Illinois Health and Hospital Association

RULE SUMMARY

APRIL 2025

MEDICARE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM – RULE SUMMARY

Overview and Resources

On April 11, 2025, the Centers for Medicare & Medicaid Services (CMS) released the federal fiscal year (FFY) 2026 proposed rule for the Medicare Long-Term Care Hospital Prospective Payment System (LTCH PPS). The proposed rule reflects the annual updates to the Medicare fee-for-service (FFS) LTCH payment rates and policies.

A set of the resources related to the LTCH PPS is available on the CMS website.. An online version of the proposed rule can be found here.

Proposed program changes will be effective for discharges on or after October 1, 2025, unless otherwise noted. CMS estimates the overall impact of this proposed rule update to be an increase of approximately $61 million in LTCH PPS payments in FFY 2026 over FFY 2025.

Comments on this proposed rule are due to CMS by June 10, 2025 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "CMS-1833-P."

Request for Information (RFI) - Deregulation

On Jan. 31, 2025, President Trump issued Executive Order (EO) 14192 'Unleashing Prosperity Through Deregulation,' which states the Administration policy to significantly reduce the private expenditures required to comply with Federal regulations to secure America's economic prosperity and national security and the highest possible quality of life for each citizen. We would like public input on approaches and opportunities to streamline regulations and reduce administrative burdens on providers, suppliers, beneficiaries, and other interested parties participating in the Medicare program. CMS has made available an RFI at https://www.cms.gov/medicare-regulatory-relief-rfi. Submit all comments in response to this RFI through the provided weblink.

LTCH Payment Rates

Only LTCH discharges that meet certain clinical criteria (detailed below) will continue to be paid at the standard LTCH PPS payment rates. LTCH discharges that do not meet the established clinical criteria will continue to be paid the lower site-neutral payment rates (with some specified exclusions), which are based on the inpatient PPS (IPPS) rates and are the lesser of either the IPPS comparable per diem amount, including any outlier payments, or 100 percent of the estimated cost of the case. The IPPS comparable per diem payment amount is capped at the lower of the IPPS comparable per diem amount and the full comparable amount to what would otherwise be paid under IPPS.

CMS uses the following criteria in order to identify cases eligible for a standard LTCH PPS payment:

- The LTCH discharge does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation;
- A case must be "immediately discharged" from an IPPS hospital. This immediate discharge will be evidenced by the dates of discharge and admission to the LTCH; and

- Must receive at least three days of care in an intensive care unit (ICU) or critical care unit (CCU) during the prior hospital stay. CMS will use the full set of ICU and CCU revenue codes when counting a patient's ICU and CCU days during the prior acute care hospital stay; and/or the patient received at least 96 hours of ventilator services in the LTCH stay.

Cases paid at the site neutral rate and those paid by Medicare Advantage are excluded when calculating whether an LTCH or LTCH satellite meets the existing greater than 25-day average length of stay requirement.

In addition, the Bipartisan Budget Act of 2018 reduces the IPPS comparable amount in the site neutral payment rate calculation by 4.6% for FFYs 2018–2026.

The LTCH discharge payment percent is the percent of all Medicare FFS discharges that are paid the standard LTCH payment rate, and not the site neutral payment rate.

The IPPS equivalent payment rate is mandated for ALL discharges for LTCHs that fail to meet the applicable discharge threshold in the prior FFY (less than 50% of patients for whom the standard LTCH PPS payment is made).

Incorporating the proposed updates and the effects of budget neutrality adjustments, the table below lists the proposed LTCH standard federal rate for FFY 2026 compared to the rate currently in effect:

	Final FFY 2025	Proposed FFY 2026	Percent Change
LTCH Standard Federal Rate	$49,383.26	$50,728.77	+2.72%

The following table provides details for the proposed updates for the LTCH standard federal rate for FFY 2026:

Proposed FFY 2026 Update Factor Component	LTCH Standard Federal Rate Update
Market Basket (MB) Update	+3.4%
Affordable Care Act (ACA)-Mandated Productivity Adjustment	-0.8 PPTs
Wage Index/Labor Share Budget Neutrality (BN)	+0.12%
Overall Rate Change	**+2.72%**

Wage Index and Labor-Related Share

As in prior years, CMS is proposing to continue to use the most recent (FFY 2026) inpatient pre-rural floor, pre-reclassified hospital wage index to adjust payment rates under the LTCH PPS for FFY 2026.

