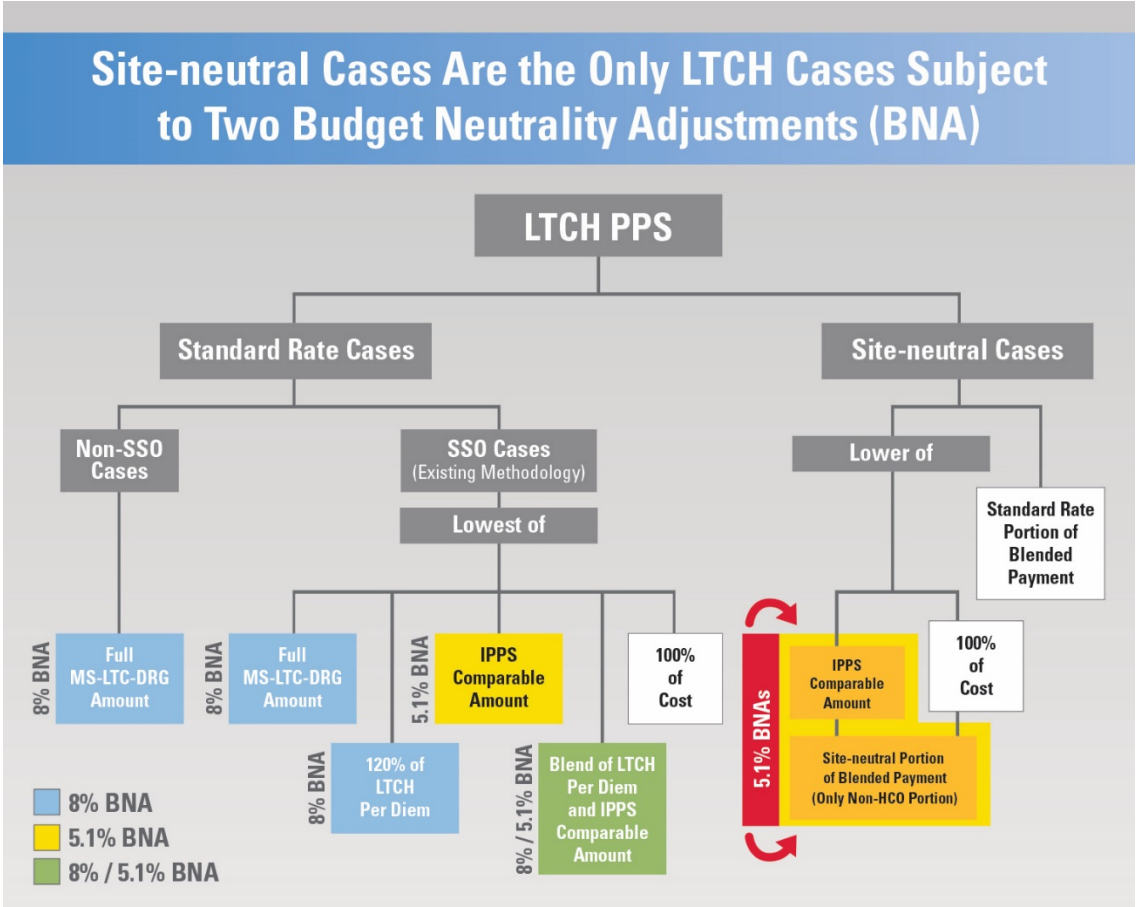
- CMS applies BNAs inconsistently between LTCH standard rate and LTCH site-neutral cases. The chart below outlines and compares BNAs applied to LTCH standard rate and site-neutral cases. Colored cells indicate those claims subject to at least one BNA. When calculating payments for the LTCH PPS standard rate cases (shown on the far left of the chart), only one BNA applies[2]. Similarly, when pricing out the LTCH PPS short-stay outliers (shown at the center of the chart) that are paid either an IPPS comparable amount or cost (similar to what site-neutral cases are being paid), only one BNA applies. However, by contrast, when calculating rates for site-neutral cases paid the IPPS comparable amount, two BNAs apply (shown on the right of the chart).

- CMS did not establish baseline for site-neutral payments. When explaining its site-neutral payment methodology, CMS noted the objective of preventing aggregate LTCH PPS payments from increasing. However, CMS has not provided a "baseline" against which the agency or stakeholders could measure such an increase. Without this baseline, we are not able to gauge whether or by how much the second BNA changes aggregate LTCH payments.

- The second BNA even applies to site-neutral cases paid cost. There is no rationale for CMS to apply any BNA adjustment to site-neutral cases paid cost. Yet, under the currently methodology, even this category of site-neutral cases has a BNA applied at the end of the payment calculation (shown on the far right of the chart).

[1] The IPPS comparable per diem amount is calculated by dividing the sum of the applicable IPPS operating standardized amount and capital federal rate (adjusted for DRG weighting factors, geographic factors, indirect medical education costs and the costs of serving a disproportionate share of low-income patients) by the geometric mean length of stay for the specific DRG, and multiplying by the covered length of stay. This amount is capped at the full IPPS DRG amount. It is the operating standardized amount and capital federal rate that have already been reduced by 5.1 percent within the IPPS framework.

[2] The LTCH standard federal payment rate, at the implementation of the LTCH PPS, was adjusted downward by a reduction factor of 8 percent to fund the estimated proportion of outlier payments under the LTCH PPS. Although never described in rulemaking by CMS as a "high-cost outlier BNA," for purposes of this illustration we use the term "8% BNA" to describe it.



- Duplicative BNA does not promote fairness between IPPS and the LTCH PPS. In the FY 2018 IPPS/LTCH proposed rule and other prior rules, CMS states that it believes that using the same fixed-loss amount for site-neutral cases as it does for IPPS cases "will reduce differences between HCO payments for similar cases under the IPPS and site-neutral payment rate cases under the LTCH PPS and promote fairness between the two systems." Yet CMS continues to apply the second, duplicative BNA to the non-HCO portion of the site-neutral payment – this not only causes disparities in the HCO and non-HCO portions of payments between IPPS and the LTCH PPS, but reduces fairness between the two systems. This disparity was also expressed by MedPAC, as noted below.

- MedPAC also views the second BNA as duplicative. In its May 31, 2016 comment letter on the FY 2017 IPPS/LTCH PPS proposed rule, the commission states that "[g]iven that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further."

- Duplicative BNA has a Substantial Negative Impact. Using the FY 2015 MedPAR data, we estimate that the second BNA within the LTCH framework reduces site-neutral payments by approximately $30-$50 million per year, a substantial amount. This estimate assumes full implementation of site-neutral payment and costs that are similar to IPPS levels versus historical LTCH costs.

SHORT-STAY OUTLIER POLICY PROPOSALS

The AHA supports CMS's proposal to change the existing short-stay outlier (SSO) policy by replacing the various payment options with a single graduated per diem adjustment. However, we urge CMS not to apply its related proposed one-time permanent budget neutrality factor to the LTCH PPS standard Federal payment rate in FY 2018. Given the tremendous instability in play with the shift to a dual-rate payment structure, application of a duplicative BNA to the site-neutral payment, and the significant increase in the proposed FY 2018 HCO fixed-loss threshold amount for LTCH standard rate cases, the LTCH field is confronting enormous financial pressure. Furthermore, it is impossible to predict the direction of the field as it struggles to adapt to the dual-rate payment structure, making the actuaries' assumption that there will be a behavioral response of a 10 percent increase in SSO cases arbitrary and inconsistent with the data that CMS examined. The field simply cannot tolerate another large reduction to payments and we urge CMS to do everything in its power to mitigate the instability already being caused.

Overview of SSO Policy and CMS's and MedPAC's Positions. In the FY 2003 LTCH PPS final rule, CMS established a special payment policy for SSO cases – those cases with a covered length of stay that is less than or equal to five-sixths of the geometric mean length of stay (GLOS) for the MS-LTC-DRG in which they are grouped (the SSO threshold). Under the current SSO methodology, Medicare pays an SSO case the lowest of several payment options.

MedPAC and CMS believe that LTCHs have an economic incentive to hold patients until just beyond the SSO threshold since non-SSO cases are generally paid a higher amount. They state that their analyses of lengths-of-stay by MS–LTC–DRG have shown that the frequency of discharges rises sharply immediately after the SSO threshold, thereby partly influencing LTCHs' discharge decisions in addition to clinical considerations.

Proposal to Revise SSO Policy. CMS proposes to revise its SSO policy starting in FY 2018. It would keep the definition of an SSO case unchanged, but pay them a single graduated per diem adjustment: a blend of the "inpatient PPS comparable amount" and 120 percent of the MS-LTC-DRG per diem amount, capped at the full LTCH PPS standard Federal payment rate. The SSO policy only applies to standard rate cases, and not to site-neutral cases. CMS's objective in revising the current policy is to remove any incentive to delay a patient's discharge for financial reasons. CMS states that it found two different impacts of the revised policy on LTCH spending: 1) increased payments to SSO cases of approximately $145 million purely due to the change in the payment adjustment; and 2) a net decrease of approximately $43 million in spending due to

June 13, 2017

Filed Electronically

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-1677-P
P.O. Box 8011
Baltimore, MD 21244-1850

***Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices*; 82 Federal Register 19,796 (April 28, 2017)**

Dear Administrator Verma:

This letter presents the comments and recommendations of Kindred Healthcare, Inc. ("Kindred") and Select Medical Holdings Corporation ("Select Medical") on the above-referenced Proposed Rule. Kindred and Select Medical collectively operate 184 hospitals that are certified by Medicare as long-term acute care hospitals ("LTCHs")—almost half of the LTCHs operating across the United States. These hospitals care for medically-complex patients who require acute care hospital services for an extended period of time. We appreciate the opportunity to express our concerns with the proposed changes to the fiscal year ("FY") 2018 LTCH prospective payment system ("LTCH PPS") and related policies, and we trust that CMS will carefully consider each of the issues raised in this letter.

CMS adds that fluctuations in the fixed-loss amount also occurred in the first few years of the LTCH PPS, but later stabilized as CMS "gain[ed] more experience with the effects and implementation of the LTCH PPS."[3] Our review of the rulemaking record found that the largest change in the HCO fixed-loss amount during the first few years of the LTCH PPS was a 24.8% *decrease* in the second year of the LTCH PPS (*i.e.*, RY 2004). A larger *decrease* of 41.2% occurred in the fourth year of the LTCH PPS (*i.e.*, RY 2006). It was not until the fifth year of the LTCH PPS (*i.e.*, RY 2007) that the HCO fixed-loss amount *increased*. At that time, it increased by more than 41%, but generally back to previous levels. However, CMS also showed a willingness to explore policy changes in these years and reevaluate the quality, accuracy and age of the data they used for HCO and short-stay outlier ("SSO") payments. That is, CMS refined its policies and the data it used as it gained "experience with the effects and implementation of the LTCH PPS." We expect that the fixed-loss amount will change in the FY 2018 final rule after CMS uses the most recent LTCH claims data from the MedPAR file and the latest cost-to-charge rations ("CCRs") from the Provider Specific File ("PSF"). But CMS should be more transparent about why there are such large year-to-year changes in the fixed-loss amount, and how much of this variability is attributable to the new dual-rate payment system.

We agree with CMS' proposals to use the proposed FY 2018 IPPS fixed-loss amount of $26,713 for cases paid at the site neutral payment rate in FY 2018, and the same 5.1% target as the IPPS for HCO payments for these cases in FY 2018.

Recommendations. We are generally in favor of continuing to use a target amount of 8% (now 7.975%) for HCOs paid using the LTCH PPS standard Federal payment rate, but we are concerned about another significant increase in the proposed FY 2018 fixed-loss amount of $30,081 for LTCH PPS standard Federal payment rate cases. We expect that the fixed-loss amount will change in the final rule after CMS uses the most recent LTCH claims data from the MedPAR file and the latest CCRs from the PSF. However, CMS should be more transparent about why there are such large year-to-year changes in the fixed-loss amount and how much of this variability is attributable to the new dual-rate payment system.

It is reasonable for CMS to use the proposed FY 2018 IPPS fixed-loss amount of $26,713 for cases paid at the site neutral payment rate in FY 2018, and the same 5.1% target as the IPPS for HCO payments for these cases in FY 2018.

2. Budget Neutrality Adjustment for Site Neutral HCO Cases

Issue. CMS also is proposing to continue to apply a budget neutrality adjustment factor under section 412.522(c)(2)(i) to all cases paid at the site neutral payment rate (including the site neutral payment rate portion of blended rate payments during the transition period) so that HCO payments for site neutral cases will not result in any change in estimated aggregate LTCH PPS payments. CMS says that "[w]e established

[3] Id. at 20,190.

this requirement because we believed, and continue to believe, that the HCO policy for site neutral payment rate cases should be budget neutral, just as the HCO policy for LTCH PPS standard Federal payment rate cases are budget neutral."[4] "To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2018 would not result in any increase in estimated aggregate FY 2018 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i)" CMS says that "it is necessary to reduce site neutral payment rate payments (or the portion of the blended payment rate payment for FY 2018 discharges occurring in LTCH cost reporting periods beginning before October 1, 2017) by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2018."[5] For FY 2018, CMS is proposing to continue to apply a budget neutrality factor of 0.949 (the decimal equivalent of a 5.1% reduction) to the site neutral payment rate cases paid under § 412.522(c)(1)(i).

Comment. **We *strongly disagree* with CMS' proposal to apply an *additional* 5.1% budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. CMS is proposing to apply a second BNA to all LTCH payments for site neutral rate cases to offset LTCH payments for HCO site neutral rate cases. As we explained in comments last year, this BNA is duplicative and unwarranted because CMS has *already* applied budget neutrality adjustments to reduce the operating and capital portions of the IPPS standard Federal payment rate by the same 5.1%, before using that rate to determine the IPPS comparable per diem amount for site neutral payment cases. MedPAC and the American Hospital Association ("AHA") agreed that this BNA is duplicative and should not be used to further adjust site neutral payments. We address each of these points in more detail below.**

a. The Proposed BNA to Site Neutral Payments is Duplicative

CMS already accounted for site neutral HCO payments by using the IPPS and Capital PPS payment rates for the IPPS comparable per diem amount. As discussed above, HCO payments for LTCH site neutral cases will be 80% of the difference between the estimated cost of the case and the proposed IPPS HCO threshold, which is $26,713 for FY 2018. The proposed IPPS HCO threshold for cases paid at the site neutral payment rate would be the sum of the site neutral payment and the proposed IPPS fixed-loss amount of $26,713. Because cases paid at the site neutral payment rate that are paid 100% of the estimated cost of the case would never be eligible for HCO payments, only site neutral cases based on the IPPS comparable per diem amount will be eligible for HCO payments. The IPPS comparable per diem amount, as determined under section 412.529(d)(4), is "based on the sum of the applicable operating inpatient prospective payment system standardized amount and the capital inpatient prospective payment system Federal rate in effect at the time of the LTCH discharge."[6] Congress required

[4] Id. at 20,191.

[5] Id.

[6] 42 C.F.R. §§ 412.522(c)(1)(i),412.529(d)(4)(i)(A).

calculation of the IPPS comparable per diem amount in this way because it is based on the existing regulation at section 412.529(d)(4) for LTCH short-stay outlier payments.[7] We note that this statute and this regulation do not require a budget neutrality adjustment.

CMS continues to believe that a separate BNA for LTCH site neutral HCO cases will "reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems."[8] However, by aligning this proposed policy with the IPPS payment system—and making the IPPS comparable per diem amount and the IPPS fixed-loss amount the primary components—CMS needs to consider the adjustments that it has already made to the proposed IPPS and capital PPS payment rates to account for outlier payments. Like MedPAC, we do not believe CMS had done this in the Proposed Rule.

Specifically, CMS already reduced the operating standardized payment amount under the IPPS and the capital federal rate under the capital PPS for outliers.[9] In determining these payment rates for FY 2018, CMS reduced the IPPS payment rate by a factor of 0.948999 and CMS reduced the capital PPS payment rate by a factor of 0.943414. As CMS explains, these 5.1% and 5.66% outlier adjustment factors, respectively, reduce the IPPS and capital PPS payment rates.[10]

b. MedPAC Agreed that the BNA to Site Neutral Payments is Duplicative and Should Not Be Applied

In MedPAC's May 31, 2016 comment letter to CMS on the Proposed Rule, MedPAC states that **CMS should <u>not</u> apply a separate budget neutrality adjustment to site neutral high-cost outliers because "the IPPS standard payment amount is already adjusted to account for HCO payments."**[11] As MedPAC explains:

> CMS proposes to use the IPPS fixed-loss amount to determine if a discharge paid under the site-neutral rate qualifies to receive an HCO payment again for FY 2017. CMS sets the IPPS fixed-loss amount each year at a level that it estimates will result in aggregate HCO payments equal 5.1 percent of total IPPS payment. **To account for the spending attributed to these outlier payments, CMS reduces the IPPS base payment rates to maintain budget neutrality in the IPPS. <u>The IPPS-comparable rate used to pay for site-neutral cases in LTCHs includes an adjustment for budget neutrality to account for spending associated with HCOs.</u>**

[7] <u>See</u> Social Security Act (SSA) § 1886(m)(6)(B)(ii)(I).

[8] 82 Fed. Reg. at 20,191.

[9] <u>Id.</u> at 20,174.

[10] <u>Id</u>. at 20,174-76.

[11] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 16 (May 31, 2016).

> With the Commission's payment principles in mind, **MedPAC urges CMS to eliminate the proposed payment adjustment for discharges paid the site-neutral rate to account for outlier payments under this payment methodology. Given that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.**[12]

These comments are equally applicable to the current Proposed Rule because CMS is using the same methodology and the same BNA factor to reduce LTCH payments.

MedPAC was also generally critical of the site neutral payment rate established by Congress because the "lesser of" mechanism results in LTCH payments *below* IPPS hospital payments, thereby failing to "equalize payments" across LTCH and IPPS provider types for such cases.[13] Specifically, MedPAC commented that the LTCH site neutral payment rate "could result in the LTCH receiving a lower payment than what it would have received for a similar discharge."[14] If CMS were to impose a second BNA to reduce LTCH site neutral payments by an additional 5.1%, it would exaggerate this disparity even further. This is contrary to the principle of site neutrality in payments.

c. CMS Should Not Apply the Proposed BNA to Site Neutral Payments

To ensure that LTCHs are only paying for high cost outliers at LTCHs, and not IPPS hospitals, CMS must not apply the separate 5.1% adjustment for LTCH site neural cases. This is illustrated in **Table 1** below using information from the Proposed Rule.

[12] Id. at 16-17 (emphasis added).

[13] Id. at 16.

[14] Id.

TABLE 1

FY 2018 LTCH Site Neutral Payment Amount Comparison – With and Without Proposed Budget Neutrality Adjustment to Site Neutral Payments

Duplicate BNAs in Proposed Rule		**Apply BNA Once by Not Applying LTCH Site Neutral HCO BNA**
IPPS Standardized Amount (before adjustments)[1]		
Labor	$3,993.72	$3,993.72
Non-Labor	$1,853.60	$1,853.60
Subtotal	$5,847.32	$5,847.32
IPPS HCO Outlier Factor (0.948998)[2]	**$(298.23)**	**$(298.23)**
Other Adjustments[3]	$46.91	$46.91
IPPS Standardized Amount (after adjustments)[4]		
Labor	$3,822.07	$3,822.07
Non-Labor	$1,773.93	$1,773.93
Subtotal	$5,596.00	$5,596.00
Capital PPS Rate (before adjustments)[5]	$446.79	$446.79
Capital PPS Outlier Factor (0.943414)[6]	**$(25.28)**	**$(25.28)**
Other Adjustments[7]	$29.86	$29.86
Capital PPS Rate (after adjustments)[8]	$451.37	$451.37
Subtotal	$6,047.37	$6,047.37
LTCH Site Neutral Outlier Factor (0.949)[9]	**$(308.42)**	**N/A**
Total	$5,738.95	$6,047.37

[1] 82 Fed. Reg. at 20,175-76 (assuming full update and wage index greater than 1.0).
[2] Id. at 20,175.
[3] Id. at 20,175-76.
[4] Id. at 20,175.
[5] Id. at 20,181-82.
[6] Id. (net change of this factor is 1.0051 or 0.51%).
[7] Id.
[8] Id.
[9] Id. at 20,191.

As **Table 1** shows, CMS is proposing to adjust LTCH site neutral payments *twice* to keep the LTCH PPS budget neutral for the estimated 5.1% of LTCH payments for site neutral HCO cases. The payment reduction is actually larger for site neutral cases that receive a HCO payment. Consistent with MedPAC's recommendation, CMS should only adjust LTCH site neutral payments *once* for outlier budget neutrality. This can be achieved under what we have labelled "Apply BNA Once" in the third column of the table. MedPAC's comments align with this approach. By eliminating the additional BNA for site neutral HCOs, CMS still has "a budget neutrality adjustment when determining payment for a case under the LTCH PPS" to avoid the situation where "any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases."[15] Moreover, this "approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases."[16] Without making this change, the duplicative BNA not only "exaggerates the disparity in payment rates across provider settings," as MedPAC states, but it is also purely punitive.

The AHA also remains very concerned that the agency continues to apply the duplicative BNA to the non-HCO portion of site-neutral payments. As the AHA has stated in the past, CMS' decision to apply two BNAs is yielding a material, unwarranted payment reduction to LTCH site-neutral cases. AHA is strongly urging CMS again this year to withdraw the duplicative BNA.

Therefore, it would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed 5.1% site neutral HCO BNA to LTCH site neutral payments. This would be the case because the IPPS comparable per diem amount is based on the IPPS and capital PPS payment rates, which have already been reduced by 5.1% for IPPS outlier payments and 5.66% for capital PPS outlier payments. Since CMS has already made these adjustments for budget neutrality, it would be inappropriate for CMS to reduce LTCH site neutral payments that are based on the IPPS and capital PPS rates by *another 5.1%* for HCOs. Accordingly, we object to CMS' proposal to apply a separate HCO BNA to LTCH site neutral payments. CMS should not make a second BNA to LTCH site neutral payments.

d. Based Upon MedPAC's Comments, CMS Also Should Not Have Finalized This BNA In FY 2016 and FY 2017

CMS addressed this issue to some extent in the FY 2016 IPPS/LTCH PPS final rule, but the agency failed to see the duplication that we identified and that MedPAC agreed is problematic. First, CMS confirmed that the IPPS base rates used to calculate LTCH site neutral payments already include the budget neutrality adjustment discussed above

[15] 80 Fed. Reg. at 49,622.

[16] Id.

for HCO payments.[17] CMS referred to this BNA as "one of the inputs" used to calculate the LTCH site neutral payment rate.[18] CMS then tried to distinguish this BNA from the LTCH site neutral HCO BNA by stating that these adjustments fund different outlier payments—the former funds outlier payments for IPPS hospitals and the latter funds site neutral outlier payments for LTCHs.[19] This is *not correct*, as MedPAC pointed out. Since "the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative."[20] **Stated another way, the budget neutrality adjustment for LTCH site neutral HCOs should not fund site neutral high cost outliers at LTCHs *and* high cost outliers at IPPS hospitals. In FY 2016 and FY 2017, multiple outlier BNAs mean that all LTCHs are effectively paying for outliers at LTCH and IPPS hospitals.**

CMS briefly responded to this issue again in the FY 2017 IPPS/LTCH PPS final rule, but CMS did not address the duplication directly. Instead, CMS speculated that Congress knew that CMS reduces LTCH PPS payments each year by estimated HCO payments, and that CMS "budget neutralized" LTCH very short-stay outlier payments since 2006 based on the same IPPS comparable per diem amount. Unfortunately, the regulation CMS refers to (42 C.F.R. § 412.529(d)(4)) does not specify a separate budget neutrality adjustment for HCO or SSO payments based upon the IPPS comparable per diem amount, and CMS does not state any other authority for this assertion. Therefore, it is difficult to see how Congress was "well aware" of this policy when it passed the PSRA. More importantly, CMS avoided responding to the basic criticism that the IPPS and Capital PPS base rates already have budget neutrality adjustments calculated upon the same 5.1% target amount for HCO payments (higher for Capital PPS HCO payments). A separate LTCH PPS budget neutrality adjustment for site neutral HCO cases plainly removes an additional 5.1% from the site neutral payment amount. At a minimum, CMS should not apply this additional budget neutrality adjustment to site neutral cases paid at 100% of the estimated cost of the case, because they will never qualify as HCOs. But CMS simply responded that they the agency will continue to apply the budget neutrality adjustment to these site neutral cases as well because of their general authority to make adjustments to base payments. The only modification that CMS made in the FY 2017 final rule was to stop applying the 0.949 budget neutrality factor to the *HCO portion* of the site neutral payment amount.

---

[17] See 80 Fed. Reg. at 49,622 ("While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments...").

[18] See id. ("...that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate.").

[19] See id. ("The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS.").

[20] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 17.

CMS' unwillingness to address these issues directly last year requires that we raise them again for further consideration this year. We ask that CMS take our concerns more seriously, now that the agency has had additional time to consider the matter. **It was incorrect for CMS to apply the 5.1% (0.949) site neutral HCO BNA to FY 2016 and FY 2017 site neutral payments for the same reasons discussed above that CMS should not apply this BNA to FY 2018 site neutral payments. CMS underpaid LTCHs for site neutral rate cases in FY 2016 by 5.1%, and CMS is doing the same thing in FY 2017. CMS should reverse this adjustment to all FY 2016 and FY 2017 payments, or make an equivalent prospective increase in payments to FY 2018 site neutral rate cases to account for this underpayment.**

Recommendations. **Consistent with MedPAC's and the AHA's comments, we *strongly disagree* with the proposed 0.949 budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. CMS already reduced the FY 2018 site neutral payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor. CMS should *not* reduce LTCH site neutral payments by *another 5.1%*.**

For the same reason, it was incorrect for CMS to apply the 5.1% site neutral HCO BNA to FY 2016 and FY 2017 payments for site neutral rate cases. CMS should reverse this adjustment to all FY 2016 and FY 2017 payments, or make an equivalent prospective increase in payments to FY 2018 site neutral rate cases to account for this underpayment.

SHORT-STAY OUTLIER PAYMENT POLICY CHANGE

Issue. CMS is proposing to streamline the short-stay outlier (SSO) payment policy at 42 C.F.R. § 412.529 by eliminating three of the payment options, leaving only one—the "blended" option at section 412.529(c)(2)(iv). Under this option, a SSO case is paid based on a blend of the IPPS comparable amount (determined under section 412.529(d)(4)(i)) and the MS-LTC-DRG per diem amount (determined under section 412.529(d)(1) in conjunction with section 412.503). As the patient's length of stay increases, more of the blended payment would be comprised of the LTCH PPS amount. This change would be effective for LTCH discharges on or after October 1, 2017.

Also, CMS is proposing to adjust FY 2018 LTCH PPS payments by a one-time, permanent budget neutrality factor of 0.9672 (*i.e.*, -3.28%) to ensure that the change in SSO payment policy at 42 C.F.R. § 412.529 does not increase aggregate LTCH PPS payments.

Comment. We agree with the proposal to pay all SSO cases using the "blended" option at section 412.529(c)(2)(iv) effective for discharges on or after October 1, 2017. This should eliminate the payment cliff at the SSO threshold (five-sixths the geometric average length of stay for the MS-LTC-DRG) and provide a more gradual increase in payment as the patient's length of stay increases. We understand that CMS is retiring

Charles N. Kahn III
President and CEO

June 13, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW Room 445-G
Washington, DC 20201

SUBJECT: CMS-1677-P. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices; April 28, 2017

Dear Administrator Verma:

The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural parts of America, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. The FAH appreciates the opportunity to comment to the Centers for Medicare & Medicaid Services ("CMS") about the referenced Notice of Proposed Rulemaking on the Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices, April 28, 2017 ("Proposed Rule").

PSRA so the revised LTCH payment system would be aligned with the LTCH ALOS requirement for all LTCHs. Site neutral and Medicare Advantage patients are now excluded from an LTCH's ALOS calculation for all LTCHs effective with their discharges in cost reporting periods that began on or after October 1, 2015. The FAH agrees with CMS's proposal to implement this provision by removing the last sentence of the regulation at 42 C.F.R. § 412.23(e)(2)(vi), which included site neutral and Medicare Advantage discharges in the calculation of the ALOS for hospitals classified as LTCHs after December 10, 2013.

4. Addendum V-D: Proposed Adjustment for LTCH PPS High-Cost Outlier ("HCO") Cases

a. HCO Target Amounts and Fixed-Loss Thresholds

CMS is proposing to continue to use the current high-cost outlier policies for standard Federal payment rate cases and site neutral payment rate cases, as modified in the FY 2016 IPPS/LTCH PPS final rule. Specifically, CMS has indicated it plans to maintain separate HCO targets, one for LTCH PPS standard Federal payment rate cases and one for cases paid at the site neutral payment rate. CMS is modifying the current LTCH PPS HCO payment methodology for LTCH PPS standard Federal payment rate cases in FY 2018, reducing the 8% outlier "pool" to 7.975% pursuant to section 15004 of the 21st Century Cures Act. CMS also is proposing to continue to use the target that is used for IPPS HCO payment of 5.1% for HCO payments to cases paid at the site neutral payment rate.

CMS is proposing a FY 2018 fixed-loss amount for LTCH PPS standard Federal payment rate cases of $30,081, based upon only cases that meet the new patient criteria; this represents a very significant increase from $21,943 in FY 2017 and $16,423 in FY 2016. CMS is proposing a $26,713 FY 2018 fixed-loss amount for cases paid at the site neutral payment rate, which is the same as the proposed FY 2018 IPPS fixed-loss amount.

While the FAH generally supports using a target amount of 8% (now 7.975%) for HCOs paid using the LTCH PPS standard Federal payment rate, it is once again concerned about another significant increase in the proposed FY 2018 fixed-loss amount of $30,081 for LTCH PPS standard Federal payment rate cases. This represents a 37% increase from the FY 2017 fixed-loss amount of $21,943, which also represented a significant increase from 2016. These large increases two years in a row are concerning and not consistent with CMS's policy goal of mitigating instability in the HCO fixed-loss amounts for LTCH PPS standard Federal payment rate cases.

The FAH supports CMS' proposal to use the proposed FY 2018 IPPS fixed-loss amount of $26,713 for cases paid at the site neutral payment rate in FY 2018, and the same 5.1% target as the IPPS for HCO payments for these cases in FY 2018.

b. Budget Neutrality Adjustment for Site Neutral HCO Cases

CMS also is proposing to continue to apply a budget neutrality adjustment factor under section 412.522(c)(2)(i) to all cases paid at the site neutral payment rate (including the site neutral payment rate portion of blended rate payments during the transition period) so that HCO

payments for site neutral cases will not result in any change in estimated aggregate LTCH PPS payments. The FAH strongly disagrees with the CMS proposal to apply an additional 5.1% budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. As discussed in our comment letter from last year, this BNA is duplicative and unwarranted because CMS has already applied budget neutrality adjustments to reduce the operating and capital portions of the IPPS standard Federal payment rate by the same 5.1%, before using that rate to determine the IPPS comparable per diem amount for site neutral payment cases.

In MedPAC's prior May 31, 2016 comment letter, it stated that CMS should not apply a separate budget neutrality adjustment to site neutral high-cost outliers because "the IPPS standard payment amount is already adjusted to account for HCO payments."[12] The FAH agrees with MedPAC that this BNA is duplicative and should not be applied. CMS should only adjust LTCH site neutral payments once for outlier budget neutrality. The FAH is raising this issue again this year because of CMS's failure to address the issue directly. Since this budget neutrality adjustment has already been applied to site neutral HCO cases in FY 2016 and FY 2017, the FAH urges CMS to reverse these adjustments to all impacted FY 2016 and FY 2017 payments or make a prospective increase in payments for FY 2018 site neutral rate cases to account for this historic underpayment.

5. Other Comments/Considerations: LTCH Patient Criteria & Site-Neutral Payment

a. Clarification of the "Immediately Preceded" Standard

Under the new two-tiered LTCH payment system, in order for a stay to qualify for payment under the LTCH PPS standard Federal payment rate under either the ICU criterion or the ventilator criterion, the LTCH admission must be immediately preceded by a discharge from a subsection (d) hospital. In the FY 2016 IPPS/LTCH PPS final rule, CMS adopted a definition of "subsection (d) hospital" in the regulation at 42 C.F.R. § 412.503: "Subsection (d) hospital means, for purposes of § 412.526, a hospital defined in section 1886(d)(1)(B) of the Social Security Act and includes any hospital that is located in Puerto Rico and that would be a subsection (d) hospital as defined in section 1886(d)(1)(B) of the Social Security Act if it were located in one of the 50 States." In the FY 2017 IPPS/LTCH PPS final rule, CMS amended this definition to fix an incorrect cross-reference. It now applies to the site-neutral payment rate regulation at section 412.522 instead of the payment provisions for "subclause II" LTCHs at section 412.526. CMS did not propose any changes to the definition of a "subsection (d) hospital" in this Proposed Rule.

The FAH recommends that CMS amend the definition of a subsection (d) hospital at section 412.503 to clarify that: (i) a subsection (d) hospital is not required to submit a Medicare claim, and (ii) a subsection (d) hospital need not be enrolled in Medicare as an IPPS hospital. CMS also should re-issue Transmittal 1544 to make conforming changes and to instruct the MACs of these clarifications. The LTCH is responsible for submitting its claim correctly, and the MAC should be responsible for paying the LTCH's claim correctly and promptly.

[12] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 16 (May 31, 2016).

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, 413, 414, 416, 486, 488, 489, and 495

[CMS–1677–F]

RIN 0938–AS98

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices

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

ACTION: Final rule.

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 2018. Some of these changes implement certain statutory provisions contained in the Pathway for Sustainable Growth Rate (SGR) Reform Act of 2013, the Improving Medicare Post-Acute Care Transformation Act of 2014, the Medicare Access and CHIP Reauthorization Act of 2015, the 21st Century Cures Act, and other legislation. We also are making changes relating to the provider-based status of Indian Health Service (IHS) and Tribal facilities and organizations and to the low-volume hospital payment adjustment for hospitals operated by the IHS or a Tribe. In addition, we are providing the market basket update that will apply to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits for FY 2018. We are updating the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for FY 2018.

In addition, we are establishing new requirements or revising existing requirements for quality reporting by specific Medicare providers (acute care hospitals, PPS-exempt cancer hospitals, LTCHs, and inpatient psychiatric facilities). We also are establishing new requirements or revising existing requirements for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. We are updating policies relating to the Hospital Value-Based Purchasing (VBP) Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition (HAC) Reduction Program.

We also are making changes relating to transparency of accrediting organization survey reports and plans of correction of providers and suppliers; electronic signature and electronic submission of the Certification and Settlement Summary page of the Medicare cost reports; and clarification of provider disposal of assets.

DATES: This final rule is effective on October 1, 2017.

FOR FURTHER INFORMATION CONTACT:

Donald Thompson, (410) 786–4487, and Michele Hudson, (410) 786–4487, Operating Prospective Payment, MS–DRGs, Wage Index, New Medical Service and Technology Add-On Payments, Hospital Geographic Reclassifications, Graduate Medical Education, Capital Prospective Payment, Excluded Hospitals, Sole Community Hospitals, Medicare Disproportionate Share Hospital (DSH) Payment Adjustment, Medicare-Dependent Small Rural Hospital (MDH) Program, and Low-Volume Hospital Payment Adjustment Issues.

Michele Hudson, (410) 786–4487, Mark Luxton, (410) 786–4530, and Emily Lipkin, (410) 786–3633, Long-Term Care Hospital Prospective Payment System and MS–LTC–DRG Relative Weights Issues.

Mollie Knight, (410) 786–7948, and Bridget Dickensheets, (410) 786–8670, Rebasing and Revising the Hospital Market Basket Issues.

Siddhartha Mazumdar, (410) 786–6673, Rural Community Hospital Demonstration Program Issues.

Jeris Smith, (410) 786–0110, Frontier Community Health Integration Project Demonstration Issues.

Lein Han, (617) 879–0129, Hospital Readmissions Reduction Program—Readmission Measures for Hospitals Issues.

James Poyer, (410) 786–2261, Hospital Readmissions Reduction Program—Administration Issues.

Elizabeth Bainger, (410) 786–0529, Hospital-Acquired Condition Reduction Program Issues.

Joseph Clift, (410) 786–4165, Hospital-Acquired Condition Reduction Program—Measures Issues.

Grace Im, (410) 786–0700, and James Poyer, (410) 786–2261, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing—Program Administration, Validation, and Reconsideration Issues.

Reena Duseja, (410) 786–1999, and Cindy Tourison, (410) 786–1093, Hospital Inpatient Quality Reporting—Measures Issues Except Hospital Consumer Assessment of Healthcare Providers and Systems Issues; and Readmission Measures for Hospitals Issues.

Kim Spaulding Bush, (410) 786–3232, Hospital Value-Based Purchasing Efficiency Measures Issues.

Elizabeth Goldstein, (410) 786–6665, Hospital Inpatient Quality Reporting—Hospital Consumer Assessment of Healthcare Providers and Systems Measures Issues.

James Poyer, (410) 786–2261, PPS-Exempt Cancer Hospital Quality Reporting Issues.

Mary Pratt, (410) 786–6867, Long-Term Care Hospital Quality Data Reporting Issues.

Jeffrey Buck, (410) 786–0407, and Cindy, Tourison (410) 786–1093, Inpatient Psychiatric Facilities Quality Data Reporting Issues.

Lisa Marie Gomez, (410) 786–1175, EHR Incentive Program Clinical Quality Measure Related Issues.

Kathleen Johnson, (410) 786–3295, and Steven Johnson (410) 786–3332, EHR Incentive Program Nonclinical Quality Measure Related Issues.

Caecilia Blondiaux, (410), 786–2190, and Ariadne Saklas, (410) 786–3322, Changes in Notice of Termination of Medicare Providers and Suppliers Issues.

Monda Shaver, (410) 786–3410, and Patricia Chmielewski, (410) 786–6899, Accrediting Organizations Survey Reporting Transparency Issues.

Kellie Shannon, (410) 786–0416, Medicare Cost Reporting and Valuation of Assets Issues.

SUPPLEMENTARY INFORMATION:

Electronic Access

This **Federal Register** document is available from the **Federal Register** online database through Federal Digital System (FDsys), a service of the U.S. Government Printing Office. This database can be accessed via the Internet at: *http://www.gpo.gov/fdsys.*

cases with high charges lends more accuracy to the threshold, as these cases have an impact on the threshold and continue to rise in volume. Therefore, we disagree with the commenter.

