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Medicare's LTCH Outlier Policy Needs Reforms to Protect Extremely Ill Beneficiaries

Executive Summary

Long-term care hospitals (LTCHs) play an important role for Medicare beneficiaries by caring for complex patients who require extended hospitalization. Traditional Medicare reimburses for this care through the LTCH prospective payment system (PPS). This PPS includes a high-cost outlier (HCO) policy that, as with similar policies in other payment systems, is intended to ensure that LTCHs are adequately reimbursed for extremely costly care provided to the most severely ill beneficiaries. It specifically does this by helping ameliorate some of the extraordinary costs LTCHs experience when caring for these beneficiaries.

Congress, beginning in 2016, put in place a dual-rate payment system under the LTCH PPS. This fundamental change in the payment system and other coinciding market factors dramatically reshaped the landscape of both LTCHs and the beneficiaries they serve. The HCO policy and underlying methodologies, however, remained largely unchanged. The result is an HCO policy that is now failing to achieve its stated purpose. Specifically, as the fixed-loss amount for HCO cases continues to rise, LTCHs are incurring greater and greater losses. Absent swift action from policymakers, financial pressures on LTCHs will likely result in loss of essential access for some of Medicare's most severely ill beneficiaries. This will have ripple effects across the care continuum, placing additional burdens on short-term acute care hospitals and their intensive care units (ICUs), which may no longer be able to partner with LTCHs for the care of this unique population due to financial challenges or closures.

AHA recommends that policymakers take a number of actions to ensure that LTCHs can continue caring for their beneficiaries and communities. Specifically, AHA suggests several reforms that CMS should make in its annual regulatory cycle to relieve the extreme pressures on LTCHs caused by the HCO policy, including:

- Revert to a market-basket based methodology for calculating the HCO fixed-loss amount, which would help ensure the fixed-loss amount grows consistent with payment;
- Including all LTCH cases in its methodology when calculating annual updates to the fixed-loss amount, which would provide more stability from year to year as well as provide only one fixed-loss amount for the entire LTCH PPS, allowing providers to better predict both HCO losses and the partial relief provided under the system; and
- Initiating an analysis of LTCH cases' cost variation within payment groups to determine whether refinements to improve overall payment accuracy are needed.

AHA also recommends that Congress make fundamental reforms to the LTCH payment system, including:

- Increasing funding for HCO cases;
- Indexing future changes to the fixed-loss amount to inflation; and
- Adopting a stop-gap policy, pending a further restructuring of the LTCH PPS.

Background

The vast majority of LTCH patients are cared for following a stay in a short-term acute-care hospital, often in the ICU, for a serious injury or illness. They are extremely medically complex and stay in the LTCH for at least 25 days, on average. Many depend on ventilators due to respiratory failure or similar ailments, which is why LTCHs played an outsized role in caring for seriously afflicted COVID-19 patients during the pandemic. Today, LTCHs partner with general acute-care hospitals around the country to deliver care for patients in need of their specialized services.

Traditional Medicare defines an LTCH as a hospital that meets the parameters of a short-term acute-care hospital but that has an inpatient average length of stay (ALOS) of greater than 25 days. To reimburse LTCHs for the care they provide to

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beneficiaries, Congress, in 1999 and 2000, directed the Centers for Medicare & Medicaid Services (CMS) to establish the LTCH PPS. It provided the agency significant discretion in the development and implementation of that system.[1] As such, from fiscal year (FY) 2003 through FY 2015, for services furnished to Medicare beneficiaries, the LTCH PPS has utilized the same classification system as the inpatient PPS (IPPS) but with a higher rate and specific adjustments relevant to LTCHs.

