American Hospital Association

Regulatory Advisory

AHA's Regulatory Advisory, a service to members, is produced whenever there is a significant development that affects the job you do in your community

CMS Issues Proposed Rule on Long-Term Care Hospitals for Rate Year 2006

A Message to AHA Members:

The Centers for Medicare & Medicaid Services (CMS) published a proposed rule on long-term care hospitals (LTCH) in the Feb. 3 *Federal Register*. This proposed rule includes the annual LTCH payment update and other regulatory changes for Rate Year 2006, which begins July 1, 2005. A copy of the proposed rule is available at http://www.cms.hhs.gov/providers/longterm/.

The attached summary addresses key provisions of the proposed rule including the market basket update, a reduction of the fixed loss amount for very high cost patients, the introduction of new labor market definitions and other changes. Also summarized is CMS' current and proposed research plan related to LTCH definition and oversight.

After reviewing this advisory, check off the following items from your to-do list:

- ✓ Share this advisory with your LTCH management team.
- ✓ Assess how CMS' proposed changes would affect your Medicare revenue.
- ✓ Submit written comments on any issues of concern in the proposed rule, including any errors in the assignment of your facility to a new labor market for the geographic wage adjustment component of LTCH Medicare payments. Comments are due by March 29.

The AHA will file comments on this proposed rule and work with CMS to help ensure a final rule that is appropriate and fair for LTCHs and the patients they serve. To discuss any questions or concerns about the proposed rule and other LTCH issues, contact Rochelle Archuleta, senior associate director of policy, at (202) 626-2320.

Sincerely,

Rick Pollack
Executive Vice President

March 17, 2005

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March 17, 2005

CMS Issues Proposed Rule on Long-Term Care Hospitals for Rate Year 2006

The Centers for Medicare & Medicaid Services (CMS) published a proposed rule concerning Rate Year 2006 payments and other policy changes for long-term care hospitals (LTCH) in the Feb. 3 *Federal Register*. The provisions of the proposed rule would take effect July 1, 2005. The deadline for public comments on the proposed rule is March 29. A copy of the proposed rule is available at http://www.cms.hhs.gov/providers/longterm/.

This regulatory advisory summarizes the key provisions of CMS' proposed rule.

Proposed LTCH Reimbursement for Rate Year 2006

The proposed rule includes a statutorily required inflationary update, which for 2006 would be 3.1 percent and would increase the standardized LTCH payment to $37,975.53. For the LTCHs that have not fully converted to the LTCH prospective payment system (PPS), Medicare reimbursement will be a blended payment of 80 percent based on the LTCH PPS and 20 percent on the former reasonable cost payment, which is being phased out.

CMS estimates that 94 percent of LTCHs have elected to fully participate in the LTCH PPS, rather than phase into PPS over five years. Therefore, to maintain LTCH payments at a level equal to what they would have been under the former reasonable cost payment system, CMS would reduce LTCH PPS payments for 2006 by 0.2 percent. A reduction of 0.1 percent is expected for 2007, with no adjustment projected for 2008.

As a result of using more recent claims and cost report data, the proposed rule would reduce the fixed loss amount for very high cost cases to $11,544 for 2006, a decrease of 35 percent.

The proposed rule also would extend for one year, the exemption to the three-day or less interrupted stay policy for LTCH patients discharged for surgery who return to the same LTCH within three days. Under this exemption, the acute care hospital providing the surgery would receive a separate payment from Medicare for the surgical treatment. During this extension, CMS will conduct further analysis to determine if this exemption should be extended.

Wage Index Adjustment and Proposed Geographic Classification Changes

The LTCH PPS, in order to account for differences in area wage levels in different LTCH markets, is phasing in an LTCH wage adjustment based on wage data from short-term acute care hospitals. The five-year phase-in of the LTCH PPS includes a concurrent phase-in of this wage adjustment. The wage adjustment will be applied at a rate of 60 percent until October 1, 2005, at which point the rate will transition to 80 percent. As it awaits further analysis, CMS is proposing to maintain the labor-related share at 72.885%.

Consistent with recent changes for short-term acute hospitals, the proposed rule would apply Core-Based Statistical Areas (CBSA) in place of Metropolitan Statistical Areas (MSA) to reflect current labor markets and account for the hospital wage levels in the area of an LTCH, relative to the national average wage level. The Office of Management and Budget developed CBSAs based on the 2000 census.