After consideration of the public comments we received, we are not making any changes to our methodology in this final rule for FY 2018. Therefore, we are using the same methodology we proposed to calculate the final outlier threshold. We note that, as stated above, we will consider for FY 2019 using data that commenters can access earlier to validate the charge inflation factor.

Similar to the table provided in the proposed rule, for this final rule, we are providing the following table that displays covered charges and cases by quarter in the periods used to calculate the charge inflation factor based on the latest claims data from the MedPAR file.

Quarter	Covered charges (April 1, 2015, through March 31, 2016)	Cases (April 1, 2015, through March 31, 2016)	Covered charges (April 1, 2016, through March 31, 2017)	Cases (April 1, 2016, through March 31, 2017)
1	$141,152,765,310	2,511,643	$117,678,018,441	2,041,566
2	128,006,070,168	2,429,952	135,162,474,098	2,412,323
3	125,050,723,246	2,350,572	131,355,245,078	2,344,249
4	130,279,257,188	2,385,573	135,647,775,015	2,374,373
Total	524,488,815,912	9,677,740	519,843,512,632	9,172,511

Under our current methodology, to compute the 1-year average annualized rate-of-change in charges per case for FY 2018, we compared the average covered charge per case of $54,195 ($524,488,815,912/9,677,740) from the third quarter of FY 2015 through the second quarter of FY 2016 (April 1, 2015, through March 31, 2016) to the average covered charge per case of $56,674 ($519,843,512,632/9,172,511) from the third quarter of FY 2016 through the second quarter of FY 2017 (April 1, 2016, through March 31, 2017). This rate-of-change is 4.6 percent (1.04574) or 9.4 percent (1.09357) over 2 years. The billed charges are obtained from the claim from the MedPAR file and inflated by the inflation factor specified above.

Similar to the proposed rule, for this final rule, we have made available a more detailed summary table by provider with the monthly charges that were used to compute the charge inflation factor on the CMS Web site at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html* (click on the link on the left titled ''FY 2018 IPPS Final Rule Home Page'' and then click the link ''FY 2018 Final Rule Data Files'').

As we have done in the past, we are establishing the FY 2018 outlier threshold using hospital CCRs from the March 2017 update to the Provider-Specific File (PSF)—the most recent available data at the time of the development of this final rule. For FY 2018, we also are continuing to apply an adjustment factor to the CCRs to account for cost and charge inflation (as explained below).

Therefore, as we did for the last 4 fiscal years, we are adjusting the CCRs from the March 2017 update of the PSF by comparing the percentage change in the national average case-weighted operating CCR and capital CCR from the March 2016 update of the PSF to the national average case-weighted operating CCR and capital CCR from the March 2017 update of the PSF. We note that we used total transfer-adjusted cases from FY 2016 to determine the national average case-weighted CCRs for both sides of the comparison.

Using the methodology above, for this final rule, we calculated a March 2016 operating national average case-weighted CCR of 0.269558 and a March 2017 operating national average case-weighted CCR of 0.265668. We then calculated the percentage change between the two national operating case-weighted CCRs by subtracting the March 2016 operating national average case-weighted CCR from the March 2017 operating national average case-weighted CCR and then dividing the result by the March 2016 national operating average case-weighted CCR. This resulted in a national operating CCR adjustment factor of 0.985569 (the factors used to determine this result were based on unrounded numbers).

We used the same methodology above to adjust the capital CCRs. Specifically, for this final rule, we calculated a March 2016 capital national average case-weighted CCR of 0.023751 and a March 2017 capital national average case-weighted CCR of 0.22615. We then calculated the percentage change between the two national capital case-weighted CCRs by subtracting the March 2016 capital national average case-weighted CCR from the March 2017 capital national average case-weighted CCR and then dividing the result by the March 2016 capital national average case-weighted CCR. This resulted in a national capital CCR adjustment factor of 0.952173 (the factors used to determine this result were based on unrounded numbers).

As discussed above, similar to the proposed rule, for FY 2018 we applied the following policies (see discussion above for more details):

- In accordance with section 10324(a) of the Affordable Care Act, we created a wage index floor of 1.0000 for all hospitals located in States determined to be frontier States.
- As we did in establishing the FY 2009 outlier threshold (73 FR 57891), in our projection of FY 2018 outlier payments, we did not make any adjustments for the possibility that hospitals' CCRs and outlier payments may be reconciled upon cost report settlement.
- We excluded the hospital VBP payment adjustments and the hospital readmissions payment adjustments from the calculation of the outlier fixed-loss cost threshold.
- We used the estimated per-discharge uncompensated care payments to hospitals eligible for the uncompensated care payment for all cases in the calculation of the outlier fixed-loss cost threshold methodology.

Using this methodology, we used the formula described in section I.C.1. of this Addendum to simulate and calculate the Federal payment rate and outlier payments for all claims. We calculated a threshold of $26,601 and calculated total operating Federal payments of $85,942,484,975 and total outlier payments of $4,618,707,285. We then divided total outlier payments by total operating Federal payments plus total outlier payments and determined that this threshold met the 5.1 percent target. As a result, we are finalizing an outlier fixed-loss cost threshold for FY 2018 equal to the prospective payment rate for the MS–DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus $26,601.

(2) Other Changes Concerning Outliers

As stated in the FY 1994 IPPS final rule (58 FR 46348), we establish an outlier threshold that is applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common threshold resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2018 will result in outlier payments that will equal 5.1 percent of operating DRG payments and 5.16 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we reduced the FY 2018 standardized amount by the same percentage to account for the projected proportion of payments paid as outliers.

The outlier adjustment factors that were applied to the standardized amount based on the FY 2018 outlier threshold are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948999	0.948400

We applied the outlier adjustment factors to the FY 2018 payment rates after removing the effects of the FY 2017 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we apply hospital-specific CCRs to the total covered charges for the case. Estimated operating and capital costs

for the case are calculated separately by applying separate operating and capital CCRs. These costs are then combined and compared with the outlier fixed-loss cost threshold.

Under our current policy at § 412.84, we calculate operating and capital CCR ceilings and assign a statewide average CCR for hospitals whose CCRs exceed 3.0 standard deviations from the mean of the log distribution of CCRs for all hospitals. Based on this calculation, for hospitals for which the MAC computes operating CCRs greater than 1.16 or capital CCRs greater than 0.155, or hospitals for which the MAC is unable to calculate a CCR (as described under § 412.84(i)(3) of our regulations), statewide average CCRs are used to determine whether a hospital qualifies for outlier payments. Table 8A listed in section VI. of this Addendum (and available only via the Internet on the CMS Web site) contains the statewide average operating CCRs for urban hospitals and for rural hospitals for which the MAC is unable to compute a hospital-specific CCR within the above range. These statewide average ratios will be effective for discharges occurring on or after October 1, 2017 and will replace the statewide average ratios from the prior fiscal year. Table 8B listed in section VI. of this Addendum (and available via the Internet on the CMS Web site) contains the comparable statewide average capital CCRs. As previously stated, the CCRs in Tables 8A and 8B will be used during FY 2018 when hospital-specific CCRs based on the latest settled cost report either are not available or are outside the range noted above. Table 8C listed in section VI. of this Addendum (and available via the Internet on the CMS Web site) contains the statewide average total CCRs used under the LTCH PPS as discussed in section V. of this Addendum.

We finally note that we published a manual update (Change Request 3966) to our outlier policy on October 12, 2005, which updated Chapter 3, Section 20.1.2 of the Medicare Claims Processing Manual. The manual update covered an array of topics, including CCRs, reconciliation, and the time value of money. We encourage hospitals that are assigned the statewide average operating and/or capital CCRs to work with their MAC on a possible alternative operating and/or capital CCR as explained in Change Request 3966. Use of an alternative CCR developed by the hospital in conjunction with the MAC can avoid possible overpayments or underpayments at cost report settlement, thereby ensuring better accuracy when making outlier payments and negating the need for outlier reconciliation. We also note that a hospital may request an alternative operating or capital CCR at any time as long as the guidelines of Change Request 3966 are followed. In addition, as mentioned above, we published an additional manual update (Change Request 7192) to our outlier policy on December 3, 2010, which also updated Chapter 3, Section 20.1.2 of the Medicare Claims Processing Manual. The manual update outlines the outlier reconciliation process for hospitals and Medicare contractors. To download and view the manual instructions on outlier reconciliation, we refer readers to the CMS Web site: *http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf*.

(3) FY 2016 Outlier Payments

Our current estimate, using available FY 2016 claims data, is that actual outlier payments for FY 2016 were approximately 5.41 percent of actual total MS–DRG payments. Therefore, the data indicate that, for FY 2016, the percentage of actual outlier payments relative to actual total payments is higher than we projected for FY 2016. Consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2016 are equal to 5.1 percent of total MS–DRG payments. As explained in the FY 2003 Outlier Final Rule (68 FR 34502), if we were to make retroactive adjustments to all outlier payments to ensure total payments are 5.1 percent of MS–DRG payments (by retroactively adjusting outlier payments), we would be removing the important aspect of the prospective nature of the IPPS. Because such an across-the-board adjustment would either lead to more or less outlier payments for all hospitals, hospitals would no longer be able to reliably approximate their payment for a patient while the patient is still hospitalized. We believe it would be neither necessary nor appropriate to make such an aggregate retroactive adjustment. Furthermore, we believe it is consistent with the statutory language at section 1886(d)(5)(A)(iv) of the Act not to make retroactive adjustments to outlier payments. This section calls for the Secretary to ensure that outlier payments are equal to or greater than 5 percent and less than or equal to 6 percent of projected or estimated (not actual) MS–DRG payments. We believe that an important goal of a PPS is predictability. Therefore, we believe that the fixed-loss outlier threshold should be projected based on the best available historical data and should not be adjusted retroactively. A retroactive change to the fixed-loss outlier threshold would affect all hospitals subject to the IPPS, thereby undercutting the predictability of the system as a whole.

We note that because the MedPAR claims data for the entire FY 2017 will not be available until after September 30, 2017, we are unable to provide an estimate of actual outlier payments for FY 2017 based on FY 2017 claims data in this final rule. We will provide an estimate of actual FY 2017 outlier payments in the FY 2019 IPPS/LTCH PPS proposed rule.

Comment: One commenter noted that, in the proposed rule, CMS stated that actual outlier payments for FY 2016 were approximately 5.37 percent of total MS–DRG payments. The commenter performed its own analysis and concluded that outlier payments for FY 2016 are approximately 5.27 percent of total MS–DRG payments. The commenter was concerned that CMS' estimate was overstated.

Response: We thank the commenter for the comments. We reviewed our data to ensure the estimate provided is accurate. Therefore, we believe we have provided a reliable estimate of the outlier percentage for FY 2016. The commenter did not provide details regarding the discrepancy. We welcome additional suggestions from the public, including the commenter, to improve the accuracy of our estimate of actual outlier payments.

5. FY 2018 Standardized Amount

The adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B listed and published in section VI. of this Addendum (and available via the Internet on the CMS Web site) contain the national standardized amounts that we are applying to all hospitals, except hospitals located in Puerto Rico, for FY 2018. The standardized amount for hospitals in Puerto Rico is shown in Table 1C listed and published in section VI. of this Addendum (and available via the Internet on the CMS Web site). The amounts shown in Tables 1A and 1B differ only in that the labor-related share applied to the standardized amounts in Table 1A is 68.3 percent, and the labor-related share applied to the standardized amounts in Table 1B is 62 percent. In accordance with sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act, we are applying a labor-related share of 62 percent, unless application of that percentage would result in lower payments to a hospital than would otherwise be made. In effect, the statutory provision means that we will apply a labor-related share of 62 percent for all hospitals whose wage indexes are less than or equal to 1.0000.

In addition, Tables 1A and 1B include the standardized amounts reflecting the applicable percentage increases for FY 2018.

The labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals for FY 2018 are set forth in Table 1C listed and published in section VI. of this Addendum (and available via the Internet on the CMS Web site). Similar to above, section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Public Law 108–173, provides that the labor-related share for hospitals located in Puerto Rico be 62 percent, unless the application of that percentage would result in lower payments to the hospital.

The following table illustrates the changes from the FY 2017 national standardized amount to the FY 2018 national standardized amount. The second through fifth columns display the changes from the FY 2017 standardized amounts for each applicable FY 2018 standardized amount. The first row of the table shows the updated (through FY 2017) average standardized amount after restoring the FY 2017 offsets for outlier payments, geographic reclassification budget neutrality, new labor market delineation wage index transition budget neutrality and removing the FY 2017 2-midnight rule one-time prospective increase. The MS–DRG reclassification and recalibration and wage index budget neutrality adjustment factors are cumulative. Therefore, those FY 2017 adjustment factors are not removed from this table.

CHANGES FROM FY 2017 STANDARDIZED AMOUNTS TO THE FY 2018 STANDARDIZED AMOUNTS

	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is NOT a meaningful EHR user	Hospital did NOT submit quality data and is a meaningful EHR user	Hospital did NOT submit quality data and is NOT a meaningful EHR user
FY 2018 Base Rate after removing:				
1. FY 2017 Geographic Reclassification Budget Neutrality (0.988136).	If Wage Index is Greater Than 1.0000:	If Wage Index is Greater Than 1.0000:	If Wage Index is Greater Than 1.0000:	If Wage Index is Greater Than 1.0000:
2. FY 2017 Operating Outlier Offset (0.948998).	Labor (68.3%): $3,993.72.	Labor (68.3%): $3,993.72.	Labor (68.3%): $3,993.72.	Labor (68.3%): $3,993.72.
3. FY 2017 2-Midnight Rule One-Time Prospective Increase (1.006).	Nonlabor (30.4%): $1,853.60.	Nonlabor (30.4%): $1,853.60.	Nonlabor (30.4%): $1,853.60.	Nonlabor (30.4%): $1,853.60.
4. FY 2017 Labor Market Delineation Wage Index Transition Budget Neutrality Factor (0.999997).	If Wage Index is less Than or Equal to 1.0000:	If Wage Index is less Than or Equal to 1.0000:	If Wage Index is less Than or Equal to 1.0000:	If Wage Index is less Than or Equal to 1.0000:
	Labor (62%): $3,625.34 .... Nonlabor (38%): $2,221.98	Labor (62%): $3,625.34 .... Nonlabor (38%): $2,221.98	Labor (62%): $3,625.34 .... Nonlabor (38%): $2,221.98	Labor (62%): $3,625.34. Nonlabor (38%): $2,221.98.
FY 2018 Update Factor	1.0135	0.99325	1.00675	0.9865.
FY 2018 MS-DRG Recalibration Budget Neutrality Factor.	0.997432	0.997432	0.997432	0.997432.
FY 2018 Wage Index Budget Neutrality Factor.	1.001148	1.001148	1.001148	1.001148.
FY 2018 Reclassification Budget Neutrality Factor.	0.988008	0.988008	0.988008	0.988008.
FY 2018 Operating Outlier Factor.	0.948999	0.948999	0.948999	0.98999.
Adjustment for FY 2018 Required under Section 414 of Public Law 114–10 (MACRA) and Section 15005 of Public Law 114–255.	1.004588	1.004588	1.004588	1.004588.
National Standardized Amount for FY 2018 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (68.3/31.7).	Labor: $3,807.12 ..... Nonlabor: $1,766.99	Labor: $3,731.05 ..... Nonlabor: $1,731.69	Labor: $3,781.76 ..... Nonlabor: $1,755.22	Labor: $3,705.70. Nonlabor: $1,719.92.
National Standardized Amount for FY 2018 if Wage Index is less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38).	Labor: $3,455.95 ..... Nonlabor: $2,118.16	Labor: $3,386.90 ..... Nonlabor: $2,075.84	Labor: $3,432.93 ..... Nonlabor: $2,104.05	Labor: $3,363.88. Nonlabor: $2,061.74.

We note that, in recent years, we have estimated the MS–DRG recalibration budget neutrality factor, wage index budget neutrality factor, reclassification budget neutrality factor and operating outlier factor to six decimal places. In the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 20176), we stated that while we are not proposing to make any changes at this time, we were interested in receiving comments from the public as to the continued necessity of six decimal places for these four estimates or if fewer decimal places would be sufficient. We did not receive any public comments regarding the necessity of six decimals. We will consider the use of fewer decimals in future rulemaking.

B. Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1C, as published in section VI. of this Addendum (and available via the Internet on the CMS Web site), contain the labor-related and nonlabor-related shares that we used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2018. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national prospective payment rate to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. For FY 2018, as discussed in section IV.B.3. of the preamble of this final rule, we will apply a labor-related share of 68.3 percent for the national standardized amounts for all IPPS hospitals (including hospitals in Puerto Rico) that have a wage index value that is greater

for errors in previous CIPI forecasts. The update factor for FY 2018 under that framework is 1.3 percent based on a projected 1.3 percent increase in the 2014-based CIPI, a 0.0 percentage point adjustment for intensity, a 0.0 percentage point adjustment for case-mix, a 0.0 percentage point adjustment for the DRG reclassification and recalibration, and a forecast error correction of 0.0 percentage point. As discussed in section III.C. of this Addendum, we continue to believe that the CIPI is the most appropriate input price index for capital costs to measure capital price changes in a given year. We also explain the basis for the FY 2018 CIPI projection in that same section of this Addendum. Below we describe the policy adjustments that we are applying in the update framework for FY 2018.

The case-mix index is the measure of the average DRG weight for cases paid under the IPPS. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patient changes (''real'' case-mix change);
- Changes in hospital documentation and coding of patient records result in higher-weighted DRG assignments (''coding effects''); and
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in documentation and coding behavior that result in assignment of cases to higher-weighted DRGs, but do not reflect higher resource requirements. The capital update framework includes the same case-mix index adjustment used in the former operating IPPS update framework (as discussed in the May 18, 2004 IPPS proposed rule for FY 2005 (69 FR 28816)). (We no longer use an update framework to make a recommendation for updating the operating IPPS standardized amounts as discussed in section II. of Appendix B to the FY 2006 IPPS final rule (70 FR 47707).)

For FY 2018, we are projecting a 0.5 percent total increase in the case-mix index. We estimated that the real case-mix increase will equal 0.5 percent for FY 2018. The net adjustment for change in case-mix is the difference between the projected real increase in case-mix and the projected total increase in case-mix. Therefore, the net adjustment for case-mix change in FY 2018 is 0.0 percentage point.

The capital update framework also contains an adjustment for the effects of DRG reclassification and recalibration. This adjustment is intended to remove the effect on total payments of prior year's changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than those due to patient severity of illness. Due to the lag time in the availability of data, there is a 2-year lag in data used to determine the adjustment for the effects of DRG reclassification and recalibration. For example, we have data available to evaluate the effects of the FY 2016 DRG reclassification and recalibration as part of our update for FY 2018. We assume, for purposes of this adjustment, that the estimate of FY 2016 DRG reclassification and recalibration resulted in no change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are making a 0.0 percentage point adjustment for reclassification and recalibration in the update framework for FY 2018.

The capital update framework also contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage point or more. There is a 2-year lag between the forecast and the availability of data to develop a measurement of the forecast error. Historically, when a forecast error of the CIPI is greater than 0.25 percentage point in absolute terms, it is reflected in the update recommended under this framework. A forecast error of 0.2 percentage point was calculated for the FY 2016 update, for which there are historical data. That is, current historical data indicate that the forecasted FY 2016 CIPI (1.3 percent) used in calculating the FY 2016 update factor was 0.2 percentage points higher than actual realized price increases (1.1 percent). However, as this does not exceed the 0.25 percentage point threshold, we are not making an adjustment for forecast error in the update for FY 2018.

Under the capital IPPS update framework, we also make an adjustment for changes in intensity. Historically, we calculated this adjustment using the same methodology and data that were used in the past under the framework for operating IPPS. The intensity factor for the operating update framework reflected how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, for changes within DRG severity, and for expected modification of practice patterns to remove noncost-effective services. Our intensity measure is based on a 5-year average.

We calculate case-mix constant intensity as the change in total cost per discharge, adjusted for price level changes (the CPI for hospital and related services) and changes in real case-mix. Without reliable estimates of the proportions of the overall annual intensity changes that are due, respectively, to ineffective practice patterns and the combination of quality-enhancing new technologies and complexity within the DRG system, we assume that one-half of the annual change is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity, to allow for increases within DRG severity and the adoption of quality-enhancing technology.

In this final rule, we are continuing to use a Medicare-specific intensity measure that is based on a 5-year adjusted average of cost per discharge for FY 2018 (we refer readers to the FY 2011 IPPS/LTCH PPS final rule (75 FR 50436) for a full description of our Medicare-specific intensity measure). Specifically, for FY 2018, we are using an intensity measure that is based on an average of cost per discharge data from the 5-year period beginning with FY 2011 and extending through FY 2015. Based on these data, we estimated that case-mix constant intensity declined during FYs 2011 through 2015. In the past, when we found intensity to be declining, we believed a zero (rather than a negative) intensity adjustment was appropriate. Consistent with this approach, because we estimate that intensity will decline during that 5-year period, we believe it is appropriate to continue to apply a zero intensity adjustment for FY 2018. Therefore, we are making a 0.0 percentage point adjustment for intensity in the update for FY 2018.

Above, we described the basis of the components we used to develop the 1.3 percent capital update factor under the capital update framework for FY 2018 as shown in the following table.

CMS FY 2018 Update Factor To The Capital Federal Rate

Capital Input Price Index*	1.3
Intensity:	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	0.5
Projected Case-Mix Change	0.5
Subtotal	1.3
Effect of FY 2016 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0
Total Update	1.3

*The capital input price index represents the 2014-based CIPI.

b. Comparison of CMS and MedPAC Update Recommendation

In its March 2017 Report to Congress, MedPAC did not make a specific update recommendation for capital IPPS payments for FY 2018. (We refer readers to MedPAC's Report to the Congress: Medicare Payment Policy, March 2017, Chapter 3, available on the Web site at: *http://www.medpac.gov*.)

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier payment methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to

the estimated proportion of capital-related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating IPPS DRG payments.

For FY 2017, we estimated that outlier payments for capital would equal 6.14 percent of inpatient capital-related payments based on the capital Federal rate in FY 2017. Based on the thresholds as set forth in section II.A. of this Addendum, we estimate that outlier payments for capital-related costs will equal 5.16 percent for inpatient capital-related payments based on the capital Federal rate in FY 2018. Therefore, we are applying an outlier adjustment factor of 0.9484 in determining the capital Federal rate for FY 2018. Thus, we estimate that the percentage of capital outlier payments to total capital Federal rate payments for FY 2018 will be lower than the percentage for FY 2017.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. The FY 2018 outlier adjustment of 0.9484 is a 1.04 percent change from the FY 2017 outlier adjustment of 0.9386. Therefore, the net change in the outlier adjustment to the capital Federal rate for FY 2018 is 1.0104(0.9484/0.9386). Thus, the outlier adjustment will increase the FY 2018 capital Federal rate by 1.04 percent compared to the FY 2017 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the GAF

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. The budget neutrality factor for DRG reclassifications and recalibration nationally is applied in determining the capital IPPS Federal rate, and is applicable for all hospitals, including those hospitals located in Puerto Rico.

To determine the national capital rate factors for FY 2018, we compared estimated aggregate capital Federal rate payments based on the FY 2017 MS–DRG classifications and relative weights and the FY 2017 GAF to estimated aggregate capital Federal rate payments based on the FY 2017 MS–DRG classifications and relative weights and the FY 2018 GAFs. To achieve budget neutrality for the changes in the national GAFs, based on calculations using updated data, we applied an incremental budget neutrality adjustment factor of 0.9994 for FY 2018 to the previous cumulative FY 2017 adjustment factor of 0.9850, yielding an adjustment factor of 0.9844 through FY 2018.

We then compared estimated aggregate capital Federal rate payments based on the FY 2017 MS–DRG relative weights and the FY 2018 GAFs to estimated aggregate capital Federal rate payments based on the cumulative effects of the FY 2018 MS–DRG classifications and relative weights and the FY 2018 GAFs. The incremental adjustment factor for DRG classifications and changes in relative weights is 0.9993. The cumulative adjustment factor for MS–DRG classifications and changes in relative weights and for changes in the GAFs through FY 2018 is 0.9837. (We note that all the values are calculated with unrounded numbers.)

The GAF/DRG budget neutrality adjustment factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows the requirement under § 412.308(c)(4)(ii) that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAFs.

The methodology used to determine the recalibration and geographic adjustment factor (GAF/DRG) budget neutrality adjustment is similar to the methodology used in establishing budget neutrality adjustments under the IPPS for operating costs. One difference is that, under the operating IPPS, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the MS–DRG relative weights. Under the capital IPPS, there is a single GAF/DRG budget neutrality adjustment factor for changes in the GAF (including geographic reclassification) and the MS–DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for DSH or IME.

The cumulative adjustment factor of 0.9986 (the product of the incremental national GAF budget neutrality adjustment factor of 0.9994 and the incremental DRG budget neutrality adjustment factor of 0.9993) accounts for the MS–DRG reclassifications and recalibration and for changes in the GAFs. It also incorporates the effects on the GAFs of FY 2018 geographic reclassification decisions made by the MGCRB compared to FY 2017 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors.

As discussed in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57062), we made an adjustment of (1/0.998) to the national capital Federal rate to remove the 0.2 percent reduction (an adjustment factor of 0.998) to the national capital Federal rate to offset the estimated increase in capital IPPS expenditures associated with the 2-midnight policy. This was consistent with the adjustment to the operating IPPS standardized amount and the hospital-specific payment rates. In addition, consistent with the approach for the operating IPPS standardized amount and hospital-specific payment rates and for the reasons discussed in the FY 2017 IPPS/LTCH PPS final rule, we made a one-time prospective adjustment of 1.006 in FY 2017 to the national capital Federal rate to address the effect of the 0.2 percent reduction to the national capital Federal rates in effect for FY 2014, FY 2015, and FY 2016. Furthermore, as provided for in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57294) we are removing this one-time prospective adjustment through an adjustment of (1/1.006) to the national capital Federal rate in FY 2018, consistent with the approach for the operating IPPS standardized amount and hospital-specific payment rates (as discussed in section V.M. of the preamble of this final rule). We refer readers to sections V.M. and VI.C. of the preamble of this final rule for a complete discussion of these issues.

4. Capital Federal Rate for FY 2018

For FY 2017, we established a capital Federal rate of $446.79 (81 FR 68947 through 68949 (Correction Notice)). We are establishing an update of 1.61 percent in determining the FY 2018 capital Federal rate for all hospitals. As a result of this update, the budget neutrality factors discussed earlier, and the adjustment to remove the one-time 0.6 percent adjustment made in FY 2017 to address the effect of the 0.2 percent reduction to the national capital Federal rates in effect for FY 2014, FY 2015, and FY 2016, as finalized in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57294), we are establishing a national capital Federal rate of $453.97 for FY 2018. The national capital Federal rate for FY 2018 was calculated as follows:

- The FY 2018 update factor is 1.0130; that is, the update is 1.3 percent.
- The FY 2018 budget neutrality adjustment factor that is applied to the capital Federal rate for changes in the MS–DRG classifications and relative weights and changes in the GAFs is 0.9986.
- The FY 2018 outlier adjustment factor is 0.9484.
- The 2-midnight policy adjustment to remove the one-time 0.6 percent adjustment is 1/1.006.

(We note that, as discussed in section VI.C. of the preamble of this final rule, we are not making an additional MS–DRG documentation and coding adjustment to the capital IPPS Federal rate for FY 2018.)

Because the FY 2018 capital Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we are not making additional adjustments in the capital Federal rate for these factors, other than the budget neutrality factor for changes in the MS–DRG classifications and relative weights and for changes in the GAFs.

We are providing the following chart that shows how each of the factors and adjustments for FY 2018 affects the computation of the FY 2018 national capital Federal rate in comparison to the FY 2017 national capital Federal rate as presented in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57291 through 57295) as corrected in the Correction Notice published October 5, 2016 (81 FR 68954). The FY 2018 update factor has the effect of increasing the capital Federal rate by 1.3 percent compared to the FY 2017 capital Federal rate. The GAF/DRG budget neutrality adjustment factor has the effect of decreasing the capital Federal rate by 0.14 percent. The FY 2018 outlier adjustment factor has the effect of increasing the capital Federal rate by 1.04 percent compared to the FY 2017 capital Federal rate. The removal of

the one-time 0.6 percent adjustment for FY 2017 relating to the 2-midnight policy has the effect of decreasing the capital Federal rate by 0.60 percent. The combined effect of all the changes will increase the national capital Federal rate by approximately 1.61 percent compared to the FY 2017 national capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2017 CAPITAL FEDERAL RATE AND FY 2018 CAPITAL FEDERAL RATE

	FY 2017	FY 2018	Change	Percent change
Update Factor [1]	1.0090	1.0130	1.0130	1.30
GAF/DRG Adjustment Factor [1]	0.9990	0.9986	0.9986	−0.14
Outlier Adjustment Factor [2]	0.9386	0.9484	1.0104	1.04
Removal of One-Time 2-Midnight Policy Adjustment Factor	1.0060	1/1.006	0.9940	−0.60
Capital Federal Rate	$446.79	$453.97	1.0161	[3] 1.61

[1] The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rates. Thus, for example, the incremental change from FY 2017 to FY 2018 resulting from the application of the 0.9986 GAF/DRG budget neutrality adjustment factor for FY 2018 is a net change of 0.9986 (or −0.14 percent).
[2] The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the FY 2018 outlier adjustment factor is 0.9484/0.9386 or 1.0104 (or 1.04 percent).
[3] Percent change may not sum due to rounding.

In this final rule, we also are providing the following chart that shows how the final FY 2018 capital Federal rate differs from the proposed FY 2018 capital Federal rate as presented in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 20179 through 20182).

COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 2018 CAPITAL FEDERAL RATE AND FINAL FY 2018 CAPITAL FEDERAL RATE

	Proposed FY 2018	Final FY 2018	Change	Percent change
Update Factor [1]	1.0120	1.0130	1.0010	0.10
GAF/DRG Adjustment Factor [1]	0.9992	0.9986	0.9994	−0.06
Outlier Adjustment Factor [2]	0.9434	0.9484	1.0053	0.53
Removal of One-Time 2-Midnight Policy Adjustment Factor	1/1.006	1/1.006	0.0000	−0.00
Capital Federal Rate	$451.37	$453.97	1.0458	0.58

B. Calculation of the Inpatient Capital-Related Prospective Payments for FY 2018

For purposes of calculating payments for each discharge during FY 2018, the capital Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (COLA for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted capital Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The outlier thresholds for FY 2018 are in section II.A. of this Addendum. For FY 2018, a case would qualify as a cost outlier if the cost for the case plus the (operating) IME and DSH payments (including both the empirically justified Medicare DSH payment and the estimated uncompensated care payment, as discussed in section II.A.4.g.(1) of this Addendum) is greater than the prospective payment rate for the MS–DRG plus the fixed-loss amount of $26,601.

Currently, as provided under § 412.304(c)(2), we pay a new hospital 85 percent of its reasonable costs during the first 2 years of operation unless it elects to receive payment based on 100 percent of the capital Federal rate. Effective with the third year of operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with capital costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input price indexes to reflect the changing composition of inputs for operating and capital expenses. For this FY 2018 IPPS/LTCH PPS final rule, we are rebasing and revising the IPPS operating and capital market baskets to reflect a 2014 base year. For a complete discussion of this rebasing, we refer readers to section IV. of the preamble of this final rule.

2. Forecast of the CIPI for FY 2018

Based on IGI, Inc.'s second quarter 2017 forecast, for this final rule, we are forecasting the 2014-based CIPI to increase 1.3 percent in FY 2018. This reflects a projected 1.6 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment), and a projected 3.5 percent increase in other capital expense prices in FY 2018, partially offset by a projected 1.3 percent decline in vintage-weighted interest expense prices in FY 2018. The weighted average of these three factors produces the forecasted 1.3 percent increase for the 2014-based CIPI in FY 2018.

IV. Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2018

Payments for services furnished in children's hospitals, 11 cancer hospitals, and hospitals located outside the 50 States, the District of Columbia and Puerto Rico (that is, short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa) that are excluded from the IPPS are made on the basis of reasonable costs based on the hospital's own historical cost experience, subject to a rate-of-increase ceiling. A per discharge limit (the target amount as defined in § 413.40(a) of the regulations) is set for each hospital based on the hospital's own cost experience in its base year, and updated annually by a rate-of-increase percentage specified in § 413.40(c)(3). In addition, in the

nonlabor-related share is comprised of a different mix of commodities and services. Therefore, we create reweighted indexes for Anchorage, Honolulu, and the average U.S. city using the respective CPI commodities index and CPI services index using the approximate 55 percent commodities/45 percent services shares obtained from the proposed 2014-based IPPS market basket. We create reweighted indexes using BLS data for 2009 through 2016—the most recent data available at the time of this rulemaking. In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50985 through 50987), we created reweighted indexes based on the FY 2010-based IPPS market basket (which was adopted for the FY 2014 update) and BLS data for 2009 through 2012 (the most recent BLS data at the time of the FY 2014 IPPS/LTCH PPS rulemaking).

We continue to believe this methodology is appropriate because we continue to make a COLA for LTCHs located in Alaska and Hawaii by multiplying the nonlabor-related portion of the LTCH PPS standard Federal rate by a COLA factor. We note that OPM's COLA factors were calculated with a statutorily mandated cap of 25 percent. As stated in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50987), when developing the COLA update methodology we finalized in the FY 2013 IPPS/LTCH PPS final rule, we exercised our discretionary authority to adjust payments to LTCHs in Alaska and Hawaii by incorporating this cap. In applying this finalized methodology for updating the COLA factors, our policy for FY 2018 continues to use a 25-percent cap, as our policy is based on OPM's COLA factors (updated by the methodology described earlier).

Applying this methodology, the COLA factors that we are establishing for FY 2018 to adjust the nonlabor related portion of the LTCH PPS standard Federal rate for LTCHs located in Alaska and Hawaii are shown in the table below. For comparison purposes, we also are showing the FY 2013 COLA factors (which were based on OPM's published COLA factors for 2009) and the COLA factors for FYs 2014 through 2017.

Lastly, as we finalized in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53700 and 53701), we are updating the COLA factors based on our methodology every 4 years, at the same time as the update to the labor-related share of the IPPS market basket.

COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII UNDER THE LTCH PPS FOR FY 2018

Area	FY 2013	FY 2014 through FY 2017	FY 2018
Alaska:			
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23	1.23	1.25
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23	1.23	1.25
City of Juneau and 80-kilometer (50-mile) radius by road	1.23	1.23	1.25
Rest of Alaska	1.25	1.25	1.25
Hawaii:			
City and County of Honolulu	1.25	1.25	1.25
County of Hawaii	1.18	1.19	1.21
County of Kauai	1.25	1.25	1.25
County of Maui and County of Kalawao	1.25	1.25	1.25

We note that the reweighted CPI for Honolulu, HI grew faster than the reweighted CPI for the average U.S. city over the 2009 to 2016 time period at 13.7 percent and 10.5 percent, respectively. As a result, for FY 2018, we calculated a COLA factor of 1.29 for the City and County of Honolulu, County of Kauai, and County of Maui and County of Kalawao. However, as stated earlier, we are applying our methodology as finalized in the FY 2013 IPPS/LTCH PPS final rule to incorporate a cap of 1.25 for these areas and thus proposed a COLA factor of 1.25 for the City and County of Honolulu, the County of Kauai, and the County of Maui and County of Kalawao. In addition, the proposed COLA factor we calculated for the County of Hawaii for FY 2018 is 1.21 compared to the FY 2013 COLA factor of 1.18. The COLA factors adopted in FY 2014 using this same methodology can be found in the table above.

Similarly, the reweighted CPI for Anchorage, AK grew faster than the reweighted CPI for the average U.S. city over the 2009 to 2016 time period, at 12.4 percent and 10.5 percent, respectively. As a result, for FY 2018, we calculated COLA factors for the City of Anchorage, City of Fairbanks, and City of Juneau to be 1.25 compared to the FY 2013 COLA factor of 1.23. For FY 2018, we calculated a COLA factor of 1.27 for the Rest of Alaska compared to the FY 2013 COLA factor of 1.25. However, as stated above, we are applying our methodology as finalized in the FY 2013 IPPS/LTCH PPS final rule to incorporate a cap of 1.25 for the rest of Alaska.

As stated above, the COLA factors adopted in the FY 2014 IPPS/LTCH PPS final rule were based on the same methodology used to determine the FY 2018 COLA factors but utilizing BLS data from 2009 through 2012 (the most recent data available at the time of the FY 2014 rulemaking) rather than through 2016 (the most recent data available at the time of this rulemaking). As we noted in the proposed rule, compared to the FY 2014 COLA factors, the proposed FY 2018 COLA factors are higher—with all areas either reaching or exceeding the cap of 1.25 except the County of Hawaii.

We did not receive any public comments in response to our discussion of the proposed FY 2018 COLA factors in the FY 2018 IPPS/LTCH PPS proposed rule. In this final rule, we are finalizing the COLA factors as proposed, effective for FY 2018.

D. Adjustment for LTCH PPS High-Cost Outlier (HCO) Cases

1. HCO Background

From the beginning of the LTCH PPS, we have included an adjustment to account for cases in which there are extraordinarily high costs relative to the costs of most discharges. Under this policy, additional payments are made based on the degree to which the estimated cost of a case (which is calculated by multiplying the Medicare allowable covered charge by the hospital's overall hospital CCR) exceeds a fixed-loss amount. This policy results in greater payment accuracy under the LTCH PPS and the Medicare program, and the LTCH sharing the financial risk for the treatment of extraordinarily high-cost cases.

We retained the basic tenets of our HCO policy in FY 2016 when we implemented the dual rate LTCH PPS payment structure under section 1206 of Public Law 113–67. LTCH discharges that meet the criteria for exclusion from the site neutral payment rate (that is, LTCH PPS standard Federal payment rate cases) are paid at the LTCH PPS standard Federal payment rate, which includes, as applicable, HCO payments under § 412.523(e). LTCH discharges that do not meet the criteria for exclusion are paid at the site neutral payment rate, which includes, as applicable, HCO payments under § 412.522(c)(2)(i). In the same rule, we established separate fixed-loss amounts and targets for the two different LTCH PPS payment rates. Under this bifurcated policy, the historic 8 percent HCO target was retained for LTCH PPS standard Federal payment rate cases, with the fixed-loss amount calculated using only data from LTCH cases that would have been paid at the LTCH PPS standard Federal payment rate if that rate had been in effect at the time of those discharges. For site neutral payment rate cases, we adopted the operating IPPS HCO target (currently 5.1 percent) and set the fixed-loss amount for site neutral payment rate cases at the value of the IPPS fixed-loss amount. Under the HCO policy for both payment rates, an LTCH receives 80 percent of the difference between the estimated cost of the case and the applicable HCO threshold, which is the sum of the LTCH PPS payment for the case and the applicable fixed-loss amount for such case.