However, for FY 2016 and beyond, Congress required CMS to reimburse LTCHs under a dual-rate payment structure.[2] Specifically, an LTCH case is paid at either the 1) "standard payment rate," or 2) a rate equivalent to the raid paid to short-term general acute-care hospitals (IPPS-equivalent rate). To receive the standard rate, a beneficiary must have been admitted directly from a short-term acute-care hospital and either 1) have spent three days or more in an ICU, or 2) have an LTCH discharge diagnosis based on the receipt of ventilator services of at least 96 hours while in the LTCH . Cases that do not meet these criteria are paid the IPPS-equivalent rate.[3]

LTCH High-cost Outlier Policy. Medicare's PPSs typically include HCO policies, which are an additional payment to hospitals when the costs of a case exceed a certain threshold (known as the HCO threshold, which is the sum of the PPS payment and a fixed-loss amount). Under the LTCH PPS, Medicare covers 80% of LTCHs' costs above the HCO threshold. CMS has indicated that the purpose of the HCO policy is to ensure that providers are adequately compensated for extremely costly cases and can continue to care for the most complex and highest acuity patients. Specifically, CMS stated that "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."[4]

LTCH standard rate cases are subject to an LTCH PPS fixed-loss amount. IPPS-equivalent rate cases are subject to the IPPS fixed-loss amount. CMS sets this fixed-loss amount so it pays out a specific percentage of total payments as outliers. It then reduces the base payment rate by the same percentage to fund outlier payments without increasing or decreasing total spending.

Prior to FY 2018, CMS used its regulatory authority to set the fixed-loss amount for LTCH standard rate cases so that outlier payments would be equal to 8% of total payments. However, beginning in FY 2018, Congress required CMS to reduce the LTCH standard rate by 8% for HCOs, but set the fixed-loss amount such that estimated outlier payments would equal only 7.975% of total LTCH payments.[5] This means that outlier payments are slightly less than the amount by which the standard rate is reduced, resulting in a net cut to the system. The LTCH PPS is the only hospital payment system where this occurs.

CMS sets the fixed-loss amount prospectively based on historical claims data. Since FY 2022, CMS has utilized a methodology that examines recent claims data to forecast growth in charges for the coming FY (known as the "charge inflation factor"). Prior to that, it utilized a different methodology, which tied the charge inflation factor to the market basket update for LTCHs. While it aims to pay 7.975% of LTCH payments as outliers, the actual percentage that is paid in a given year may be more or less than these amounts (i.e., total outlier payments may be more or less than 7.975% of total LTCH payments).

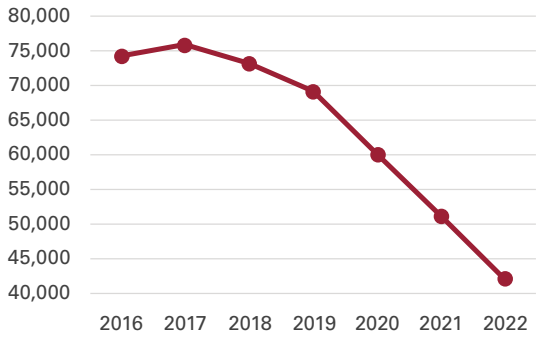
Recent Dynamics Exposed Limitations of the LTCH HCO System

The implementation of the dual-rate payment structure in FY 2016 significantly altered the population of Medicare beneficiaries cared for by LTCHs. The number of LTCH cases has fallen dramatically, while beneficiaries' acuity has climbed. These trends, along with the increasing fixed-loss amount, have led to the current HCO policy becoming inadequate in meeting its goal of reasonably reducing the financial losses that would otherwise be incurred by hospitals when treating beneficiaries in need of the costliest care. Further, this inadequacy is being exacerbated by other market dynamics, including inadequate payment updates, growth in Medicare Advantage, and a workforce crisis, resulting in payments that fall short of the cost of care and an uncertain future for the LTCH field.

Inadequate HCO Policy Forcing LTCHs to Absorb Increasing Financial Losses

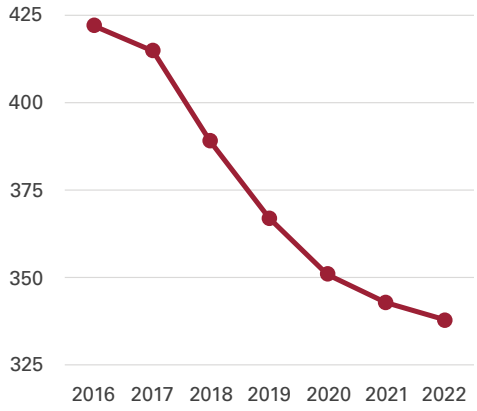
Since implementation of the dual-rate payment system in FY 2016, the volume of standard rate LTCH cases has fallen by over 40%, from 74,294 in FY 2016 to 42,132 in FY 2022 (see Figure 1). The number of LTCH providers has also decreased, by 20% in that same period — from 422 to 338 (see Figure 2).

