



## 2007 UPDATES TO THE MEDICARE LONG TERM CARE HOSPITAL PPS

In the May 12, 2006 *Federal Register* (pages 27798 – 27939), 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 contains policy changes effective for rate year (RY) 2007 (July 1, 2006 through June 30, 2007). All page references are to the May 12, 2006 *Federal Register*, except where noted.

### **1. PATIENT CLASSIFICATION PROVISIONS – THE LONG TERM CARE DIAGNOSIS RELATED GROUPS**

**(PAGES 27803 – 27808):** Changes to the long term care hospital diagnosis related groups (LTC-DRGs) and relative weights are linked to changes in the inpatient DRGs which are updated in October of each year. Code changes requiring updates to the LTC-DRG assignment rules (Grouper) may also occur in April of each year. Therefore, the LTCH PPS could have three different Groupers during one rate year. Grouper 1 would be in effect from July 1 through September 30; Grouper 2 would be in effect from October 1 through March 31; and Grouper 3 would be in effect from April 1 through June 30.

- **Grouper Updates for July 2006:** Since October 1, 2005, LTCH patients have been classified using the Version 23 Medicare inpatient DRG Grouper. See *Industry Insight No. 354, CMS Updates Long Term Care PPS for October 1, 2005*. At the September 2005 ICD-9-CM Coordination and Maintenance Committee meeting, there were no requests for an April 1, 2006 implementation of code changes. Therefore the LTCH PPS is still using the Version 23 Grouper and will continue to do so until September 30, 2006.
- **October Update to the LTC-DRG Grouper:** In the April 25, 2006 *Federal Register*, CMS published the inpatient PPS proposed rule, including proposed inpatient DRG changes for October 1, 2006 (Version 24.0). As part of this proposed rule, CMS presented a new set of LTC-DRGs based upon the proposed Version 24.0 DRG Grouper (April 25, 2006 *Federal Register*, pages 24050 – 24052). For October 2006, CMS is proposing only limited DRG changes. No new DRGs are proposed and no DRGs will be deleted. A summary of these proposed DRG changes can be found in *Industry Insight No. 390, Proposed Medicare DRG Changes for FY 2007*. These LTC-DRG changes will be in effect for discharges occurring on or after October 1, 2006.
- **Major DRG Changes Proposed for October 2007:** For October 2007 (federal fiscal year 2008), CMS is proposing major changes to the inpatient DRGs in an attempt to better recognize severity of illness among the Medicare population. Proposed severity-adjusted DRGs are described in *Industry Insight No. 389, Medicare Proposes Major Changes to the Inpatient PPS in Response to MedPAC Recommendations*. If severity-adjusted DRGs are adopted for the inpatient PPS, CMS will evaluate whether it is appropriate to implement these same DRGs under the LTCH PPS. Any proposed changes to the LTCH patient classification system will be done through notice and comment rulemaking (page 27804).

**2. MARKET BASKET (PAGES 27809 – 27818):** Historically, LTCH PPS rates were established using a market basket adjustment based on the goods and services for all Medicare participating rehabilitation, psychiatric, long term care, cancer, and children's hospitals. This "excluded hospital with capital market basket" was based on 1997 cost report data. Beginning with RY

2007, LTCH rates will be updated using the 2002-based “rehabilitation, psychiatric and long term care (RPL) market basket”. CMS has noted that it was not possible to produce an exclusive market basket for LTCHs due to the small number of these facilities and a lack of significant data.