In order to maintain budget neutrality, consistent with the budget neutrality requirement for HCO payments to LTCH PPS standard Federal rate payment cases, we also

adopted a budget neutrality requirement for HCO payments to site neutral payment rate cases by applying a budget neutrality factor to the LTCH PPS payment for those site neutral payment rate cases. (We refer readers to § 412.522(c)(2)(i) of the regulations for further details.) We note that, during the 2-year transitional period, the site neutral payment rate HCO budget neutrality factor did not apply to the LTCH PPS standard Federal payment rate portion of the blended rate at § 412.522(c)(3) payable to site neutral payment rate cases. (For additional details on the HCO policy adopted for site neutral payment rate cases under the dual rate LTCH PPS payment structure, including the budget neutrality adjustment for HCO payments to site neutral payment rate cases, we refer readers to the FY 2016 IPPS/LTCH PPS final rule (80 FR 49617 through 49623).)

2. Determining LTCH CCRs Under the LTCH PPS

a. Background

As noted above, CCRs are used to determine payments for HCO adjustments for both payment rates under the LTCH PPS, and also are currently used to determine payments for SSO cases under § 412.529 as well as payments for site neutral payment rate cases. (We note that the provisions of § 412.529 are only applicable to LTCH PPS standard Federal payment rate cases). However, we stated in the FY 2018 IPPS/LTCH PPS proposed rule that if our proposed SSO payment method is finalized, CCRs would no longer be used to determine the payment adjustment for SSO cases. Therefore, as we are finalizing our proposed SSO payment methodology, this discussion will only apply to HCO and site neutral payment rate calculations in FY 2018.

As noted earlier, in determining HCO, SSO payments prior to FY 2018, and the site neutral payment rate (regardless of whether the case is also an HCO) payments, we generally calculate the estimated cost of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case. An overall CCR is used because the LTCH PPS uses a single prospective payment per discharge that covers both inpatient operating and capital-related costs. The LTCH's overall CCR is generally computed based on the sum of LTCH operating and capital costs (as described in Section 150.24, Chapter 3, of the Medicare Claims Processing Manual (Pub. 100–4)) as compared to total Medicare charges (that is, the sum of its operating and capital inpatient routine and ancillary charges), with those values determined from either the most recently settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period. However, in certain instances, we use an alternative CCR, such as the statewide average CCR, a CCR that is specified by CMS, or one that is requested by the hospital. (We refer readers to § 412.525(a)(4)(iv) of the regulations for further details regarding HCO adjustments for either LTCH PPS payment rate, § 412.529(f)(4) for SSO adjustments under the current policy, and § 412.522(c)(1)(ii) for the site neutral payment rate, respectively.)

The LTCH's calculated CCR is then compared to the LTCH total CCR ceiling. Under our established policy, an LTCH with a calculated CCR in excess of the applicable maximum CCR threshold (that is, the LTCH total CCR ceiling, which is calculated as 3 standard deviations from the national geometric average CCR) is generally assigned the applicable statewide CCR. This policy is premised on a belief that calculated CCRs above the LTCH total CCR ceiling are most likely due to faulty data reporting or entry, and CCRs based on erroneous data should not be used to identify and make payments for outlier cases.

b. LTCH Total CCR Ceiling

Consistent with our historical practice, we used the most recent data to determine the LTCH total CCR ceiling for FY 2018 in this final rule. Specifically, in this final rule, using our established methodology for determining the LTCH total CCR ceiling based on IPPS total CCR data from the March 2017 update of the Provider Specific File (PSF), which is the most recent data available, we are establishing an LTCH total CCR ceiling of 1.280 under the LTCH PPS for FY 2018 in accordance with § 412.525(a)(4)(iv)(C)(*2*) for HCO cases under either payment rate and § 412.522(c)(1)(ii) for the site neutral payment rate. (For additional information on our methodology for determining the LTCH total CCR ceiling, we refer readers to the FY 2007 IPPS final rule (71 FR 48118 through 48119).)

c. LTCH Statewide Average CCRs

Our general methodology for determining the statewide average CCRs used under the LTCH PPS is similar to our established methodology for determining the LTCH total CCR ceiling because it is based on ''total'' IPPS CCR data. (For additional information on our methodology for determining statewide average CCRs under the LTCH PPS, we refer readers to the FY 2007 IPPS final rule (71 FR 48119 through 48120).) Under the LTCH PPS HCO policy for cases paid under either payment rate at § 412.525(a)(4)(iv)(C)(2), the current SSO policy at § 412.529(f)(4)(iii)(B), and the site neutral payment rate at § 412.522(c)(1)(ii), the MAC may use a statewide average CCR, which is established annually by CMS, if it is unable to determine an accurate CCR for an LTCH in one of the following circumstances: (1) New LTCHs that have not yet submitted their first Medicare cost report (a new LTCH is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18); (2) LTCHs whose calculated CCR is in excess of the LTCH total CCR ceiling; and (3) other LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the MAC may consider in determining an LTCH's CCR include data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as an LTCH (that is, the period of at least 6 months that it was paid as a short-term, acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

Consistent with our historical practice of using the best available data, in this final rule, using our established methodology for determining the LTCH statewide average CCRs, based on the most recent complete IPPS ''total CCR'' data from the March 2017 update of the PSF, we are establishing LTCH PPS statewide average total CCRs for urban and rural hospitals that will be effective for discharges occurring on or after October 1, 2017, through September 30, 2018, in Table 8C listed in section VI. of the Addendum to this final rule (and available via the Internet on the CMS Web site). Consistent with our historical practice, as we proposed, we used more recent data to determine the LTCH PPS statewide average total CCRs for FY 2018 in this final rule.

Under the current LTCH PPS labor market areas, all areas in Delaware, the District of Columbia, New Jersey, and Rhode Island are classified as urban. Therefore, there are no rural statewide average total CCRs listed for those jurisdictions in Table 8C. This policy is consistent with the policy that we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48119 through 48121) and is the same as the policy applied under the IPPS. In addition, although Connecticut has areas that are designated as rural, in our calculation of the LTCH statewide average CCRs, there was no data available from short-term, acute care IPPS hospitals to compute a rural statewide average CCR or there were no short-term, acute care IPPS hospitals or LTCHs located in that area as of March 2017.

Therefore, consistent with our existing methodology, we used the national average total CCR for rural IPPS hospitals for rural Connecticut in Table 8C. While Massachusetts also has rural areas, the statewide average CCR for rural areas in Massachusetts is based on one provider whose CCR is an atypical 1.222. Because this is much higher than the statewide urban average and furthermore implies costs exceeded charges, as with Connecticut, we used the national average total CCR for rural hospitals for hospitals located in rural Massachusetts. Furthermore, consistent with our existing methodology, in determining the urban and rural statewide average total CCRs for Maryland LTCHs paid under the LTCH PPS, we continued to use, as a proxy, the national average total CCR for urban IPPS hospitals and the national average total CCR for rural IPPS hospitals, respectively. We used this proxy because we believe that the CCR data in the PSF for Maryland hospitals may not be entirely accurate (as discussed in greater detail in the FY 2007 IPPS final rule (71 FR 48120)).

d. Reconciliation of HCO and SSO Payments

Under the HCO policy for cases paid under either payment rate at § 412.525(a)(4)(iv)(D) and SSO cases prior to FY 2018 at § 412.529(f)(4)(iv), the payments for HCO and SSO cases are subject to reconciliation. Specifically, any such payments are reconciled at settlement based on the CCR that is calculated based on the cost report coinciding with the discharge. However, under our changes to the SSO payment methodology discussed in section VIII.D. of

the preamble of this final rule, we removed estimated cost as a consideration for payment to SSO cases. As such, consistent with our changes to the SSO payment methodology, SSO payments are no longer be subject to reconciliation. Specifically, as we proposed, we are revising paragraph (f) of § 412.529 to specify that SSO payments will be reconciled only for discharges occurring before October 1, 2017.

For additional information on the reconciliation policy, we refer readers to Sections 150.26 through 150.28 of the Medicare Claims Processing Manual (Pub. 100–4), as added by Change Request 7192 (Transmittal 2111; December 3, 2010), and the RY 2009 LTCH PPS final rule (73 FR 26820 through 26821).

3. High-Cost Outlier Payments for LTCH PPS Standard Federal Payment Rate Cases

a. Changes to High-Cost Outlier Payments for LTCH PPS Standard Federal Payment Rate Cases

When we implemented the LTCH PPS, we established a fixed-loss amount so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS (67 FR 56022 through 56026). Furthermore, § 412.523(d)(1) requires the LTCH PPS standard Federal payment rate be adjusted by a reduction factor of 8 percent, the estimated proportion of outlier payments under § 412.525(a) payable to LTCH PPS standard Federal payment rate cases. Section 15004(b) of the 21st Century Cures Act (Pub. L. 114–255) amended section 1886(m) of the Act by adding new paragraph (7), which specifies certain treatment of HCO payments for fiscal years beginning on or after October 1, 2017 (FY 2018). Specifically, section 1886(m)(7)(A) of the Act requires, beginning in FY 2018, that the LTCH PPS standard Federal payment rate be reduced as if estimated HCO payments for standard Federal payment rate cases would be equal to 8 percent of estimated aggregate payments for standard Federal payment rate cases for a given year. In other words, section 1886(m)(7)(A) of the Act makes our existing regulatory budget neutrality requirement at § 412.523(d)(1) for the 8 percent HCO target for standard Federal payment rate cases a statutory requirement beginning in FY 2018. In addition, section 1886(m)(7)(B) of the Act requires, beginning in FY 2018, that the fixed-loss amount for HCO payments for LTCH PPS standard Federal payment rate cases be determined so that the estimated aggregate amount of HCO payments for such cases in a given year are equal to 99.6875 percent of the 8 percent estimated aggregate payments for standard Federal payment rate cases (that is, 7.975 percent). In other words, sections 1886(m)(7)(A) and (7)(B) require that we adjust the standard Federal payment rate each year to ensure budget neutrality for HCO payments as if estimated aggregate HCO payments made for standard Federal payment rate discharges remain at 8 percent, while the fixed-loss amount for the HCO payments is set each year so that the estimated aggregate HCO payments for standard Federal payment rate cases are 7.975 percent of estimated aggregate payments for standard Federal payment rate cases.

More specifically, section 1886(m)(7)(A) of the Act stipulates that, for fiscal years beginning on or after October 1, 2017, the Secretary shall reduce the standard Federal payment rate as if the estimated aggregate amount of HCO payments for standard Federal payment rate discharges for each such fiscal year would be equal to 8 percent of estimated aggregate payments for standard Federal payment rate discharges for each such fiscal year; while section 1886(m)(7)(B) of the Act states that the Secretary shall set the fixed loss amount for HCO payments such that the estimated aggregate amount of HCO payments made for standard Federal payment rate discharges for fiscal years beginning on or after October 1, 2017, shall be equal to 99.6875 percent of 8 percent of estimated aggregate payments for standard Federal payment rate discharges for each such fiscal year. Furthermore, section 1886(m)(7)(C) of the Act requires that any reduction in payments resulting from the application of paragraph (B) shall not be taken into account in applying any budget neutrality provision. Finally, section 1886(m)(7)(D) of the Act provides there will be no effect on HCO payments to site neutral payment rate cases by this certain treatment of HCO payments by requiring that this paragraph shall not apply with respect to the computation of the applicable site neutral payment rate under section 1886(m)(6) of the Act.

To codify the treatment of HCO payments provided by section 15004(b) of the 21st Century Cures Act (discussed earlier), as we proposed, we are revising § 412.525(a) by redesignating paragraph (2) as paragraph (2)(i) and adding paragraph (2)(ii) which would specify that, for FY 2018 and subsequent years, the fixed-loss amount for LTCH discharges described under § 412.522(a)(2) is determined such that the estimated proportion of outlier payments under § 412.522(a) that are payable for such discharges is projected to be equal to 99.6875 percent of 8 percent. We also are making conforming changes to § 412.523(d)(1) to specify that the provisions under § 412.525(a)(2)(ii) will not affect the reduction factor of 8 percent that is applied to the LTCH PPS standard Federal payment rate under § 412.523(d)(1).

b. Establishment of the Fixed-Loss Amount for LTCH PPS Standard Federal Payment Rate Cases for FY 2018

When we implemented the LTCH PPS, we established a fixed loss amount so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS (67 FR 56022 through 56026). When we implemented the dual rate LTCH PPS payment structure beginning in FY 2016, we established that, in general, the historical LTCH PPS HCO policy will continue to apply to LTCH PPS standard Federal payment rate cases. That is, the fixed-loss amount and target for LTCH PPS standard Federal payment rate cases is determined using the LTCH PPS HCO policy adopted when the LTCH PPS was first implemented, but we limited the data used under that policy to LTCH cases that would have been LTCH PPS standard Federal payment rate cases if the statutory changes had been in effect at the time of those discharges.

To determine the applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases, we estimate outlier payments and total LTCH PPS payments for each LTCH PPS standard Federal payment rate case (or for each case that would have been a LTCH PPS standard Federal payment rate case if the statutory changes had been in effect at the time of the discharge) using claims data from the MedPAR files. Historically, the applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases results in estimated total outlier payments being projected to be equal to 8 percent of projected total LTCH PPS payments for LTCH PPS standard Federal payment rate cases. We use MedPAR claims data and CCRs based on data from the most recent PSF (or from the applicable statewide average CCR if an LTCH's CCR data are faulty or unavailable) to establish an applicable fixed-loss threshold amount for LTCH PPS standard Federal payment rate cases. For FY 2018 and subsequent fiscal years, as we proposed, we are continuing to use the same general approach as in previous years, but the applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases will be estimated so that total HCO payments are 7.975 percent (that is, 99.6875 percent of 8 percent) of projected total LTCH PPS payments for LTCH PPS standard Federal payment rate cases, consistent with section 1886(m)(7)(B) of the Act (as discussed above).

In the FY 2018 IPS/LTCH PPS proposed rule (82 FR 20189), we proposed to continue to use our current methodology to calculate an applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2018 using the best available data that would maintain estimated HCO payments at the projected 7.975 percent of total estimated LTCH PPS payments for LTCH PPS standard Federal payment rate cases (based on the rates and policies for these cases presented in that proposed rule).

Specifically, based on the most recent complete LTCH data available at that time (that is, LTCH claims data from the December 2016 update of the FY 2016 MedPAR file and CCRs from the December 2016 update of the PSF), we determined that a proposed fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2018 of $30,081 would result in estimated outlier payments projected to be equal to 7.975 percent of estimated FY 2018 payments for such cases. Under this proposal, we would continue to make an additional HCO payment for the cost of an LTCH PPS standard Federal payment rate case that exceeds the HCO threshold amount that is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted LTCH PPS standard Federal payment rate payment and the fixed-loss amount for LTCH PPS standard Federal payment rate cases of $30,081). We also noted that the proposed fixed-loss amount for HCO cases paid under the LTCH PPS standard Federal payment rate in FY 2018 of $30,081 is notably higher than the FY 2017 fixed-loss amount for LTCH PPS standard Federal payment rate cases of $21,943, and

explained that the increase is largely attributable to rate-of-change in the Medicare allowable charges on the claims data in the MedPAR file.

Based on the most recent available data at the time of the proposed rule, we found that the current FY 2017 HCO threshold of $21,943 results in estimated HCO payments for LTCH PPS standard Federal payment rate cases of approximately 8.6 percent of the estimated total LTCH PPS payments in FY 2016, which exceeds the 8 percent target by 0.6 percentage points. We also noted that fluctuations in the fixed-loss amount occurred in the first few years after the implementation of the LTCH PPS, due, in part, to the changes in LTCH behavior (such as Medicare beneficiary treatment patterns) in response to the new payment system and the lack of data and information available to predict how those changes would affect the estimate costs of LTCH cases. As we gained more experience with the effects and implementation of the LTCH PPS, the annual changes on the fixed-loss amount generally stabilized relative to the fluctuations that occurred in the early years of the LTCH PPS. Therefore, we did not propose any changes to our method for the inflation factor applied to update the costs of each case (that is, an inflation factor based on the most recent estimate of the 2013-based LTCH market basket as determined by the Office of the Actuary) in determining the proposed fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2018. We stated our continued belief that it is appropriate to continue to use our historical approach until we gain experience with the effects and implementation of the dual rate LTCH PPS payment structure that began with discharges occurring in cost reporting periods beginning on or after October 1, 2015, and the types of cases paid at the LTCH PPS standard Federal payment rate under this dual rate payment structure. We stated that we may revisit this issue in the future if data demonstrate such a change is warranted, and would propose any changes in the future through the notice-and-comment rulemaking process. Furthermore, we invited public comments on potential improvements to the determination of the fixed-loss amount for LTCH PPS standard Federal payment rate cases, including the most appropriate method of determining an inflation factor for projecting the costs of each case when determining the fixed-loss threshold.

Comment: A few commenters expressed concern with the increase in the proposed FY 2018 fixed-loss amount for LTCH PPS standard Federal payment rate cases as compared to the current fixed-loss amount for such cases. Some of these commenters expressed general support for using the required target amount of 7.975 percent for HCO payments for LTCH PPS standard Federal payment rate cases. Some commenters stated that they are concerned about the potential instability in the fixed-loss amount from year to year and requested that CMS continue to be transparent about the possible causes for such large year-to-year changes in the fixed-loss amount and how much of this variability may be attributable to the new dual rate LTCH PPS payment. In addition to using the most recent LTCH claims data and CCRs, some commenters suggested we consider whether the new dual rate LTCH PPS payment structure warrants the use of other relevant data or a change in the inflation factor for projecting the costs of each case when determining the fixed-loss amount, but did not make any specific recommendations for other data or factors.

Response: We understand the commenters' concern with the proposed increase to the fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2018, and we appreciate the commenters' support for our proposed use of a HCO target amount of 7.975 percent for LTCH PPS standard Federal payment rate cases. As we discussed in the proposed rule, based on the best available data at that time and using our historical methodology, we estimate that the current FY 2017 HCO fixed-loss amount of $21,943 results in estimated HCO payments for LTCH PPS standard Federal payment rate cases in excess of the FY 2017 target of 8 percent by 0.6 percentage points. Additionally, we note that we invited public comment on potential improvements to the determination of the fixed-loss amount for LTCH PPS standard Federal payment rate cases, including the most appropriate method of determining an inflation factor for projecting the costs of each case when determining the fixed-loss threshold but received no specific suggestions from comments.

As discussed in the proposed rule, fluctuations in the fixed-loss amount have occurred previously under LTCH PPS, due, in part, to the changes in LTCH behavior in response to the changes in Medicare payments and the lack of data and information available to predict how those changes affect the estimate costs of LTCH cases. As was the case when there were fluctuations in the fixed-loss amount in the early years of the LTCH PPS, we expect annual changes to the fixed-loss amount to generally stabilize as experience is gained under the new dual rate LTCH PPS payment structure. We intend to continue to monitor annual changes in the HCO fixed-loss amount, including factors that drive any such changes. We appreciate the general feedback commenters' noted for potential improvements to the determination of the fixed-loss amount for LTCH PPS standard Federal payment rate cases, including the use of other relevant data or a change in the inflation factor for projecting the costs of each case when determining the fixed-loss amount. As we indicated in the proposed rule, we may revisit this issue in the future if data demonstrate such a change is warranted, and would propose any changes in the future through the notice-and-comment rulemaking process. For these reasons we continue to maintain our historical methodology and thus believe it is necessary and appropriate to increase to the fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2017 to maintain estimated HCO payments would equal 8 percent of estimated total LTCH PPS payments for such cases as required under § 412.525(a). We note, as in greater detail discussed below, the fixed-loss amount for FY 2018 for LTCH PPS standard Federal payment rate cases we are establishing in this final rule, after consideration of public comments and based on the most recent LTCH claims data from the MedPAR file and the latest CCRs from the PSF, does result in a fixed-loss amount for such cases that is lower than the proposed fixed-loss amount. We also note that based on the most recent available data for this final rule (discussed below), the current FY 2017 HCO threshold of $21,943 results in estimated HCO payments for LTCH PPS standard Federal payment rate cases which exceeds the FY 2017 target of 8 percent target by 0.1 percentage points. (We also note the change in our estimate of FY 2017 HCO payments between the proposed and final rule decreased from 8.6 percent to 8.1 percent, and this change is largely attributable to updates to CCRs from the December 2016 update of the PSF to the March 2017 update of the PSF.)

After consideration of the public comments we received, for the reasons discussed above, we are finalizing our proposal to continue to use the current LTCH PPS HCO payment methodology for LTCH PPS standard Federal payment rate cases for FY 2018 without modification, as we proposed. Therefore, in this final rule, for FY 2018, we determined an applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases using data from LTCH PPS standard Federal payment rate cases (or cases that would have been LTCH PPS standard Federal payment rate cases had the dual rate LTCH PPS payment structure been in effect at the time of those discharges). The fixed-loss amount for LTCH PPS standard Federal payment rate cases will continue to be determined so that estimated HCO payments will be projected to equal 7.975 percent of estimated total LTCH PPS standard Federal payment rate cases. Furthermore, in accordance with § 412.523(d)(1), a budget neutrality factor will continue to be applied to LTCH PPS standard Federal payment rate cases to offset that 8 percent so that HCO payments for LTCH PPS standard Federal payment rate cases will be budget neutral. Below we present our calculation of the fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2018, which, except for the statutory changes to the HCO target from 8 percent to 7.975 percent, is consistent with the methodology used to establish the FY 2017 LTCH PPS fixed-loss amount, as we proposed.

In this final rule, we are continuing to use our current methodology to calculate an applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2018 using the best available data that will maintain estimated HCO payments at the projected 7.975 percent of total estimated LTCH PPS payments for LTCH PPS standard Federal payment rate cases (based on the payment rates and policies for these cases presented in this final rule). Specifically, based on the most recent available data available (that is, LTCH claims data from the March 2017 update of the FY 2016 MedPAR file and CCRs from the March 2017 update of the PSF), we determined a fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2018 results that

will result in estimated outlier payments of 7.975 percent of estimated FY 2018 payments for such cases. Under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of the BIPA, we are establishing a fixed-loss amount of $27,382 for LTCH PPS standard Federal payment rate cases for FY 2018. Under our policy, we will continue to make an additional HCO payment for the cost of an LTCH PPS standard Federal payment rate case that exceeds the HCO threshold amount that is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted LTCH PPS standard Federal payment rate payment and the fixed-loss amount for LTCH PPS standard Federal payment rate cases of $27,382).

We note that the fixed-loss amount for HCO cases paid under the LTCH PPS standard Federal payment rate in FY 2018 of $27,382 is somewhat lower than proposed FY 2018 fixed-loss amount of $30,081 but notably higher than the FY 2017 fixed-loss amount for LTCH PPS standard Federal payment rate cases of $21,943. However, based on the most recent available data at the time of this final rule, we found that the current FY 2017 HCO threshold of $21,943 results in estimated HCO payments for LTCH PPS standard Federal payment rate cases of approximately 8.1 percent of the estimated total LTCH PPS payments in FY 2017, which exceeds the 8 percent target by 0.1 percentage points. We continue to believe, as discussed in detail in the FY 2017 IPPS/LTCH PPS proposed rule (81 FR 25287), this increase is largely attributable to rate-of-change (that is, increase) in the Medicare allowable charges on the claims data in the MedPAR file. In addition, using the historic 8-percent target for projected aggregate outlier payments (absent the required changes under the 21st Century Cures Act for comparison purposes), the HCO threshold would be $27,240, which represents a 24-percent increase from the final FY 2017 HCO threshold of $21,943. This increase is in line with the 34 percent increase in the HCO threshold between FY 2016 and FY 2017, and is consistent with our expectation that annual changes to the fixed-loss amount to generally stabilize as experience is gained under the new dual rate LTCH PPS payment structure. For these reasons, we continue to believe it is necessary and appropriate to increase the fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2018 to maintain estimated HCO payments that would equal to 7.975 percent of estimated total LTCH PPS payments for such cases as required under § 412.525(a)(2)(ii).

c. Application of the High-Cost Outlier Policy to Short Stay Outlier (SSO) Cases

Under our implementation of the dual rate LTCH PPS payment structure required by statute, in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 20190), we proposed that LTCH PPS standard Federal payment rate cases (that is, LTCH discharges that meet the criteria for exclusion from the site neutral payment rate) would continue to be paid based on the LTCH PPS standard Federal payment rate, and would include all of the existing payment adjustments under § 412.525(d), such as the adjustments for SSO cases under § 412.529. Under some rare circumstances, an LTCH discharge can qualify as an SSO case (as defined in the regulations at § 412.529 in conjunction with § 412.503) and also as an HCO case, as discussed in the August 30, 2002 final rule (67 FR 56026). In this scenario, a patient could be hospitalized for less than five-sixths of the geometric average length of stay for the specific MS–LTC–DRG, and yet incur extraordinarily high treatment costs. If the estimated costs exceeded the HCO threshold (that is, the SSO payment plus the applicable fixed-loss amount), the discharge is eligible for payment as an HCO. (We noted that, under our change to the SSO policy discussed in section VIII.D. of this final rule, SSO cases would still be eligible to qualify for an HCO payment.) Therefore, for an SSO case in FY 2018, as proposed, we are establishing that the HCO payment will be 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the fixed-loss amount of $27,382 and the amount paid under the SSO policy as specified in § 412.529).

4. High-Cost Outlier Payments for Site Neutral Payment Rate Cases

Under § 412.525(a), site neutral payment rate cases receive an additional HCO payment for costs that exceed the HCO threshold that is equal to 80 percent of the difference between the estimated cost of the case and the applicable HCO threshold (80 FR 49618 through 49629). In the following discussion, we note that the statutory transitional payment method for cases that are paid the site neutral payment rate for LTCH discharges occurring in cost reporting periods beginning during FY 2016 or FY 2017 uses a blended payment rate, which is determined as 50 percent of the site neutral payment rate amount for the discharge and 50 percent of the standard Federal prospective payment rate amount for the discharge (§ 412.522(c)(3)). The transitional blended payment rate uses the same blend percentages (that is, 50 percent) for both years of the 2-year transition period. For FY 2018, the site neutral payment rate effective date for a given LTCH is determined based on the date on which that LTCH's cost reporting period begins during FY 2018. Specifically, for a given LTCH, those site neutral payment rate cases discharged in FY 2018 and in a cost reporting period that begins *before* October 1, 2017 continue to be paid under the blended payment rate. However, site neutral payment rate cases discharged in FY 2018 during the LTCH's cost reporting period beginning on or *after* October 1, 2017 will no longer be paid under the blended payment rate and instead will be paid the site neutral payment rate amount as determined under § 412.522(c)(1). As such, for FY 2018 discharges paid under the transitional payment method, the discussion below pertains only to the site neutral rate portion in § 412.522(c)(3)(i)) of the blended payment rate (as well as to FY 2018 discharges paid the site neutral payment rate amount determined under § 412.522(c)(1)).

When we implemented the application of the site neutral payment rate in FY 2016, in examining the appropriate fixed-loss amount for site neutral payment rate cases issue, we considered how LTCH discharges based on historical claims data would have been classified under the dual rate LTCH PPS payment structure and the CMS' Office of the Actuary projections regarding how LTCHs will likely respond to our implementation of policies resulting from the statutory payment changes. We again relied on these considerations and actuarial projections in FY 2017 because the historical claims data available in FY 2017 predated the LTCH PPS dual rate payment system. Similarly, for FY 2018, we continue to rely on these considerations and actuarial projections because, due to the rolling effective date of the site neutral payment policy, not all claims in FY 2016 were subject to the site neutral payment system.

For both FY 2016 and FY 2017, at that time our actuaries projected that the proportion of cases that would qualify as LTCH PPS standard Federal payment rate cases versus site neutral payment rate cases under the statutory provisions would remain consistent with what is reflected in the historical LTCH PPS claims data. Although our actuaries did not project an immediate change in the proportions found in the historical data, they did project cost and resource changes to account for the lower payment rates. Our actuaries also projected that the costs and resource use for cases paid at the site neutral payment rate would likely be lower, on average, than the costs and resource use for cases paid at the LTCH PPS standard Federal payment rate and would likely mirror the costs and resource use for IPPS cases assigned to the same MS–DRG, regardless of whether the proportion of site neutral payment rate cases in the future remains similar to what is found based on the historical data. As discussed in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49619), this actuarial assumption is based on our expectation that site neutral payment rate cases would generally be paid based on an IPPS comparable per diem amount under the statutory LTCH PPS payment changes that began in FY 2016, which, in the majority of cases, is much lower than the payment that would have been paid if these statutory changes were not enacted. (We note, in section I.J.1 of the Regulatory Impact in Appendix A of this final rule, we summarize and respond to a comment that references to this actuarial assumption.) In light of these projections and expectations, we discussed that we believed that the use of a single fixed-loss amount and HCO target for all LTCH PPS cases would be problematic. In addition, we discussed that we did not believe that it would be appropriate for comparable LTCH PPS site neutral payment rate cases to receive dramatically different HCO payments from those cases that would be paid under the IPPS (80 FR 49617 through 49619 and 81 FR 57305 through 57307). For those reasons, we stated that we believed that the most appropriate fixed-loss amount for site neutral payment rate cases for both FY 2016 and FY 2017 would be equal to the IPPS fixed-loss amount for that year. Therefore, we established the fixed-loss amount for site neutral payment rate cases as the FY 2016 and FY 2017 IPPS fixed-loss amounts, in FY 2016 and FY 2017 respectively. In particular,

in FY 2017, we established that the fixed-loss amount for site neutral payment rate cases is the FY 2017 IPPS fixed-loss amount of $23,570.

As noted earlier, because not all claims in the data used for this final rule were subject to the site neutral payment rate system, we continue to rely on the same considerations and actuarial projections used in FY 2016 and FY 2017 when developing a fixed-loss amount for site neutral payment rate cases for FY 2018. Because our actuaries continue to project that site neutral payment rate cases in FY 2018 will continue to mirror an IPPS case paid under the same MS–DRG, we continue to believe that it would be inappropriate for comparable LTCH PPS site neutral payment rate cases to receive dramatically different HCO payments from those cases that would be paid under the IPPS. More specifically, as with FY 2016 and FY 2017, our actuaries project that the costs and resource use for FY 2018 cases paid at the site neutral payment rate would likely be lower, on average, than the costs and resource use for cases paid at the LTCH PPS standard Federal payment rate and will likely mirror the costs and resource use for IPPS cases assigned to the same MS–DRG, regardless of whether the proportion of site neutral payment rate cases in the future remains similar to what is found based on the historical data. (Based on the most recent FY 2016 LTCH claims data, approximately 58 percent of LTCH cases would have been paid the LTCH PPS standard Federal payment rate and approximately 42 percent of LTCH cases would have been paid the site neutral payment rate if those rates had been in effect at that time for all LTCH discharges occurring in FY 2016, regardless of LTCHs' cost reporting period beginning dates.)

For these reasons, we continue to believe that the most appropriate fixed-loss amount for site neutral payment rate cases for FY 2018 is the IPPS fixed-loss amount for FY 2018. Therefore, consistent with past practice, in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 20191), for FY 2018, we proposed that the applicable HCO threshold for site neutral payment rate cases is the sum of the site neutral payment rate for the case and the IPPS fixed-loss amount. That is, we proposed a fixed-loss amount for site neutral payment rate cases of $26,713, which was the same proposed FY 2018 IPPS fixed-loss amount discussed in section II.A.4.g.(1) of the Addendum to the proposed rule. We continue to believe that this policy would reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems. Accordingly, for FY 2018, we proposed to calculate a HCO payment for site neutral payment rate cases with costs that exceed the HCO threshold amount, which is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of proposed site neutral payment rate payment and the proposed fixed-loss amount for site neutral payment rate cases of $26,713).

Comment: Some commenters expressed support for our proposal to continue to use the FY 2017 IPPS fixed-loss amount and 5.1 percent HCO target for LTCH discharges paid at the site neutral payment rate in FY 2018.

Response: We appreciate the commenters support for our proposal to continue to use the FY 2018 IPPS fixed-loss amount and 5.1 percent HCO target for LTCH discharges paid at the site neutral payment rate in FY 2018. Given the current expectation that cases paid at the site neutral payment rate would likely be similar to IPPS cases assigned to the same MS–DRG, we continue to believe the most appropriate fixed-loss amount for site neutral payment rate cases is the IPPS fixed-loss amount for that fiscal year. As we indicated in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49619), to the extent experience under the revised LTCH PPS indicates site neutral payment rate cases differ sufficiently from these expectations, we agree it would be appropriate to revisit in future rulemaking the most appropriate fixed-loss amount used to determine HCO payments for site neutral payment rate cases. As we discuss in greater detail in section I.J.1., the Regulatory Impact Analysis, in Appendix A of this final rule, given the rolling nature of the start of the transition to the site neutral payment rate, many LTCH claims from FY 2016 were not subject to the site neutral payment rate at all as many LTCHs did not begin their FY 2016 cost reporting period until the fourth quarter of that fiscal year. In addition, all claims which were subject to the site neutral payment rate in FY 2016 were paid under the blended payment rate which included a payment based on 50 percent of the LTCH PPS standard Federal payment rate. As such, FY 2016 claims may not yet reflect the expected change in cost and resources once the payment for site neutral payment rate cases is fully based on the site neutral payment rate.

After consideration of public comments we received, we are finalizing without modification, our proposals to use the FY 2018 IPPS fixed-loss amount and 5.1 percent HCO target for LTCH discharges paid at the site neutral payment rate in FY 2018. Therefore, for FY 2018, as we proposed, we are establishing that the applicable HCO threshold for site neutral payment rate cases is the sum of the site neutral payment rate for the case and the IPPS fixed loss amount. That is, we are establishing a fixed-loss amount for site neutral payment rate cases of $26,601, which is the same FY 2018 IPPS fixed-loss amount discussed in section II.A.4.g.(1). of the Addendum to this final rule. We continue to believe that this policy will reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems. Accordingly, under this policy, for FY 2018, we will calculate a HCO payment for site neutral payment rate cases with costs that exceed the HCO threshold amount, which is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of site neutral payment rate payment and the fixed loss amount for site neutral payment rate cases of $26,601).

In establishing a HCO policy for site neutral payment rate cases, we established a budget neutrality adjustment under § 412.522(c)(2)(i). We established this requirement because we believed, and continue to believe, that the HCO policy for site neutral payment rate cases should be budget neutral, just as the HCO policy for LTCH PPS standard Federal payment rate cases are budget neutral, meaning that estimated site neutral payment rate HCO payments should not result in any change in estimated aggregate LTCH PPS payments.

To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2018 would not result in any increase in estimated aggregate FY 2018 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i), it is necessary to reduce site neutral payment rate payments (or the portion of the blended payment rate payment for FY 2018 discharges occurring in LTCH cost reporting periods beginning before October 1, 2017) by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2018. In order to achieve this, for FY 2018, in general, as we proposed, we are continuing to use the policy adopted for FY 2017.

As discussed earlier, consistent with the IPPS HCO payment threshold, we expect a fixed-loss threshold of $26,601 results in HCO payments for site neutral payment rate cases equal to 5.1 percent of the site neutral payment rate payments that are based on the IPPS comparable per diem amount. As such, to ensure estimated HCO payments payable for site neutral payment rate cases in FY 2018 would not result in any increase in estimated aggregate FY 2018 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i), it is necessary to reduce the site neutral payment rate amount paid under § 412.522(c)(1)(i) by 5.1 percent to account for the estimated additional HCO payments payable for site neutral payment rate cases in FY 2018. In order to achieve this, for FY 2018, we proposed to apply a budget neutrality factor of 0.949 (that is, the decimal equivalent of a 5.1 percent reduction, determined as 1.0 − 5.1/100 = 0.949) to the site neutral payment rate for those site neutral payment rate cases paid under § 412.522(c)(1)(i). We noted that, consistent with the policy adopted for FY 2017, under this proposed policy the HCO budget neutrality adjustment would not be applied to the HCO portion of the site neutral payment rate amount (80 FR 57309).

Comment: As was the case in the FY 2016 and FY 2017 rulemaking cycle, commenters again objected to the proposed site neutral payment rate HCO budget neutrality adjustment, claiming that it results in savings to the Medicare program instead of being budget neutral. The commenters' primary objection was again based on their belief that, because the IPPS base rates used in the IPPS comparable per diem amount calculation of the site neutral payment rate include a budget neutrality adjustment for IPPS HCO payments (that is, a 5.1 percent adjustment on the operating IPPS standardized amount), an ''additional'' budget neutrality factor is not necessary and is, in fact, duplicative.

Response: We continue to disagree with the commenters that a budget neutrality adjustment for site neutral payment rate HCO payments is inappropriate, unnecessary, or duplicative. As we discussed in response to

similar comments (81 FR 57308 through 57309 and 80 FR 49621 through 49622), we have the authority to adopt the site neutral payment rate HCO policy in a budget neutral manner. More importantly, we continue to believe this budget neutrality adjustment is appropriate for reasons outlined in our response to the nearly identical comments in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57308 through 57309) and our response to similar comments in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49621 through 49622).

After consideration of the public comments we received, we are finalizing our proposal to apply a budget neutrality adjustment for HCO payments made to site neutral payment rate cases. Therefore, to ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2018 will not result any increase in estimated aggregate FY 2018 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i), it is necessary to reduce the site neutral payment rate portion of the blended rate payment by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2018. In order to achieve this, for FY 2018, in this final rule, to, as proposed, we are applying a budget neutrality factor of 0.949 (that is, the decimal equivalent of a 5.1 percent reduction, determined as 1.0—5.1/100 = 0.949) to the site neutral payment rate (without any applicable HCO payment).