Figure 1: Number of LTCH PPS Standard Rate Cases, FY 2016 through FY 2022



Source: *FY 2015-2022 LTCH Medicare Provider Analysis and Review (MedPAR) files; CMS LTCH PPS public use files.*

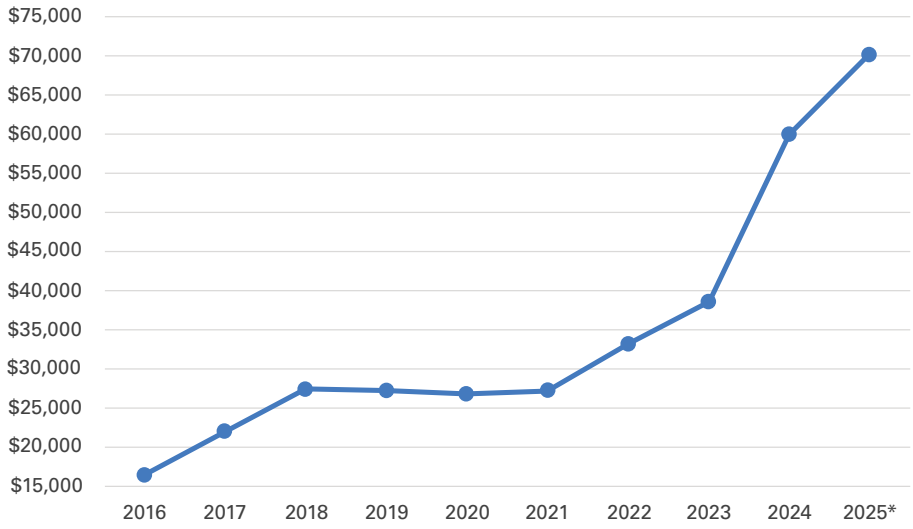
Figure 2: Number of LTCHs



Source: *FY 2015-2022 LTCH Medicare Provider Analysis and Review (MedPAR) files; CMS LTCH PPS public use files.*

However, while cases and providers have decreased, the outlier fixed-loss amount has increased. Specifically, it has increased by a staggering 265%, from $16,423 in FY 2016 to $59,873 in FY 2024 (see Figure 3). This means that the financial loss that LTCHs must take on before the outlier policy provides relief has more than tripled and is projected to quadruple without further action. Indeed, due to the rise in the fixed-loss amount from $16,423 to $59,873, the total additional loss that the LTCH field must incur before seeing financial relief through additional HCO payments is approximately $250 million annually.[6] Because LTCH volume is decreasing, these financial losses are having an increasingly outsized impact on the remaining providers. More specifically, the ability of LTCHs to admit patients that will be reimbursed with a margin has become more limited, so the high loss HCO cases are even more disruptive to LTCH operations.

Figure 3: LTCH PPS Fixed-loss Amounts, FY 2016 through FY 2025



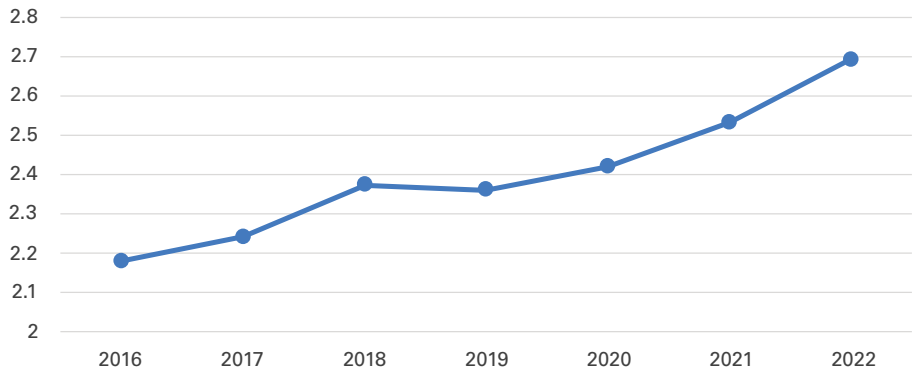
Source: *FY 2016-2024 LTCH PPS Final Rules*