3. **FEDERAL STANDARD RATE (PAGES 27818 – 27828)**: CMS generally calculates the standard federal payment rate for the LTCH PPS by multiplying the previous year’s rate by the most recent estimated market basket increase for the cost of goods and services furnished by inpatient LTCHs. For RY 2007, CMS is providing a zero percent update to the federal standard rate. CMS estimates that the RPL market basket increase for RY 2007 is 3.4%. This increase, however, is being offset by an adjustment of equal size to mitigate the effects of recent increases in the overall LTCH casemix index which are largely due to coding changes and practices, rather than true changes in patient impairment, functional status and comorbidities. It is important to eliminate the effects of coding or classification changes because they do not reflect the true cost of treating patients. The federal standard rate will remain \$38,086.04, the same rate used for RY 2006.
4. **LTC-DRG RELATIVE WEIGHTS (PAGES 27808 – 27809)**: Payment weights are used to account for the relative differences in resource use across LTC-DRGs. CMS will utilize two sets of LTC-DRG weights during the upcoming LTCH rate year.
  - **Weights for July 1, 2006 through September 30, 2006**: For the period July 1 through September 30, while the Version 23.0 LTC-DRG Grouper remains in effect, CMS will continue to use the current LTC-DRG weights. These weights are published in Table 3 (pages 27931 – 27939) of the May 12, 2006 *Federal Register* and are the same weights previously published in Table 11 of the FY 2006 inpatient PPS final rule (August 12, 2005 *Federal Register*, pages 47681 – 47690).
  - **October 1, 2006 Weight Update**: Proposed Version 24.0 LTC-DRGs and their respective weights can be found in Table 11 of the April 25, 2006 *Federal Register* (pages 24394 – 24403). These proposed weights, which would be effective on October 1, 2006, were created using LTCH cases from the December 2005 update of the FY 2005 MedPAR data. Details on the proposed Version 24.0 LTC-DRG weights can be found in the April 25, 2006 *Federal Register* (pages 24052 – 24068).
  - **April 2007 Weight Update**: There will be no April 2007 update to the LTC-DRG weights, even if new ICD-9-CM codes are added. April codes, if added, will be handled through mapping, with no new LTC-DRGs created and no existing LTC-DRGs deleted.
  - **Low Volume and No Volume LTC-DRGs**: In developing the LTC-DRG weights, CMS has implemented special procedures for low volume (less than 25 LTCH cases) and no volume LTC-DRGs (April 25, 2006 *Federal Register*, pages 24052 – 24058, 24060 – 24068). For October 2006 (Version 24.0), there are 173 proposed LTC-DRGs with less than 25 cases and 191 proposed LTC-DRGs with no cases. Low volume LTC-DRGs are listed in the April 25, 2006 *Federal Register* (pages 24054 – 24058). No volume LTC-DRGs are also listed in the April 25, 2006 *Federal Register* (pages 24062 – 24067). 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).
5. **LOCAL WAGE DIFFERENCE ADJUSTMENTS (PAGES 27828 – 27831)**: CMS is continuing the LTCH PPS phase-in for wage index adjustments. Because the LTCH PPS is being phased-in over a 5-year period, only a portion of the wage index is utilized during each of the phase-in years. Phase-in percentages are based on the start of the LTCH’s cost reporting period and are as follows:

COST REPORTING PERIOD BEGINNING ON OR AFTER	PHASE-IN % OF FULL WAGE INDEX
October 1, 2004	60% (3/5)
October 1, 2005	80% (4/5)
October 1, 2006	100% (5/5)

Wage index values for the RY 2007 are shown in Table 1 of the May 12, 2006 *Federal Register* for urban areas (pages 27906 – 27929) and Table 2 for rural areas (pages 27929 – 27930). Each table shows the full wage index, as well as a three-fifths and four-fifths pro-rated wage index. The labor-related share is the portion of the LTCH's costs that are considered labor-related and subject to wage adjustment. CMS is changing this value from 72.885% to 75.665%.

6. **COST OF LIVING ADJUSTMENT (PAGES 27831 – 27832):** CMS is continuing to provide a cost of living adjustment (COLA) for payments to LTCHs in Alaska and Hawaii. The factors are listed below and are the same as those implemented in RY 2006.

LOCATION	COLA ADJUSTMENT
Alaska	1.25
Honolulu County	1.25
Hawaii County	1.165
Kauai County	1.2325
Maui and Kalawao	1.2375

7. **COST OUTLIER PAYMENTS (PAGES 27832 – 27839):** CMS is continuing to make outlier payments for discharges whose estimated costs exceed an outlier threshold. Costs are determined by multiplying allowable charges by a facility-specific cost-to-charge ratio.

- **Cost-to-Charge Ratios:** CMS is not finalizing proposals to annually establish a statewide average “total” cost-to-charge ratio (including both operating and capital portions) and a ceiling cost-to-charge ratio (CCR) based on inpatient PPS data. These changes were initially discussed in the January 27, 2006 LTCH proposed rule (*Federal Register*, pages 4674 – 4679) and then expanded upon in the April 25, 2006 inpatient PPS proposed rule (*Federal Register*, pages 24126 – 24135). CMS expects to finalize its position in the FY 2007 inpatient PPS final rule that will be published later this summer.
- **Outlier Threshold:** For RY 2007, the outlier threshold is equal to the sum of the adjusted payment amount for the applicable LTC-DRG and a fixed-loss of \$14,887. This threshold is statistically calculated to ensure that total outlier payments are equal to 8% of the total LTCH PPS payments. This amount is significantly higher than the RY 2006 amount of \$10,501, mostly due to the anticipated decrease in LTCH PPS payments resulting from changes in the short stay outlier policy and changes to the LTCH relative weights. Outlier adjustments will continue to be calculated as 80% of the difference between costs and the outlier threshold.