E. Update to the IPPS Comparable/Equivalent Amounts To Reflect the Statutory Changes to the IPPS DSH Payment Adjustment Methodology

In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50766), we established a policy to reflect the changes to the Medicare IPPS DSH payment adjustment methodology made by section 3133 of the Affordable Care Act in the calculation of the ''IPPS comparable amount'' under the SSO policy at § 412.529 and the ''IPPS equivalent amount'' under the 25-percent threshold payment adjustment policy at § 412.534 and § 412.536. Historically, the determination of both the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' includes an amount for inpatient operating costs ''for the costs of serving a disproportionate share of low-income patients.'' Under the statutory changes to the Medicare DSH payment adjustment methodology that began in FY 2014, in general, eligible IPPS hospitals receive an empirically justified Medicare DSH payment equal to 25 percent of the amount they otherwise would have received under the statutory formula for Medicare DSH payments prior to the amendments made by the Affordable Care Act. The remaining amount, equal to an estimate of 75 percent of the amount that otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals who are uninsured, is made available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. The additional uncompensated care payments are based on the hospital's amount of uncompensated care for a given time period relative to the total amount of uncompensated care for that same time period reported by all IPPS hospitals that receive Medicare DSH payments.

To reflect the statutory changes to the Medicare DSH payment adjustment methodology in the calculation of the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' under the LTCH PPS, we stated that we will include a reduced Medicare DSH payment amount that reflects the projected percentage of the payment amount calculated based on the statutory Medicare DSH payment formula prior to the amendments made by the Affordable Care Act that will be paid to eligible IPPS hospitals as empirically justified Medicare DSH payments and uncompensated care payments in that year (that is, a percentage of the operating Medicare DSH payment amount that has historically been reflected in the LTCH PPS payments that is based on IPPS rates). We also stated that the projected percentage will be updated annually, consistent with the annual determination of the amount of uncompensated care payments that will be made to eligible IPPS hospitals. We believe that this approach results in appropriate payments under the LTCH PPS and is consistent with our intention that the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' under the LTCH PPS closely resemble what an IPPS payment would have been for the same episode of care, while recognizing that some features of the IPPS cannot be translated directly into the LTCH PPS (79 FR 50766 through 50767).

For FY 2018, as discussed in greater detail in section V.G.3. of the preamble of this final rule, based on the most recent data available, our estimate of 75 percent of the amount that would otherwise have been paid as Medicare DSH payments (under the methodology outlined in section 1886(r)(2) of the Act) is adjusted to 58.01 percent of that amount to reflect the change in the percentage of individuals who are uninsured. The resulting amount is then used to determine the amount available to make uncompensated care payments to eligible IPPS hospitals in FY 2018. In other words, the amount of the Medicare DSH payments that would have been made prior to the amendments made by the Affordable Care Act will be adjusted to 43.51 percent (the product of 75 percent and 58.01 percent) and the resulting amount will be used to calculate the uncompensated care payments to eligible hospitals. As a result, for FY 2018, we project that the reduction in the amount of Medicare DSH payments pursuant to section 1886(r)(1) of the Act, along with the payments for uncompensated care under section 1886(r)(2) of the Act, will result in overall Medicare DSH payments of 68.51 percent of the amount of Medicare DSH payments that would otherwise have been made in the absence of the amendments made by the Affordable Care Act (that is, 25 percent + 43.51 percent = 68.51 percent).

In the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 20192), for FY 2018, we proposed to establish that the calculation of the ''IPPS comparable amount'' under § 412.529 and the ''IPPS equivalent amount'' under § 412.538 would include an applicable operating Medicare DSH payment amount that is equal to 68.51 percent of the operating Medicare DSH payment amount that would have been paid based on the statutory Medicare DSH payment formula but for the amendments made by the Affordable Care Act. Furthermore, consistent with our historical practice, we proposed that if more recent data became available, if appropriate, we would use that data to determine this factor in the final rule.

We did not receive any public comments on our proposal. In addition, there is no more recent data available that would affect the calculations in the proposed rule. Therefore, we are finalizing our proposal that the calculation of the ''IPPS comparable amount'' under § 412.529 and the ''IPPS equivalent amount'' under § 412.538 would include an applicable operating Medicare DSH payment amount that is equal to 68.51 percent of the operating Medicare DSH payment amount that would have been paid based on the statutory Medicare DSH payment formula but for the amendments made by the Affordable Care Act.

F. Computing the Adjusted LTCH PPS Federal Prospective Payments for FY 2018

Section 412.525 sets forth the adjustments to the LTCH PPS standard Federal payment rate. Under the dual rate LTCH PPS payment structure, only LTCH PPS cases that meet the statutory criteria to be excluded from the site neutral payment rate are paid based on the LTCH PPS standard Federal payment rate. Under § 412.525(c), the proposed LTCH PPS standard Federal payment rate is adjusted to account for differences in area wages by multiplying the proposed labor-related share of the LTCH PPS standard Federal payment rate for a case by the applicable LTCH PPS wage index (the FY 2018 values are shown in Tables 12A through 12B listed in section VI. of the Addendum of this final rule and are available via the Internet on the CMS Web site). The LTCH PPS standard Federal payment rate is also adjusted to account for the higher costs of LTCHs located in Alaska and Hawaii by the applicable COLA factors (the FY 2018 factors are shown in the chart in section V.C. of this Addendum) in accordance with § 412.525(b). In this final rule, we are establishing an LTCH PPS standard Federal payment rate for FY 2018 of $41,430.56, as discussed in section V.A. of the Addendum to this final rule. We illustrate the methodology to adjust the LTCH PPS standard Federal payment rate for FY 2018 in the following example:

Example

During FY 2018, a Medicare discharge that meets the criteria to be excluded from the site neutral payment rate, that is, an LTCH PPS standard Federal payment rate case, is from an LTCH that is located in Chicago, Illinois (CBSA 16974). The FY 2018 LTCH PPS wage index value for CBSA 16974 is 1.0547 (obtained from Table 12A listed in section VI. of the Addendum of this final rule and available via the Internet on the CMS Web site). The Medicare patient case is classified into MS–LTC–DRG 189 (Pulmonary Edema & Respiratory Failure), which has a relative weight for FY 2018 of 0.9655 (obtained from Table 11 listed in section VI. of the Addendum of this final rule and available via the Internet on the CMS Web site). The LTCH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 424, and 495

[CMS–1694–P]

RIN 0938–AT27

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims

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

ACTION: Proposed rule.

SUMMARY: We are proposing to revise 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 2019. Some of these proposed changes implement certain statutory provisions contained in the 21st Century Cures Act and the Bipartisan Budget Act of 2018, and other legislation. We also are proposing to make changes relating to Medicare graduate medical education (GME) affiliation agreements for new urban teaching hospitals. In addition, we are proposing to provide the market basket update that would apply to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits for FY 2019. We are proposing to update the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for FY 2019.

In addition, we are proposing to establish new requirements or revise existing requirements for quality reporting by specific Medicare providers (acute care hospitals, PPS-exempt cancer hospitals, and LTCHs). We also are proposing to establish new requirements or revise existing requirements for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (now referred to as the Promoting Interoperability Programs). In addition, we are proposing changes to the requirements that apply to States operating Medicaid Promoting Interoperability Prrograms. We are proposing to update policies for the Hospital Value-Based Purchasing (VBP) Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition (HAC) Reduction Program.

We also are proposing to make changes relating to the required supporting documentation for an acceptable Medicare cost report submission and the supporting information for physician certification and recertification of claims.

DATES: *Comment Period:* To be assured consideration, comments must be received at one of the addresses provided in the **ADDRESSES** section, no later than 5 p.m. on June 25, 2018.

ADDRESSES: In commenting, please refer to file code CMS–1694–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1694–P, P.O. Box 8011, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1694–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, we refer readers to the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Donald Thompson, (410) 786–4487, and Michele Hudson, (410) 786–4487, Operating Prospective Payment, MS–DRGs, Wage Index, New Medical Service and Technology Add-On Payments, Hospital Geographic Reclassifications, Graduate Medical Education, Capital Prospective Payment, Excluded Hospitals, Sole Community Hospitals, Medicare Disproportionate Share Hospital (DSH) Payment Adjustment, Medicare-Dependent Small Rural Hospital (MDH) Program, and Low-Volume Hospital Payment Adjustment Issues.

Michele Hudson, (410) 786–4487, Mark Luxton, (410) 786–4530, and Emily Lipkin, (410) 786–3633, Long-Term Care Hospital Prospective Payment System and MS–LTC–DRG Relative Weights Issues.

Siddhartha Mazumdar, (410) 786–6673, Rural Community Hospital Demonstration Program Issues.

Jeris Smith, (410) 786–0110, Frontier Community Health Integration Project Demonstration Issues.

Cindy Tourison, (410) 786–1093, Hospital Readmissions Reduction Program—Readmission Measures for Hospitals Issues.

James Poyer, (410) 786–2261, Hospital Readmissions Reduction Program—Administration Issues.

Elizabeth Bainger, (410) 786–0529, Hospital-Acquired Condition Reduction Program Issues.

Joseph Clift, (410) 786–4165, Hospital-Acquired Condition Reduction Program—Measures Issues.

Grace Snyder, (410) 786–0700 and James Poyer, (410) 786–2261, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing—Program Administration, Validation, and Reconsideration Issues.

Reena Duseja, (410) 786–1999 and Cindy Tourison, (410) 786–1093, Hospital Inpatient Quality Reporting—Measures Issues Except Hospital Consumer Assessment of Healthcare Providers and Systems Issues; and Readmission Measures for Hospitals Issues.

Kim Spalding Bush, (410) 786–3232, Hospital Value-Based Purchasing Efficiency Measures Issues.

Elizabeth Goldstein, (410) 786–6665, Hospital Inpatient Quality Reporting—Hospital Consumer Assessment of Healthcare Providers and Systems Measures Issues.

Joel Andress, (410) 786–5237 and Caitlin Cromer, (410) 786–3106, PPS-Exempt Cancer Hospital Quality Reporting Issues.

Mary Pratt, (410) 786–6867, Long-Term Care Hospital Quality Data Reporting Issues.

capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common threshold resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2019 will result in outlier payments that will equal 5.1 percent of operating DRG payments and 5.06 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we are proposing to reduce the FY 2019 standardized amount by the same percentage to account for the projected proportion of payments paid as outliers.

The proposed outlier adjustment factors that would be applied to the standardized amount based on the proposed FY 2019 outlier threshold are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948999	0.949367

We are proposing to apply the outlier adjustment factors to the proposed FY 2019 payment rates after removing the effects of the FY 2018 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we currently apply hospital-specific CCRs to the total covered charges for the case. Estimated operating and capital costs for the case are calculated separately by applying separate operating and capital CCRs. These costs are then combined and compared with the outlier fixed-loss cost threshold.

Under our current policy at § 412.84, we calculate operating and capital CCR ceilings and assign a statewide average CCR for hospitals whose CCRs exceed 3.0 standard deviations from the mean of the log distribution of CCRs for all hospitals. Based on this calculation, for hospitals for which the MAC computes operating CCRs greater than 1.167 or capital CCRs greater than 0.154, or hospitals for which the MAC is unable to calculate a CCR (as described under § 412.84(i)(3) of our regulations), statewide average CCRs are used to determine whether a hospital qualifies for outlier payments. Table 8A listed in section VI. of this Addendum (and available only via the internet on the CMS website) contains the proposed statewide average operating CCRs for urban hospitals and for rural hospitals for which the MAC is unable to compute a hospital-specific CCR within the above range. These statewide average ratios would be effective for discharges occurring on or after October 1, 2018 and would replace the statewide average ratios from the prior fiscal year. Table 8B listed in section VI. of this Addendum (and available via the internet on the CMS website) contains the comparable proposed statewide average capital CCRs. As previously stated, the proposed CCRs in Tables 8A and 8B would be used during FY 2019 when hospital-specific CCRs based on the latest settled cost report either are not available or are outside the range noted above. Table 8C listed in section VI. of this Addendum (and available via the internet on the CMS website) contains the proposed statewide average total CCRs used under the LTCH PPS as discussed in section V. of this Addendum.

We finally note that we published a manual update (Change Request 3966) to our outlier policy on October 12, 2005, which updated Chapter 3, Section 20.1.2 of the Medicare Claims Processing Manual. The manual update covered an array of topics, including CCRs, reconciliation, and the time value of money. We encourage hospitals that are assigned the statewide average operating and/or capital CCRs to work with their MAC on a possible alternative operating and/or capital CCR as explained in Change Request 3966. Use of an alternative CCR developed by the hospital in conjunction with the MAC can avoid possible overpayments or underpayments at cost report settlement, thereby ensuring better accuracy when making outlier payments and negating the need for outlier reconciliation. We also note that a hospital may request an alternative operating or capital CCR at any time as long as the guidelines of Change Request 3966 are followed. In addition, as mentioned above, we published an additional manual update (Change Request 7192) to our outlier policy on December 3, 2010, which also updated Chapter 3, Section 20.1.2 of the Medicare Claims Processing Manual. The manual update outlines the outlier reconciliation process for hospitals and Medicare contractors. To download and view the manual instructions on outlier reconciliation, we refer readers to the CMS website: *http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf.*

(3) Alternative Considered for a Potential Change to the CCRs Used for Outliers, New Technology Add-On Payments, and Payments to IPPS-Excluded Cancer Hospitals for Chimeric Antigen Receptor (CAR) T-Cell Therapy

As discussed in section II.F.2.d. of the preamble of this proposed rule, we have received many inquiries from the public regarding payment of CAR T-cell therapy. For FY 2019, one suggestion from the public was to allow hospitals to utilize a CCR specific to the ICD–10–PCS procedure codes used to report the performance of procedures involving the use of CAR T-cell therapy drugs, for example a CCR of 1.0, when determining whether an individual case qualifies for FY 2019 outlier payments and to determine the cost of an individual case for FY 2019 for purposes of a new technology add-on payment, if approved. As previously discussed, procedures involving the use of CAR T-cell therapy drugs are currently identified with ICD–10–PCS procedure codes XW033C3 (Introduction of engineered autologous chimeric antigen receptor t-cell immunotherapy into peripheral vein, percutaneous approach, new technology group 3) and XW043C3 (Introduction of engineered autologous chimeric antigen receptor t-cell immunotherapy into central vein, percutaneous approach, new technology group 3), which both became effective October 1, 2017.

Two CAR T-cell therapy drugs received FDA approval in 2017. KYMRIAH™ (manufactured by Novartis Pharmaceuticals Corporation) was approved for the use in the treatment of patients up to 25 years of age with B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse. YESCARTA™ (manufactured by Kite Pharma, Inc.) was approved for the use in the treatment of adult patients with certain types of large B-cell lymphoma and who have not responded to or who have relapsed after at least two other kinds of treatment.

As discussed in greater detail in section II.H.5.a. of the preamble of this proposed rule, the manufacturer of KYMRIAH™ and the manufacturer of YESCARTA™ submitted separate applications for new technology add-on payments for FY 2019. We believe that, in the context of these pending new technology add-on payment applications, there may also be merit in the suggestion from the public to allow hospitals to utilize a CCR specific to procedures involving the ICD–10–PCS procedures codes describing CAR T-cell therapy drugs for FY 2019 as part of the determination of the cost of a case for purposes of calculating outlier payments for individual FY 2019 cases, new technology add-on payments, if approved, for individual FY 2019 cases, and payments to IPPS-excluded cancer hospitals beginning in FY 2019. For example, a CCR of 1.0 could be used for charges associated with ICD–10–PCS procedure codes XW033C3 and XW043C3, as many public inquirers believed hospitals would be unlikely to set charges different from costs for the use of KYMRIAH™ and YESCARTA™. Such a change would result in a higher outlier payment, higher new technology add-on payment, or the determination of higher costs for IPPS-excluded cancer hospital cases. For example, if a hospital charged $400,000 for the procedure described by ICD–10–PCS procedure code XW033C3, the application of a hypothetical CCR of 0.25 results in a cost of $100,000 (= $400,000 * 0.25) while the application of a hypothetical CCR of 1.00 results in a cost of $400,000 (= $400,000 * 1.0).

We are inviting public comments on this alternative approach for FY 2019.

We also are inviting comments on how this payment alternative would affect access to care, as well as how it affects incentives to encourage lower drug prices, which is a high priority for this Administration. In addition, we are considering alternative approaches and authorities to encourage value-based care and lower drug prices. We solicit comments on how the payment methodology alternatives may intersect and affect future participation in any such alternative approaches.

(4) FY 2017 Outlier Payments

Our current estimate, using available FY 2017 claims data, is that actual outlier payments for FY 2017 were approximately 5.53 percent of actual total MS–DRG payments. Therefore, the data indicate that, for FY 2017, the percentage of actual outlier payments relative to actual total payments is higher than we projected for FY 2017. Consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not make retroactive adjustments to outlier payments

had been in effect at the time of those discharges.

To determine the applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases, we estimate outlier payments and total LTCH PPS payments for each LTCH PPS standard Federal payment rate case (or for each case that would have been a LTCH PPS standard Federal payment rate case if the statutory changes had been in effect at the time of the discharge) using claims data from the MedPAR files. In accordance with § 412.525(a)(2)(ii), the applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases results in estimated total outlier payments being projected to be equal to 7.975 percent of projected total LTCH PPS payments for LTCH PPS standard Federal payment rate cases. We use MedPAR claims data and CCRs based on data from the most recent PSF (or from the applicable statewide average CCR if an LTCH's CCR data are faulty or unavailable) to establish an applicable fixed-loss threshold amount for LTCH PPS standard Federal payment rate cases.

In this FY 2019 IPPS/LTCH PPS proposed rule, we are proposing to continue to use our current methodology to calculate an applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2019 using the best available data that would maintain estimated HCO payments at the projected 7.975 percent of total estimated LTCH PPS payments for LTCH PPS standard Federal payment rate cases (based on the proposed payment rates and policies for these cases presented in this proposed rule). Specifically, based on the most recent complete LTCH data available at this time (that is, LTCH claims data from the December 2017 update of the FY 2017 MedPAR file and CCRs from the December 2017 update of the PSF), we are proposing to determine a proposed fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2019 of $30,639 that would result in estimated outlier payments projected to be equal to 7.975 percent of estimated FY 2019 payments for such cases. Under this proposal, we would continue to make an additional HCO payment for the cost of an LTCH PPS standard Federal payment rate case that exceeds the HCO threshold amount that is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the proposed adjusted LTCH PPS standard Federal payment rate payment and the proposed fixed-loss amount for LTCH PPS standard Federal payment rate cases of $30,639).

We note that the proposed fixed-loss amount for HCO cases paid under the LTCH PPS standard Federal payment rate in FY 2019 of $30,639 is higher than the FY 2018 fixed-loss amount of $27,381 for LTCH PPS standard Federal payment rate cases. However, based on the most recent available data at the time of the development of this FY 2019 IPPS/LTCH PPS proposed rule, we found that the current FY 2018 HCO threshold of $27,381 results in estimated HCO payments for LTCH PPS standard Federal payment rate cases of approximately 7.988 percent of the estimated total LTCH PPS payments in FY 2018, which exceeds the 7.975 percent target by 0.01 percentage points. We continue to believe, as discussed in detail in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38542 through 38543), this increase is largely attributable to the rate-of-change (that is, increase) in the Medicare allowable charges on the claims data in addition to updates to CCRs from the December 2016 update of the PSF to the March 2017 update of the PSF. Consistent with our historical practice of using the best data available, we are proposing that, when determining the fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2019 in the final rule, we would use the most recent available LTCH claims data and CCR data at the time.

3. Proposed High-Cost Outlier Payments for Site Neutral Payment Rate Cases

Under § 412.525(a), site neutral payment rate cases receive an additional HCO payment for costs that exceed the HCO threshold that is equal to 80 percent of the difference between the estimated cost of the case and the applicable HCO threshold (80 FR 49618 through 49629). In the following discussion, we note that the statutory transitional payment method for cases that are paid the site neutral payment rate for LTCH discharges occurring in cost reporting periods beginning during FY 2016 through FY 2019 uses a blended payment rate, which is determined as 50 percent of the site neutral payment rate amount for the discharge and 50 percent of the LTCH PPS standard Federal payment rate amount for the discharge (§ 412.522(c)(3)). As such, for FY 2019 discharges paid under the transitional payment method, the discussion below pertains only to the site neutral payment rate portion of the blended payment rate under § 412.522(c)(3)(i).

When we implemented the application of the site neutral payment rate in FY 2016, in examining the appropriate fixed-loss amount for site neutral payment rate cases issue, we considered how LTCH discharges based on historical claims data would have been classified under the dual rate LTCH PPS payment structure and the CMS' Office of the Actuary projections regarding how LTCHs will likely respond to our implementation of policies resulting from the statutory payment changes. We again relied on these considerations and actuarial projections in FY 2017 and FY 2018 because the historical claims data available in each of these years were not all subject to the LTCH PPS dual rate payment system. Similarly, for FY 2019, we continue to rely on these considerations and actuarial projections because, due to the transitional blended payment policy for site neutral payment rate cases, FY 2017 claims for these cases were not subject to the full effect of the site neutral payment rate.

For FYs 2016 through 2018, at that time our actuaries projected that the proportion of cases that would qualify as LTCH PPS standard Federal payment rate cases versus site neutral payment rate cases under the statutory provisions would remain consistent with what is reflected in the historical LTCH PPS claims data. Although our actuaries did not project an immediate change in the proportions found in the historical data, they did project cost and resource changes to account for the lower payment rates. Our actuaries also projected that the costs and resource use for cases paid at the site neutral payment rate would likely be lower, on average, than the costs and resource use for cases paid at the LTCH PPS standard Federal payment rate and would likely mirror the costs and resource use for IPPS cases assigned to the same MS–DRG, regardless of whether the proportion of site neutral payment rate cases in the future remains similar to what is found based on the historical data. As discussed in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49619), this actuarial assumption is based on our expectation that site neutral payment rate cases would generally be paid based on an IPPS comparable per diem amount under the statutory LTCH PPS payment changes that began in FY 2016, which, in the majority of cases, is much lower than the payment that would have been paid if these statutory changes were not enacted. In light of these projections and expectations, we discussed that we believed that the use of a single fixed-loss amount and HCO target for all LTCH PPS cases would be problematic. In addition, we discussed that we did not believe that it would be appropriate for comparable LTCH PPS site neutral payment rate cases to receive dramatically different HCO payments from those cases that would be paid under the IPPS (80 FR 49617 through 49619 and 81 FR 57305 through 57307). For those reasons, we stated that we believed that the most appropriate fixed-loss amount for site neutral payment rate cases for FYs 2016 through 2018 would be equal to the IPPS fixed-loss amount for that particular fiscal year. Therefore, we established the fixed-loss amount for site neutral payment rate cases as the corresponding IPPS fixed-loss amounts for FYs 2016 through 2018. In particular, in FY 2018, we established the fixed-loss amount for site neutral payment rate cases as the FY 2018 IPPS fixed-loss amount of $26,537 (82 FR 46145).

As noted earlier, because not all claims in the data used for this proposed rule were subject to the site neutral payment rate, we continue to rely on the same considerations and actuarial projections used in FYs 2016 through 2018 when developing a proposed fixed-loss amount for site neutral payment rate cases for FY 2019. Because our actuaries continue to project that site neutral payment rate cases in FY 2019 will continue to mirror an IPPS case paid under the same MS–DRG, we continue to believe that it would be inappropriate for comparable LTCH PPS site neutral payment rate cases to receive dramatically different HCO payments from those cases that would be paid under the IPPS. More specifically, as with FYs 2016 through 2018, our actuaries project that the costs and resource use for FY 2019 cases paid at the site neutral payment rate would likely be lower, on average, than the costs and resource use for cases paid at the LTCH PPS standard Federal payment rate and will likely mirror the costs and resource use for IPPS cases assigned to the same MS–DRG, regardless of whether the proportion of site neutral payment rate cases in the future remains similar to what is found based on the

historical data. (Based on the most recent FY 2017 LTCH claims data, approximately 64 percent of LTCH cases would have been paid the LTCH PPS standard Federal payment rate and approximately 36 percent of LTCH cases would have been paid the site neutral payment rate for discharges occurring in FY 2017.)

For these reasons, we continue to believe that the most appropriate proposed fixed-loss amount for site neutral payment rate cases for FY 2019 is the proposed IPPS fixed-loss amount for FY 2019. Therefore, consistent with past practice, in this FY 2019 IPPS/LTCH PPS proposed rule, for FY 2019, we are proposing that the applicable HCO threshold for site neutral payment rate cases is the sum of the site neutral payment rate for the case and the proposed IPPS fixed-loss amount. That is, we are proposing a fixed-loss amount for site neutral payment rate cases of $27,545, which is the same proposed FY 2019 IPPS fixed-loss amount discussed in section II.A.4.g.(1) of the Addendum to this proposed rule. We continue to believe that this policy would reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems. Accordingly, for FY 2019, we are proposing to calculate a HCO payment for site neutral payment rate cases with costs that exceed the HCO threshold amount that is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the proposed site neutral payment rate payment and the proposed fixed-loss amount for site neutral payment rate cases of $27,545).

In establishing a HCO policy for site neutral payment rate cases, we established a budget neutrality adjustment under § 412.522(c)(2)(i). We established this requirement because we believed, and continue to believe, that the HCO policy for site neutral payment rate cases should be budget neutral, just as the HCO policy for LTCH PPS standard Federal payment rate cases is budget neutral, meaning that estimated site neutral payment rate HCO payments should not result in any change in estimated aggregate LTCH PPS payments.

To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2019 would not result in any increase in estimated aggregate FY 2019 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i), it is necessary to reduce site neutral payment rate payments (or the portion of the blended payment rate payment for FY 2018 discharges occurring in LTCH cost reporting periods beginning before October 1, 2017) by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2019. In order to achieve this, for FY 2019, in general, we are proposing to continue to use the policy adopted for FY 2018.

As discussed earlier, consistent with the IPPS HCO payment threshold, we estimate our proposed fixed-loss threshold of $27,545 results in HCO payments for site neutral payment rate cases to equal 5.1 percent of the site neutral payment rate payments that are based on the IPPS comparable per diem amount. As such, to ensure estimated HCO payments payable for site neutral payment rate cases in FY 2019 would not result in any increase in estimated aggregate FY 2019 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i), it is necessary to reduce the site neutral payment rate amount paid under § 412.522(c)(1)(i) by 5.1 percent to account for the estimated additional HCO payments payable for site neutral payment rate cases in FY 2019. In order to achieve this, for FY 2019, we are proposing to apply a budget neutrality factor of 0.949 (that is, the decimal equivalent of a 5.1 percent reduction, determined as $1.0 - 5.1/100 = 0.949$) to the site neutral payment rate for those site neutral payment rate cases paid under § 412.522(c)(1)(i). We note that, consistent with the policy adopted for FY 2018, this proposed HCO budget neutrality adjustment would not be applied to the HCO portion of the site neutral payment rate amount (81 FR 57309).

E. Proposed Update to the IPPS Comparable/Equivalent Amounts To Reflect the Statutory Changes to the IPPS DSH Payment Adjustment Methodology

In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50766), we established a policy to reflect the changes to the Medicare IPPS DSH payment adjustment methodology made by section 3133 of the Affordable Care Act in the calculation of the ''IPPS comparable amount'' under the SSO policy at § 412.529 and the ''IPPS equivalent amount'' under the 25-percent threshold payment adjustment policy at § 412.534 and § 412.536. Historically, the determination of both the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' includes an amount for inpatient operating costs ''for the costs of serving a disproportionate share of low-income patients.'' Under the statutory changes to the Medicare DSH payment adjustment methodology that began in FY 2014, in general, eligible IPPS hospitals receive an empirically justified Medicare DSH payment equal to 25 percent of the amount they otherwise would have received under the statutory formula for Medicare DSH payments prior to the amendments made by the Affordable Care Act. The remaining amount, equal to an estimate of 75 percent of the amount that otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals who are uninsured, is made available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. The additional uncompensated care payments are based on the hospital's amount of uncompensated care for a given time period relative to the total amount of uncompensated care for that same time period reported by all IPPS hospitals that receive Medicare DSH payments.

To reflect the statutory changes to the Medicare DSH payment adjustment methodology in the calculation of the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' under the LTCH PPS, we stated that we will include a reduced Medicare DSH payment amount that reflects the projected percentage of the payment amount calculated based on the statutory Medicare DSH payment formula prior to the amendments made by the Affordable Care Act that will be paid to eligible IPPS hospitals as empirically justified Medicare DSH payments and uncompensated care payments in that year (that is, a percentage of the operating Medicare DSH payment amount that has historically been reflected in the LTCH PPS payments that is based on IPPS rates). We also stated that the projected percentage will be updated annually, consistent with the annual determination of the amount of uncompensated care payments that will be made to eligible IPPS hospitals. We believe that this approach results in appropriate payments under the LTCH PPS and is consistent with our intention that the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' under the LTCH PPS closely resemble what an IPPS payment would have been for the same episode of care, while recognizing that some features of the IPPS cannot be translated directly into the LTCH PPS (79 FR 50766 through 50767).

For FY 2019, as discussed in greater detail in section IV.F.3. of the preamble of this proposed rule, based on the most recent data available, our estimate of 75 percent of the amount that would otherwise have been paid as Medicare DSH payments (under the methodology outlined in section 1886(r)(2) of the Act) is adjusted to 67.51 percent of that amount to reflect the change in the percentage of individuals who are uninsured. The resulting amount is then used to determine the amount available to make uncompensated care payments to eligible IPPS hospitals in FY 2018. In other words, the amount of the Medicare DSH payments that would have been made prior to the amendments made by the Affordable Care Act will be adjusted to 50.63 percent (the product of 75 percent and 67.51 percent) and the resulting amount will be used to calculate the uncompensated care payments to eligible hospitals. As a result, for FY 2019, we project that the reduction in the amount of Medicare DSH payments pursuant to section 1886(r)(1) of the Act, along with the payments for uncompensated care under section 1886(r)(2) of the Act, will result in overall Medicare DSH payments of 75.63 percent of the amount of Medicare DSH payments that would otherwise have been made in the absence of the amendments made by the Affordable Care Act (that is, 25 percent + 50.63 percent = 75.63 percent).

In this FY 2019 IPPS/LTCH PPS proposed rule, for FY 2019, we are proposing to establish that the calculation of the ''IPPS comparable amount'' under § 412.529 would include an applicable operating Medicare DSH payment amount that is equal to 75.63 percent of the operating Medicare DSH payment amount that would have been paid based on the statutory Medicare DSH payment formula absent the amendments made by the Affordable Care Act. Furthermore, consistent with our historical practice, we are proposing that if more recent data became available, if appropriate, we will use that data to determine this factor in the final rule.

June 22, 2018

Filed Electronically

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-1694-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers;
***Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims*; 83 Federal Register 20,164 (May 7, 2018)**

Dear Administrator Verma:

This letter presents the comments and recommendations of LifeCare Health Partners ("LifeCare") on the above-referenced Proposed Rule. LifeCare operates a network of 19 long-term acute care hospitals ("LTCHs") in 9 states that care for medically-complex patients who require acute care hospital services for an extended period of time. We appreciate the opportunity to express our concerns with the proposed changes to the fiscal year ("FY") 2019 LTCH prospective payment system ("LTCH PPS") and related policies, and we trust that CMS will carefully consider each of the issues raised in this letter.

THE 25% RULE SHOULD BE RETIRED, AS PROPOSED, BECAUSE THE NEW PATIENT CRITERIA MAKE IT UNNECESSARY, BUT CMS SHOULD NOT APPLY A BNA

Issue. The *Medicare, Medicaid and SCHIP Extension Act of 2007* ("MMSEA") (Pub. L. 110-173), as amended, temporarily froze the implementation of the 25% Rule regulations at 42 C.F.R. §§ 412.534 and 412.536 (*i.e.*, the "25% Rule"). This regulatory relief has been extended a number of times to create a "statutory moratorium" until cost reporting periods beginning on or after July 1, 2016 and, under section 15006 of the *21st Century Cures Act* (Pub. L. 114-255), for discharges occurring on or after October 1, 2016 and

We do not think this was Congress' intent. There are only two provisions in BBA section 51005. The first provides additional relief to LTCHs, the second provision pays for that relief. Accordingly, both provisions should apply to hospital fiscal years to be implemented consistently. It is clear that the 4.6% payment cut to the IPPS comparable per diem amount should take effect simultaneously with the extension of the blended payment rate, based on LTCH cost reporting periods.

Recommendations. **CMS should implement both parts of section 51005 of the BBA by LTCH cost reporting periods. Thus, the 4.6% payment cut to LTCH site neutral payments under the BBA should be applied to LTCH discharges in cost reporting periods beginning on or after October 1, 2017 through September 30, 2026. This is necessary to be consistent with the rest of the site neutral payment statute and regulation, as well as congressional intent.**

CMS SHOULD NOT APPLY AN ADDITIONAL BUDGET NEUTRALITY ADJUSTMENT TO SITE NEUTRAL PAYMENTS FOR HIGH-COST OUTLIERS

Issue. CMS is proposing to continue to apply a budget neutrality adjustment ("BNA") factor under section 412.522(c)(2)(i) to all cases paid at the site neutral payment rate (including the site neutral payment rate portion of blended rate payments during the transition period) so that HCO payments for site neutral cases will not result in any change in estimated aggregate LTCH PPS payments. CMS says that "[w]e established this requirement because we believed, and continue to believe, that the HCO policy for site neutral payment rate cases should be budget neutral, just as the HCO policy for LTCH PPS standard Federal payment rate cases are budget neutral."[25] "To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2019 would not result in any increase in estimated aggregate FY 2019 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i)" CMS says that "it is necessary to reduce site neutral payment rate payments (or the portion of the blended payment rate payment for FY 2018 discharges occurring in LTCH cost reporting periods beginning before October 1, 2017) by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2019."[26] For FY 2019, CMS is proposing to continue to apply a budget neutrality factor of 0.949 (the decimal equivalent of a 5.1% reduction) to the site neutral payment rate cases paid under § 412.522(c)(1)(i).

[25] 83 Fed. Reg. at 20,596.

[26] Id. CMS incorrectly refers to FY 2018 discharges and cost reporting periods beginning after October 1, 2017 in the parenthetical. This should say FY 2019 discharges and cost reporting periods beginning after October 1, 2018. We assume this was simply an oversight because CMS is using the same language it used last year to describe the budget neutrality adjustment.

Comment. **As in recent years, we *strongly disagree* with CMS' proposal to apply an *additional* 5.1% budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. This BNA is duplicative and unwarranted because CMS has *already* applied budget neutrality adjustments to reduce the operating and capital portions of the IPPS standard Federal payment rate by the same 5.1%, before using that rate to determine the IPPS comparable per diem amount for site neutral payment cases. MedPAC agreed.**

In MedPAC's May 31, 2016 comment letter to CMS on the Proposed Rule, MedPAC states that CMS should not apply a separate budget neutrality adjustment to site neutral high-cost outliers because "the IPPS standard payment amount is already adjusted to account for HCO payments."[27] As MedPAC explains:

> CMS proposes to use the IPPS fixed-loss amount to determine if a discharge paid under the site-neutral rate qualifies to receive an HCO payment again for FY 2017. CMS sets the IPPS fixed-loss amount each year at a level that it estimates will result in aggregate HCO payments equal 5.1 percent of total IPPS payment. **To account for the spending attributed to these outlier payments, CMS reduces the IPPS base payment rates to maintain budget neutrality in the IPPS. The IPPS-comparable rate used to pay for site-neutral cases in LTCHs includes an adjustment for budget neutrality to account for spending associated with HCOs.**
>
> With the Commission's payment principles in mind, **MedPAC urges CMS to eliminate the proposed payment adjustment for discharges paid the site-neutral rate to account for outlier payments under this payment methodology. Given that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.**[28]

CMS addressed this issue to some extent in the FY 2016 IPPS/LTCH PPS final rule, but the agency did not see the duplication that MedPAC says is problematic. First, CMS confirmed that the IPPS base rates used to calculate LTCH site neutral payments already include the budget neutrality adjustment discussed above for HCO payments.[29] CMS referred to this BNA as "one of the inputs" used to calculate the LTCH site neutral payment

---

[27] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 16 (May 31, 2016).

[28] Id. at 16-17 (emphasis added).

[29] See 80 Fed. Reg. at 49,622 ("While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments . . .").

rate.[30] CMS then tried to distinguish this BNA from the LTCH site neutral HCO BNA by stating that these adjustments fund different outlier payments—the former funds outlier payments for IPPS hospitals and the latter funds site neutral outlier payments for LTCHs.[31] This is *not correct*, as MedPAC points out. Since "the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative."[32] **Stated another way, because CMS is using the adjusted IPPS base rates for LTCH site neutral payments, the rates are already reduced 5.1% for outlier budget neutrality. The separate 5.1% budget neutrality adjustment for LTCH site neutral HCOs reduces such payments by *another* 5.1%, for a total BNA of 10.2%.**

CMS briefly responded to this issue again in the FY 2017 IPPS/LTCH PPS final rule, but CMS did not address the duplication directly. Instead, CMS speculated that Congress knew when passing the PSRA that CMS reduces LTCH PPS payments each year by estimated HCO payments, and that CMS "budget neutralized" LTCH very short-stay outlier payments since 2006 based on the same IPPS comparable per diem amount. Unfortunately, the regulation CMS refers to (42 C.F.R. § 412.529(d)(4)) does not specify a separate budget neutrality adjustment for HCO or SSO payments based upon the IPPS comparable per diem amount, and CMS does not state any other authority for this assertion. Therefore, it is difficult to see how Congress was "well aware" of this policy when it passed the PSRA. More importantly, CMS avoided responding to the basic criticism that the IPPS and Capital PPS base rates already have budget neutrality adjustments calculated upon the same 5.1% target amount for HCO payments (higher that year for Capital PPS HCO payments).

In the FY 2018 IPPS/LTCH PPS final rule, CMS acknowledged the continued objections from commenters to this BNA for LTCH site neutral HCOs, but simply disagreed and referred readers to the agency's previous rulemakings. CMS said that they "continue to believe this budget neutrality adjustment is appropriate."[33]

Because CMS has been unwilling to address these issues directly the past two years, we are forced to raise them again for consideration this year. We hope that CMS will take our concerns more seriously, now that the agency has had additional time to consider the matter.

---

[30] See id. (". . . that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate.").

[31] See id. ("The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS.").

[32] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 17.

[33] 82 Fed. Reg. at 38,546.

To ensure that LTCHs are only paying for high cost outliers at LTCHs once, not twice, CMS must not apply the separate 5.1% budget neutrality adjustment for LTCH site neutral cases. CMS is proposing to adjust LTCH site neutral payments *twice* to keep the LTCH PPS budget neutral for the estimated 5.1% of LTCH payments for site neutral HCO cases. The payment reduction is actually larger for site neutral cases that receive a HCO payment. Consistent with MedPAC's recommendation, CMS should only adjust LTCH site neutral payments *once* for outlier budget neutrality. By eliminating the additional BNA for site neutral HCOs, CMS still has "a budget neutrality adjustment when determining payment for a case under the LTCH PPS" to avoid the situation where "any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases."[34] Moreover, this "approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases."[35] Without making this change, the duplicative BNA not only "exaggerates the disparity in payment rates across provider settings," as MedPAC states, but it is also purely punitive.