**Projected fixed-loss amount based upon analysis of FY 2022 to FY 2023 claims.*

The dual-rate payment system has also driven up the acuity of standard rate HCO cases. Specifically, the acuity of these cases (as measured by their "outlier-adjusted" case-mix index (CMI)) has increased by 23%, from 2.18 in FY 2016 to 2.69 in FY 2022 (see Figure 4).[7] By comparison, the average outlier-adjusted CMI of all standard-rate cases in FY 2022 was 1.44.[8] The ALOS for these cases has also increased, by 23%, from 53.9 days in FY 2016 to 66.47 days in FY 2022 (see Figure 5). By comparison, the ALOS for all standard rate cases in FY 2022 was 29 days.[9] This rising acuity (and therefore cost of caring) has resulted in many cases that once would have qualified for an HCO payment now falling well below the threshold. Thus, for these high-acuity cases, LTCHs must now absorb substantial losses without any relief.

Indeed, these phenomena are not surprising to providers who cautioned the dual-rate payment system would have such an effect. In the FY 2016 and 2017 rulemakings, CMS noted increases in the fixed-loss amounts, and said it believed that it was due to the new dual-rate payment system.[10] However, it stated that it "expect[s] annual changes to the fixed-loss amount to generally stabilize as experience is gained under the new dual rate LTCH PPS payment structure."[11] The agency stated that it would continue to monitor the issue and would revisit if warranted.

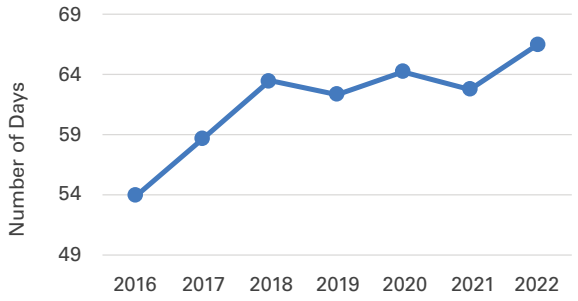
Figure 4: Average Outlier-adjusted Case-mix Index, LTCH PPS Standard Rate HCO Cases, FY 2016 through FY 2022



Source: *FY 2015-2022 LTCH Medicare Provider Analysis and Review (MedPAR) files; CMS LTCH PPS public use files.*

Finally, decreasing number of LTCH cases is leading to their significant consolidation into a relatively small number of LTCH PPS diagnosis-related groups (DRGs). Specifically, ten groups account for more than half of all LTCH cases.[12] However, within these cases, there is great variation in patient severity, and therefore in actual cost. The lack of precision in payment for these cases leads to a notable number of them qualifying for HCO payments because the DRG payment is not sufficient.

Figure 5: ALOS, LTCH PPS Standard Rate HCO Cases, FY 2016 through FY 2022



Source: *FY 2015-2022 LTCH Medicare Provider Analysis and Review (MedPAR) files; CMS LTCH PPS public use files.*

Other Market Dynamics Exacerbate the Inadequacy of the Outlier Policy

A confluence of other market dynamics has put additional and unsustainable financial pressure on LTCHs. Inadequate payment updates, growth in Medicare Advantage, and a workforce crisis has resulted in payments that fall short of the cost of care, leaving LTCHs to face an uncertain future. Specifically, in FY 2011 through FY 2013, LTCHs' aggregate average Medicare margin ranged from 6.6% to 7.4%.[13] However, from FY 2017 through FY 2019, that margin fell substantially into the negative, ranging from -0.5% to -2.2%.[14] AHA estimates that FY 2022 margins will remain negative.[15] While the years during the pandemic saw a return to positive margins, this can be entirely attributable to the temporary suspension of the dual-rate payment system by Congress, which has since expired.