The wage index, which is used to adjust payment for differences in area wage levels, is applied to the portion of the LTCH standard federal rate that CMS considers to be labor-related. CMS estimates the labor-related portion of the LTCH standard federal rate using the 2022-based LTCH market basket. CMS is proposing an increase to the labor-related share from 72.8% for FFY 2025 to 73.1% for FFY 2026.

CMS applies a 5% cap on any decrease to the LTCH wage index, compared with the previous year's wage index. The cap is applied regardless of the reason for the decrease and implemented in a budget neutral manner. This also means that if an LTCH's prior FFY wage index is calculated with the application of the 5% cap, the following year's wage index will not be less than 95% of the LTCH's capped wage index in the

prior FFY. A new LTCH is paid the wage index for the area in which it is geographically located for its first full or partial FFY with no cap applied, because a new LTCH will not have a wage index in the prior FFY.

CMS also applies the 5% permanent cap on the IPPS comparable wage indexes as well for the calculation of site-neutral payments with the same stipulations, but not in a budget neutral manner.

CMS is also proposing a wage index and labor-related share budget neutrality factor of 1.0012146 for FFY 2026 to ensure that aggregate payments made under the LTCH PPS are not greater or less than would otherwise be made if wage adjustments had not changed. This budget neutrality factor also includes the impact of the 5% cap on LTCH wage index decreases.

Updates to the Medicare Severity-Long Term Care-Diagnosis Related Groups (MS-LTC-DRG)

Each year, CMS updates the MS-LTC-DRG classifications and relative weights. These updates are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. Although the DRGs used to classify patients under the LTCH PPS are the same as those used under IPPS, the relative weights are different for each setting. The MS-LTC-DRG relative weights are 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). CMS is proposing to continue to use its existing methodology to determine the MS-LTC-DRG relative weights.

CMS is also proposing to continue to apply a 10% cap on the reduction of a MS-LTC-DRG's relative weight in a given year compared to the weight in the previous year to MS-LTC-DRGs with at least 25 applicable LTCH cases in the claims data used to calculate the relative weights for the FFY. CMS is proposing to implement the cap in a budget neutral manner, with a budget neutrality factor applied directly to the MS-LTC-DRG weights.

The full list of proposed MS-LTC-DRGs for FFY 2026 can be here.

High-Cost Outlier (HCO) Payments

HCO payments were established under the LTCH PPS to provide additional payments for very costly cases. Outlier payments are made if the estimated cost of the case exceeds the payment for the case plus a fixed-loss amount. Costs are determined by multiplying the facility's overall cost-to-charge ratio (CCR) by the allowable charges for the case. When a case qualifies for an outlier payment, CMS pays 80% of the difference between the estimated cost of the case and the fixed-loss amount as a separate outlier payment, in addition to the traditional DRG payment.

If an LTCH's CCR is higher than the LTCH total CCR ceiling, the LTCH is assigned the statewide average CCR, which would then be used in the HCO formula. CMS is proposing a total CCR ceiling of 1.359 for FFY 2026 for both LTCH PPS standard federal payment rate cases and site neutral payment rate cases.

There are two separate HCO targets – one for LTCH PPS standard federal payment rate cases and one for site neutral payment rate cases. Under the two-tiered system, there is an 8% HCO target for standard LTCH PPS cases using only standard LTCH cases. For site neutral cases, CMS uses a 5.1% target, the same as the operating IPPS target.

CMS is proposing an increase to the threshold for cases paid under the LTCH standard federal payment rate from $77,048 in FFY 2025 to $91,247 in FFY 2026. CMS recognizes that the proposed threshold is significantly higher than the previous fixed-loss amount for FFY 2025 and is seeking comments on the proposed fixed-loss amount.

CMS is also proposing a fixed-loss threshold for cases paid under the site neutral payment rate decrease from $49,237 in FFY 2025 to $44,305 in FFY 2026. This proposed fixed-loss amount for site-neutral payment rate cases is the same as the FFY 2026 proposed IPPS fixed-loss amount.

CMS is proposing to continue to make an additional HCO payment for the cost of a 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 fixed-loss amount and the amount paid under the SSO policy) for both LTCH standard cases and site-neutral cases.

To ensure that estimated HCO payments payable to site-neutral payment rate cases would not result in any increase in aggregated payments, CMS is proposing to continue to apply a budget neutrality adjustment that reduces site-neutral payment rate by 5.1% in FFY 2026, which is the same as FFY 2025. CMS would apply the 5.1% only to the non-HCO portion of the site-neutral rate payment amount.