8. **SHORT STAY OUTLIER PAYMENTS (PAGES 27845 – 27871):** Short stay outliers (SSOs) 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. For RY 2007, CMS is changing the SSO payment policy to remove any inappropriate financial incentives which encourage LTCHs to admit cases that do not typically belong in LTCHs, but would be more appropriately treated in another setting. This includes patients that may be prematurely and even inappropriately discharged from the referring acute hospital. For RY 2007, payment for short stay outliers is the lesser of four options:

- 100% of the estimated costs of the discharge (**was 120% previously**);
- 120% of the LTC-DRG per diem payment amount multiplied by the length of stay;
- Full LTC-DRG payment; or
- **(New option)** Blend of the inpatient PPS “comparable” per diem payment amount (capped at the full inpatient PPS “comparable” payment) and 120% of the LTC-DRG per diem payment amount. The term “comparable” is used to indicate that this inpatient PPS payment alternative is not exactly the same as the true inpatient PPS payment. For example, this “comparable” inpatient PPS payment is adjusted for geographic wage differences, medical education and disproportionate share, but is not adjusted for high costs or new technologies. The blend used in this option varies with length of stay. Thus, as the length of stay of the SSO stay increases, and the cases begins to resemble a more “typical” LTCH stay, the percentage of the payment based on the inpatient PPS comparable per diem amount decreases and the percentage of the payment based on the LTC-DRG-specific per diem increases.

**9. INTERRUPTED STAY POLICY (PAGES 27872 – 27875):** CMS has defined an interrupted stay as a patient who is discharged from the LTCH for any reason and is readmitted to the same LTCH within 3 days. For these cases, Medicare pays the LTCH for only one discharge, and any treatment or medical services furnished to the individual during the 3-day or less absence is not separately billable to either Medicare or the beneficiary. For RY 2005 and 2006, CMS provided a limited exception to this interrupted stay policy. Exceptions applied to patients receiving inpatient care in an acute care hospital if that care grouped to a surgical DRG. In these situations, the acute care hospital received a separate payment for the surgical DRG. The LTCH, however, only received a single LTC-DRG payment, as the readmission was considered a continuation of the original LTCH stay. For RY 2007, CMS is discontinuing the surgical DRG exception policy for interrupted stays of 3 days or less.

**10. TRANSITION PERIOD (PAGES 27827 – 27828, 27882 – 27883):** LTCH payments continue to be a blend of PPS payment and the pre-PPS cost-based (TEFRA) payment. For RY 2007, blend percentages are listed in the following table. CMS estimates that 98% of LTCHs have elected to bypass the transition blend and are reimbursed using 100% of the federal rate. New LTCHs will be paid at 100% of the federal rate.

<b>COST REPORTING PERIODS BEGINNING ON OR AFTER</b>	<b>PPS REIMBURSEMENT %</b>	<b>COST-BASED PAYMENT %</b>
October 1, 2005	80%	20%
October 1, 2006	100%	0%

**11. BUDGET NEUTRALITY OFFSET FOR TRANSITION METHODOLOGY (PAGES 27839 – 27841):** For the 2007 LTCH rate year, CMS is not applying a budget neutrality adjustment to the LTCH standard federal rate. In previous years, the LTCH standard federal rate was reduced to account for the costs of the transition methodology and the fact that not all LTCHs were paid 100% of the standard federal rate. CMS has determined that for 2007 the additional costs to the Medicare program resulting from the transition methodology are so small that a budget neutrality factor is not required.

**12. OTHER HOSPITAL ADJUSTMENTS (PAGE 27839):** For RY 2007, CMS is not adding any hospital-specific adjustments for indirect medical education (IME), disproportionate share (DSH), geographic reclassification, or rural location. CMS plans to conduct a comprehensive evaluation of payment system adjustments after the completion of the 5-year transition, when sufficient data captured while the LTCHs are subject to the LTCH PPS should be available.

**13. IMPACT ANALYSIS (PAGES 27886 – 27898):** CMS estimates that total RY 2007 payments to the 347 LTCHs will decrease by approximately \$156 million. This significant decrease is due to proposed policy changes for short stay outliers, changes in wage adjustment, and the increase in the cost outlier fixed-loss amount.

**FOR FURTHER INFORMATION**

If you have questions regarding Medicare's long term care hospital prospective payment system (LTCH PPS), please contact our Client Services Department at 1-800-999-DRGS(3747). Be sure to check the HSS web site ([hssweb.com](http://hssweb.com)) for up-to-date information and additional ***Industry Insights*** on regulatory issues.