Inadequate Medicare Payment Updates. In recent years, annual LTCH PPS market basket updates from Medicare have failed to keep up with the pace of inflation, further straining the field. Specifically, during the COVID-19 pandemic and concurrent inflationary environment, CMS' market

Table 1: LTCH Market Basket Updates, FY 2021 through FY 2023

Year	FY 2021	FY 2022	FY 2023	Total
Market Basket Update in Final Rule	2.3%	2.6%	4.1%	9.0%
Actual/Updated Market Basket Forecast*	2.8%	5.5%	4.9%**	13.2%
Difference	**(0.5%)**	**(2.9%)**	**(0.8%)**	**(4.2%)**

**Based on the Four-quarter Moving Average Percent Change from Q3 of the Fiscal Year.*
***Most recent forecast as published by CMS OACT.*

basket updates struggled to accurately forecast the rising costs of goods and services. Indeed, from FY 2021 through FY 2023, market basket updates fell short of actual inflation by a total of 4.2% (see Table 1).

These underpayments are permanent and compound the issue, as payment updates in subsequent years are based upon the prior year's rates. As such, by FY 2028, these forecast errors will have resulted in an underpayment to LTCHs of at least $375 million over the prior four years.[16] Further, these underpayments also drive increases in the fixed-loss amount. Specifically, as payment fails to keep up with cost, more cases will have costs above the threshold; to maintain the 7.975% outlier payment pool, CMS must keep raising the fixed-loss amount. For these reasons, AHA has requested that CMS use its authority to make a one-time forecast error adjustment to the market basket to account for these shortfalls.

Inadequate IPPS-Equivalent Payment Rate. Approximately one-third of all LTCH discharges nationally are paid the IPPS-equivalent rate, but these reimbursements fall well short of the cost of care. Specifically, AHA analysis shows that as of FY 2020, reimbursement for these cases totaled only 46% of the cost of care.[17] This is because LTCH beneficiaries have notably higher rates of major complications and comorbidities as well as significantly longer lengths of stay as compared to their acute-care counterparts (see Table 2).

Medicare Advantage Growth. The growth of Medicare Advantage has also contributed to financial instability in the LTCH field. Specifically, the share of Medicare beneficiaries enrolled in Medicare Advantage has grown by 54% since 2016. As of 2023, more than half of all Medicare beneficiaries are now enrolled in the program, and projections estimate it will continue to grow (see Figure 6).

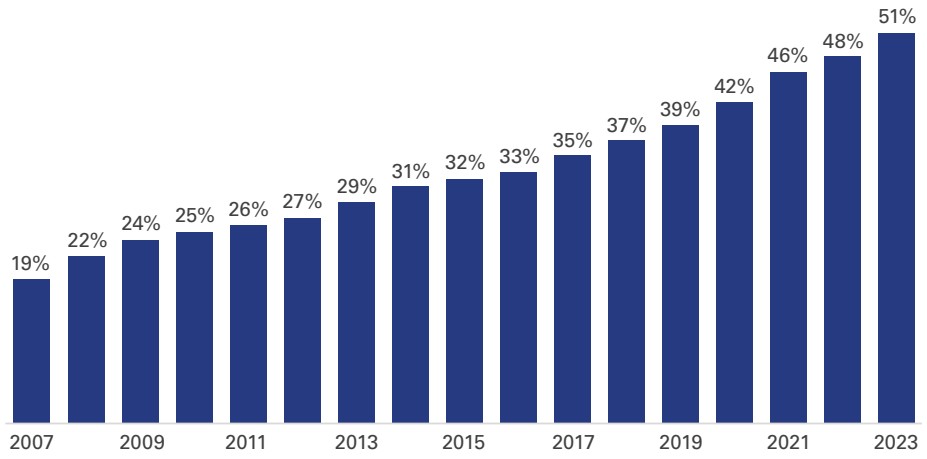
Table 2: LTCH IPPS-equivalent Cases Compared to IPPS Cases with Fewer than Three ICU Days

	IPPS Cases with <3 ICU Days	LTCH IPPS-equivalent Cases
Number of Cases	6,818,125	30,093
Average Length of Stay	3.9	23.0
% of Cases with 0 CC/MCCs	22%	7%
% of Cases with 1-4 CC/MCCs	62%	52%
% of Cases with 5+ CC/MCCs	16%	41%
Average Cost	$11,980	$32,591
Average Medicare FFS Payment**	$12,167	$14,950
Payment to Cost Ratio	102%	46%

**FY 2018 MedPAR cases with FY 2020 payment parameters.*
***With full IPPS-equivalent payment.*

Note that for both the inpatient PPS and LTCH scenarios, only providers in the respective FY 2020 proposed rule impact files were selected.