Therefore, it would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed 5.1% site neutral HCO BNA to LTCH site neutral payments. This would be the case because the IPPS comparable per diem amount is based on the IPPS and capital PPS payment rates, which have already been reduced by 5.1% and 5.06%, respectively, for outlier payments. Since CMS has already made these adjustments for budget neutrality, it would be inappropriate for CMS to reduce LTCH site neutral payments that are based on the IPPS and capital PPS rates by *another 5.1%* for HCOs. Accordingly, we object to CMS' proposal to apply a separate HCO BNA to LTCH site neutral payments. CMS should not reduce LTCH site neutral payments for HCOs by 10.2% in total to keep the LTCH PPS budget neutral.

For the same reasons, it was incorrect for CMS to apply the 5.1% (0.949) site neutral HCO BNA to FY 2016, FY 2017 and FY 2018 site neutral rate cases. CMS is underpaying LTCHs for site neutral rate cases in FY 2016 through FY 2018 by 5.1%. CMS should reverse this adjustment to all FY 2016 through FY 2018 payments, or make an equivalent prospective increase in payments to FY 2019 site neutral rate cases to account for this underpayment.

Recommendations. **Consistent with MedPAC's prior comments, we *strongly disagree* with the proposed additional 5.1% (0.949) budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. There is no precedent for multiplying a budget neutrality adjustment to the annual payment rate determination for the LTCH PPS. CMS already reduced the FY 2019 site neutral payment amount for estimated outlier payments by 5.1% via the IPPS HCO outlier factor and the capital PPS outlier factor. CMS should *not* reduce LTCH site neutral payments by *another 5.1%*. For the same reason, CMS should reverse this**

[34] 80 Fed. Reg. at 49,622.

[35] Id.

duplicative adjustment to all FY 2016 through FY 2018 payments, or make an equivalent prospective increase in payments to FY 2019 site neutral rate cases to account for this underpayment.

THE REGULATIONS ON PHYSICIAN DOCUMENTATION REQUIREMENTS SHOULD BE REVISED

Issue. CMS is proposing to revise the regulation at 42 C.F.R. § 412.3(a) to remove the language that a physician order must be present in the medical record, supported by the physician admission and progress notes, for the hospital to be paid for hospital inpatient services under Medicare Part A. CMS says that Medicare payments are being denied for some otherwise medically necessary inpatient admissions because of technical discrepancies with the documentation of inpatient admission orders, such as missing physician admission signatures, missing co-signatures or authentication signatures, and signatures after patient discharge. CMS is also proposing to clarify the regulation at 42 C.F.R. § 424.11(c) by deleting the sentence that says that physician statements that certify or recertify the medical necessity of certain covered services to Medicare beneficiaries must state where in the medical record supporting information from the physician, such as physician progress notes, can be found. Currently, claims can be denied if the physician statement does not specify where this information is found in the record, even if such supporting information is obvious to the claim reviewer. CMS would move other language in this regulation to clarify that supporting information contained elsewhere in the provider's records need not be repeated in the certification or recertification statement itself.

Comment. We support the proposed changes to both of these regulations. Medically necessary inpatient claims should not be denied solely on the basis of a technical discrepancy in the beneficiary's medical record. We agree with CMS that when a provider is complying with the hospital CoPs, claim reviews should not be focused on identifying technical issues with the documentation. Hospitals are already required under the CoPs to appropriately admit patients and document the need for admissions. The medical record CoP for hospitals requires that "[t]he medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services."[36] Thus, we agree with CMS' proposals to revise the requirements related to the documentation of physician orders and physician certifications of medical necessity. We appreciate that CMS has decided to make these changes to the regulations so that otherwise allowable Medicare claims for medically necessary services will not be denied based on technicalities. Fewer technical denials will mean fewer payment interruptions to providers. It will also reduce the administrative burden on providers and require fewer claim appeals at a time when the claims appeal system is already having great difficulty rendering timely decisions.

[36] 42 C.F.R. § 482.24(c).

June 25, 2018

Filed Electronically

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS-1694-P
P.O. Box 8011
Baltimore, MD 21244-1850

***Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims*; 83 Federal Register 20,164 (May 7, 2018)**

Dear Administrator Verma:

This letter presents the comments and recommendations of Kindred Healthcare, Inc. ("Kindred Healthcare") and Select Medical Holdings Corporation ("Select Medical") on the above-referenced Proposed Rule. Kindred Healthcare and Select Medical collectively operate 174 hospitals that are certified by Medicare as long-term acute care hospitals ("LTCHs")—almost half of the LTCHs operating across the United States. These hospitals care for medically-complex patients who require acute care hospital services for an extended period of time. We appreciate the opportunity to express our support and concerns related to the proposed changes to the fiscal year ("FY") 2019 LTCH prospective payment system ("LTCH PPS") and related policies, and we trust that CMS will carefully consider each of the issues raised in this letter.

at page 20,581 of the Proposed Rule. CMS calculated a 1-year average annualized rate-of-change in charges per case for FY 2019 of 4.2 percent (1.04205) or 8.6[57] percent (1.085868) over two years. The same charge inflation factor applies to the fixed-loss threshold for LTCH site neutral cases because CMS currently uses the IPPS fixed-loss threshold for these LTCH cases. However, CMS does not provide a detailed explanation of its methodology for calculating the outlier fixed-loss threshold for LTCH standard rate cases. CMS also does not provide the charge inflation factor it used to calculate the proposed outlier fixed-loss threshold for LTCH standard rate cases. After contacting CMS, we learned that CMS used a 5.4 percent charge inflation factor.

As discussed above, the amount of the outlier fixed-loss threshold has increased dramatically each year since CMS began implementing the dual-rate LTCH PPS. It increased more than 33 percent from FY 2016 to FY 2017. CMS raised it another 25 percent in FY 2018. Now, CMS is proposing a 12 percent increase to the fixed-loss amount. CMS continues to say that the rate-of-change in the Medicare allowable charges on the claims data in the MedPAR was a significant contributing factor to the notable increase in the HCO threshold. Yet, CMS does not provide enough information in the proposed rule to evaluate the accuracy of this statement. The charge inflation factor is an important part of the calculation for the outlier fixed-loss threshold. If increases in LTCH charges are largely responsible for the significant year-over-year increases in the outlier threshold for LTCH standard rate cases, as CMS says, it is even more important for CMS to be transparent about the charge inflation factor it uses to set the threshold.

Recommendations. **CMS should provide more information in the proposed rule for the annual payment update to the LTCH PPS about how it calculates the outlier threshold for LTCH standard rate cases. In particular, CMS should provide the charge inflation factor and an explanation of how it was calculated. CMS provides this information for the IPPS. It should do the same for the LTCH PPS.**

2. Budget Neutrality Adjustment for Site Neutral HCO Cases

Issue. CMS also is proposing to continue to apply a budget neutrality adjustment factor under section 412.522(c)(2)(i) to all cases paid at the site neutral payment rate (including the site neutral payment rate portion of blended rate payments during the transition period) so that HCO payments for site neutral cases will not result in any change in estimated aggregate LTCH PPS payments. CMS says that "[w]e established this requirement because we believed, and continue to believe, that the HCO policy for site neutral payment rate cases should be budget neutral, just as the HCO policy for LTCH PPS standard Federal payment rate cases are budget neutral."[58] "To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2019 would not result in any increase in estimated aggregate FY 2019 LTCH PPS payments, under

[57] The preamble incorrectly says 9.5.

[58] 83 Fed. Reg. at 20,596.

the budget neutrality requirement at § 412.522(c)(2)(i)" CMS says that "it is necessary to reduce site neutral payment rate payments (or the portion of the blended payment rate payment for FY 2018 discharges occurring in LTCH cost reporting periods beginning before October 1, 2017) by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2019."[59] For FY 2019, CMS is proposing to continue to apply a budget neutrality factor of 0.949 (the decimal equivalent of a 5.1% reduction) to the site neutral payment rate cases paid under § 412.522(c)(1)(i).

Comment. **We *strongly disagree* with CMS' proposal to apply an *additional* 5.1% budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. CMS is proposing to apply a second BNA to all LTCH payments for site neutral rate cases to offset LTCH payments for HCO site neutral rate cases. As we explained in previous comments, this BNA is duplicative and unwarranted because CMS has *already* applied budget neutrality adjustments to reduce the operating and capital portions of the IPPS standard Federal payment rate by the same 5.1%, before using that rate to determine the IPPS comparable per diem amount for site neutral payment cases. MedPAC and the AHA agreed that this BNA is duplicative and should not be used to further adjust site neutral payments. We address each of these points in more detail below. We request that CMS take a fresh look at this issue to avoid a continuation of this erroneous policy.**

a. The Proposed BNA to Site Neutral Payments is Duplicative

CMS already accounted for site neutral HCO payments by using the IPPS and Capital PPS payment rates for the IPPS comparable per diem amount. As discussed above, HCO payments for LTCH site neutral cases will be 80% of the difference between the estimated cost of the case and the proposed IPPS HCO threshold, which is proposed to be $27,545 for FY 2019. The proposed IPPS HCO threshold for cases paid at the site neutral payment rate would be the sum of the site neutral payment and the proposed IPPS fixed-loss amount of $27,545. Because cases paid at the site neutral payment rate that are paid 100% of the estimated cost of the case would never be eligible for HCO payments, only site neutral cases based on the IPPS comparable per diem amount will be eligible for HCO payments. The IPPS comparable per diem amount, as determined under section 412.529(d)(4), is "based on the sum of the applicable operating inpatient prospective payment system standardized amount and the capital inpatient prospective payment system Federal rate in effect at the time of the LTCH discharge."[60] Congress required calculation of the IPPS comparable per diem amount in this way because it is based on the existing regulation at section 412.529(d)(4) for

[59] Id. CMS incorrectly refers to FY 2018 discharges and cost reporting periods beginning after October 1, 2017 in the parenthetical. This should say FY 2019 discharges and cost reporting periods beginning after October 1, 2018. We assume this was simply an oversight because CMS is using the same language it used last year to describe the budget neutrality adjustment.

[60] 42 C.F.R. § 412.529(d)(4)(i)(A).

LTCH short-stay outlier payments.[61] We note that this statute and this regulation do not require a budget neutrality adjustment.

CMS continues to believe that a separate BNA for LTCH site neutral HCO cases will "reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems."[62] However, by aligning this proposed policy with the IPPS payment system—and making the IPPS comparable per diem amount and the IPPS fixed-loss amount the primary components—CMS needs to consider the adjustments that it has *already* made to the proposed IPPS and capital PPS payment rates to account for outlier payments. Like MedPAC and the AHA, we do not believe CMS had done this in the Proposed Rule.

Specifically, CMS already reduced the operating standardized payment amount under the IPPS and the capital Federal rate under the capital PPS for outliers. In determining these payment rates for FY 2019, CMS reduced the IPPS payment rate by a factor of 0.948999[63] and CMS reduced the capital PPS payment rate by a factor of 0.9494.[64] As CMS explains, these 5.1% and 5.06% outlier adjustment factors, respectively, already reduce the IPPS and capital PPS payment rates.[65]

b. MedPAC Agreed that the BNA to Site Neutral Payments is Duplicative and Should Not Be Applied

In MedPAC's May 31, 2016 comment letter to CMS on the FY 2017 IPPS/LTCH PPS proposed rule, MedPAC states that **CMS should <u>not</u> apply a separate budget neutrality adjustment to site neutral high-cost outliers because "the IPPS standard payment amount is already adjusted to account for HCO payments."**[66] As MedPAC explains:

> CMS proposes to use the IPPS fixed-loss amount to determine if a discharge paid under the site-neutral rate qualifies to receive an HCO payment again for FY 2017. CMS sets the IPPS fixed-loss amount each year at a level that it estimates will result in aggregate HCO payments equal 5.1 percent of total IPPS payment. **To account for the spending attributed to these outlier payments, CMS reduces the IPPS base payment rates to maintain budget neutrality in the IPPS. <u>The IPPS-comparable rate used to pay for site-neutral cases in LTCHs includes</u>**

[61] <u>See</u> SSA § 1886(m)(6)(B)(ii)(I).

[62] 83 Fed. Reg. at 20,596.

[63] <u>Id.</u> at 20,584.

[64] <u>Id.</u> at 20,589.

[65] <u>Id.</u> at 20,582-84.

[66] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 16 (May 31, 2016).

> **an adjustment for budget neutrality to account for spending associated with HCOs.**
>
> With the Commission's payment principles in mind, **MedPAC urges CMS to eliminate the proposed payment adjustment for discharges paid the site-neutral rate to account for outlier payments under this payment methodology. Given that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.**[67]

These comments are equally applicable to the current Proposed Rule because CMS is using the same methodology and the same BNA factor to reduce LTCH payments.

MedPAC was also generally critical of the site neutral payment rate established by Congress because the "lesser of" mechanism results in LTCH payments *below* IPPS hospital payments, thereby failing to "equalize payments" across LTCH and IPPS provider types for such cases.[68] Specifically, MedPAC commented that the LTCH site neutral payment rate "could result in the LTCH receiving a lower payment than what it would have received for a similar discharge."[69] If CMS were to impose a second BNA to reduce LTCH site neutral payments by an additional 5.1%, it would exaggerate this disparity even further. This is contrary to the principle of site neutrality in payments.

c. CMS Should Not Apply the Proposed BNA to Site Neutral Payments

To ensure that LTCHs are only paying for high cost outliers at LTCHs, and not IPPS hospitals, CMS must not apply the separate 5.1% adjustment for LTCH site neutral cases. This is illustrated in **Table 1** below using information from the Proposed Rule.

[67] Id. at 16-17 (emphasis added).

[68] Id. at 16.

[69] Id.

TABLE 1

FY 2019 LTCH Site Neutral Payment Amount Comparison – With and Without Proposed Budget Neutrality Adjustment to Site Neutral Payments

Duplicate BNAs in Proposed Rule		**Apply BNA Once by Not Applying LTCH Site Neutral HCO BNA**
IPPS Standardized Amount (before adjustments)[1]		
Labor	$4,059.36	$4,059.36
Non-Labor	$1,884.07	$1,884.07
Subtotal A	$5,943.43	$5,943.43
IPPS HCO Outlier Factor (0.948999)[2]	**$(303.12)**	**$(303.12)**
Other Adjustments[3]	$15.87	$15.87
IPPS Standardized Amount (after adjustments)[4]		
Labor	$3,863.17	$3,863.17
Non-Labor	$1,793.01	$1,793.01
Subtotal B	$5,656.18	$5,656.18
Capital PPS Rate (before adjustments)[5]	$453.95	$453.95
Capital PPS Outlier Factor (0.9494)[6]	**$(22.97)**	**$(22.97)**
Other Adjustments[7]	$28.80	$28.80
Capital PPS Rate (after adjustments)[8]	$459.78	$459.78
Subtotal B + Capital PPS Rate (after adjustments)	$6,115.96	$6,115.96
LTCH Site Neutral Outlier Factor (0.949)[9]	**$(311.91)**	**N/A**
Total	$5,804.05	$6,115.96

[1] 83 Fed. Reg. at 20,584 (assuming full update and wage index greater than 1.0).
[2] Id.
[3] Id.
[4] Id.
[5] Id. at 20,589.
[6] Id. (net change of this factor is 1.0012 or 0.12%).
[7] Id.
[8] Id.
[9] Id. at 20,596.

As **Table 1** shows, CMS is proposing to adjust LTCH site neutral payments *twice* to keep the LTCH PPS budget neutral for the estimated 5.1% of LTCH payments for site neutral HCO cases. The payment reduction is actually larger for site neutral cases that receive a HCO payment. Consistent with MedPAC's recommendation, CMS should only adjust LTCH site neutral payments *once* for outlier budget neutrality. This can be achieved under what we have labelled "Apply BNA Once" in the third column of the table. MedPAC's comments align with this approach. By eliminating the additional BNA for site neutral HCOs, CMS still has "a budget neutrality adjustment when determining payment for a case under the LTCH PPS"—the IPPS HCO Outlier Factor and Capital PPS Outlier Factor in column two—to avoid the situation where "any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases."[70] Moreover, this "approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases."[71] If CMS does not drop the extra BNA, it will continue to "exaggerate[] the disparity in payment rates across provider settings," as MedPAC states, and act as an unwarranted payment penalty for treating site neutral patients in LTCHs.

The AHA also remains very concerned that the agency continues to apply the duplicative BNA to the non-HCO portion of site-neutral payments. As the AHA stated in its March 23, 2018 letter[72] to Administrator Verma, CMS' decision to apply two BNAs is yielding a material, unwarranted payment reduction to LTCH site-neutral cases of approximately $28 million per year—a substantial amount. AHA is strongly urging CMS again this year to withdraw the duplicative BNA.

Therefore, it would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed 5.1% site neutral HCO BNA to LTCH site neutral payments. This would be the case because the IPPS comparable per diem amount is based on the IPPS and capital PPS payment rates, which have already been reduced by 5.1% for IPPS outlier payments and 5.06% for capital PPS outlier payments. Since CMS has already made these adjustments for budget neutrality, it would be inappropriate for CMS to reduce LTCH site neutral payments that are based on the IPPS and capital PPS rates by *another 5.1%* for HCOs. Accordingly, we object to CMS' proposal to apply a separate HCO BNA to LTCH site neutral payments. CMS should not make a second BNA to LTCH site neutral payments.

[70] 80 Fed. Reg. at 49,622.

[71] Id.

[72] AHA letter to CMS Administrator, Concerns regarding Payment for LTCH PPS Site-neutral Cases and the LTCH 25% Rule (March 23, 2018), https://www.aha.org/system/files/2018-03/180325-fy-2019-ltch-p-rule.pdf.

d. Based Upon MedPAC's Comments, CMS Also Should Not Have Finalized This BNA In FYs 2016, 2017 and 2018

CMS addressed this issue to some extent in the FY 2016 IPPS/LTCH PPS final rule, but the agency failed to see the duplication that we identified and that MedPAC agreed is problematic. First, CMS confirmed that the IPPS base rates used to calculate LTCH site neutral payments already include the budget neutrality adjustment discussed above for HCO payments.[73] CMS referred to this BNA as "one of the inputs" used to calculate the LTCH site neutral payment rate.[74] CMS then tried to distinguish this BNA from the LTCH site neutral HCO BNA by stating that these adjustments fund different outlier payments—the former funds outlier payments for IPPS hospitals and the latter funds site neutral outlier payments for LTCHs.[75] This is *not correct*, as MedPAC pointed out. Since "the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative."[76] **For CMS' statement to be true, CMS would have to remove the outlier adjustment factors (i.e., BNAs) from the IPPS and Capital PPS rates before applying the 5.1% BNA to LTCH site neutral payments. This is precisely what we have been telling CMS needs to be done.**

CMS briefly responded to this issue again in the FY 2017 IPPS/LTCH PPS final rule, but CMS did not address the duplication directly. Instead, CMS speculated that Congress knew that CMS reduces LTCH PPS payments each year by estimated HCO payments, and that CMS "budget neutralized" LTCH very short-stay outlier payments since 2006 based on the same IPPS comparable per diem amount. Unfortunately, the regulation CMS refers to (42 C.F.R. § 412.529(d)(4)) does not specify a separate budget neutrality adjustment for HCO or SSO payments based upon the IPPS comparable per diem amount, and CMS does not state any other authority for this assertion. Therefore, it is difficult to see how Congress was "well aware" of this policy when it passed the PSRA. More importantly, CMS avoided responding to the basic criticism that the IPPS and Capital PPS base rates already have budget neutrality adjustments calculated upon the same 5.1% target amount for HCO payments (higher for Capital PPS HCO payments). A separate LTCH PPS budget neutrality adjustment for site neutral HCO cases plainly removes an additional 5.1% from the site neutral payment amount. At a minimum, CMS should not apply this additional budget neutrality adjustment to site neutral cases paid at

[73] See 80 Fed. Reg. at 49,622 ("While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments...").

[74] See id. ("...that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate.").

[75] See id. ("The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS.").

[76] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 17.

100% of the estimated cost of the case, because they will never qualify as HCOs. But CMS simply responded that they the agency will continue to apply the budget neutrality adjustment to these site neutral cases as well because of their general authority to make adjustments to base payments. The only modification that CMS made in the FY 2017 final rule was to stop applying the 0.949 budget neutrality factor to the *HCO portion* of the site neutral payment amount. But CMS still applies this duplicative BNA to the base site neutral payment.

In the FY 2018 IPPS/LTCH PPS final rule, CMS acknowledged continued objections from commenters to this BNA for site neutral HCOs, but simply disagreed and referred readers to the agency's previous rulemakings. CMS said that they "continue to believe this budget neutrality adjustment is appropriate."[77]

CMS' unwillingness to address these issues directly the past two years requires that we raise them again for further consideration this year. We ask that CMS take our concerns more seriously, now that the agency has had additional time to consider the matter and the analysis and table we provided. **It was incorrect for CMS to apply the 5.1% (0.949) site neutral HCO BNA to FY 2016, FY 2017 and FY 2018 site neutral payments for the same reasons that CMS should not apply this BNA to FY 2019 site neutral payments, as discussed above. CMS underpaid LTCHs for site neutral rate cases by 5.1% in FY 2016, FY 2017 and FY 2018. If CMS continues to apply this BNA, LTCHs will be systematically underpaid for site neutral payments by 5.1% in FY 2019 as well. CMS should reverse this adjustment to all FY 2016, FY 2017 and FY 2018 payments, or make an equivalent prospective increase in payments to FY 2019 site neutral rate cases to account for this underpayment.**

Recommendations. **Consistent with MedPAC's and the AHA's comments, we *strongly disagree* with the proposed 0.949 budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. CMS already reduced the FY 2019 site neutral payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor. CMS should *not* reduce LTCH site neutral payments by *another 5.1%*.**

For the same reason, it was incorrect for CMS to apply the 5.1% site neutral HCO BNA to FY 2016, FY 2017 and FY 2018 payments for site neutral rate cases. CMS should reverse this adjustment to all FY 2016, FY 2017 and FY 2018 payments, or make an equivalent prospective increase in payments to FY 2019 site neutral rate cases to account for this underpayment.

MS-DRG RELATIVE WEIGHTS FOR LTCH SITE NEUTRAL PAYMENTS

Issue. In connection with the proposed rule, CMS released a number of tables and data files that are available on the CMS website. Table 5 contains a listing of MS-DRGs, MS-DRG narrative descriptions, relative weights, and geometric and arithmetic

[77] 82 Fed. Reg. at 38,546.

June 25, 2018

Filed Electronically

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1694–P
P.O. Box 8011
Baltimore, MD 21244-8011

***Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims*; Proposed Rule; 83 Federal Register 20,164 (May 7, 2018)**

Dear Ms. Verma:

This letter presents the comments and recommendations of Vibra Healthcare on the above-referenced Proposed Rule. Vibra Healthcare operates a network of 26 long-term acute care hospitals ("LTCHs") that care for medically-complex patients who require acute care hospital services for an extended period of time. We appreciate the opportunity to express our support and concerns with the proposed changes to the fiscal year ("FY") 2019 LTCH prospective payment system ("LTCH PPS") and related policies, and we trust that CMS will carefully consider each of the issues raised in this letter.

LTCH 25% RULE

Issue. The "25% Rule" is a set of payment adjustment policies under the LTCH PPS. CMS applies the 25% Rule payment adjustment to LTCH discharges that exceed the applicable percentage threshold. The applicable percentage threshold is 25%, or up to 50% for rural LTCHs and referring hospitals that are urban single or MSA-dominant.

to site neutral payment for serious wound cases in rural, LTCH hospitals-within-hospitals under section 231 of the *Consolidated Appropriations Act of 2016*, Pub. L. 114-113. In the explanatory statement to this section, Congress stated that CMS should complete their report on the study of traditional Medicare patients requiring specialized wound care in urban and rural settings, *and how LTCH site neutral payment will impact access to such care*. More recently, Congress created a second temporary exception to site neutral payment for serious wound care cases at all LTCH hospitals-within-hospitals under section 15010 of the *21st Century Cures Act*, Pub. L. 114-255. However, these exceptions are temporary and only help a small number of patients at few LTCHs. CMS needs to do more to help preserve patient access to LTCH care.

Although CMS has stated that it does not believe it has the authority to pay any rate other than the site neutral payment rate, or when the case qualifies, the LTCH PPS standard Federal payment rate,[29] this binary view of the LTCH PPS does not account for the role of policies to adjust LTCH payments. CMS has established policies in the LTCH PPS to adjust for high-cost outliers, short-stay outliers, interrupted stays, etc., under section 307(b)(1) of the *Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000,* Pub. L. 106–554 ("BIPA"). A new payment adjustment policy to increase LTCH payments for wound care cases is a necessary and appropriate response to maintain access to quality wound care at LTCHs.

We acknowledge that in last year's final rule, CMS reiterated its claim that the agency does "not have the authority to pay anything other than the site neutral payment rate for any LTCH discharge that does not meet the exclusion criteria."[30] However, we continue to believe that CMS is overlooking the Secretary's broad statutory authority pursuant to section 123 of the *Balanced Budget Refinement* Act, Pub. L. 106-113 ("BBRA"), as amended by BIPA section 307(b). CMS frequently invokes this broad statutory authority to make adjustments to the LTCH PPS. Accordingly, we believe that CMS should use this broad authority to implement a new payment adjustment for wound care cases so that the LTCH patient criteria, site neutral payment rate, and other LTCH PPS payment policies, do not impede beneficiary access to LTCH wound care programs.

Recommendations. **CMS should make the exception to site neutral payment permanent for patients with serious, complex or multiple wounds through new payment adjustments that equal the full LTCH DRG payment rate, but at a minimum the 50/50 blended payment rate.**

CMS SHOULD NOT APPLY AN ADDITIONAL BUDGET NEUTRALITY ADJUSTMENT TO SITE NEUTRAL PAYMENTS FOR HIGH-COST OUTLIERS

Issue. CMS proposes to continue to apply a BNA under section 412.522(c)(2)(i) to all cases paid at the site neutral payment rate (including the site neutral payment rate portion of blended rate payments during the transition period) so that high-cost outlier ("HCO") payments for site neutral cases will not result in any change in estimated

[29] 80 Fed Reg. 49,326, 49,602 (Aug. 17, 2015).

[30] 82 Fed. Reg. at 38,318.

aggregate LTCH PPS payments. CMS says that "[w]e established this requirement because we believed, and continue to believe, that the HCO policy for site neutral payment rate cases should be budget neutral, just as the HCO policy for LTCH PPS standard Federal payment rate cases are budget neutral."[31] "To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2019 would not result in any increase in estimated aggregate FY 2019 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i)" CMS says that "it is necessary to reduce site neutral payment rate payments (or the portion of the blended payment rate payment for FY 2018 discharges occurring in LTCH cost reporting periods beginning before October 1, 2017) by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2019."[32] For FY 2019, CMS is proposing to continue to apply a budget neutrality factor of 0.949 (the decimal equivalent of a 5.1% reduction) to the site neutral payment rate cases paid under section 412.522(c)(1)(i).

Comment. **We *strongly disagree* with CMS' proposal to apply an *additional* 5.1% budget neutrality adjustment for site neutral cases that qualify as high-cost outliers.** CMS is proposing to apply a second BNA to all LTCH payments for site neutral rate cases to offset LTCH payments for HCO site neutral rate cases. **As we explained in our comments to the FY 2017 IPPS/LTCH PPS final rule and FY 2018 IPPS/LTCH PPS final rule, this BNA is duplicative and unwarranted because CMS has *already* applied budget neutrality adjustments to reduce the operating and capital portions of the IPPS standard Federal payment rate by the same 5.1%, before using that rate to determine the IPPS comparable per diem amount for site neutral payment cases. MedPAC agreed.**

In MedPAC's comment letter to CMS on the FY 2017 IPPS/LTCH PPS proposed rule, MedPAC states that CMS should <u>not</u> apply a separate budget neutrality adjustment to site neutral high-cost outliers because "the IPPS standard payment amount is already adjusted to account for HCO payments."[33] As MedPAC explains:

> CMS proposes to use the IPPS fixed-loss amount to determine if a discharge paid under the site-neutral rate qualifies to receive an HCO payment again for FY 2017. CMS sets the IPPS fixed-loss amount each year at a level that it estimates will result in aggregate HCO payments equal 5.1 percent of total IPPS payment. **To account for the spending attributed to these outlier payments, CMS reduces the IPPS base payment rates to maintain budget neutrality in the IPPS. <u>The IPPS-comparable rate used to pay for site-neutral cases in LTCHs includes</u>**

[31] 83 Fed. Reg. 20,164, 20,596 (May 7, 2018).

[32] <u>Id.</u> CMS incorrectly refers to FY 2018 discharges and cost reporting periods beginning after October 1, 2017 in the parenthetical. This should say FY 2019 discharges and cost reporting periods beginning after October 1, 2018. We assume this was simply an oversight because CMS is using the same language it used last year to describe the budget neutrality adjustment.

[33] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 16 (May 31, 2016).

> **an adjustment for budget neutrality to account for spending associated with HCOs.**
>
> With the Commission's payment principles in mind, **MedPAC urges CMS to eliminate the proposed payment adjustment for discharges paid the site-neutral rate to account for outlier payments under this payment methodology. Given that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further.**[34]

CMS addressed this issue to some extent in the FY 2016 IPPS/LTCH PPS final rule, but the agency did not see the duplication that MedPAC now agrees is problematic. First, CMS confirmed that the IPPS base rates used to calculate LTCH site neutral payments already include the budget neutrality adjustment discussed above for HCO payments.[35] CMS referred to this BNA as "one of the inputs" used to calculate the LTCH site neutral payment rate.[36] CMS then tried to distinguish this BNA from the LTCH site neutral HCO BNA by stating that these adjustments fund different outlier payments—the former funds outlier payments for IPPS hospitals and the latter funds site neutral outlier payments for LTCHs.[37] This is *not correct*, as MedPAC points out. Since "the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative."[38] **Stated another way, because CMS is using the adjusted IPPS base rates for LTCH site neutral payments, the rates are already reduced 5.1% for outlier budget neutrality. The separate 5.1% budget neutrality adjustment for LTCH site neutral HCOs reduces such payments by *another* 5.1%, for a total BNA of 10.2%.**

CMS briefly responded to this issue again in the FY 2017 IPPS/LTCH PPS final rule, but CMS did not address the duplication directly. Instead, CMS speculated that Congress knew when passing the PSRA that CMS reduces LTCH PPS payments each year by estimated HCO payments, and that CMS "budget neutralized" LTCH very short-stay

---

[34] Id. at 16-17 (emphasis added).

[35] See 80 Fed. Reg. 49,326, 49,622 (Aug. 17, 2015) ("While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments . . .").

[36] See id. (". . . that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate.").

[37] See id. ("The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS.").

[38] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 17.

outlier payments since 2006 based on the same IPPS comparable per diem amount. Unfortunately, the regulation CMS refers to (42 C.F.R. § 412.529(d)(4)) does not specify a separate budget neutrality adjustment for HCO or SSO payments based upon the IPPS comparable per diem amount, and CMS does not state any other authority for this assertion. Therefore, it is difficult to see how Congress was "well aware" of this policy when it passed the PSRA. More importantly, CMS avoided responding to the basic criticism that the IPPS and Capital PPS base rates already have budget neutrality adjustments calculated upon the same 5.1% target amount for HCO payments (higher for Capital PPS HCO payments).

In the FY 2018 IPPS/LTCH PPS final rule, CMS acknowledged the continued objections from commenters to this BNA for LTCH site neutral HCOs, but simply disagreed and referred readers to the agency's previous rulemakings. CMS said that they "continue to believe this budget neutrality adjustment is appropriate."[39]

Because CMS has been unwilling to address these issues directly the past two years, we are forced to raise them again for consideration this year. We hope that CMS will take our concerns more seriously, now that the agency has had additional time to consider the matter.

To ensure that LTCHs are only paying for high cost outliers at LTCHs, and not IPPS hospitals, CMS must not apply the separate 5.1% adjustment for LTCH site neural cases. CMS is proposing to adjust LTCH site neutral payments *twice* to keep the LTCH PPS budget neutral for the estimated 5.1% of LTCH payments for site neutral HCO cases. The payment reduction is actually larger for site neutral cases that receive a HCO payment. Consistent with MedPAC's recommendation, CMS should only adjust LTCH site neutral payments *once* for outlier budget neutrality. By eliminating the additional BNA for site neutral HCOs, CMS still has "a budget neutrality adjustment when determining payment for a case under the LTCH PPS" to avoid the situation where "any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases."[40] Moreover, this "approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases."[41] Without making this change, the duplicative BNA not only "exaggerates the disparity in payment rates across provider settings," as MedPAC states, but it is also purely punitive.

Therefore, it would be duplicative (*i.e.*, CMS would be removing outlier payments twice) if CMS also applies the proposed 5.1% site neutral HCO BNA to LTCH site neutral payments. This would be the case because the IPPS comparable per diem amount is based on the IPPS and capital PPS payment rates, which have already been reduced

[39] 82 Fed. Reg. at 38,546.

[40] 80 Fed. Reg. at 49,622.

[41] Id.

by 5.1% for IPPS outlier payments and 5.06% for capital PPS outlier payments. Since CMS has already made these adjustments for budget neutrality, it would be inappropriate for CMS to reduce LTCH site neutral payments that are based on the IPPS and capital PPS rates by *another 5.1%* for HCOs. Accordingly, we object to CMS' proposal to apply a separate HCO BNA to LTCH site neutral payments. CMS should not reduce LTCH site neutral payments for HCOs by 10.2% in total to keep the LTCH PPS budget neutral.

For the same reasons, it was incorrect for CMS to apply the 5.1% (0.949) site neutral HCO BNA to FY 2016, FY 2017 and FY 2018 site neutral rate cases. CMS is underpaying LTCHs for site neutral rate cases in each of these prior years by 5.1%. CMS should reverse this adjustment to all FY 2016, FY 2017 and FY 2018 payments, or make an equivalent prospective increase in payments to FY 2019 site neutral rate cases to account for this underpayment.

Recommendations. **Consistent with MedPAC's prior comments, we *strongly disagree* with the proposed 5.1% (0.949) budget neutrality adjustment for site neutral cases that qualify as high-cost outliers. There is no precedent for multiplying a budget neutrality adjustment to the annual payment rate determination for the LTCH PPS. Moreover, CMS already reduced the FY 2019 site neutral payment amount for estimated outlier payments via the IPPS HCO outlier factor and the capital PPS outlier factor. CMS should *not* reduce LTCH site neutral payments by *another 5.1%*. For the same reason, CMS should reverse this duplicative adjustment to all FY 2016, FY 2017 and FY 2018 payments, or make an equivalent prospective increase in payments to FY 2019 site neutral rate cases to account for this underpayment.**

ADDITIONAL COST REPORT DOCUMENTATION

Issue. CMS proposes new requirements for additional documentation to be included with provider cost reports. Effective for cost reporting periods beginning on or after October 1, 2018, new section 413.24(f)(5)(i)(E) would require providers claiming costs on their cost report that are allocated from a home office or chain organization to include a Home Office Cost Statement with their cost report. The Home Office Cost Statement must be completed by the home office or chain organization that corresponds to the amounts allocated from the home office or chain organization to the provider's cost report. Provider cost reports will be rejected if they do not include a copy of the Home Office Cost Statement. According to CMS, this additional documentation requirement would not create any additional burden for providers because providers are already estimating the home office or chain organization allocated costs.

Comment. We generally support CMS' proposed changes to the cost report documentation requirements. However, we do not support the change to the regulation that would require separate copies of the Home Office Cost Statement to be included with each and every provider cost report in a chain organization. We believe that CMS is underestimating the additional burden on chain organizations if they are required to provide a Home Office Cost Statement with every cost report in the organization. Chain

Charles N. Kahn III
President & CEO

June 25, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: CMS-1694-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims; Proposed Rule (Vol. 83, No. 88), May 7, 2018

Dear Administrator Verma:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. The FAH appreciates the opportunity to comment to the Centers for Medicare & Medicaid Services (CMS) about the referenced Notice of Proposed Rulemaking on the Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and

actual cost to charge ration of .323 from its filed June 30, 2017 year-end cost report, which shows $14,625,758 of total charges and $4,727,723 of total costs.

Therefore, CMS is setting the outlier threshold for FY 2019 based on an erroneous data element that significantly influences the calculation of the threshold. ***CMS can and should eliminate the influence of Provider No. 34-2021's data in the outlier threshold calculation either by using the above actual CCR to determine what if any outlier payments the provider would have received for this year or by eliminating the provider's data entirely.*** Either approach would have the same effect, reducing the threshold by about $1,096. CMS has used this approach most recently in calculating provider UC-DSH Factor 3 percentages, by requiring providers with anomalous data to correct or normalize their data before it could be used to calculate their Factor 3 percentages.

Budget Neutrality Adjustment (BNA) for Site Neutral HCO Cases

CMS also proposes to continue to apply a BNA reduction factor of 5.1% under section 412.522(c)(2)(i) to all cases paid at the site neutral payment rate (including the site neutral payment rate portion of blended rate payments during the transition period) so that HCO payments for site neutral cases will not result in any change in estimated aggregate LTCH PPS payments.

The FAH strongly disagrees with CMS's proposal to apply an additional 5.1% BNA for site neutral cases that qualify as high-cost outliers. As the FAH explained in previous years' comments, this BNA is duplicative and unwarranted because CMS has already applied budget neutrality adjustments to reduce the operating and capital portions of the IPPS standard Federal payment rate by the same 5.1%, before using that rate to determine the IPPS comparable per diem amount for site neutral payment cases.

The IPPS comparable per diem amount, as determined under section 412.529(d)(4), is "based on the sum of the applicable operating inpatient prospective payment system standardized amount and the capital inpatient prospective payment system Federal rate in effect at the time of the LTCH discharge."[16] CMS claims that a separate BNA for LTCH site neutral HCO cases will "reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems." 83 Fed. Reg. at 20596. However, by aligning this proposed policy with the IPPS payment system—and making the IPPS comparable per diem amount and the IPPS fixed-loss amount the primary components—CMS also is required to consider the adjustments that it has *already* made to the proposed IPPS and capital PPS payment rates to account for outlier payments. And, as noted earlier, CMS already reduced the operating standardized payment amount under the IPPS and the capital federal rate under the capital PPS for outliers. As CMS explains, these 5.1% (IPPS) and 5.06% (capital) outlier adjustment factors, respectively, already reduce the IPPS and capital PPS payment rates. *Id.* at 20582-84.

