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2005 UPDATES TO THE LONG TERM CARE HOSPITAL PPS

In the May 7, 2004 *Federal Register* (pages 25674 - 25749), the Centers for Medicare and Medicaid Services (CMS) published a final rule updating the Medicare prospective payment system (PPS) for inpatient services provided by long-term care hospitals (LTCHs). This final rule updates Federal payment rates and makes a number of policy changes, as described below. These changes are effective July 1, 2004. Changes to the long term care diagnosis related group (LTC-DRG) classifications and weights remain linked to the October update of the inpatient DRGs.

LTC-DRG UPDATES FOR 2005 (PAGES 25677 - 25679): For the 2005 rate year (July through June), two versions of the LTC-DRGs will be applied. For July 1 through September 30, the current LTC-DRGs, which are based upon Version 21.0 of the inpatient DRG Grouper will be utilized (see *Industry Insight 230, CMS Updates Long Term Care Hospital PPS* for details). A new set of LTC-DRGs based upon the Version 22.0 DRG Grouper will be used for discharges beginning on October 1. Details on the LTC-DRG update for October 1, 2004 will be published in the inpatient PPS proposed and final rules and will be discussed in future *Industry Insights*.

BUDGET NEUTRAL STANDARD FEDERAL PAYMENT RATE (PAGES 25682 - 25683): Payment for the LTCH PPS is discharge-based with separate payment rates established for each LTC-DRG. In general, these payment rates are equal to a budget neutral, standard Federal payment rate multiplied by a relative weight which accounts for the variation in resource use across LTC-DRGs. The proposed budget neutral standard Federal payment rate (or base rate) for the 2005 LTCH rate year is \$36,833.69.

LTC-DRG RELATIVE WEIGHTS (PAGES 25681 - 25682): CMS will utilize two sets of LTC-DRG weights for the upcoming LTCH rate year. For the period July 1 through September 30, the current LTC-DRG weights will remain in effect. These weights are published in Table 3 (pages 25741 - 25749) of the May 7, 2004 *Federal Register* and are the same weights previously published in the August 1, 2003 inpatient PPS final rule (*Federal Register*, August 1, 2003, pages 45650 - 45658). CMS will update relative weights for October 1, 2004 when the new LTC-DRGs (based upon the Version 22.0 DRGs) go into effect. New LTC-DRG weights will be presented for public comment in the inpatient PPS proposed rule and will be finalized in the inpatient PPS final rule. In developing LTC-DRG weights, CMS has implemented special procedures for low volume (less than 25 LTCH cases) and no volume LTC-DRGs. In addition, since it is not anticipated that these procedures will be performed in the LTCH setting, CMS has assigned a relative weight of 0.0000 to the LTC-DRGs for heart, kidney, liver, lung, pancreas, and simultaneous pancreas/kidney transplants (LTC-DRGs 103, 302, 480, 495, 512 and 513).

TRANSITION (PAGES 25676, 25683 - 25684, 25710 - 25711): LTCH payment continues to be a blend of PPS payment and the pre-PPS cost-based (TEFRA) payment. Blend percentages in effect during the 2005 LTCH rate year are as follow.

Cost Reporting Periods Beginning on or After	PPS Federal Payment %	Cost-Based Payment %
October 1, 2002	20	80
October 1, 2003	40	60
October 1, 2004	60	40

A LTCH may elect to be paid based on 100% of the Federal LTCH PPS rate, but once this election is made, the facility cannot revert back to the blended transition methodology. New LTCHs will be paid at 100% of the Federal rate.

ADJUSTMENT FOR LOCAL AREA WAGE DIFFERENCES (PAGES 25684 - 25686): For the 2005 LTCH rate year, CMS will adjust for local area wage differences using a pro-rated percentage of the FY 2004 inpatient acute care hospital wage data without reclassification. Because the LTCH PPS is being phased-in over 5 years, only a proportionate fraction of this wage index is utilized during each of the phase-in years. Wage index phase-in percentages are based on the start of the LTCH's cost reporting period and for discharges occurring on or after July 1, 2004 through June 30, 2005 are as follow:

- For LTCHs with cost reporting periods beginning on or after October 1, 2002 and before October 1, 2003, one-fifth or 20% of the applicable wage index value will be used.
- For LTCHs with cost reporting periods beginning on or after October 1, 2003 and before October 1, 2004, two-fifths or 40% of the applicable wage index value will be used.
- For LTCHs with cost reporting periods beginning on or after October 1, 2004 and before October 1, 2005, three-fifths or 60% of the applicable wage index value will be applied.

Because the phase-in of the wage index does not coincide with the LTCH PPS rate year, most LTCHs will experience a change in the wage index phase-in percentages during the LTCH PPS rate year. Wage index values for the 2005 LTCH rate year are shown in Table 1 for urban areas (pages 25722 - 25740) and Table 2 for rural areas (pages 25740 - 25741). Each table has four columns showing the full wage index value, as well as the one-fifth, two-fifths and three-fifths pro-rated wage index. For the 2005 LTCH rate year, CMS will continue to recognize 72.885% of LTCH costs as labor-related.