Figure 6: Medicare Advantage Enrollment, 2007 through 2023



Note that enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 60.0 million people are enrolled in Medicare Parts A and B in 2023.

Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2023; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; and Medicare Enrollment Dashboard 2021-2023.

These Medicare Advantage plans often inappropriately deny beneficiaries access to LTCH care.[18] Indeed, while about half of Medicare beneficiaries were enrolled in Medicare Advantage in 2022, only about 31% of LTCHs' Medicare discharges were for Medicare Advantage beneficiaries.[19] Further, those beneficiaries that are allowed access to LTCH care are often of the highest acuity. These trends have led to CMS taking steps to ensure that Medicare Advantage plans do not restrict access to covered benefits such as LTCH care.[20]

Workforce Crisis. LTCHs continue to face very real difficulties and uncertainties due to the pandemic and the workforce crisis that it exacerbated. Specifically, the most recent Kaufman Hall *National Hospital Flash Report* analysis indicates that from 2020 to present, overall expenses have risen by 20% for hospitals.[21] This has been driven in large part by labor costs, including contract labor costs, which have risen 258% since 2019.[22] This inflation is felt sharply by LTCHs, which care for some of the most critically ill patients with lengths of stay averaging at least 25 days, and who require labor-intensive care and a wide range of specialty drugs and devices. Indeed, inflationary and labor pressures on LTCHs and other hospitals will continue, with the Department of Health and Human Services (HHS) finding that health care workforce shortages will persist well into the future.[23]

Because LTCHs are in the middle of the continuum of care, they experience both upstream and downstream consequences of the crisis. For example, they are experiencing challenges placing patients in skilled-nursing facilities and home health agencies due to the critical workforce shortages those providers are facing. This leads to longer lengths of stay and capacity issues in LTCHs. However, these capacity issues then in turn mean that LTCHs may need to delay accepting patients from short-term acute-care hospitals.[24] As a result, these patients may arrive sicker and more debilitated than they would have been. In addition, if LTCHs do have capacity, they may accept more IPPS-equivalent cases than usual to help relieve capacity issues at short-term acute-care hospitals. The fact that reimbursement for these cases, as noted, is so far below the cost of caring, further exacerbates their financial instability.

LTCH Field Outlook Under Current Policy

As these recent trends and pressures on the LTCH field continue, the HCO policy will become more and more inadequate. This was borne out in CMS' FY 2024 LTCH PPS proposed rule, in which the agency proposed an HCO fixed-loss amount of $94,378 — a 145% increase over the FY 2023 amount. This astronomical figure would have resulted in LTCHs either taking catastrophic losses on extremely ill beneficiaries or considering limiting their access to care. Fortunately, CMS finalized a lower amount of $59,873 for FY 2024; however, even this figure was a 55% increase over the FY 2023 amount.

In addition, AHA projects that the fixed-loss amount will again substantially increase in FY 2025. Specifically, based on an analysis of FY 2022 to FY 2023 claims, AHA projects a fixed-loss amount of $70,117 for FY 2025.[25] This represents a further 17% increase over the FY 2024 amount and an 82% increase over the FY 2023 amount. AHA also projects that increasing the figure by that amount would result in the LTCH field incurring an additional $54 million in losses in FY 2025 as compared to FY 2024. This is a staggering amount considering that payments under the entire LTCH PPS total less than $2.6 billion annually.

If not halted by meaningful reform, this continued anticipated increase in the fixed-loss amount will lead to a loss of beneficiary access to care. The LTCH field will continue to contract due to unsustainable losses and other mounting financial pressures. To protect their ability to care for their communities at large, those LTCHs that remain will be forced to carefully consider whether they are able to admit the most critically ill beneficiaries. It is likely that the sickest of the sick, those beneficiaries for which LTCHs typically receive an HCO payment, will be unable to access LTCH care. Historically marginalized Medicare beneficiaries may be disproportionately affected by this loss of access to care. Specifically, while dual-eligible Medicare/Medicaid beneficiaries represent 17% of all beneficiaries, they make up 44% of LTCH cases.[26] In addition, Black beneficiaries also utilize LTCHs at a rate disproportionate to other Medicare beneficiaries.