MedPAC's prior May 31, 2016 comment letter states that CMS should not apply a separate budget neutrality adjustment to site neutral high-cost outliers because "the IPPS

[16] 42 C.F.R. § 412.529(d)(4)(i)(A).

standard payment amount is already adjusted to account for HCO payments."[17] The FAH agrees with MedPAC that this BNA is duplicative and should not be applied. CMS should only adjust LTCH site neutral payments once for outlier budget neutrality.

CMS's unwillingness to address these issues directly the past two years requires that we raise them again for further consideration this year. The FAH asks that CMS acknowledge these concerns, as it appears incorrect for CMS to have applied the 5.1% (0.949) site neutral HCO BNA to FY 2016, FY 2017 and FY 2018 site neutral payments for the same reasons that CMS should not apply this BNA to FY 2019 site neutral payments. Accordingly, ***CMS should reverse this adjustment to all FY 2016, FY 2017, and FY 2018 payments, or make an equivalent prospective increase in payments to FY 2019 site neutral rate cases to account for this continuing underpayment.***

QUALITY DATA REPORTING

VIII.A. Hospital Inpatient Quality Reporting Program

Removal of Measures

The FAH strongly supports the proposed removal of 39 measures from the IQR Program. We agree that the IQR Program measure set should be streamlined to focus on those measures, which are not addressed in one of the three pay-for-performance programs, and meet the goal of improving patient care and outcomes that are most meaningful to patients.

Performance on 19 of the 39 measures proposed for removal will continue to be reported on the Hospital Compare website because these measures will continue to be part of one of the three acute hospital pay-for-performance programs. As noted in the proposed rule, eliminating duplication of measures across programs will prevent situations in which hospitals must track performance on the same measures for different performance periods. For example, for the CDC NSHN infection measures, the IQR Program reporting period is one calendar year (e.g., 2016 performance for FY 2018 payment), and for the HAC Reduction Program, it is two consecutive calendar years (2015 and 2016 performance for FY 2018 payment). We appreciate that CMS understands that the burden of quality measurement is not limited to data collection and submission; hospitals must track performance and develop quality improvement strategies for all measures, even those that are calculated by CMS based on claims data.

Of the remaining 20 measures proposed for removal, seven are electronic clinical quality measures (eCQMs). The FAH agrees with CMS that reducing the number of eCQMs would create a streamlined measure set and make it easier for vendors to maintain specifications for the

[17] MedPAC Comment Letter to CMS re: File Code CMS-1655-P at 16 (May 31, 2016). The letter states further: "MedPAC urges CMS to eliminate the proposed payment adjustment for discharges paid the site-neutral rate to account for outlier payments under this payment methodology. Given that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS's proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further." *Id*. @ 16-17 (emphasis added).

American Hospital Association

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

June 25, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: CMS-1694-P. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims.

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 312 long-term care hospitals (LTCHs), the American Hospital Association (AHA) appreciates the opportunity to comment on the LTCH provisions in the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2019 proposed rule for the inpatient and LTCH prospective payment systems (PPS). This letter addresses the LTCH payment and quality-reporting provisions in the proposed rule. We are submitting separate letters on the agency's inpatient PPS (IPPS) proposals and request for information related to price transparency.

The AHA supports several of the proposed rule's provisions. **In particular, we appreciate and endorse the agency's proposal to permanently withdraw the 25% Rule; however, we oppose the associated budget neutrality adjustment (BNA) proposed by CMS.** We also support the proposed changes related to co-located satellite facilities, and the streamlining of the LTCH quality reporting program (QRP). In addition, this letter reiterates our concerns related to underpayment for site-neutral cases.

SITE-NEUTRAL CASES ARE BEING UNDERPAID

As the AHA has reported to CMS, LTCH site-neutral cases are being materially underpaid. Yet, the proposed rule only makes brief mention of CMS's continuing expectation that these cases will eventually have a cost and length-of-stay profile that mirrors those of inpatient PPS cases with the same DRG. Contrary to this view, we have seen no movement in that direction since the implementation of site-neutral payment began, as shown in Chart 2 below. We also note that the rule's mention of its projected FY 2019 fiscal impact on site-neutral cases makes no reference to the disturbing underpayment pattern discussed below in a re-iteration of the concerns we shared in our March 2018 letter to CMS that is cited on page 3 of this letter.

Background on LTCH Site-neutral Payment Policy and the Duplicative Budget Neutrality Adjustments. The Bipartisan Budget Act of 2013 established a LTCH site-neutral payment rate for certain cases. Since the policy's implementation began in fall 2015, it has affected approximately one out of two LTCH cases. Once fully phased-in, the site-neutral payment rate will be only about 42 percent of the standard LTCH PPS rate, based on FY 2019 estimates by the AHA. However, when paying site-neutral cases, CMS applies two BNAs related to high-cost outlier (HCO) payments: the first occurs during the establishment of the inpatient PPS rates used as the basis for LTCH site-neutral payment, the second occurs while setting the LTCH payment. The AHA and MedPAC both agree that the second adjustment is duplicative and should not occur. This is because the inpatient PPS-standard payment amount – the basis for the LTCH site-neutral "IPPS-comparable payments" – already is adjusted to account for HCO budget neutrality. Specifically, in its May 31, 2016 comment letter on the FY 2017 inpatient PPS/LTCH PPS proposed rule, MedPAC states that:

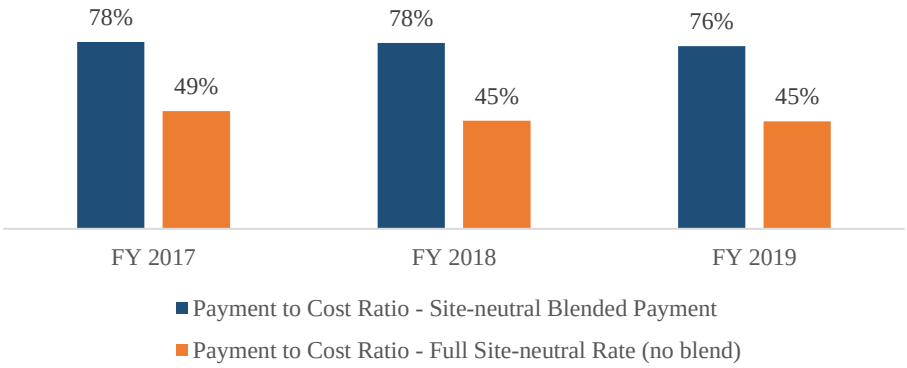
> *"[g]iven that the IPPS standard payment amount is already adjusted to account for HCO payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further."*

The AHA's concerns regarding the duplicative BNA were explained in detail in our comment letters on the FYs 2017 and 2018 proposed rules for the LTCH PPS, as well as during in-person meetings and calls with CMS staff.

In partial recognition of these concerns, CMS, in FY 2017, stopped applying the second BNA to the HCO portion of LTCH site-neutral payments. However, it still applies to the non-HCO portion of the site-neutral portion of the blend. Based on our analysis of FY 2016 MedPAR data, the AHA estimates that the second BNA inappropriately reduces aggregate payments (of the fully implemented policy) by approximately $28 million per year, a substantial amount.

Underpayment of LTCH Site-neutral Cases. While the AHA previously has weighed in regarding the redundant BNA, our concerns have grown due to our analysis demonstrating the vast underpayment that is occurring for LTCH site-neutral cases. This underpayment threatens access to care and is unnecessarily exacerbated by the unwarranted 5.1 percent BNA. Specifically, as shown in Chart 2 below, under the full site-neutral policy, average payment covers only 45 percent of the cost of care, even though these cases have a high level of medical complexity, on average. Unfortunately, even under the 50/50 blended payments during the transition to full site-neutral payment, only an average of 76 percent of costs are covered.

Chart 2. Payment to Cost Ratios for LTCH Site-neutral Cases; With and Without Blended Payment



Sources: FY 2017 MedPAR file; FY 2017 and 2018 final rule and FY 2019 proposed rule CMS public use files for inpatient PPS and LTCH PPS; CMS Provider Specific File (April 2018 update).

Our analyses show that these substantial underpayments are occurring because, contrary to CMS's projections, the acuity level and cost of care for LTCH site-neutral cases far exceed those of comparable inpatient PPS cases.[3] One key driver of the higher cost of treating site-neutral cases is that they have a higher average level of clinical acuity. Specifically, we found that 54 percent of these cases have between one and four complications and comorbidities/major complications and comorbidities (CC/MCC), while 42 percent have five or more CC/MCCs (see Chart 3 below). Compared to inpatient PPS cases (those with fewer than three days in the intensive care unit (ICU)), 62 percent have one to four CCs/MCCs but only 12 percent have five or more. Consistent with their higher acuity levels, LTCH site-neutral cases also have an average length of stay of 25.1 days, which is much more similar to that of LTCH cases paid a standard rate than to the 4.0 day average length of stay for comparable inpatient PPS cases. The contrast is equally stark when comparing Medicare payment-to-cost ratios: 0.47 for LTCH site-neutral cases, and 0.99 for inpatient PPS cases with fewer than three ICU days.[4] Average costs per case for these cases were $32,941 and $11,190, respectively.[5] **Collectively, these data, which also are presented in the chart below, show that LTCH site-neutral cases are, on average,**

[3] 2016 MedPAR data.
[4] Note that overall, Medicare payments to general acute-care hospitals covered only 87 cents for every dollar spent caring for Medicare patients in 2016.
[5] FY 2016 cases with FY 2018 payment parameters.

sicker and cost three times more than inpatient PPS cases with fewer than three ICU days. Yet, the full site-neutral rate covers less than half the cost of care.

Chart 3. Comparing LTCH Site-neutral Cases & Inpatient PPS Cases with Fewer than 3 ICU Days*		
	IPPS Cases with <3 ICU Days	**LTCH Site-neutral Cases**
Number of Cases	6,974,091	50,781
Length of Stay	4.0	25.1
% of Cases with 1-4 CC/MCCs	62%	54%
% of Cases with 5+ CC/MCCs	12%	42%
Average Cost	$11,190	$32,941
Average Medicare FFS Payment**	$11,108	$15,592
Payment to Cost Ratio	0.99	0.47

*FY 2016 cases with FY 2018 payment parameters.
**Without the site-neutral blend.

In summary, AHA continues to have the following concerns:

- The clinical and cost profile of LTCH site-neutral cases continues to be misaligned with its inpatient PPS-based payments, as recognized by CMS in its FY 2018 rulemaking and this rule, and is driving systematic underpayment of these cases.
- The second BNA lacks a policy justification and, as noted by MedPAC, compounds the underpayment of LTCH site-neutral cases.

Given these concerns, we again call on CMS to remove the second site-neutral payment BNA. In addition, in alignment with its plan put forth in the FY 2018 LTCH PPS final rule that stated CMS would continue to monitor the differential between LTCH site-neutral and inpatient PPS cases, we encourage the agency to share with stakeholders in the pending final rule its promised analyses comparing these two groups. In particular, a DRG-level study comparing the relative levels of clinical severity, lengths of stay, cost, and Medicare payment would be of great value to beneficiaries, policymakers, and stakeholders.

PROPOSED CHANGES FOR CO-LOCATED SATELLITES

The AHA thanks CMS for its proposed changes to the separateness and control criteria that apply to satellite hospitals that are excluded from the inpatient PPS and co-located with another excluded hospital. Specifically, we support CMS's proposal to exempt satellites from Medicare separateness and control requirements, in line with changes made in FY 2018 for hospitals-within-a-hospital (HwH). HwHs and satellites would still be held to these requirements when co-located with an inpatient PPS hospital. We support CMS's rationale for this proposed change, agreeing that the definitions for HwHs and satellites are significantly similar and their co-location policies have been based on many of the same concerns, most notably that patients

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 424, and 495

[CMS–1694–F]

RIN 0938–AT27

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2019 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims

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

ACTION: Final rule.

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 2019. Some of these changes implement certain statutory provisions contained in the 21st Century Cures Act and the Bipartisan Budget Act of 2018, and other legislation. We also are making changes relating to Medicare graduate medical education (GME) affiliation agreements for new urban teaching hospitals. In addition, we are providing the market basket update that will apply to the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis, subject to these limits for FY 2019. We are updating the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) for FY 2019.

In addition, we are establishing new requirements or revising existing requirements for quality reporting by specific Medicare providers (acute care hospitals, PPS-exempt cancer hospitals, and LTCHs). We also are establishing new requirements or revising existing requirements for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (now referred to as the Promoting Interoperability Programs). In addition, we are finalizing modifications to the requirements that apply to States operating Medicaid Promoting Interoperability Programs. We are updating policies for the Hospital Value-Based Purchasing (VBP) Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition (HAC) Reduction Program.

We also are making changes relating to the required supporting documentation for an acceptable Medicare cost report submission and the supporting information for physician certification and recertification of claims.

DATES: This final rule is effective on October 1, 2018.

FOR FURTHER INFORMATION CONTACT: Donald Thompson, (410) 786–4487, and Michele Hudson, (410) 786–4487, Operating Prospective Payment, MS–DRGs, Wage Index, New Medical Service and Technology Add-On Payments, Hospital Geographic Reclassifications, Graduate Medical Education, Capital Prospective Payment, Excluded Hospitals, Sole Community Hospitals, Medicare Disproportionate Share Hospital (DSH) Payment Adjustment, Medicare-Dependent Small Rural Hospital (MDH) Program, and Low-Volume Hospital Payment Adjustment Issues.

Michele Hudson, (410) 786–4487, Mark Luxton, (410) 786–4530, and Emily Lipkin, (410) 786–3633, Long-Term Care Hospital Prospective Payment System and MS–LTC–DRG Relative Weights Issues.

Siddhartha Mazumdar, (410) 786–6673, Rural Community Hospital Demonstration Program Issues.

Jeris Smith, (410) 786–0110, Frontier Community Health Integration Project Demonstration Issues.

Cindy Tourison, (410) 786–1093, Hospital Readmissions Reduction Program—Readmission Measures for Hospitals Issues.

James Poyer, (410) 786–2261, Hospital Readmissions Reduction Program—Administration Issues.

Elizabeth Bainger, (410) 786–0529, Hospital-Acquired Condition Reduction Program Issues.

Joseph Clift, (410) 786–4165, Hospital-Acquired Condition Reduction Program—Measures Issues.

Grace Snyder, (410) 786–0700 and James Poyer, (410) 786–2261, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing—Program Administration, Validation, and Reconsideration Issues.

Reena Duseja, (410) 786–1999 and Cindy Tourison, (410) 786–1093, Hospital Inpatient Quality Reporting—Measures Issues Except Hospital Consumer Assessment of Healthcare Providers and Systems Issues; and Readmission Measures for Hospitals Issues.

Kim Spalding Bush, (410) 786–3232, Hospital Value-Based Purchasing Efficiency Measures Issues.

Elizabeth Goldstein, (410) 786–6665, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing—Hospital Consumer Assessment of Healthcare Providers and Systems Measures Issues.

Joel Andress, (410) 786–5237 and Caitlin Cromer, (410) 786–3106, PPS-Exempt Cancer Hospital Quality Reporting Issues.

Mary Pratt, (410) 786–6867, Long-Term Care Hospital Quality Data Reporting Issues.

Elizabeth Holland, (410) 786–1309, Promoting Interoperability Programs Clinical Quality Measure Related Issues.

Kathleen Johnson, (410) 786–3295 and Steven Johnson (410) 786–3332, Promoting Interoperability Programs Nonclinical Quality Measure Related Issues.

Kellie Shannon, (410) 786–0416, Acceptable Medicare Cost Report Submissions Issues.

Thomas Kessler, (410) 786–1991, Physician Certification and Recertification of Claims.

SUPPLEMENTARY INFORMATION:

Electronic Access

This **Federal Register** document is available from the **Federal Register** online database through Federal Digital System (FDsys), a service of the U.S. Government Printing Office. This database can be accessed via the internet at: *http://www.gpo.gov/fdsys.*

Tables Available Through the Internet on the CMS Website

In the past, a majority of the tables referred to throughout this preamble and in the Addendum to the proposed rule and the final rule were published in the **Federal Register** as part of the annual proposed and final rules. However, beginning in FY 2012, the majority of the IPPS tables and LTCH PPS tables are no longer published in the **Federal Register**. Instead, these tables, generally, will be available only through the internet. The IPPS tables for this final rule are available through the internet on the CMS website at: *http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/*

from time periods after the dual rate LTCH PPS payment structure applies are used to calculate the relative weights (80 FR 49624). That is, under our current methodology, our MS–LTC–DRG relative weight calculations do not use data from cases paid at the site neutral payment rate under § 412.522(c)(1) or data from cases that would have been paid at the site neutral payment rate if the dual rate LTCH PPS payment structure had been in effect at the time of that discharge. For the remainder of this discussion, we use the phrase ''applicable LTCH cases'' or ''applicable LTCH data'' when referring to the resulting claims data set used to calculate the relative weights (as described later in greater detail in section VII.B.3.c. of the preamble of this final rule). In addition, in this FY 2019 IPPS/LTCH PPS final rule, for FY 2019, as we proposed, we are continuing to exclude the data from all-inclusive rate providers and LTCHs paid in accordance with demonstration projects, as well as any Medicare Advantage claims from the MS–LTC–DRG relative weight calculations for the reasons discussed in section VII.B.3.c. of the preamble of this final rule.

Furthermore, for FY 2019, in using data from applicable LTCH cases to establish MS–LTC–DRG relative weights, as we proposed, we are continuing to establish low-volume MS–LTC–DRGs (that is, MS–LTC–DRGs with less than 25 cases) using our quintile methodology in determining the MS–LTC–DRG relative weights because LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. Therefore, for purposes of determining the relative weights for the large number of low-volume MS–LTC–DRGs, we grouped all of the low-volume MS–LTC–DRGs into five quintiles based on average charges per discharge. Then, under our existing methodology, we accounted for adjustments made to LTCH PPS standard Federal payments for short-stay outlier (SSO) cases (that is, cases where the covered length of stay at the LTCH is less than or equal to five-sixths of the geometric average length of stay for the MS–LTC–DRG), and we made adjustments to account for nonmonotonically increasing weights, when necessary. The methodology is premised on more severe cases under the MS–LTC–DRG system requiring greater expenditure of medical care resources and higher average charges such that, in the severity levels within a base MS–LTC–DRG, the relative weights should increase monotonically with severity from the lowest to highest severity level. (We discuss each of these components of our MS–LTC–DRG relative weight methodology in greater detail in section VII.B.3.g. of the preamble of this final rule.)

2. Patient Classifications Into MS–LTC–DRGs

a. Background

The MS–DRGs (used under the IPPS) and the MS–LTC–DRGs (used under the LTCH PPS) are based on the CMS DRG structure. As noted previously in this section, we refer to the DRGs under the LTCH PPS as MS–LTC–DRGs although they are structurally identical to the MS–DRGs used under the IPPS.

The MS–DRGs are organized into 25 major diagnostic categories (MDCs), most of which are based on a particular organ system of the body; the remainder involve multiple organ systems (such as MDC 22, Burns). Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Surgical DRGs are assigned based on a surgical hierarchy that orders operating room (O.R.) procedures or groups of O.R. procedures by resource intensity. The GROUPER software program does not recognize all ICD–10–PCS procedure codes as procedures affecting DRG assignment. That is, procedures that are not surgical (for example, EKGs), or minor surgical procedures (for example, a biopsy of skin and subcutaneous tissue (procedure code 0JBH3ZX)) do not affect the MS–LTC–DRG assignment based on their presence on the claim.

Generally, under the LTCH PPS, a Medicare payment is made at a predetermined specific rate for each discharge that varies based on the MS–LTC–DRG to which a beneficiary's discharge is assigned. Cases are classified into MS–LTC–DRGs for payment based on the following six data elements:

- Principal diagnosis;
- Additional or secondary diagnoses;
- Surgical procedures;
- Age;
- Sex; and
- Discharge status of the patient.

Currently, for claims submitted using version ASC X12 5010 format, up to 25 diagnosis codes and 25 procedure codes are considered for an MS–DRG assignment. This includes one principal diagnosis and up to 24 secondary diagnoses for severity of illness determinations. (For additional information on the processing of up to 25 diagnosis codes and 25 procedure codes on hospital inpatient claims, we refer readers to section II.G.11.c. of the preamble of the FY 2011 IPPS/LTCH PPS final rule (75 FR 50127).)

Under the HIPAA transactions and code sets regulations at 45 CFR parts 160 and 162, covered entities must comply with the adopted transaction standards and operating rules specified in Subparts I through S of Part 162. Among other requirements, on or after January 1, 2012, covered entities were required to use the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Institutional (837), May 2006, ASC X12N/005010X223, and Type 1 Errata to Health Care Claim: Institutional (837) ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October 2007, ASC X12N/005010X233A1 for the health care claims or equivalent encounter information transaction (45 CFR 162.1102(c)).

HIPAA requires covered entities to use the applicable medical data code set requirements when conducting HIPAA transactions (45 CFR 162.1000). Currently, upon the discharge of the patient, the LTCH must assign appropriate diagnosis and procedure codes from the most current version of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD–10–PCS) for inpatient hospital procedure coding, both of which were required to be implemented October 1, 2015 (45 CFR 162.1002(c)(2) and (3)). For additional information on the implementation of the ICD–10 coding system, we refer readers to section II.F.1. of the FY 2017 IPPS/LTCH PPS final rule (81 FR 56787 through 56790) and section II.F.1. of the preamble of this final rule. Additional coding instructions and examples are published in the AHA's *Coding Clinic for ICD–10–CM/PCS.*

To create the MS–DRGs (and by extension, the MS–LTC–DRGs), base DRGs were subdivided according to the presence of specific secondary diagnoses designated as complications or comorbidities (CCs) into one, two, or three levels of severity, depending on the impact of the CCs on resources used for those cases. Specifically, there are sets of MS–DRGs that are split into 2 or 3 subgroups based on the presence or absence of a CC or a major complication or comorbidity (MCC). We refer readers to section II.D. of the FY 2008 IPPS final rule with comment period for a detailed discussion about the creation of MS–DRGs based on severity of illness levels (72 FR 47141 through 47175).

MACs enter the clinical and demographic information submitted by LTCHs into their claims processing systems and subject this information to

known as the national adjusted standardized amount. This amount reflects the national average hospital cost per case from a base year, updated for inflation.

SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal national rate (including, as discussed in section IV.G. of the preamble of this final rule, uncompensated care payments under section 1886(r)(2) of the Act); the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on FY 2006 costs per discharge.

Under section 1886(d)(5)(G) of the Act, MDHs historically were paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever was higher. However, section 5003(a)(1) of Public Law 109–171 extended and modified the MDH special payment provision that was previously set to expire on October 1, 2006, to include discharges occurring on or after October 1, 2006, but before October 1, 2011. Under section 5003(b) of Public Law 109–171, if the change results in an increase to an MDH's target amount, we must rebase an MDH's hospital specific rates based on its FY 2002 cost report. Section 5003(c) of Public Law 109–171 further required that MDHs be paid based on the Federal national rate or, if higher, the Federal national rate plus 75 percent of the difference between the Federal national rate and the updated hospital specific rate. Further, based on the provisions of section 5003(d) of Public Law 109–171, MDHs are no longer subject to the 12-percent cap on their DSH payment adjustment factor. Section 50205 of the Bipartisan Budget Act of 2018 extended the MDH program for discharges on or after October 1, 2017 through September 30, 2022.

As discussed in section IV.B. of the preamble of this final rule, in accordance with section 1886(d)(9)(E) of the Act as amended by section 601 of the Consolidated Appropriations Act, 2016 (Pub. L. 114–113), for FY 2019, subsection (d) Puerto Rico hospitals will continue to be paid based on 100 percent of the national standardized amount. Because Puerto Rico hospitals are paid 100 percent of the national standardized amount and are subject to the same national standardized amount as subsection (d) hospitals that receive the full update, our discussion below does not include references to the Puerto Rico standardized amount or the Puerto Rico-specific wage index.

As discussed in section II. of this Addendum, as we proposed, we are making changes in the determination of the prospective payment rates for Medicare inpatient operating costs for acute care hospitals for FY 2019. In section III. of this Addendum, we discuss our policy changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2019. In section IV. of this Addendum, we are setting forth the rate-of-increase percentage for determining the rate-of-increase limits for certain hospitals excluded from the IPPS for FY 2019. In section V. of this Addendum, we discuss policy changes for determining the LTCH PPS standard Federal rate for LTCHs paid under the LTCH PPS for FY 2019. The tables to which we refer in the preamble of this final rule are listed in section VI. of this Addendum and are available via the internet on the CMS website.

II. Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for Acute Care Hospitals for FY 2019

The basic methodology for determining prospective payment rates for hospital inpatient operating costs for acute care hospitals for FY 2005 and subsequent fiscal years is set forth under § 412.64. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico for FY 2005 and subsequent fiscal years is set forth under §§ 412.211 and 412.212. Below we discuss the factors we used for determining the prospective payment rates for FY 2019.

In summary, the standardized amounts set forth in Tables 1A, 1B, and 1C that are listed and published in section VI. of this Addendum (and available via the internet on the CMS website) reflect—

- Equalization of the standardized amounts for urban and other areas at the level computed for large urban hospitals during FY 2004 and onward, as provided for under section 1886(d)(3)(A)(iv)(II) of the Act.
- The labor-related share that is applied to the standardized amounts to give the hospital the highest payment, as provided for under sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act. For FY 2019, depending on whether a hospital submits quality data under the rules established in accordance with section 1886(b)(3)(B)(viii) of the Act (hereafter referred to as a hospital that submits quality data) and is a meaningful EHR user under section 1886(b)(3)(B)(ix) of the Act (hereafter referred to as a hospital that is a meaningful EHR user), there are four possible applicable percentage increases that can be applied to the national standardized amount. We refer readers to section IV.B. of the preamble of this final rule for a complete discussion on the FY 2019 inpatient hospital update. Below is a table with these four options:

FY 2019	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is NOT a meaningful EHR user	Hospital did NOT submit quality data and is a meaningful EHR user	Hospital did NOT submit quality data and is NOT a meaningful EHR user
Market Basket Rate-of-Increase	2.9	2.9	2.9	2.9
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	−0.725	−0.725
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0.0	−2.175	0.0	−2.175
MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	−0.8	−0.8	−0.8	−0.8
Statutory Adjustment under Section 1886(b)(3)(B)(xii) of the Act	−0.75	−0.75	−0.75	−0.75
Applicable Percentage Increase Applied to Standardized Amount	1.35	−0.825	0.625	−1.55

We note that section 1886(b)(3)(B)(viii) of the Act, which specifies the adjustment to the applicable percentage increase for ''subsection (d)'' hospitals that do not submit quality data under the rules established by the Secretary, is not applicable to hospitals located in Puerto Rico.

In addition, section 602 of Public Law 114–113 amended section 1886(n)(6)(B) of the Act to specify that Puerto Rico hospitals are eligible for incentive payments for the meaningful use of certified EHR technology, effective beginning FY 2016, and also to apply the adjustments to the applicable percentage increase under section 1886(b)(3)(B)(ix) of the Act to Puerto Rico hospitals that are not meaningful EHR users, effective FY 2022. Accordingly, because the provisions of section 1886(b)(3)(B)(ix) of the Act are not applicable to hospitals located in Puerto Rico until FY 2022, the adjustments under this provision are not applicable for FY 2019.

- An adjustment to the standardized amount to ensure budget neutrality for DRG recalibration and reclassification, as provided for under section 1886(d)(4)(C)(iii) of the Act.
- An adjustment to ensure the wage index and labor-related share changes (depending on the fiscal year) are budget neutral, as provided for under section 1886(d)(3)(E)(i) of the Act (as discussed in the FY 2006 IPPS

final rule (70 FR 47395) and the FY 2010 IPPS final rule (74 FR 44005)). We note that section 1886(d)(3)(E)(i) of the Act requires that when we compute such budget neutrality, we assume that the provisions of section 1886(d)(3)(E)(ii) of the Act (requiring a 62-percent labor-related share in certain circumstances) had not been enacted.

- An adjustment to ensure the effects of geographic reclassification are budget neutral, as provided for under section 1886(d)(8)(D) of the Act, by removing the FY 2018 budget neutrality factor and applying a revised factor.
- A positive adjustment of 0.5 percent in FYs 2019 through 2023 as required under section 414 of the MACRA.
- An adjustment to ensure the effects of the Rural Community Hospital Demonstration program required under section 410A of Public Law 108–173, as amended by sections 3123 and 10313 of Public Law 111–148, which extended the demonstration program for an additional 5 years, as amended by section 15003 of Public Law 114–255 which amended section 410A of Public Law 108–173 to provide for a 10-year extension of the demonstration program (in place of the 5-year extension required by the Affordable Care Act) beginning on the date immediately following the last day of the initial 5-year period under section 410A(a)(5) of Public Law 108–173, are budget neutral as required under section 410A(c)(2) of Public Law 108–173.
- An adjustment to remove the FY 2018 outlier offset and apply an offset for FY 2019, as provided for in section 1886(d)(3)(B) of the Act.

For FY 2019, consistent with current law, as we proposed, we applied the rural floor budget neutrality adjustment to hospital wage indexes. Also, consistent with section 3141 of the Affordable Care Act, instead of applying a State-level rural floor budget neutrality adjustment to the wage index, as we proposed, we applied a uniform, national budget neutrality adjustment to the FY 2019 wage index for the rural floor. We note that, in section III.H.2.b. of the preamble to this final rule, as we proposed, we are not extending the imputed floor policy (neither the original methodology nor the alternative methodology) for FY 2019. Therefore, for FY 2019, in this final rule, we are not including the imputed floor (calculated under the original methodology and alternative methodology) in calculating the uniform, national rural floor budget neutrality adjustment, which is reflected in the FY 2019 wage index.

A. Calculation of the Adjusted Standardized Amount

1. Standardization of Base-Year Costs or Target Amounts

In general, the national standardized amount is based on per discharge averages of adjusted hospital costs from a base period (section 1886(d)(2)(A) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. The September 1, 1983 interim final rule (48 FR 39763) contained a detailed explanation of how base-year cost data (from cost reporting periods ending during FY 1981) were established for urban and rural hospitals in the initial development of standardized amounts for the IPPS.

Sections 1886(d)(2)(B) and 1886(d)(2)(C) of the Act require us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, IME costs, and costs to hospitals serving a disproportionate share of low-income patients.

For FY 2019, as we proposed, we are continuing to use the national labor-related and nonlabor-related shares (which are based on the 2014-based hospital market basket) that were used in FY 2018. Specifically, under section 1886(d)(3)(E) of the Act, the Secretary estimates, from time to time, the proportion of payments that are labor-related and adjusts the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs of the DRG prospective payment rates. We refer to the proportion of hospitals' costs that are attributable to wages and wage-related costs as the ''labor-related share.'' For FY 2019, as discussed in section III. of the preamble of this final rule, as we proposed, we are continuing to use a labor-related share of 68.3 percent for the national standardized amounts for all IPPS hospitals (including hospitals in Puerto Rico) that have a wage index value that is greater than 1.0000. Consistent with section 1886(d)(3)(E) of the Act, as we proposed, we applied the wage index to a labor-related share of 62 percent of the national standardized amount for all IPPS hospitals (including hospitals in Puerto Rico) whose wage index values are less than or equal to 1.0000.

The standardized amounts for operating costs appear in Tables 1A, 1B, and 1C that are listed and published in section VI. of the Addendum to this final rule and are available via the internet on the CMS website.

2. Computing the National Average Standardized Amount

Section 1886(d)(3)(A)(iv)(II) of the Act requires that, beginning with FY 2004 and thereafter, an equal standardized amount be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. Accordingly, as we proposed, we calculated the FY 2019 national average standardized amount irrespective of whether a hospital is located in an urban or rural location.

3. Updating the National Average Standardized Amount

Section 1886(b)(3)(B) of the Act specifies the applicable percentage increase used to update the standardized amount for payment for inpatient hospital operating costs. We note that, in compliance with section 404 of the MMA, in this final rule, as we proposed, we used the 2014-based IPPS operating and capital market baskets for FY 2019. As discussed in section IV.B. of the preamble of this final rule, in accordance with section 1886(b)(3)(B) of the Act, as amended by section 3401(a) of the Affordable Care Act, as we proposed, we reduced the FY 2019 applicable percentage increase (which for this final rule is based on IGI's second quarter 2018 forecast of the 2014-based IPPS market basket) by the MFP adjustment (the 10-year moving average of MFP for the period ending FY 2019) of 0.8 percentage point, which for this final rule is also calculated based on IGI's second quarter 2018 forecast.

In addition, in accordance with section 1886(b)(3)(B)(i) of the Act, as amended by sections 3401(a) and 10319(a) of the Affordable Care Act, as we proposed, we further updated the standardized amount for FY 2019 by the estimated market basket percentage increase less 0.75 percentage point for hospitals in all areas. Sections 1886(b)(3)(B)(xi) and (xii) of the Act, as added and amended by sections 3401(a) and 10319(a) of the Affordable Care Act, further state that these adjustments may result in the applicable percentage increase being less than zero. The percentage increase in the market basket reflects the average change in the price of goods and services required as inputs to provide hospital inpatient services.

Based on IGI's 2018 second quarter forecast of the hospital market basket increase (as discussed in Appendix B of this final rule), the forecast of the hospital market basket increase for FY 2019 for this final rule is 2.9 percent. As discussed earlier, for FY 2019, depending on whether a hospital submits quality data under the rules established in accordance with section 1886(b)(3)(B)(viii) of the Act and is a meaningful EHR user under section 1886(b)(3)(B)(ix) of the Act, there are four possible applicable percentage increases that can be applied to the standardized amount. We refer readers to section IV.B. of the preamble of this final rule for a complete discussion on the FY 2019 inpatient hospital update to the standardized amount. We also refer readers to the table above for the four possible applicable percentage increases that will be applied to update the national standardized amount. The standardized amounts shown in Tables 1A through 1C that are published in section VI. of this Addendum and that are available via the internet on the CMS website reflect these differential amounts.

Although the update factors for FY 2019 are set by law, we are required by section 1886(e)(4) of the Act to recommend, taking into account MedPAC's recommendations, appropriate update factors for FY 2019 for both IPPS hospitals and hospitals and hospital units excluded from the IPPS. Section 1886(e)(5)(A) of the Act requires that we publish our recommendations in the **Federal Register** for public comment. Our recommendation on the update factors is set forth in Appendix B of this final rule.

4. Methodology for Calculation of the Average Standardized Amount

The methodology we used to calculate the FY 2019 standardized amount is as follows:

- To ensure we are only including hospitals paid under the IPPS in the calculation of the standardized amount, we applied the following inclusion and exclusion criteria: Include hospitals whose last four digits fall between 0001 and 0879 (section 2779A1 of Chapter 2 of the State Operations Manual on the CMS website at:

appropriate to determine the budget neutrality offset amount for FY 2019. We refer readers to section IV.L. of the preamble of this final rule on complete details regarding the availability of additional data prior to the FY 2019 IPPS/LTCH PPS final rule.

f. Adjustment for FY 2019 Required Under Section 414 of Public Law 114–10 (MACRA)

As stated in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56785), once the recoupment required under section 631 of the ATRA was complete, we had anticipated making a single positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under section 631 of the ATRA. However, section 414 of the MACRA (which was enacted on April 16, 2015) replaced the single positive adjustment we intended to make in FY 2018 with a 0.5 percent positive adjustment for each of FYs 2018 through 2023. (As noted in the FY 2018 IPPS/LTCH PPS proposed and final rules, section 15005 of the 21st Century Cures Act (Pub. L. 114–255), which was enacted December 13, 2016, reduced the adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points.) Therefore, for FY 2019, as we proposed, we are implementing the required +0.5 percent adjustment to the standardized amount. This is a permanent adjustment to the payment rates.

g. Outlier Payments

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for ''outlier'' cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the MS–DRG, any IME and DSH payments, uncompensated care payments, any new technology add-on payments, and the ''outlier threshold'' or ''fixed-loss'' amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for an outlier payment). We refer to the sum of the prospective payment rate for the MS–DRG, any IME and DSH payments, uncompensated care payments, any new technology add-on payments, and the outlier threshold as the outlier ''fixed-loss cost threshold.'' To determine whether the costs of a case exceed the fixed-loss cost threshold, a hospital's CCR is applied to the total covered charges for the case to convert the charges to estimated costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the estimated costs above the fixed-loss cost threshold. The marginal cost factor for FY 2019 is 80 percent, or 90 percent for burn MS–DRGs 927, 928, 929, 933, 934 and 935. We have used a marginal cost factor of 90 percent since FY 1989 (54 FR 36479 through 36480) for designated burn DRGs as well as a marginal cost factor of 80 percent for all other DRGs since FY 1995 (59 FR 45367).

In accordance with section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year are projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments (which does not include IME and DSH payments) plus outlier payments. When setting the outlier threshold, we compute the 5.1 percent target by dividing the total operating outlier payments by the total operating DRG payments plus outlier payments. We do not include any other payments such as IME and DSH within the outlier target amount. Therefore, it is not necessary to include Medicare Advantage IME payments in the outlier threshold calculation. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amount by a factor to account for the estimated proportion of total DRG payments made to outlier cases. More information on outlier payments may be found on the CMS website at: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier.htm*.

(1) FY 2019 Outlier Fixed-Loss Cost Threshold

In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50977 through 50983), in response to public comments on the FY 2013 IPPS/LTCH PPS proposed rule, we made changes to our methodology for projecting the outlier fixed-loss cost threshold for FY 2014. We refer readers to the FY 2014 IPPS/LTCH PPS final rule for a detailed discussion of the changes.

As we have done in the past, to calculate the FY 2019 outlier threshold, we simulated payments by applying FY 2019 payment rates and policies using cases from the FY 2017 MedPAR file. As noted in section II.C. of this Addendum, we specify the formula used for actual claim payment which is also used by CMS to project the outlier threshold for the upcoming fiscal year. The difference is the source of some of the variables in the formula. For example, operating and capital CCRs for actual claim payment are from the PSF while CMS uses an adjusted CCR (as described below) to project the threshold for the upcoming fiscal year. In addition, charges for a claim payment are from the bill while charges to project the threshold are from the MedPAR data with an inflation factor applied to the charges (as described earlier).