COST-OF-LIVING ADJUSTMENT FOR ALASKA AND HAWAII (PAGE 25686): CMS will continue to apply a cost-of-living adjustment (COLA) for payments to LTCHs located in Alaska and Hawaii. For the 2005 rate year, the standard Federal payment rate will be multiplied by one of the following adjustment factors:

- 1.25 for Alaska
- 1.25 for Honolulu County
- 1.165 for Hawaii County
- 1.2325 for Kauai County
- 1.2375 for Maui and Kalawao Counties

COST OUTLIER PAYMENTS (PAGES 25686 - 25689): CMS will continue to make outlier payments for discharges whose estimated costs exceed an outlier threshold. Costs will be determined by multiplying Medicare allowable covered charges times a hospital-specific cost-to-charge ratio. For the 2005 LTCH rate year, the outlier threshold will be equal to the sum of the adjusted payment rate for the applicable LTC-DRG, plus a fixed-loss amount of \$17,864. The outlier adjustment will continue to be calculated as 80% of the difference between costs and the outlier threshold.

SHORT STAY OUTLIERS (PAGE 25690): Short stay outliers are cases that have a length of stay between one day and five-sixths of the geometric average length of stay for the assigned LTC-DRG. These cases represent patients who received less than the full course of treatment at the LTCH before expiring or being discharged to home or to another site. If LTCHs received full payment for these cases, they would be significantly “overpaid” for the resources actually expended. Payment for short stay outliers will be reduced and will be the lesser of:

- 120% of the LTC-DRG-specific per diem amount multiplied by the length of stay of that discharge,
- 120% of the costs for the case, or
- the full LTC-DRG payment.

LTC-DRG-specific per diems are determined by dividing the standard Federal payment rate for the LTC-DRG (standard Federal rate times the LTC-DRG weight) by the geometric mean length of stay for the LTC-DRG. Costs for a case are determined by multiplying Medicare allowable charges by the hospital-specific cost-to-charge ratio (RCC). Short-stay outlier thresholds for July through September of 2004 for each LTC-DRG, i.e. five-sixths of the LTC-DRG’s geometric average length of stay) can be found in Table 3 (pages 25741 – 25749). Thresholds for October 2004 through June 2005 will be published in the IPPS proposed and final rules.

SHORT STAY OUTLIERS CHANGES FOR LTCHS PRIMARILY SERVING PATIENTS WITH NEOPLASTIC DISEASES (PAGE 25690): CMS will continue to adjust the short stay outlier payment methodology for LTCHs that primarily serve patients with neoplastic diseases. This adjustment is applicable during the transition period and revises the facility’s short stay outlier payment percentage. This percentage (which is normally 120%) is changed to 195% for year 1 of the transition; 193% for year 2; 165% for year 3; 136% for year 4; and, 120% for year 5 and after.

PROPOSED EXTENSION OF THE INTERRUPTED STAY POLICY (PAGES 25690 - 25700): CMS is revising the definition of an interrupted stay to include situations in which a patient is discharged from a LTCH for any reason and readmitted to the same LTCH within 3 days. Such readmissions will not constitute a new episode of care.

- **General Policy:** In cases with a 3-day or less interruption of stay (except as indicated below), Medicare will pay the LTCH for only one discharge and any treatment or medical services furnished to the individual during the 3-day or less absence will not be separately billable to either Medicare or the beneficiary. The entire stay will generate one LTC-DRG payment, which will be considered “payment in full”. If any care is provided to the patient during the 3-day window, the length of stay applicable to the LTCH combined episode will be calculated to include the days between discharge and readmission. If no care is provided to the patient during the days away, the LTCH length of stay will be calculated to exclude the days between discharge and readmission.
- **Rate Year 2005 Exception:** CMS is providing a limited one-year exception to the above policy. This exception will apply to patients receiving inpatient care in an acute care hospital if that care groups to a surgical DRG. For the 2005 LTCH rate year, the acute care hospital will receive a separate payment from Medicare for the surgical DRG. The LTCH, however, will receive a single LTC-DRG payment, as the readmission to the LTCH will be considered a continuation of the original LTCH stay.

BUDGET NEUTRALITY OFFSET TO ACCOUNT FOR PROPOSED TRANSITION METHODOLOGY (PAGES 25701 - 25704): The LTCH standard Federal rate was calculated as if all LTCHs were paid based on 100% of the standard Federal rate. CMS estimates, however, that for the 2005 LTCH rate year only 93% of LTCHs will elect to be paid based on 100% of the Federal rate, and that the remaining 7% will be paid using the transition blend methodology. To ensure budget neutrality, CMS is reducing Medicare payments during the transition period by a factor that is equal to 1 minus the ratio of estimated pre-PPS cost-based payments to projected PPS payments. To maintain budget neutrality, CMS will reduce LTCH payments during the 2005 LTCH rate year, i.e., for discharges occurring on or after July 1, 2004 and through June 30, 2005, by 0.5% (0.995). Based upon best available data at this time, the following future budget neutrality offsets are projected: 0.4% (0.996) for the 2006 rate year; 0.1% (0.999) for the 2007 rate year, and 0.0% (no adjustment) for the 2008 rate year.

IMPACT ANALYSIS (PAGE 25713 - 25720): CMS estimates that the 3.1% increase in the standard Federal rate for the 2005 LTCH PPS rate year, in conjunction with an increase in casemix and a decrease in the budget neutrality offset, will result in a \$235 million (13.8%) increase in payments to the 239 LTCHs. The average per case payment will increase from \$27,181 (2004 rate year) to \$29,629 (2005 rate year), a 9.0% increase. Because changes in the LTCH PPS payment rate are budget neutral, no budgetary impact for the Medicare program is anticipated.

FOR FURTHER INFORMATION

Be sure to check the HSS web site (www.hssweb.com) for up-to-date information on Medicare regulatory activities. **Hssweb** is updated on a regular basis with new and timely **Industry Insights**, as well as access to source documents including the **Federal Register** rules referenced above.