Beneficiary care in other facilities may also be affected. For example, the most severely ill beneficiaries in IPPS ICUs typically go on to receive LTCH care. Specifically, of IPPS beneficiaries that spent three days or more in the ICU in FY 2022, the average outlier-adjusted case-mix index for those discharged to LTCHs was 7.07, compared to just 2.89 for all

IPPS discharges. If LTCHs are not available to care for these severely ill beneficiaries, the strain on short-term acute-care hospitals, and particularly on their ICU capacity, would notably increase, creating ripple effects throughout the continuum.

Recommended Policy Reforms to Improve the LTCH PPS HCO System

To ensure that the most severely ill Medicare beneficiaries retain access to LTCH care and to minimize strain on other parts of the health care continuum, AHA urges policymakers to expeditiously take action. Below, AHA sets forth several possible actions for reforming the HCO policy so that it serves its intended purpose of ensuring adequate beneficiary access to care. Specifically, AHA suggests several reforms CMS could make in its annual regulatory cycle to relieve the extreme pressures on LTCHs due to the inadequacies of current HCO policy. AHA also recommends that the Congress make fundamental reforms to the system.

Because the LTCH field is under such financial strain and LTCH PPS payments are less than the cost of care, these actions should be undertaken by adding funds to the LTCH PPS. Doing so is necessary to provide stability for LTCHs, and in turn for beneficiaries, and allow LTCHs to continue to provide their expertise to the most complex beneficiaries without risk of devastating financial loss.

Recommended Regulatory Reforms

Revert to a Market Basket-based Methodology for Calculating the Fixed-loss Amount. Until FY 2022, CMS calculated the fixed-loss amount by forecasting growth in charges using the market basket for LTCHs. It did this because indexing the charge growth to market basket growth helped ensure the fixed-loss amount grew consistent with payment. However, in FY 2022, the agency began utilizing a methodology that examines recent claims data to forecast growth in charges for the coming FY. When CMS made the change, the field warned it would lead to volatility, and indeed, these concerns have borne out and there have since been sharp increases in the fixed-loss amount.

As such, AHA recommends CMS revert to its pre-FY 2022 methodology for updating its fixed-loss amount. That methodology has proven to provide more stability for both beneficiaries and providers alike. Specifically, AHA has forecast that under this methodology, the fixed-loss amount for FY 2025 would be approximately $54,590, very similar to the FY 2024 amount of $59,873 and substantially more reasonable than the $70,117 projected under the current methodology.

Analyze All LTCH Cases When Calculating the Fixed-loss Amount. Recent decreases in the number of LTCH cases means that each case has a larger financial impact on LTCH providers as well as on the PPS system. As such, AHA recommends CMS consider utilizing both standard and IPPS-equivalent rate cases to calculate the fixed-loss amount. Combining the two sets of cases would provide more stability from year to year as a higher number of cases would be less prone to volatility, as is seen in other payment systems with larger sets of outlier cases. Further, doing so would provide only one fixed-loss amount under the entire LTCH PPS, allowing providers to better predict both HCO losses and the partial relief provided under the PPS.

Initiate Analysis of LTCH DRG Cost Variation. As presented in this paper, the decreasing number of LTCH cases is leading to their significant consolidation into a small group of ten DRGs, which is lessening the accuracy of the payment system. AHA recommends CMS consider analyzing these variations, including those driven by differences in beneficiaries' complications and comorbidities, and consider how the payment accuracy of DRGs can be improved to mitigate the negative effects to the LTCH payment system.

Recommended Statutory Reforms

Increase Funding for HCO Cases. AHA recommends policymakers consider increasing the amount of funding dedicated to HCO cases. In recent years, the percentage of LTCH PPS payments dedicated to HCOs has approached 12% of total payments; as such, adding enough funds to the system to permanently achieve these levels of HCO payments would be appropriate.

Index Future Changes to the HCO Fixed-loss Amount to Inflation. AHA recommends policymakers consider increasing the fixed-loss amount annually by an inflation-related index, such as the LTCH PPS market basket or the Consumer Price Index for All Urban Consumers. Doing so with new funding would ensure that the fixed-loss amount grows consistently with payments.