In order to determine the FY 2019 outlier threshold, we inflated the charges on the MedPAR claims by 2 years, from FY 2017 to FY 2019. As discussed in the FY 2015 IPPS/LTCH PPS final rule, we believe a methodology that is based on 1-year of charge data will provide a more stable measure to project the average charge per case because our prior methodology used a 6-month measure, which inherently uses fewer claims than a 1-year measure and makes it more susceptible to fluctuations in the average charge per case as a result of any significant charge increases or decreases by hospitals. As finalized in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57282), we are using the following methodology to calculate the charge inflation factor for FY 2019:

- To produce the most stable measure of charge inflation, we applied the following inclusion and exclusion criteria of hospitals claims in our measure of charge inflation: Include hospitals whose last four digits fall between 0001 and 0899 (section 2779A1 of Chapter 2 of the State Operations Manual on the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf*); include CAHs that were IPPS hospitals for the time period of the MedPAR data being used to calculate the charge inflation factor; include hospitals in Maryland; and remove PPS-excluded cancer hospitals who have a ''V'' in the fifth position of their provider number or a ''E'' or ''F'' in the sixth position.
- We excluded Medicare Advantage IME claims for the reasons described in section I.A.4. of this Addendum. We refer readers to the FY 2011 IPPS/LTCH PPS final rule for a complete discussion on our methodology of identifying and adding the total Medicare Advantage IME payment amount to the budget neutrality adjustments.
- In order to ensure that we capture only FFS claims, we included claims with a ''Claim Type'' of 60 (which is a field on the MedPAR file that indicates a claim is an FFS claim).
- In order to further ensure that we capture only FFS claims, we excluded claims with a ''GHOPAID'' indicator of 1 (which is a field on the MedPAR file that indicates a claim is not an FFS claim and is paid by a Group Health Organization).
- We examined the MedPAR file and removed pharmacy charges for anti-hemophilic blood factor (which are paid separately under the IPPS) with an indicator of ''3'' for blood clotting with a revenue code of ''0636'' from the covered charge field. We also removed organ acquisition charges from the covered charge field because organ acquisition is a pass-through payment not paid under the IPPS.

In the FY 2016 IPPS/LTCH PPS final rule (80 FR 49779 through 49780), we stated that commenters were concerned that they were unable to replicate the calculation of the charge inflation factor that CMS used in the proposed rule. In response to those comments, we stated that we continue to believe that it is optimal to use the most recent period of charge data available to measure charge inflation. In response to those comments, similar to FY 2016, FY 2017, and FY 2018, for FY 2019, we grouped claims data by quarter in the table below in order that the public would be able to replicate the claims summary for the claims with discharge dates through September 30, 2017, that are available under the current limited data set (LDS) structure. In order to provide even more information in response to the commenters' request, similar to FY 2016, FY 2017, and FY 2018, for FY 2019, we made available on the CMS website at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html* (click on the links on the left titled ''FY 2019 IPPS Proposed Rule Home Page'' and then click the link ''FY 2019 Proposed Rule Data Files'') more detailed summary tables by provider with the monthly charges that were used to compute the charge inflation factor. In the proposed rule, we stated that we continue to work with our systems teams and privacy office to explore expanding the information available in the current LDS, perhaps through the provision of a supplemental data file for future rulemaking.

did not make any adjustments for the possibility that hospitals' CCRs and outlier payments may be reconciled upon cost report settlement.

- We excluded the hospital VBP payment adjustments and the hospital readmissions payment adjustments from the calculation of the outlier fixed-loss cost threshold.
- We used the estimated per-discharge uncompensated care payments to hospitals eligible for the uncompensated care payment for all cases in the calculation of the outlier fixed-loss cost threshold methodology.

Using this methodology, we used the formula described in section I.C.1 of this Addendum to simulate and calculate the Federal payment rate and outlier payments for all claims. We used a threshold of $25,769 and calculated total operating Federal payments of $88,484,589,041 and total outlier payments of $4,755,375,555. We then divided total outlier payments by total operating Federal payments plus total outlier payments and determined that this threshold met the 5.1 percent target (($88,484,589,041/$93,239,964,596) × 100 = 5.1 percent). As a result, we are finalizing an outlier fixed-loss cost threshold for FY 2019 equal to the prospective payment rate for the MS–DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus $25,769.

(2) Other Changes Concerning Outliers

As stated in the FY 1994 IPPS final rule (58 FR 46348), we establish an outlier threshold that is applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common threshold resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2019 will result in outlier payments that will equal 5.1 percent of operating DRG payments and 5.06 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, as we proposed, we reduced the FY 2019 standardized amount by the same percentage to account for the projected proportion of payments paid as outliers.

The outlier adjustment factors applied to the standardized amount based on the FY 2019 outlier threshold are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948999	0.949431

We applied the outlier adjustment factors to the FY 2019 payment rates after removing the effects of the FY 2018 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we currently apply hospital-specific CCRs to the total covered charges for the case. Estimated operating and capital costs for the case are calculated separately by applying separate operating and capital CCRs. These costs are then combined and compared with the outlier fixed-loss cost threshold.

Under our current policy at § 412.84, we calculate operating and capital CCR ceilings and assign a statewide average CCR for hospitals whose CCRs exceed 3.0 standard deviations from the mean of the log distribution of CCRs for all hospitals. Based on this calculation, for hospitals for which the MAC computes operating CCRs greater than 1.159 or capital CCRs greater than 0.151, or hospitals for which the MAC is unable to calculate a CCR (as described under § 412.84(i)(3) of our regulations), statewide average CCRs are used to determine whether a hospital qualifies for outlier payments. Table 8A listed in section VI. of this Addendum (and available only via the internet on the CMS website) contains the statewide average operating CCRs for urban hospitals and for rural hospitals for which the MAC is unable to compute a hospital-specific CCR within the above range. These statewide average ratios will be effective for discharges occurring on or after October 1, 2018 and will replace the statewide average ratios from the prior fiscal year. Table 8B listed in section VI. of this Addendum (and available via the internet on the CMS website) contains the comparable statewide average capital CCRs. As previously stated, the CCRs in Tables 8A and 8B will be used during FY 2019 when hospital-specific CCRs based on the latest settled cost report either are not available or are outside the range noted above. Table 8C listed in section VI. of this Addendum (and available via the internet on the CMS website) contains the statewide average total CCRs used under the LTCH PPS as discussed in section V. of this Addendum.

We finally note that we published a manual update (Change Request 3966) to our outlier policy on October 12, 2005, which updated Chapter 3, Section 20.1.2 of the Medicare Claims Processing Manual. The manual update covered an array of topics, including CCRs, reconciliation, and the time value of money. We encourage hospitals that are assigned the statewide average operating and/or capital CCRs to work with their MAC on a possible alternative operating and/or capital CCR as explained in Change Request 3966. Use of an alternative CCR developed by the hospital in conjunction with the MAC can avoid possible overpayments or underpayments at cost report settlement, thereby ensuring better accuracy when making outlier payments and negating the need for outlier reconciliation. We also note that a hospital may request an alternative operating or capital CCR at any time as long as the guidelines of Change Request 3966 are followed. In addition, as mentioned above, we published an additional manual update (Change Request 7192) to our outlier policy on December 3, 2010, which also updated Chapter 3, Section 20.1.2 of the Medicare Claims Processing Manual. The manual update outlines the outlier reconciliation process for hospitals and Medicare contractors. To download and view the manual instructions on outlier reconciliation, we refer readers to the CMS website: *http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf.*

(3) Alternative Considered for a Potential Change to the CCRs Used for Outliers, New Technology Add-on Payments, and Payments to IPPS-Excluded Cancer Hospitals for Chimeric Antigen Receptor (CAR) T-Cell Therapy

In the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20583), we stated we believe that, in the context of the pending new technology add-on payment applications for KYMRIAH® and YESCARTA®, there may also be merit in the suggestion from the public to allow hospitals to utilize a CCR specific to procedures involving the ICD–10–PCS procedures codes describing CAR T-cell therapy drugs for FY 2019 as part of the determination of the cost of a case for purposes of calculating outlier payments for individual FY 2019 cases, new technology add-on payments, if approved, for individual FY 2019 cases, and payments to IPPS-excluded cancer hospitals beginning in FY 2019.

We invited public comments on this alternative approach for FY 2019. We also invited public comments on how this payment alternative would affect access to care, as well as how it affects incentives to encourage lower drug prices, which is a high priority for this Administration. In addition, we stated that we were considering alternative approaches and authorities to encourage value-based care and lower drug prices. We solicited comments on how the payment methodology alternatives may intersect and affect future participation in any such alternative approaches. A summary of those comments and our responses can be found in section II.F.2.d. of the preamble of this final rule.

As also discussed in section II.F.2.d. of the preamble of this final rule, building on President Trump's *Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs,* the CMS Center for Medicare and Medicaid Innovation (Innovation Center) solicited public comment in the CY 2019 OPPS/ASC proposed rule on key design considerations for developing a potential model that would test private market strategies and introduce competition to improve quality of care for beneficiaries, while reducing both Medicare expenditures and beneficiaries' out of pocket spending. Given the relative newness of CAR T-cell therapy, the potential model, and our request for feedback on this model approach, we believe it would be premature to adopt changes to our existing payment mechanisms for FY 2019, including allowing hospitals to utilize a CCR specific to procedures involving the ICD–10–PCS procedures codes describing CAR T-cell therapy drugs for FY 2019 as part of the determination of the cost of a case for purposes of calculating outlier payments for individual FY 2019 cases, new technology add-on payments for individual FY 2019 cases, and payments to IPPS-excluded cancer hospitals beginning in FY 2019.

(4) FY 2017 Outlier Payments

Our current estimate, using available FY 2017 claims data, is that actual outlier payments for FY 2017 were approximately 5.57 percent of actual total MS–DRG payments. Therefore, the data indicate that,

for FY 2017, the percentage of actual outlier payments relative to actual total payments is higher than we projected for FY 2017. Consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2017 are equal to 5.1 percent of total MS–DRG payments. As explained in the FY 2003 Outlier Final Rule (68 FR 34502), if we were to make retroactive adjustments to all outlier payments to ensure total payments are 5.1 percent of MS–DRG payments (by retroactively adjusting outlier payments), we would be removing the important aspect of the prospective nature of the IPPS. Because such an across-the-board adjustment would either lead to more or less outlier payments for all hospitals, hospitals would no longer be able to reliably approximate their payment for a patient while the patient is still hospitalized. We believe it would be neither necessary nor appropriate to make such an aggregate retroactive adjustment. Furthermore, we believe it is consistent with the statutory language at section 1886(d)(5)(A)(iv) of the Act not to make retroactive adjustments to outlier payments. This section states that outlier payments be equal to or greater than 5 percent and less than or equal to 6 percent of projected or estimated (not actual) MS–DRG payments. We believe that an important goal of a PPS is predictability. Therefore, we believe that the fixed-loss outlier threshold should be projected based on the best available historical data and should not be adjusted retroactively. A retroactive change to the fixed-loss outlier threshold would affect all hospitals subject to the IPPS, thereby undercutting the predictability of the system as a whole.

We note that, because the MedPAR claims data for the entire FY 2018 will not be available until after September 30, 2018, we are unable to provide an estimate of actual outlier payments for FY 2018 based on FY 2018 claims data in this final rule. We will provide an estimate of actual FY 2018 outlier payments in the FY 2020 IPPS/LTCH PPS proposed rule.

Comment: One commenter noted that, in the proposed rule, CMS stated that actual outlier payments for FY 2017 were approximately 5.53 percent of total MS–DRG payments. The commenter performed its own analysis and concluded that outlier payments for FY 2017 are approximately 5.30 percent of total MS–DRG payments. The commenter was concerned that CMS' estimate was overstated.

Response: We thank the commenter for the comments. We reviewed our data to ensure the estimate provided is accurate. Therefore, we believe we have provided a reliable estimate of the outlier percentage for FY 2017. The commenter did not provide details regarding the discrepancy. We welcome additional suggestions from the public, including the commenter, to improve the accuracy of our estimate of actual outlier payments.

5. FY 2019 Standardized Amount

The adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B listed and published in section VI. of this Addendum (and available via the internet on the CMS website) contain the national standardized amounts that we are applying to all hospitals, except hospitals located in Puerto Rico, for FY 2019. The standardized amount for hospitals in Puerto Rico is shown in Table 1C listed and published in section VI. of this Addendum (and available via the internet on the CMS website). The amounts shown in Tables 1A and 1B differ only in that the labor-related share applied to the standardized amounts in Table 1A is 68.3 percent, and the labor-related share applied to the standardized amounts in Table 1B is 62 percent. In accordance with sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act, we are applying a labor-related share of 62 percent, unless application of that percentage would result in lower payments to a hospital than would otherwise be made. In effect, the statutory provision means that we will apply a labor-related share of 62 percent for all hospitals whose wage indexes are less than or equal to 1.0000.

In addition, Tables 1A and 1B include the standardized amounts reflecting the applicable percentage increases for FY 2019.

The labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals for FY 2019 are set forth in Table 1C listed and published in section VI. of this Addendum (and available via the internet on the CMS website). Similar to above, section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Public Law 108–173, provides that the labor-related share for hospitals located in Puerto Rico be 62 percent, unless the application of that percentage would result in lower payments to the hospital.

The following table illustrates the changes from the FY 2018 national standardized amount to the FY 2019 national standardized amount. The second through fifth columns display the changes from the FY 2018 standardized amounts for each applicable FY 2019 standardized amount. The first row of the table shows the updated (through FY 2018) average standardized amount after restoring the FY 2018 offsets for outlier payments and the geographic reclassification budget neutrality. The MS–DRG reclassification and recalibration and wage index budget neutrality adjustment factors are cumulative. Therefore, those FY 2018 adjustment factors are not removed from this table.

CHANGES FROM FY 2018 STANDARDIZED AMOUNTS TO THE FY 2019 STANDARDIZED AMOUNTS

	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is NOT a meaningful EHR user	Hospital did NOT submit quality data and is a meaningful EHR user	Hospital did NOT submit quality data and is NOT a meaningful EHR user
FY 2018 Base Rate after removing: 1. FY 2018 Geographic Reclassification Budget Neutrality (0.987985) 2. FY 2018 Operating Outlier Offset (0.948998)	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,059.36. Nonlabor (30.4%): $1,884.07. If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92. Nonlabor (38%): $2,258.50.	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,059.36. Nonlabor (30.4%): $1,884.07. If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92. Nonlabor (38%): $2,258.50.	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,059.36. Nonlabor (30.4%): $1,884.07. If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92. Nonlabor (38%): $2,258.50.	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4,059.36. Nonlabor (30.4%): $1,884.07. If Wage Index is less Than or Equal to 1.0000: Labor (62%): $3,684.92. Nonlabor (38%): $2,258.50.
FY 2019 Update Factor	1.0135	0.99175	1.00625	0.9845.
FY 2019 MS-DRG Recalibration Budget Neutrality Factor.	0.997192	0.997192	0.997192	0.997192.
FY 2019 Wage Index Budget Neutrality Factor.	1.000748	1.000748	1.000748	1.000748.
FY 2019 Reclassification Budget Neutrality Factor.	0.985932	0.985932	0.985932	0.985932.
FY 2019 Operating Outlier Factor	0.948999	0.948999	0.948999	0.948999.
FY 2019 Rural Demonstration Budget Neutrality Factor.	0.999467	0.999467	0.999467	0.999467.
Adjustment for FY 2019 Required under Section 414 of Public Law 114–10 (MACRA).	1.005	1.005	1.005	1.005.
National Standardized Amount for FY 2019 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (68.3/31.7).	Labor: $3,858.62 Nonlabor: $1,790.90	Labor: $3,775.81 Nonlabor: $1,752.47	Labor: $3,831.02 Nonlabor: $1,778.09	Labor: $3,748.21. Nonlabor: $1,739.66.

CHANGES FROM FY 2018 STANDARDIZED AMOUNTS TO THE FY 2019 STANDARDIZED AMOUNTS—Continued

	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is NOT a meaningful EHR user	Hospital did NOT submit quality data and is a meaningful EHR user	Hospital did NOT submit quality data and is NOT a meaningful EHR user
National Standardized Amount for FY 2019 if Wage Index is Less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38).	Labor: $3,502.70 ..... Nonlabor: $2,146.82	Labor: $3,427.53 ..... Nonlabor: $2,100.75	Labor: $3,477.65 ..... Nonlabor: $2,131.46	Labor: $3,402.48. Nonlabor: $2,085.39.

B. Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1C, as published in section VI. of this Addendum (and available via the internet on the CMS website), contain the labor-related and nonlabor-related shares that we used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2019. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national prospective payment rate to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. For FY 2019, as discussed in section IV.B.3. of the preamble of this final rule, we are applying a labor-related share of 68.3 percent for the national standardized amounts for all IPPS hospitals (including hospitals in Puerto Rico) that have a wage index value that is greater than 1.0000. Consistent with section 1886(d)(3)(E) of the Act, we are applying the wage index to a labor-related share of 62 percent of the national standardized amount for all IPPS hospitals (including hospitals in Puerto Rico) whose wage index values are less than or equal to 1.0000. In section III. of the preamble of this final rule, we discuss the data and methodology for the FY 2019 wage index.

2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act provides discretionary authority to the Secretary to make adjustments as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. To account for higher nonlabor-related costs for these two States, we multiply the nonlabor-related portion of the standardized amount for hospitals in Alaska and Hawaii by an adjustment factor.

In the FY 2013 IPPS/LTCH PPS final rule, we established a methodology to update the COLA factors for Alaska and Hawaii that were published by the U.S. Office of Personnel Management (OPM) every 4 years (at the same time as the update to the labor-related share of the IPPS market basket), beginning in FY 2014. We refer readers to the FY 2013 IPPS/LTCH PPS proposed and final rules for additional background and a detailed description of this methodology (77 FR 28145 through 28146 and 77 FR 53700 through 53701, respectively).

For FY 2018, in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38530 through 38531), we updated the COLA factors published by OPM for 2009 (as these are the last COLA factors OPM published prior to transitioning from COLAs to locality pay) using the methodology that we finalized in the FY 2013 IPPS/LTCH PPS final rule.

Based on the policy finalized in the FY 2013 IPPS/LTCH PPS final rule, for FY 2019, as we proposed, we are continuing to use the same COLA factors in FY 2019 that were used in FY 2018 to adjust the nonlabor-related portion of the standardized amount for hospitals located in Alaska and Hawaii. Below is a table listing the COLA factors for FY 2019.

FY 2019 COST-OF-LIVING ADJUSTMENT FACTORS: ALASKA AND HAWAII HOSPITALS

Area	Cost of living adjustment factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.25
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.25
City of Juneau and 80-kilometer (50-mile) radius by road	1.25
Rest of Alaska	1.25
City and County of Honolulu	1.25
County of Hawaii	1.21
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Based on the policy finalized in the FY 2013 IPPS/LTCH PPS final rule, the next update to the COLA factors for Alaska and Hawaii would occur at the same time as the update to the labor-related share of the IPPS market basket (no later than FY 2022).

C. Calculation of the Prospective Payment Rates

General Formula for Calculation of the Prospective Payment Rates for FY 2019

In general, the operating prospective payment rate for all hospitals (including hospitals in Puerto Rico) paid under the IPPS, except SCHs and MDHs, for FY 2019 equals the Federal rate (which includes uncompensated care payments).

Section 205 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114–10, enacted on April 16, 2015) extended the MDH program (which, under previous law, was to be in effect for discharges on or before March 31, 2015 only) for discharges occurring on or after April 1, 2015, through FY 2017 (that is, for discharges occurring on or before September 30, 2017). Section 50205 of the Bipartisan Budget Act of 2018 (Pub. L. 115–123), enacted February 9, 2018, extended the MDH program for discharges on or after October 1, 2017 through September 30, 2022.

SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal national rate (which, as discussed in section V.G. of the preamble of this final rule, includes uncompensated care payments); the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on FY 2006 costs per discharge to determine the rate that yields the greatest aggregate payment.

The prospective payment rate for SCHs for FY 2019 equals the higher of the applicable

Federal rate, or the hospital-specific rate as described below. The prospective payment rate for MDHs for FY 2019 equals the higher of the Federal rate, or the Federal rate plus 75 percent of the difference between the Federal rate and the hospital-specific rate as described below. For MDHs, the updated hospital-specific rate is based on FY 1982, FY 1987, or FY 2002 costs per discharge, whichever yields the greatest aggregate payment.

1. Operating and Capital Federal Payment Rate and Outlier Payment Calculation

Note: The formula below is used for actual claim payment and is also used by CMS to project the outlier threshold for the upcoming fiscal year. The difference is the source of some of the variables in the formula. For example, operating and capital CCRs for actual claim payment are from the PSF while CMS uses an adjusted CCR (as described above) to project the threshold for the upcoming fiscal year. In addition, charges for a claim payment are from the bill while charges to project the threshold are from the MedPAR data with an inflation factor applied to the charges (as described earlier).

Step 1—Determine the MS–DRG and MS–DRG relative weight for each claim based on the ICD–10–CM procedure and diagnosis codes on the claim.

Step 2—Select the applicable average standardized amount depending on whether the hospital submitted qualifying quality data and is a meaningful EHR user, as described above.

Step 3—Compute the operating and capital Federal payment rate:

—Federal Payment Rate for Operating Costs = MS–DRG Relative Weight × [(Labor-Related Applicable Standardized Amount × Applicable CBSA Wage Index) + (Nonlabor-Related Applicable Standardized Amount × Cost-of-Living Adjustment)] × (1 + IME + (DSH * 0.25))
—Federal Payment for Capital Costs = MS–DRG Relative Weight × Federal Capital Rate × Geographic Adjustment Fact × (l + IME + DSH)

Step 4—Determine operating and capital costs:

—Operating Costs = (Billed Charges × Operating CCR)
—Capital Costs = (Billed Charges × Capital CCR).

Step 5—Compute operating and capital outlier threshold (CMS applies a geographic adjustment to the operating and capital outlier threshold to account for local cost variation):

—Operating CCR to Total CCR = (Operating CCR)/(Operating CCR + Capital CCR)
—Operating Outlier Threshold = [Fixed Loss Threshold × ((Labor-Related Portion × CBSA Wage Index) + Nonlabor-Related portion)] × Operating CCR to Total CCR + Federal Payment with IME, DSH + Uncompensated Care Payment + New Technology Add-On Payment Amount
—Capital CCR to Total CCR = (Capital CCR)/(Operating CCR + Capital CCR)
—Capital Outlier Threshold = (Fixed Loss Threshold × Geographic Adjustment Factor × Capital CCR to Total CCR) + Federal Payment with IME and DSH

Step 6—Compute operating and capital outlier payments:

—Marginal Cost Factor = 0.80 or 0.90 (depending on the MS–DRG)
—Operating Outlier Payment = (Operating Costs—Operating Outlier Threshold) × Marginal Cost Factor
—Capital Outlier Payment = (Capital Costs—Capital Outlier Threshold) × Marginal Cost Factor

The payment rate may then be further adjusted for hospitals that qualify for a low-volume payment adjustment under section 1886(d)(12) of the Act and 42 CFR 412.101(b). The base-operating DRG payment amount may be further adjusted by the hospital readmissions payment adjustment and the hospital VBP payment adjustment as described under sections 1886(q) and 1886(o) of the Act, respectively. Payments also may be reduced by the 1-percent adjustment under the HAC Reduction Program as described in section 1886(p) of the Act. We also make new technology add-on payments in accordance with section 1886(d)(5)(K) and (L) of the Act. Finally, we add the uncompensated care payment to the total claim payment amount. As noted in the formula above, we take uncompensated care payments and new technology add-on payments into consideration when calculating outlier payments.

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on FY 2006 costs per discharge to determine the rate that yields the greatest aggregate payment.

As noted above, as discussed in section IV.G. of the preamble of this FY 2019 IPPS/LTCH PPS final rule, section 205 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114–10, enacted on April 16, 2015) extended the MDH program (which, under previous law, was to be in effect for discharges on or before March 31, 2015 only) for discharges occurring on or after April 1, 2015, through FY 2017 (that is, for discharges occurring on or before September 30, 2017). Section 50205 of the Bipartisan Budget Act of 2018, enacted February 9, 2018, extended the MDH program for discharges on or after October 1, 2017 through September 30, 2022. For MDHs, the updated hospital-specific rate is based on FY 1982, FY 1987, or FY 2002 costs per discharge, whichever yields the greatest aggregate payment.

For a more detailed discussion of the calculation of the hospital-specific rates, we refer readers to the FY 1984 IPPS interim final rule (48 FR 39772); the April 20, 1990 final rule with comment period (55 FR 15150); the FY 1991 IPPS final rule (55 FR 35994); and the FY 2001 IPPS final rule (65 FR 47082).

b. Updating the FY 1982, FY 1987, FY 1996, FY 2002 and FY 2006 Hospital-Specific Rate for FY 2019

Section 1886(b)(3)(B)(iv) of the Act provides that the applicable percentage increase applicable to the hospital-specific rates for SCHs and MDHs equals the applicable percentage increase set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as for all other hospitals subject to the IPPS). Because the Act sets the update factor for SCHs and MDHs equal to the update factor for all other IPPS hospitals, the update to the hospital-specific rates for SCHs and MDHs is subject to the amendments to section 1886(b)(3)(B) of the Act made by sections 3401(a) and 10319(a) of the Affordable Care Act. Accordingly, the applicable percentage increases to the hospital-specific rates applicable to SCHs and MDHs are the following:

FY 2019	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is NOT a meaningful EHR user	Hospital did NOT submit quality data and is a meaningful EHR user	Hospital did NOT submit quality data and is NOT a meaningful EHR user
Market Basket Rate-of-Increase	2.9	2.9	2.9	2.9
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0	0	−0.725	−0.725
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0	−2.175	0	−2.175
MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	−0.8	−0.8	−0.8	−0.8
Statutory Adjustment under Section 1886(b)(3)(B)(xii) of the Act	−0.75	−0.75	−0.75	−0.75
Applicable Percentage Increase Applied to Standardized Amount	1.35	−0.825	0.625	−1.55

For a complete discussion of the applicable percentage increase applied to the hospital-specific rates for SCHs and MDHs, we refer readers to section IV.B. of the preamble of this final rule.

In addition, because SCHs and MDHs use the same MS–DRGs as other hospitals when they are paid based in whole or in part on the hospital-specific rate, the hospital-specific rate is adjusted by a budget neutrality factor to ensure that changes to the MS–DRG classifications and the recalibration of the MS–DRG relative weights are made in a manner so that aggregate IPPS payments are unaffected. Therefore, the hospital-specific rate for an SCH or an MDH is adjusted by the MS–DRG reclassification and recalibration budget neutrality factor of 0.997192, as discussed in section III. of this Addendum. The resulting rate is used in determining the payment rate that an SCH or MDH will receive for its discharges beginning on or after October 1, 2018. We note that, in this final rule, for FY 2019, we are not making a documentation and coding adjustment to the hospital-specific rate. We refer readers to section II.D. of the preamble of this final rule for a complete discussion regarding our policies and previously finalized policies (including our historical adjustments to the payment rates) relating to the effect of changes in documentation and coding that do not reflect real changes in case-mix.

III. Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2019

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. The basic methodology for determining Federal capital prospective rates is set forth in the regulations at 42 CFR 412.308 through 412.352. Below we discuss the factors that we used to determine the capital Federal rate for FY 2019, which will be effective for discharges occurring on or after October 1, 2018.

All hospitals (except ''new'' hospitals under § 412.304(c)(2)) are paid based on the capital Federal rate. We annually update the capital standard Federal rate, as provided in § 412.308(c)(1), to account for capital input price increases and other factors. The regulations at § 412.308(c)(2) also provide that the capital Federal rate be adjusted annually by a factor equal to the estimated proportion of outlier payments under the capital Federal rate to total capital payments under the capital Federal rate. In addition, § 412.308(c)(3) requires that the capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for exceptions under § 412.348. (We note that, as discussed in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53705), there is generally no longer a need for an exceptions payment adjustment factor.) However, in limited circumstances, an additional payment exception for extraordinary circumstances is provided for under § 412.348(f) for qualifying hospitals. Therefore, in accordance with § 412.308(c)(3), an exceptions payment adjustment factor may need to be applied if such payments are made. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the effects of the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor (GAF) are budget neutral.

Section 412.374 provides for payments to hospitals located in Puerto Rico under the IPPS for acute care hospital inpatient capital-related costs, which currently specifies capital IPPS payments to hospitals located in Puerto Rico are based on 100 percent of the Federal rate.

A. Determination of the Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update for FY 2019

In the discussion that follows, we explain the factors that we used to determine the capital Federal rate for FY 2019. In particular, we explain why the FY 2019 capital Federal rate will increase approximately 1.27 percent, compared to the FY 2018 capital Federal rate. As discussed in the impact analysis in Appendix A to this final rule, we estimate that capital payments per discharge will increase approximately 2.1 percent during that same period. Because capital payments constitute approximately 10 percent of hospital payments, a 1-percent change in the capital Federal rate yields only approximately a 0.1 percent change in actual payments to hospitals.

1. Projected Capital Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the capital standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and several other policy adjustment factors. Specifically, we adjust the projected CIPI rate of change as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The update factor for FY 2019 under that framework is 1.4 percent based on a projected 1.4 percent increase in the 2014-based CIPI, a 0.0 percentage point adjustment for intensity, a 0.0 percentage point adjustment for case-mix, a 0.0 percentage point adjustment for the DRG reclassification and recalibration, and a forecast error correction of 0.0 percentage point. As discussed in section III.C. of this Addendum, we continue to believe that the CIPI is the most appropriate input price index for capital costs to measure capital price changes in a given year. We also explain the basis for the FY 2019 CIPI projection in that same section of this Addendum. Below we describe the policy adjustments that we are applying in the update framework for FY 2019.

The case-mix index is the measure of the average DRG weight for cases paid under the IPPS. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patient changes (''real'' case-mix change);
- Changes in hospital documentation and coding of patient records result in higher-weighted DRG assignments (''coding effects''); and
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients, as opposed to changes in documentation and coding behavior that result in assignment of cases to higher-weighted DRGs, but do not reflect higher resource requirements. The capital update framework includes the same case-mix index adjustment used in the former operating IPPS update framework (as discussed in the May 18, 2004 IPPS proposed rule for FY 2005 (69 FR 28816)). (We no longer use an update framework to make a recommendation for updating the operating IPPS standardized amounts, as discussed in section II. of Appendix B to the FY 2006 IPPS final rule (70 FR 47707).)

For FY 2019, we are projecting a 0.5 percent total increase in the case-mix index. We estimated that the real case-mix increase will equal 0.5 percent for FY 2019. The net adjustment for change in case-mix is the difference between the projected real increase in case-mix and the projected total increase in case-mix. Therefore, the net adjustment for case-mix change in FY 2019 is 0.0 percentage point.

The capital update framework also contains an adjustment for the effects of DRG reclassification and recalibration. This adjustment is intended to remove the effect on total payments of prior year's changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than those due to patient severity of illness. Due to the lag time in the availability of data, there is a 2-year lag in data used to determine the adjustment for the effects of DRG reclassification and recalibration. For example, we have data available to evaluate the effects of the FY 2017 DRG reclassification and recalibration as part of our update for FY 2019. We assume, for purposes of this adjustment, that the estimate of FY 2017 DRG reclassification and recalibration resulted in no change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, as we proposed, we are making a 0.0 percentage point adjustment for reclassification and recalibration in the update framework for FY 2019.

The capital update framework also contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input

price index for any year is off by 0.25 percentage point or more. There is a 2-year lag between the forecast and the availability of data to develop a measurement of the forecast error. Historically, when a forecast error of the CIPI is greater than 0.25 percentage point in absolute terms, it is reflected in the update recommended under this framework. A forecast error of 0.0 percentage point was calculated for the FY 2017 update, for which there are historical data. That is, current historical data indicated that the forecasted FY 2017 CIPI (1.2 percent) used in calculating the FY 2017 update factor was 0.0 percentage point higher than actual realized price increases (1.2 percent). As this does not exceed the 0.25 percentage point threshold, as we proposed, we are not making an adjustment for forecast error in the update for FY 2019.

Under the capital IPPS update framework, we also make an adjustment for changes in intensity. Historically, we calculated this adjustment using the same methodology and data that were used in the past under the framework for operating IPPS. The intensity factor for the operating update framework reflected how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, for changes within DRG severity, and for expected modification of practice patterns to remove noncost-effective services. Our intensity measure is based on a 5-year average.

We calculate case-mix constant intensity as the change in total cost per discharge, adjusted for price level changes (the CPI for hospital and related services) and changes in real case-mix. Without reliable estimates of the proportions of the overall annual intensity changes that are due, respectively, to ineffective practice patterns and the combination of quality-enhancing new technologies and complexity within the DRG system, we assume that one-half of the annual change is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity, to allow for increases within DRG severity and the adoption of quality-enhancing technology.

In this final rule, as we proposed, we are continuing to use a Medicare-specific intensity measure that is based on a 5-year adjusted average of cost per discharge for FY 2019 (we refer readers to the FY 2011 IPPS/LTCH PPS final rule (75 FR 50436) for a full description of our Medicare-specific intensity measure). Specifically, for FY 2019, we are using an intensity measure that is based on an average of cost per discharge data from the 5-year period beginning with FY 2012 and extending through FY 2016. Based on these data, we estimated that case-mix constant intensity declined during FYs 2012 through 2016. In the past, when we found intensity to be declining, we believed a zero (rather than a negative) intensity adjustment was appropriate. Consistent with this approach, because we estimated that intensity will decline during that 5-year period, we believe it is appropriate to continue to apply a zero intensity adjustment for FY 2019. Therefore, as we proposed, we are making a 0.0 percentage point adjustment for intensity in the update for FY 2019.

Above we described the basis of the components we used to develop the 1.4 percent capital update factor under the capital update framework for FY 2019, as shown in the following table.

CMS FY 2019 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index*	1.4
Intensity	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	0.5
Projected Case-Mix Change	0.5
Subtotal	1.4
Effect of FY 2017 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0
Total Update	1.4

*The capital input price index represents the 2014-based CIPI.

b. Comparison of CMS and MedPAC Update Recommendation

In its March 2018 Report to Congress, MedPAC did not make a specific update recommendation for capital IPPS payments for FY 2019. (We refer readers to MedPAC's Report to the Congress: Medicare Payment Policy, March 2018, Chapter 3, available on the website at: *http://www.medpac.gov*.)

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier payment methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital-related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating IPPS DRG payments.

For FY 2018, we estimated that outlier payments for capital would equal 5.17 percent of inpatient capital-related payments based on the capital Federal rate in FY 2018. Based on the thresholds, as set forth in section II.A. of this Addendum, we estimate that outlier payments for capital-related costs will equal 5.06 percent for inpatient capital-related payments based on the capital Federal rate in FY 2019. Therefore, we are applying an outlier adjustment factor of 0.9494 in determining the capital Federal rate for FY 2019. Thus, we estimate that the percentage of capital outlier payments to total capital Federal rate payments for FY 2019 will be lower than the percentage for FY 2018.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. The FY 2019 outlier adjustment of 0.9494 is a 0.12 percent change from the FY 2018 outlier adjustment of 0.9483. Therefore, the net change in the outlier adjustment to the capital Federal rate for FY 2019 is 1.0012 (0.9494/0.9483) so that the outlier adjustment will increase the FY 2019 capital Federal rate by 0.12 percent compared to the FY 2018 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the GAF

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate, after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF, are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. The budget neutrality factor for DRG reclassifications and recalibration nationally is applied in determining the capital IPPS Federal rate, and is applicable for all hospitals, including those hospitals located in Puerto Rico.

To determine the factors for FY 2019, we compared estimated aggregate capital Federal rate payments based on the FY 2018 MS–DRG classifications and relative weights and the FY 2018 GAF to estimated aggregate capital Federal rate payments based on the FY 2018 MS–DRG classifications and relative weights and the FY 2019 GAFs. To achieve budget neutrality for the changes in the GAFs, based on calculations using updated data, we are applying an incremental budget neutrality adjustment factor of 0.9986 for FY 2019 to the previous cumulative FY 2018 adjustment factor.

We then compared estimated aggregate capital Federal rate payments based on the FY 2018 MS–DRG relative weights and the FY 2019 GAFs to estimate aggregate capital Federal rate payments based on the cumulative effects of the FY 2019 MS–DRG classifications and relative weights and the FY 2019 GAFs. The incremental adjustment factor for DRG classifications and changes in relative weights is 0.9989. The incremental adjustment factors for MS–DRG classifications and changes in relative weights and for changes in the GAFs through FY 2019 is 0.9975. We note that all the values are calculated with unrounded numbers.

The GAF/DRG budget neutrality adjustment factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows the requirement under § 412.308(c)(4)(ii) that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAFs.

The methodology used to determine the recalibration and geographic adjustment factor (GAF/DRG) budget neutrality adjustment is similar to the methodology used in establishing budget neutrality adjustments under the IPPS for operating costs. One difference is that, under the operating IPPS, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the MS–DRG

relative weights. Under the capital IPPS, there is a single GAF/DRG budget neutrality adjustment factor for changes in the GAF (including geographic reclassification) and the MS–DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for DSH or IME.

The incremental adjustment factor of 0.9975 (the product of the incremental national GAF budget neutrality adjustment factor of 0.9986 and the incremental DRG budget neutrality adjustment factor of 0.9989) accounts for the MS–DRG reclassifications and recalibration and for changes in the GAFs. It also incorporates the effects on the GAFs of FY 2019 geographic reclassification decisions made by the MGCRB compared to FY 2018 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors.

4. Capital Federal Rate for FY 2019

For FY 2018, we established a capital Federal rate of $453.95 (82 FR 46144 through 46145). We are establishing an update of 1.4 percent in determining the FY 2019 capital Federal rate for all hospitals. As a result of this update and the budget neutrality factors discussed earlier, we are establishing a national capital Federal rate of $459.72 for FY 2019. The national capital Federal rate for FY 2019 was calculated as follows:

- The FY 2019 update factor is 1.014; that is, the update is 1.4 percent.
- The FY 2019 budget neutrality adjustment factor that is applied to the capital Federal rate for changes in the MS–DRG classifications and relative weights and changes in the GAFs is 0.9975.
- The FY 2019 outlier adjustment factor is 0.9494.