A CBSA is defined as "a geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties." CBSAs are comprised of several county-based area definitions, including "metropolitan areas," "micropolitan areas," and rural areas "outside CBSAs." A micropolitan area is mostly rural, but includes areas currently designated as an urban MSA.

Under the proposed rule, the LTCH PPS would continue to use urban and rural labor market areas. CBSAs that are in the category of metropolitan areas (including "New England MSA", "Metropolitan Division" designations) would be treated as urban labor market areas. CBSAs in the categories of micropolitan areas and "outside CBSAs" would be treated as rural labor market areas.

The proposed wage indices for each CBSA and CBSA provider codes are available in Table 1 (urban CBSAs), Table 2 (rural CBSAs), and Table 4 (hospital-specific CBSAs) in the proposed rule. LTCHs should carefully review their assignment to a CBSA county and labor market area and email corrections to CMS at ltchpps@cms.hhs.gov.

The proposed rule would not phase-in the use of CBSAs for the LTCH PPS. CMS states that a CBSA phase-in for LTCHs was not selected due to the ongoing phase-in of the LTCH PPS including the wage index, which would mitigate the impact of full implementation of CBSAs.

Proposed New Reporting Requirements

The proposed rule would require an LTCH configured as a hospital-within-a-hospital or satellite to notify its CMS regional office and fiscal intermediary of the name, address and Medicare provider number of its host hospital and any other co-located providers, including inpatient rehabilitation units, inpatient psychiatric units and skilled nursing facilities. LTCHs would be required to provide this information in writing, on an on-going, prospective manner.

LTCH Research

In June 2004, the Medicare Payment Advisory Commission (MedPAC) issued LTCH recommendations that call for Congress and the Secretary of the U.S. Department of Health and Human Services to:

- define patient and facility criteria for LTCHs to "ensure that patients admitted to these facilities are medically complex and have a good chance at improvement;" and

- require CMS' Quality Improvement Organizations to review LTCH admissions for medical necessity and monitor LTCH compliance.

MedPAC suggests that the facility criteria should characterize LTCH care by features such as staffing, patient evaluation and review processes, and mix of patients. Patient criteria, it suggests, should identify specific clinical characteristics and treatment modalities.

Using the MedPAC research and recommendations as a starting point, CMS has initiated a two-part research project with the Research Triangle Institute (RTI). As outlined in the proposed rule, RTI will analyze claims and other data on LTCH and acute hospital patients to identify and distinguish the role of LTCHs as a Medicare provider. In addition, RTI will address the feasibility of MedPAC's recommendations, including a separate analysis on LTCH patients with diagnoses typically treated in inpatient rehabilitation facilities. These analyses may lead to future rulemaking by CMS pertaining to the definition and oversight of LTCHs.

In addition to summarizing the RTI research project, CMS describes its intent to monitor and research several other LTCH issues including:

- Medicare beneficiary movement to and from LTCHs and other Medicare providers;
- Changes in average length of stay for particular facilities and specific long-term care diagnostic related groups;
- Trends in the supply, utilization and cost of LTCH care during an episode of care, including the use of medical record review;
- Patients staying in an LTCH for six months or longer to determine if skilled nursing care may be more appropriate;
- LTCHs with specific diagnosis codes related to medically unnecessary admissions, or perhaps high levels of short-stay outliers;
- Improper payments for LTCH admissions based on coding and lack of medical necessity;
- LTCH short-stay outliers to determine whether patients are truly in need of a hospital-level of care; and,
- The need to assess and build a quality measurement program for the LTCH setting.

Written Comments

LTCHs should file written comments with CMS on any issue of concern in the proposed rule, including any errors in the assignment of your facility to a new labor market for the geographic wage adjustment component of LTCH Medicare payments.

Comments must be received by March 29 and may be emailed to http://www.cms.hhs.gov/regulations/ecomments. If mailed, send one original and two copies to:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS—1483—P
P.O. Box 8011
Baltimore, MD 21244-8011

The AHA will comment on this proposed rule and work with CMS to help ensure a final rule that is appropriate and fair for LTCHs.