Adopt a Stop-gap Policy, Pending a Further Restructuring of the LTCH PPS. If a more immediate, permanent policy reform cannot be made to address the shortcomings of the HCO policy, AHA recommends that policymakers consider taking temporary actions until the underlying causes of the LTCH fields' financial instability can be addressed. These could include, for example, temporarily freezing or lowering the fixed-loss amount, creating a temporary add-on payment for beneficiaries that meet or exceed certain severity levels, waiving certain budget neutrality restrictions under the LTCH PPS, or making a one-time forecast error adjustment to the market basket to account for past shortfalls. Doing so with new funding would provide financial stability to the LTCHs while additional reforms are considered.

Endnotes

1. See section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (P.L. 106-113, Title VII, §123) and section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554, Appendix F, §307(b))
2. Bipartisan Budget Act Of 2013 (P.L. 113–67).
3. LTCH discharges with a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation are also paid the IPPS-equivalent rate.
4. 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; 80 Fed. Reg. 49325, 49,617 (Aug. 17, 2015).
5. Section 15004(a) of the 21ST Century Cures Act added section 1886(m)(7) to the Act.
6. Based upon FY 2022 outlier volume.
7. To calculate the outlier-adjusted CMI, we use the same concept as what CMS presents in the LTCH impact files. We multiply the MS-LTC-DRG service intensity weights by an adjustment factor calculated as the total estimated LTCH PPS payment amount (including the outlier amount) divided by the estimated "inlier" payment amount (the payment amount excluding the outlier payment). An HCO case would then have a higher adjusted weight than a non-HCO case since its adjustment factor would be greater than 1, reflecting the higher service intensity not captured in base DRG payments. The outlier-adjusted CMI is then calculated as the average of the adjusted MS-LTC-DRG weights.
8. FY 2015-2022 LTCH MedPAR files; CMS LTCH PPS public use files.
9. FY 2015-2022 LTCH MedPAR files; CMS LTCH PPS public use files.
10. FY 2016 IPPS/LTCH PPS Final Rule, 80 Fed. Reg. 49326, 49621 (Aug. 17, 2015).
11. FY 2017 IPPS/LTCH PPS Final Rule, 81 Fed. Reg. 56762, 57305 (Aug. 22, 2016).
12. Medicare Payment Advisory Commission, Health Care Spending and the Medicare Program, July 2023 (https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC.pdf).
13. MedPAC, March 2015 Report to Congress, Ch. 11, pg. 275 (https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-11-long-term-care-hospital-services-march-2015-report-.pdf).
14. MedPAC March 2022 Report to Congress Chapter 11, pg. 351 (https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch10_SEC.pdf).
15. AHA analysis of FY 2021-FY2023 Medicare cost reports.
16. Based upon FFS claims data and projected statutory updates.
17. https://www.aha.org/system/files/media/file/2019/06/aha-cms-long-term-care-proposed-rule-fy2020-6-21-2019_0.pdf

18. HHS, Office of Inspector General (OIG); Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (April 2022) (https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf).

19. Data from Strata Decision Technology, a health care technology and consulting firm (https://www.stratadecision.com/company/).

20. Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program; 88 Fed. Reg. 22,120 (April 12, 2023).

21. Kaufman Hall | *National Hospital Flash Report* (November 2023) https://www.kaufmanhall.com/sites/default/files/2023-11/November_NHFR-2023.pdf.

22. Syntellis and AHA, *Hospital Vitals: Financial and Operational Trends at 2* (last visited May 8, 2023), https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf.

23. ASPE Office of Health Policy, *Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce*, HP-2022-13 at 1 (May 3, 2022).

24. American Hospital Association. Issue Brief: Patients and Providers Faced with Increasing Delays in Timely Discharges (December 2022) https://www.aha.org/issue-brief/2022-12-05-patients-and-providers-faced-increasing-delays-timely-discharges.

25. Medicare fee-for-service claims, Centers for Medicare & Medicaid Services, Chronic Conditions Data Warehouse, www2.ccwdata.org/web/guest/home.

26. MedPAC March 2022 Report to Congress; Chapter 10, Long-Term Care Hospital Services (https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch10_SEC.pdf).