We are providing the following chart that shows how each of the factors and adjustments for FY 2019 affects the computation of the FY 2019 national capital Federal rate in comparison to the FY 2018 national capital Federal rate as presented in the FY 2018 IPPS/LTCH PPS Correction Notice (82 FR 46144 through 46145). The FY 2019 update factor has the effect of increasing the capital Federal rate by 1.4 percent compared to the FY 2018 capital Federal rate. The GAF/DRG budget neutrality adjustment factor has the effect of decreasing the capital Federal rate by 0.25 percent. The FY 2019 outlier adjustment factor has the effect of increasing the capital Federal rate by 0.12 percent compared to the FY 2018 capital Federal rate. The combined effect of all the changes will increase the national capital Federal rate by approximately 1.27 percent, compared to the FY 2018 national capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2018 CAPITAL FEDERAL RATE AND FY 2019 CAPITAL FEDERAL RATE

	FY 2018	FY 2019	Change	Percent change
Update Factor [1]	1.0130	1.0140	1.014	1.40
GAF/DRG Adjustment Factor [1]	0.9987	0.9975	0.9975	−0.25
Outlier Adjustment Factor [2]	0.9483	0.9494	1.0012	0.12
Capital Federal Rate	$453.95	$459.72	1.0127	1.27 [3]

[1] The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rates. Thus, for example, the incremental change from FY 2018 to FY 2019 resulting from the application of the 0.9975 GAF/DRG budget neutrality adjustment factor for FY 2019 is a net change of 0.9975 (or –0.25 percent).

[2] The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the FY 2019 outlier adjustment factor is 0.9494/0.9483 or 1.0012 (or 0.12 percent).

[3] Percent change may not sum due to rounding.

In this final rule, we also are providing the following chart that shows how the final FY 2019 capital Federal rate differs from the proposed FY 2019 capital Federal rate as presented in the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20587 through 20589).

COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 2019 CAPITAL FEDERAL RATE AND FINAL FY 2019 CAPITAL FEDERAL RATE

	Proposed FY 2019	Final FY 2019	Change	Percent change *
Update Factor	1.0120	1.0140	1.0020	0.20
GAF/DRG Adjustment Factor	0.9997	0.9975	−0.0022	−0.22
Outlier Adjustment Factor	0.9494	0.9494	0.0000	0.00
Capital Federal Rate	$459.78	$459.72	0.9999	−0.01

* Percent change may not sum due to rounding.

B. Calculation of the Inpatient Capital-Related Prospective Payments for FY 2019

For purposes of calculating payments for each discharge during FY 2019, the capital Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (COLA for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted capital Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The outlier thresholds for FY 2019 are in section II.A. of this Addendum. For FY 2019, a case will qualify as a cost outlier if the cost for the case plus the (operating) IME and DSH payments (including both the empirically justified Medicare DSH payment and the estimated uncompensated care payment, as discussed in section II.A.4.g.(1) of this Addendum) is greater than the prospective payment rate for the MS–DRG plus the fixed-loss amount of $25,769.

Currently, as provided under § 412.304(c)(2), we pay a new hospital 85 percent of its reasonable costs during the first 2 years of operation, unless it elects to receive payment based on 100 percent of the capital Federal rate. Effective with the third year of operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with capital costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior

COST-OF-LIVING ADJUSTMENT FACTORS FOR ALASKA AND HAWAII UNDER THE LTCH PPS FOR FY 2019

Area	FY 2018 and FY 2019
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.25
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.25
City of Juneau and 80-kilometer (50-mile) radius by road	1.25
Rest of Alaska	1.25
City and County of Honolulu	1.25
County of Hawaii	1.21
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

D. Adjustment for LTCH PPS High Cost Outlier (HCO) Cases

1. HCO Background

From the beginning of the LTCH PPS, we have included an adjustment to account for cases in which there are extraordinarily high costs relative to the costs of most discharges. Under this policy, additional payments are made based on the degree to which the estimated cost of a case (which is calculated by multiplying the Medicare allowable covered charge by the hospital's overall hospital CCR) exceeds a fixed-loss amount. This policy results in greater payment accuracy under the LTCH PPS and the Medicare program, and the LTCH sharing the financial risk for the treatment of extraordinarily high-cost cases.

We retained the basic tenets of our HCO policy in FY 2016 when we implemented the dual rate LTCH PPS payment structure under section 1206 of Public Law 113–67. LTCH discharges that meet the criteria for exclusion from the site neutral payment rate (that is, LTCH PPS standard Federal payment rate cases) are paid at the LTCH PPS standard Federal payment rate, which includes, as applicable, HCO payments under § 412.523(e). LTCH discharges that do not meet the criteria for exclusion are paid at the site neutral payment rate, which includes, as applicable, HCO payments under § 412.522(c)(2)(i). In the FY 2016 IPPS/LTCH PPS final rule, we established separate fixed-loss amounts and targets for the two different LTCH PPS payment rates. Under this bifurcated policy, the historic 8-percent HCO target was retained for LTCH PPS standard Federal payment rate cases, with the fixed-loss amount calculated using only data from LTCH cases that would have been paid at the LTCH PPS standard Federal payment rate if that rate had been in effect at the time of those discharges. For site neutral payment rate cases, we adopted the operating IPPS HCO target (currently 5.1 percent) and set the fixed-loss amount for site neutral payment rate cases at the value of the IPPS fixed-loss amount. Under the HCO policy for both payment rates, an LTCH receives 80 percent of the difference between the estimated cost of the case and the applicable HCO threshold, which is the sum of the LTCH PPS payment for the case and the applicable fixed-loss amount for such case.

In order to maintain budget neutrality, consistent with the budget neutrality requirement for HCO payments to LTCH PPS standard Federal rate payment cases, we also adopted a budget neutrality requirement for HCO payments to site neutral payment rate cases by applying a budget neutrality factor to the LTCH PPS payment for those site neutral payment rate cases. (We refer readers to § 412.522(c)(2)(i) of the regulations for further details.) We note that, during the 2-year transitional period, the site neutral payment rate HCO budget neutrality factor did not apply to the LTCH PPS standard Federal payment rate portion of the blended payment rate at § 412.522(c)(3) payable to site neutral payment rate cases. (For additional details on the HCO policy adopted for site neutral payment rate cases under the dual rate LTCH PPS payment structure, including the budget neutrality adjustment for HCO payments to site neutral payment rate cases, we refer readers to the FY 2016 IPPS/LTCH PPS final rule (80 FR 49617 through 49623).)

2. Determining LTCH CCRs Under the LTCH PPS

a. Background

As noted above, CCRs are used to determine payments for HCO adjustments for both payment rates under the LTCH PPS and also are used to determine payments for site neutral payment rate cases. As noted earlier, in determining HCO and the site neutral payment rate payments (regardless of whether the case is also an HCO), we generally calculate the estimated cost of the case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case. An overall CCR is used because the LTCH PPS uses a single prospective payment per discharge that covers both inpatient operating and capital-related costs. The LTCH's overall CCR is generally computed based on the sum of LTCH operating and capital costs (as described in Section 150.24, Chapter 3, of the Medicare Claims Processing Manual (Pub. 100–4)) as compared to total Medicare charges (that is, the sum of its operating and capital inpatient routine and ancillary charges), with those values determined from either the most recently settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period. However, in certain instances, we use an alternative CCR, such as the statewide average CCR, a CCR that is specified by CMS, or one that is requested by the hospital. (We refer readers to § 412.525(a)(4)(iv) of the regulations for further details regarding HCO adjustments for either LTCH PPS payment rate and § 412.522(c)(1)(ii) for the site neutral payment rate.)

The LTCH's calculated CCR is then compared to the LTCH total CCR ceiling. Under our established policy, an LTCH with a calculated CCR in excess of the applicable maximum CCR threshold (that is, the LTCH total CCR ceiling, which is calculated as 3 standard deviations from the national geometric average CCR) is generally assigned the applicable statewide CCR. This policy is premised on a belief that calculated CCRs above the LTCH total CCR ceiling are most likely due to faulty data reporting or entry, and CCRs based on erroneous data should not be used to identify and make payments for outlier cases.

b. LTCH Total CCR Ceiling

Consistent with our historical practice, as we proposed, we used the most recent data available to determine the LTCH total CCR ceiling for FY 2019 in this final rule. Specifically, in this final rule, using our established methodology for determining the LTCH total CCR ceiling based on IPPS total CCR data from the March 2018 update of the Provider Specific File (PSF), which is the most recent data available, we are establishing an LTCH total CCR ceiling of 1.27 under the LTCH PPS for FY 2019 in accordance with § 412.525(a)(4)(iv)(C)(*2*) for HCO cases under either payment rate and § 412.522(c)(1)(ii) for the site neutral payment rate. (For additional information on our methodology for determining the LTCH total CCR ceiling, we refer readers to the FY 2007 IPPS final rule (71 FR 48118 through 48119).

We did not receive any public comments on our proposals. Therefore, we are finalizing our proposals as described above, without modification.

c. LTCH Statewide Average CCRs

Our general methodology for determining the statewide average CCRs used under the LTCH PPS is similar to our established methodology for determining the LTCH total CCR ceiling because it is based on ''total'' IPPS CCR data. (For additional information on our methodology for determining statewide average CCRs under the LTCH PPS, we refer readers to the FY 2007 IPPS final rule (71 FR 48119 through 48120).) Under the LTCH PPS HCO policy for cases paid under either payment rate at § 412.525(a)(4)(iv)(C)(*2*), the current SSO policy at § 412.529(f)(4)(iii)(B), and the site neutral payment rate at § 412.522(c)(1)(ii), the MAC may use a statewide average CCR, which is established annually by CMS, if it

is unable to determine an accurate CCR for an LTCH in one of the following circumstances: (1) New LTCHs that have not yet submitted their first Medicare cost report (a new LTCH is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18); (2) LTCHs whose calculated CCR is in excess of the LTCH total CCR ceiling; and (3) other LTCHs for whom data with which to calculate a CCR are not available (for example, missing or faulty data). (Other sources of data that the MAC may consider in determining an LTCH's CCR include data from a different cost reporting period for the LTCH, data from the cost reporting period preceding the period in which the hospital began to be paid as an LTCH (that is, the period of at least 6 months that it was paid as a short-term, acute care hospital), or data from other comparable LTCHs, such as LTCHs in the same chain or in the same region.)

Consistent with our historical practice of using the best available data, in this final rule, using our established methodology for determining the LTCH statewide average CCRs, based on the most recent complete IPPS ''total CCR'' data from the March 2018 update of the PSF, as we proposed, we are establishing LTCH PPS statewide average total CCRs for urban and rural hospitals that will be effective for discharges occurring on or after October 1, 2018, through September 30, 2019, in Table 8C listed in section VI. of the Addendum to this final rule (and available via the internet on the CMS website). Consistent with our historical practice, as we also proposed, we used more recent data to determine the LTCH PPS statewide average total CCRs for FY 2019 in this final rule.

Under the current LTCH PPS labor market areas, all areas in Delaware, the District of Columbia, New Jersey, and Rhode Island are classified as urban. Therefore, there are no rural statewide average total CCRs listed for those jurisdictions in Table 8C. This policy is consistent with the policy that we established when we revised our methodology for determining the applicable LTCH statewide average CCRs in the FY 2007 IPPS final rule (71 FR 48119 through 48121) and is the same as the policy applied under the IPPS. In addition, although Connecticut has areas that are designated as rural, in our calculation of the LTCH statewide average CCRs, there was no data available from short-term, acute care IPPS hospitals to compute a rural statewide average CCR or there were no short-term, acute care IPPS hospitals or LTCHs located in that area as of March 2018. Therefore, consistent with our existing methodology, as we proposed, we used the national average total CCR for rural IPPS hospitals for rural Connecticut in Table 8C. While Massachusetts also has rural areas, the statewide average CCR for rural areas in Massachusetts is based on one IPPS provider whose CCR is an atypical 1.215. Because this is much higher than the statewide urban average and furthermore implies costs exceeded charges, as with Connecticut, as we proposed, we used the national average total CCR for rural hospitals for hospitals located in rural Massachusetts. Furthermore, consistent with our existing methodology, in determining the urban and rural statewide average total CCRs for Maryland LTCHs paid under the LTCH PPS, as we proposed, we are continuing to use, as a proxy, the national average total CCR for urban IPPS hospitals and the national average total CCR for rural IPPS hospitals, respectively. We are using this proxy because we believe that the CCR data in the PSF for Maryland hospitals may not be entirely accurate (as discussed in greater detail in the FY 2007 IPPS final rule (71 FR 48120)).

We did not receive any public comments on our proposals. Therefore, we are finalizing our proposals as described above, without modification.

d. Reconciliation of HCO Payments

Under the HCO policy for cases paid under either payment rate at § 412.525(a)(4)(iv)(D), the payments for HCO cases are subject to reconciliation. Specifically, any such payments are reconciled at settlement based on the CCR that was calculated based on the cost report coinciding with the discharge. For additional information on the reconciliation policy, we refer readers to Sections 150.26 through 150.28 of the Medicare Claims Processing Manual (Pub. 100–4), as added by Change Request 7192 (Transmittal 2111; December 3, 2010), and the RY 2009 LTCH PPS final rule (73 FR 26820 through 26821).

3. High-Cost Outlier Payments for LTCH PPS Standard Federal Payment Rate Cases

a. Changes to High-Cost Outlier Payments for LTCH PPS Standard Federal Payment Rate Cases

Under the regulations at § 412.525(a)(2)(ii) and as required by section 1886(m)(7) of the Act, the fixed-loss amount for HCO payments is set each year so that the estimated aggregate HCO payments for LTCH PPS standard Federal payment rate cases are 99.6875 percent of 8 percent (that is, 7.975 percent) of estimated aggregate LTCH PPS payments for LTCH PPS standard Federal payment rate cases. (For more details on the requirements for high-cost outlier payments in FY 2018 and subsequent years under section 1886(m)(7) of the Act and additional information regarding high-cost outlier payments prior to FY 2018, we refer readers to the FY 2018 IPPS/LTCH PPS final rule (82 FR 38542 through 38544).)

b. Establishment of the Fixed-Loss Amount for LTCH PPS Standard Federal Payment Rate Cases for FY 2019

When we implemented the LTCH PPS, we established a fixed-loss amount so that total estimated outlier payments are projected to equal 8 percent of total estimated payments under the LTCH PPS (67 FR 56022 through 56026). When we implemented the dual rate LTCH PPS payment structure beginning in FY 2016, we established that, in general, the historical LTCH PPS HCO policy would continue to apply to LTCH PPS standard Federal payment rate cases. That is, the fixed-loss amount and target for LTCH PPS standard Federal payment rate cases would be determined using the LTCH PPS HCO policy adopted when the LTCH PPS was first implemented, but we limited the data used under that policy to LTCH cases that would have been LTCH PPS standard Federal payment rate cases if the statutory changes had been in effect at the time of those discharges.

To determine the applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases, we estimate outlier payments and total LTCH PPS payments for each LTCH PPS standard Federal payment rate case (or for each case that would have been a LTCH PPS standard Federal payment rate case if the statutory changes had been in effect at the time of the discharge) using claims data from the MedPAR files. In accordance with § 412.525(a)(2)(ii), the applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases results in estimated total outlier payments being projected to be equal to 7.975 percent of projected total LTCH PPS payments for LTCH PPS standard Federal payment rate cases. We use MedPAR claims data and CCRs based on data from the most recent PSF (or from the applicable statewide average CCR if an LTCH's CCR data are faulty or unavailable) to establish an applicable fixed-loss threshold amount for LTCH PPS standard Federal payment rate cases.

In the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20595), we proposed to continue to use our current methodology to calculate an applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2019 using the best available data that would maintain estimated HCO payments at the projected 7.975 percent of total estimated LTCH PPS payments for LTCH PPS standard Federal payment rate cases (based on the payment rates and policies for these cases presented in that proposed rule).

Specifically, based on the most recent complete LTCH data available at that time (that is, LTCH claims data from the December 2017 update of the FY 2017 MedPAR file and CCRs from the December 2017 update of the PSF), we determined a proposed fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2019 of $30,639 that would result in estimated outlier payments projected to be equal to 7.975 percent of estimated FY 2019 payments for such cases. Under this proposal, we would continue to make an additional HCO payment for the cost of an LTCH PPS standard Federal payment rate case that exceeds the HCO threshold amount that is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted LTCH PPS standard Federal payment rate payment and the fixed-loss amount for LTCH PPS standard Federal payment rate cases of $30,639).

Comment: Several commenters expressed concerns with the proposed fixed-loss amount for HCO cases paid under the LTCH PPS standard Federal payment rate, noting that the proposed fixed-loss amount, 11.9 percent greater than the fixed-loss amount in FY 2018, is the third consecutive year with a greater than 10-percent increase. Moreover, some commenters noted that the provider data used for the proposed rule included one new provider with a CCR of 1.029 which accounted for 2.65 percent of all outlier payments, despite accounting for only 0.116 percent of all LTCH PPS standard Federal

payment rate cases. Commenters attributed approximately $1,100 of the proposed increase to the fixed-loss amount to this one provider.

Response: In the FY 2019 IPPS/LTCH PPPS proposed rule (83 FR 20595), we noted that the proposed fixed-loss amount for HCO cases paid under the LTCH PPS standard Federal payment rate in FY 2019 of $30,639 is higher than the FY 2018 fixed-loss amount of $27,381 for LTCH PPS standard Federal payment rate cases. However, based on the most recent available data at the time of the development of the proposed rule, we found that the current FY 2018 HCO threshold of $27,381 results in estimated HCO payments for LTCH PPS standard Federal payment rate cases of approximately 7.988 percent of the estimated total LTCH PPS payments in FY 2018, which exceeds the 7.975 percent target by 0.01 percentage points.

As described in the FY 2019 IPPS/LTCH PPS proposed rule (82 FR 20595), we used CCRs from the December 2017 update of the PSF as they were the best available data at that time, which included the provider with a CCR of 1.029 as point out by some commenters. We note that while a CCR over 1.0 is generally considered high, and is significantly higher than prior CCRs for that provider, a CCR of 1.029 is within the current CCR ceiling of 1.280 established in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38541). In addition, that provider's CCR was in the PSF with an effective date of July 1, 2016 and, therefore, was the CCR used to determine that provider's LTCH PPS payments (such as outliers and site neutral payment rate payments) until it was updated with an effective date of January 1, 2018, which, as anticipated by some commenters, has resulted in lowering the fixed-loss amount for FY 2019 as compared to the proposed FY 2019 fixed-loss amount of $30,639 (as described in more detail below). For these reasons, we did not believe it was inappropriate to use that provider's CCR for the calculations in the proposed rule.

Consistent with our historical practice of using the best data available, as we proposed, for this final rule we are using the best available data, including CCRs from the March 2018 update of the PSF as described below. We note that the CCR for the provider noted by the commenters has decreased from 1.029 to 0.323, which we used for the calculations in this final rule.

Comment: A few commenters requested that CMS provide more information regarding the fixed-loss amount for HCO cases paid under the LTCH PPS standard Federal payment rate, specifically requesting the charge inflation factor for LTCH PPS standard Federal payment rate cases and an explanation on its calculation.

Response: We regret the inadvertent omission of the 2-year inflation factor from FY 2017 to FY 2019 in the FY 2019 IPPS/LTCH PPS proposed rule. Consistent with our historical approach, in the proposed rule we applied a factor based on IGI's most recent estimate of the 2013-based LTCH market basket increase from FY 2017 to FY 2019, which, at that time, was 5.3 percent. For this FY 2019 IPPS/LTCH PPS final rule, based on the Office of Actuary's most recent second quarter 2018 forecast of the 2013-based of the LTCH market basket increase from FY 2017 to FY 2019, we are using an inflation factor of 5.7 percent.

Comment: One commenter stated that, with the increasing the fixed-loss amount for HCO cases paid under the LTCH PPS standard Federal payment rate over the past 5 years, the ''additional 'days of losses' covered by the HCO amount is now approaching 10 days'', and requested that CMS evaluate if the 8-percent outlier target is satisfactory under the LTCH PPS.

Response: We agree that an increase in the HCO amount can lead to an increase in the ''days of losses.'' However, a change to the HCO payment target for LTCH PPS standard Federal payment rate cases can only be accomplished through statute. Specifically, section 1886(m)(7) of the Act, requires that the fixed-loss amount for HCO payments is set each year so that the estimated aggregate HCO payments for LTCH PPS standard Federal payment rate cases are 99.6875 percent of 8 percent (that is, 7.975 percent) of estimated aggregate LTCH PPS payments for LTCH PPS standard Federal payment rate cases.

Consistent with our historical practice of using the best data available, as we proposed, when determining the fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2019 in this final rule, we used the most recent available LTCH claims data and CCR data. In this FY 2019 IPPS/LTCH PPS final rule, we are continuing to use our current methodology to calculate an applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2019 using the best available data that will maintain estimated HCO payments at the projected 7.975 percent of total estimated LTCH PPS payments for LTCH PPS standard Federal payment rate cases (based on the payment rates and policies for these cases presented in this final rule). Specifically, based on the most recent complete LTCH data available at this time (that is, LTCH claims data from the March 2018 update of the FY 2017 MedPAR file and CCRs from the March 2018 update of the PSF), we determined a fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2019 of $27,124 that will result in estimated outlier payments projected to be equal to 7.975 percent of estimated FY 2019 payments for such cases. Under the broad authority of section 123(a)(1) of the BBRA and section 307(b)(1) of the BIPA, we are establishing a fixed-loss amount of $27,124 for LTCH PPS standard Federal payment rate cases for FY 2019. Under this policy, we would continue to make an additional HCO payment for the cost of an LTCH PPS standard Federal payment rate case that exceeds the HCO threshold amount that is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted LTCH PPS standard Federal payment rate payment and the fixed-loss amount for LTCH PPS standard Federal payment rate cases of $27,124).

We note that the fixed-loss amount for HCO cases paid under the LTCH PPS standard Federal payment rate in FY 2019 of $27,124 is significantly lower than proposed FY 2019 fixed-loss amount of $30,639, and slightly lower than the FY 2018 fixed-loss amount for LTCH PPS standard Federal payment rate cases of $27,381. This decrease is primarily attributable to the updated CCRs used for this final rule, including the provider discussed above whose CCR decreased from 1.029 to 0.323.

Based on the most recent available data at the time of this final rule, we found that the current FY 2018 HCO threshold of $27,381 results in estimated HCO payments for LTCH PPS standard Federal payment rate cases of approximately 7.4 percent of the estimated total LTCH PPS payments in FY 2018, which is below the 7.975 percent target by approximately 0.6 percentage points. We also note the change in our estimate of FY 2018 HCO payments between the proposed and final rule decreased from 8.0 percent to 7.4 percent, and this change is largely attributable to updates to CCRs, from the December 2017 update of the PSF to the March 2018 update of the PSF and includes the provider discussed above whose CCR decreased from 1.029 to 0.323.

4. High-Cost Outlier Payments for Site Neutral Payment Rate Cases

Under § 412.525(a), site neutral payment rate cases receive an additional HCO payment for costs that exceed the HCO threshold that is equal to 80 percent of the difference between the estimated cost of the case and the applicable HCO threshold (80 FR 49618 through 49629). In the following discussion, we note that the statutory transitional payment method for cases that are paid the site neutral payment rate for LTCH discharges occurring in cost reporting periods beginning during FY 2016 through FY 2019 uses a blended payment rate, which is determined as 50 percent of the site neutral payment rate amount for the discharge and 50 percent of the LTCH PPS standard Federal payment rate amount for the discharge (§ 412.522(c)(3)). As such, for FY 2019 discharges paid under the transitional payment method, the discussion below pertains only to the site neutral payment rate portion of the blended payment rate under § 412.522(c)(3)(i).

When we implemented the application of the site neutral payment rate in FY 2016, in examining the appropriate fixed-loss amount for site neutral payment rate cases issue, we considered how LTCH discharges based on historical claims data would have been classified under the dual rate LTCH PPS payment structure and the CMS' Office of the Actuary projections regarding how LTCHs will likely respond to our implementation of policies resulting from the statutory payment changes. We again relied on these considerations and actuarial projections in FY 2017 and FY 2018 because the historical claims data available in each of these years were not all subject to the LTCH PPS dual rate payment system. Similarly, for FY 2019, we continue to rely on these considerations and actuarial projections because, due to the transitional blended payment policy for site neutral payment rate cases, FY 2017 claims for these cases were not subject to the full effect of the site neutral payment rate.

For FYs 2016 through 2018, at that time our actuaries projected that the proportion of

cases that would qualify as LTCH PPS standard Federal payment rate cases versus site neutral payment rate cases under the statutory provisions would remain consistent with what is reflected in the historical LTCH PPS claims data. Although our actuaries did not project an immediate change in the proportions found in the historical data, they did project cost and resource changes to account for the lower payment rates. Our actuaries also projected that the costs and resource use for cases paid at the site neutral payment rate would likely be lower, on average, than the costs and resource use for cases paid at the LTCH PPS standard Federal payment rate and would likely mirror the costs and resource use for IPPS cases assigned to the same MS–DRG, regardless of whether the proportion of site neutral payment rate cases in the future remains similar to what is found based on the historical data. As discussed in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49619), this actuarial assumption is based on our expectation that site neutral payment rate cases would generally be paid based on an IPPS comparable per diem amount under the statutory LTCH PPS payment changes that began in FY 2016, which, in the majority of cases, is much lower than the payment that would have been paid if these statutory changes were not enacted. In light of these projections and expectations, we discussed that we believed that the use of a single fixed-loss amount and HCO target for all LTCH PPS cases would be problematic. In addition, we discussed that we did not believe that it would be appropriate for comparable LTCH PPS site neutral payment rate cases to receive dramatically different HCO payments from those cases that would be paid under the IPPS (80 FR 49617 through 49619 and 81 FR 57305 through 57307). For those reasons, we stated that we believed that the most appropriate fixed-loss amount for site neutral payment rate cases for FYs 2016 through 2018 would be equal to the IPPS fixed-loss amount for that particular fiscal year. Therefore, we established the fixed-loss amount for site neutral payment rate cases as the corresponding IPPS fixed-loss amounts for FYs 2016 through 2018. In particular, in FY 2018, we established the fixed-loss amount for site neutral payment rate cases as the FY 2018 IPPS fixed-loss amount of $26,537 (82 FR 46145).

As noted earlier, because not all claims in the data used for this final rule were subject to the site neutral payment rate, we continue to rely on the same considerations and actuarial projections used in FYs 2016 through 2018 when developing a fixed-loss amount for site neutral payment rate cases for FY 2019. Because our actuaries continue to project that site neutral payment rate cases in FY 2019 will continue to mirror an IPPS case paid under the same MS–DRG, we continue to believe that it would be inappropriate for comparable LTCH PPS site neutral payment rate cases to receive dramatically different HCO payments from those cases that would be paid under the IPPS. More specifically, as with FYs 2016 through 2018, our actuaries project that the costs and resource use for FY 2019 cases paid at the site neutral payment rate would likely be lower, on average, than the costs and resource use for cases paid at the LTCH PPS standard Federal payment rate and will likely mirror the costs and resource use for IPPS cases assigned to the same MS–DRG, regardless of whether the proportion of site neutral payment rate cases in the future remains similar to what is found based on the historical data. (Based on the most recent FY 2017 LTCH claims data, approximately 64 percent of LTCH cases would have been paid the LTCH PPS standard Federal payment rate and approximately 36 percent of LTCH cases would have been paid the site neutral payment rate for discharges occurring in FY 2017.)

For these reasons, we continue to believe that the most appropriate fixed-loss amount for site neutral payment rate cases for FY 2019 is the IPPS fixed-loss amount for FY 2019. Therefore, consistent with past practice, in the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20595 and 20596), for FY 2019, we proposed that the applicable HCO threshold for site neutral payment rate cases is the sum of the site neutral payment rate for the case and the IPPS fixed-loss amount. That is, we proposed a fixed-loss amount for site neutral payment rate cases of $27,545, which is the same proposed FY 2019 IPPS fixed-loss amount discussed in section II.A.4.g.(1) of the Addendum to the proposed rule. We continue to believe that this policy would reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems. Accordingly, for FY 2019, we proposed to calculate a HCO payment for site neutral payment rate cases with costs that exceed the HCO threshold amount that is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the proposed site neutral payment rate payment and the proposed fixed-loss amount for site neutral payment rate cases of $27,545).

We did not receive any public comments on our proposals to use the FY 2019 IPPS fixed-loss amount and 5.1 percent HCO target for LTCH discharges paid at the site neutral payment rate in FY 2019. In this final rule, we are finalizing these proposals without modification.

Therefore, for FY 2019, as we proposed, we are establishing that the applicable HCO threshold for site neutral payment rate cases is the sum of the site neutral payment rate for the case and the IPPS fixed loss amount. That is, we are establishing a fixed-loss amount for site neutral payment rate cases of $25,769, which is the same FY 2019 IPPS fixed-loss amount discussed in section II.A.4.g.(1). of the Addendum to this final rule. We continue to believe that this policy will reduce differences between HCO payments for similar cases under the IPPS and site neutral payment rate cases under the LTCH PPS and promote fairness between the two systems. Accordingly, under this policy, for FY 2019, we will calculate a HCO payment for site neutral payment rate cases with costs that exceed the HCO threshold amount, which is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of site neutral payment rate payment and the fixed loss amount for site neutral payment rate cases of $25,769).

In establishing a HCO policy for site neutral payment rate cases, we established a budget neutrality adjustment under § 412.522(c)(2)(i). We established this requirement because we believed, and continue to believe, that the HCO policy for site neutral payment rate cases should be budget neutral, just as the HCO policy for LTCH PPS standard Federal payment rate cases is budget neutral, meaning that estimated site neutral payment rate HCO payments should not result in any change in estimated aggregate LTCH PPS payments.

To ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2019 would not result in any increase in estimated aggregate FY 2019 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i), it is necessary to reduce site neutral payment rate payments (or the portion of the blended payment rate payment for FY 2018 discharges occurring in LTCH cost reporting periods beginning before October 1, 2017) by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2019. In order to achieve this, for FY 2019, in general, as we proposed, we are continuing to use the policy adopted for FY 2018.

As discussed earlier, consistent with the IPPS HCO payment threshold, we estimate our fixed-loss threshold of $25,769 results in HCO payments for site neutral payment rate cases to equal 5.1 percent of the site neutral payment rate payments that are based on the IPPS comparable per diem amount. As such, to ensure estimated HCO payments payable for site neutral payment rate cases in FY 2019 would not result in any increase in estimated aggregate FY 2019 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i), it is necessary to reduce the site neutral payment rate amount paid under § 412.522(c)(1)(i) by 5.1 percent to account for the estimated additional HCO payments payable for site neutral payment rate cases in FY 2019. In order to achieve this, for FY 2019, we proposed to apply a budget neutrality factor of 0.949 (that is, the decimal equivalent of a 5.1 percent reduction, determined as $1.0 - 5.1/100 = 0.949$) to the site neutral payment rate for those site neutral payment rate cases paid under § 412.522(c)(1)(i). We noted that, consistent with the policy adopted for FY 2018, this proposed HCO budget neutrality adjustment would not be applied to the HCO portion of the site neutral payment rate amount (81 FR 57309).

Comment: As was the case in the FY 2016 through FY 2018 rulemaking cycles, commenters again objected to the proposed site neutral payment rate HCO budget neutrality adjustment, claiming that it results in savings to the Medicare program instead of being budget neutral. The commenters' primary objection was again based on their belief that, because the IPPS base rates used in the IPPS comparable per diem amount calculation of the site neutral payment rate include a budget neutrality adjustment for IPPS HCO payments (that is, a 5.1 percent adjustment on the operating IPPS

standardized amount), an ''additional'' budget neutrality factor is not necessary and is, in fact, duplicative.

Response: We continue to disagree with the commenters that a budget neutrality adjustment for site neutral payment rate HCO payments is inappropriate, unnecessary, or duplicative. As we discussed in response to similar comments (82 FR 38545 through 38546, 81 FR 57308 through 57309, and 80 FR 49621 through 49622), we have the authority to adopt the site neutral payment rate HCO policy in a budget neutral manner. More importantly, we continue to believe this budget neutrality adjustment is appropriate for reasons outlined in our response to the nearly identical comments in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57308 through 57309) and our response to similar comments in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49621 through 49622).

After consideration of the public comments we received, we are finalizing our proposal to apply a budget neutrality adjustment for HCO payments made to site neutral payment rate cases. Therefore, to ensure that estimated HCO payments payable to site neutral payment rate cases in FY 2019 will not result any increase in estimated aggregate FY 2019 LTCH PPS payments, under the budget neutrality requirement at § 412.522(c)(2)(i), it is necessary to reduce the site neutral payment rate portion of the blended rate payment by 5.1 percent to account for the estimated additional HCO payments payable to those cases in FY 2019. In order to achieve this, for FY 2019, in this final rule, as proposed, we are applying a budget neutrality factor of 0.949 (that is, the decimal equivalent of a 5.1 percent reduction, determined as 1.0 − 5.1/100 = 0.949) to the site neutral payment rate (without any applicable HCO payment).

E. Update to the IPPS Comparable Amount To Reflect the Statutory Changes to the IPPS DSH Payment Adjustment Methodology

In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50766), we established a policy to reflect the changes to the Medicare IPPS DSH payment adjustment methodology made by section 3133 of the Affordable Care Act in the calculation of the ''IPPS comparable amount'' under the SSO policy at § 412.529 and the ''IPPS equivalent amount'' under the 25-percent threshold payment adjustment policy at § 412.534 and § 412.536. Historically, the determination of both the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' includes an amount for inpatient operating costs ''for the costs of serving a disproportionate share of low-income patients.'' Under the statutory changes to the Medicare DSH payment adjustment methodology that began in FY 2014, in general, eligible IPPS hospitals receive an empirically justified Medicare DSH payment equal to 25 percent of the amount they otherwise would have received under the statutory formula for Medicare DSH payments prior to the amendments made by the Affordable Care Act. The remaining amount, equal to an estimate of 75 percent of the amount that otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals who are uninsured, is made available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. The additional uncompensated care payments are based on the hospital's amount of uncompensated care for a given time period relative to the total amount of uncompensated care for that same time period reported by all IPPS hospitals that receive Medicare DSH payments.

To reflect the statutory changes to the Medicare DSH payment adjustment methodology in the calculation of the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' under the LTCH PPS, we stated that we will include a reduced Medicare DSH payment amount that reflects the projected percentage of the payment amount calculated based on the statutory Medicare DSH payment formula prior to the amendments made by the Affordable Care Act that will be paid to eligible IPPS hospitals as empirically justified Medicare DSH payments and uncompensated care payments in that year (that is, a percentage of the operating Medicare DSH payment amount that has historically been reflected in the LTCH PPS payments that is based on IPPS rates). We also stated that the projected percentage will be updated annually, consistent with the annual determination of the amount of uncompensated care payments that will be made to eligible IPPS hospitals. We believe that this approach results in appropriate payments under the LTCH PPS and is consistent with our intention that the ''IPPS comparable amount'' and the ''IPPS equivalent amount'' under the LTCH PPS closely resemble what an IPPS payment would have been for the same episode of care, while recognizing that some features of the IPPS cannot be translated directly into the LTCH PPS (79 FR 50766 through 50767).

For FY 2019, as discussed in greater detail in the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20596) as well as in section IV.F.3. of the preamble of this final rule, based on the most recent data available, our estimate of 75 percent of the amount that would otherwise have been paid as Medicare DSH payments (under the methodology outlined in section 1886(r)(2) of the Act) is adjusted to 67.51 percent of that amount to reflect the change in the percentage of individuals who are uninsured. The resulting amount is then used to determine the amount available to make uncompensated care payments to eligible IPPS hospitals in FY 2018. In other words, the amount of the Medicare DSH payments that would have been made prior to the amendments made by the Affordable Care Act will be adjusted to 50.63 percent (the product of 75 percent and 67.51 percent) and the resulting amount will be used to calculate the uncompensated care payments to eligible hospitals. As a result, for FY 2019, we projected that the reduction in the amount of Medicare DSH payments pursuant to section 1886(r)(1) of the Act, along with the payments for uncompensated care under section 1886(r)(2) of the Act, will result in overall Medicare DSH payments of 75.63 percent of the amount of Medicare DSH payments that would otherwise have been made in the absence of the amendments made by the Affordable Care Act (that is, 25 percent + 50.63 percent = 75.63 percent).

In the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20596), for FY 2019, we proposed to establish that the calculation of the ''IPPS comparable amount'' under § 412.529 would include an applicable operating Medicare DSH payment amount that is equal to 75.63 percent of the operating Medicare DSH payment amount that would have been paid based on the statutory Medicare DSH payment formula absent the amendments made by the Affordable Care Act. Furthermore, consistent with our historical practice, we proposed that if more recent data became available, if appropriate, we would use that data to determine this factor in this final rule.

We did not receive any public comments in response to our proposal. In addition, there are no more recent data available to use that would affect the calculations determined in the proposed rule. Therefore, we are finalizing our proposal that, for FY 2019, the calculation of the ''IPPS comparable amount'' under § 412.529 includes an applicable operating Medicare DSH payment amount that is equal to 75.63 percent of the operating Medicare DSH payment amount that would have been paid based on the statutory Medicare DSH payment formula absent the amendments made by the Affordable Care Act. (We note that we also proposed that the ''IPPS equivalent amount'' under § 412.538 would include an applicable operating Medicare DSH payment amount that is equal to 75.63 percent of the operating Medicare DSH payment amount that would have been paid based on the statutory Medicare DSH payment formula absent the amendments made by the Affordable Care Act. However, as discussed in section VII.E. of the preamble of this final rule, we are finalizing our proposal to remove the provisions of § 412.538, and reserving this section.)

F. Computing the Adjusted LTCH PPS Federal Prospective Payments for FY 2019

Section 412.525 sets forth the adjustments to the LTCH PPS standard Federal payment rate. Under the dual rate LTCH PPS payment structure, only LTCH PPS cases that meet the statutory criteria to be excluded from the site neutral payment rate are paid based on the LTCH PPS standard Federal payment rate. Under § 412.525(c), the LTCH PPS standard Federal payment rate is adjusted to account for differences in area wages by multiplying the labor-related share of the LTCH PPS standard Federal payment rate for a case by the applicable LTCH PPS wage index (the FY 2019 values are shown in Tables 12A through 12B listed in section VI. of the Addendum to this final rule and are available via the internet on the CMS website). The LTCH PPS standard Federal payment rate is also adjusted to account for the higher costs of LTCHs located in Alaska and Hawaii by the applicable COLA factors (the FY 2019 factors are shown in the chart in section V.C. of this Addendum) in accordance with § 412.525(b). In this final rule, as we proposed, we are establishing an LTCH PPS standard Federal payment rate for FY 2019 of $41,579.65, as discussed in section V.A. of the Addendum to this final rule. We illustrate the