Short-Stay Outlier (SSO) Payments

SSO payments are established under the LTCH PPS to ensure that LTCH payments, which are predicated on long lengths of stay (LOS), are not applied to cases where the patient may have received only partial treatment at a LTCH. A SSO case is a covered length of stay that is less than or equal to 5/6ths of the geometric average length of stay for a specific MS-LTC-DRG. Generally, the average length of stay for an LTCH is 25 days. CMS did not propose any major changes to the SSO policy.

Updates to the LTCH Quality Reporting Program (LTCH QRP)

The applicable annual update is reduced by two percentage points for any LTCH that does not meet the QRP requirements.

The following table lists the previously adopted LTCH QRP measures and payment determination years.

Measures	NQF #	Finalized Cross-Setting Measure	Payment Determination Year
National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	#0138		FFY 2015+
NHSN Central Line-Associated Blood Stream Infection (CLABSI) Outcome Measure	#0139		FFY 2015+
Influenza Vaccination Coverage among Healthcare Personnel	#0431		FFY 2016+
NHSN Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure	#1717		FFY 2017+
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)	#0674	Yes	FFY 2018+
Functional Outcome Measure: Change in Mobility among LTCH Patients Requiring Ventilator Support	#2632		FFY 2018+
Medicare Spending Per Beneficiary (MSPB) – Post Acute Care (PAC) LTCH Quality Reporting Program (QRP)	N/A	Yes	FFY 2018+

Discharge to Community – Post Acute Care PAC LTCH QRP	N/A	Yes	FFY 2018+
Potentially Preventable 30-Day Post-Discharge Readmission Measure for LTCH QRP	N/A	Yes	FFY 2018+
Drug Regimen Review Conducted With Follow-Up for Identified Issues- PAC LTCH QRP	N/A	Yes	FFY 2020+
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	N/A		FFY 2020+
Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay	N/A		FFY 2020+
Ventilator Liberation Rate	N/A		FFY 2020+
Transfer of Health Information to the Provider PAC	N/A		FFY 2022+
Transfer of Health Information to the Patient PAC	N/A		FFY 2022+
COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)	N/A		FFY 2023+
Discharge Function Score	N/A		FFY 2025+
COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date	N/A		FFY 2026+

CMS is not proposing to adopt any new measures for the LTCH QRP. However, CMS is updating the NHSN measures in alignment with the Centers for Disease Control and Prevention (CDC) efforts to update the baseline using CY 2022 data.

Separately, CMS is proposing to modify the reporting requirements for the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure. Beginning with patients admitted on or after October 1, 2026 LTCHs would no longer be required to submit the Patient/Resident COVID-19 Vaccine item on the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) with respect to patients who have expired in the LTCH. CMS proposes to remove the Patient/Resident COVID-19 Vaccine item from future LCDS forms that LTCHs use for expired patients.

Beginning with the FFY 2028 LTCH QRP, CMS is proposing to remove the following items from the LCDS that were previously adopted in the FFY 2025 LTCH final rule:

- Living Situation (R0310);
- Food (R0320A and R0320B); and
- Utilities (R0330).

Reconsideration Request Policy and Process

In this rule, CMS is proposing to amend the reconsideration request policy and process. Specifically, CMS is proposing to replace the term “extenuating circumstances” with “extraordinary circumstances”. CMS is also proposing that LTCHs must submit their request for an extension to file a reconsideration request to CMS via email no later than 30 calendar days from the date of the written notification of noncompliance.

CMS proposes to notify the LTCH in writing of the final decision regarding the request for an extension via email as it would allow for more expedient correspondence, given the 30-day reconsideration timeframe.

Additionally, CMS is proposing to modify the reconsideration policy to grant a timely request for reconsideration, and reverse an initial finding of non-compliance, only if CMS determines that the LTCH was in full compliance with the LTCH QRP requirements for the applicable program year.

Request for Information (RFI) – Measure Concepts Under Consideration for Future Years

CMS is seeking input on four measure concepts under consideration for the LTCH QRP: Interoperability, Well-Being, Nutrition & Delirium.

RFI – Potential Revision of Final Data Submission Deadline

CMS is seeking feedback on the potential future reduction of the LTCH QRP data submission deadline from 4.5 months to 45 days. Specifically, CMS is requesting comment on:

- How this potential change could improve the timeliness and actionability of LTCH QRP quality measures;
- How this potential change could improve public display of quality information; and
- How this potential change could impact LTCH workflows or require updates to systems.

RFI – Advancing Digital Quality Measurement (DQM) in LTCH QRP

In order to improve healthcare quality data by promoting the adoption of interoperable health information technology (IT) using Fast Healthcare Interoperability Resources® (FHIR®) standards, CMS is seeking comment on the current state of health IT use, specifically those topics listed on pages 902–904.

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