American Hospital Association

Regulatory Advisory

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Long Term Care Hospital Proposed and Final Policy Changes for 2006

A Message to AHA Members:

The Centers for Medicare & Medicaid Services (CMS) published May 4 in the *Federal Register* the inpatient prospective payment system (PPS) proposed rule, which includes long term care hospital (LTCH) provisions that would take effect October 1, 2005. In addition to these provisions, CMS published on May 6, 2005 in the *Federal Register* a final LTCH rule that includes the annual LTCH payment update and other regulatory changes that take effect July 1, 2005. Both the proposed and final LTCH provisions are described in the attached advisory. A copy of both rules is available at www.cms.hhs.gov/providers/longterm/. AHA documents on these and related LTCH and post-acute issues are available at www.aha.org/postacute.

Please review this advisory and share it with key hospital and LTCH staff to determine its impact on your organization. We also encourage you to develop written comments on LTCH issues of concern in the proposed inpatient PPS rule. Comments must be received by June 24, 2005, and may be submitted electronically at www.cms.hhs.gov/regulations/ecomments, or mailed to CMS. 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 American Hospital Association (AHA) will comment on many components of the proposed IPPS rule including several LTCH provisions, and will distribute our comment letters for review before June 24. We'll also continue working with CMS to help ensure that the final rule is appropriate and fair for all hospitals and the patients they serve. If you have questions or concerns about the final or proposed LTCH provisions, please contact Rochelle Archuleta, senior associate director of policy, at (202) 626-2320.

Sincerely,

Rick Pollack
Executive Vice President

June 14, 2005

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The Centers for Medicare & Medicaid Services (CMS) published May 4 in the *Federal Register* the inpatient prospective payment system (PPS) proposed rule, which includes long term care hospital (LTCH) provisions that would take effect October 1, 2005. In addition to these provisions, CMS published on May 6, 2005 in the *Federal Register* a final LTCH rule that includes the annual LTCH payment update and other regulatory changes that take effect July 1, 2005. Both the final and proposed LTCH provisions are described below.

The LTCH PPS final rule has an estimated overall fiscal impact of *positive* 5.7 percent due to the statutorily required market basket update and other policy changes. However, it is important to note that proposed LTCH changes included in the *inpatient PPS proposed rule* would be a *negative* 4.6 percent for FY 2006 due to the annual re-weighting of the LTCH payment categories.

LTCH Provisions in IPPS Proposed Rule for FY 2006

Re-Weighting of LTCH DRGs

CMS calculates a relative weight for each LTCH payment category called a diagnostic related group (DRG), which represents the resources needed by an average patient in each category. The inpatient PPS proposed rule includes the annual re-weighting of the LTCH DRGs, which would take effect October 1, 2005 and reduce Medicare payments to LTCHs by 4.6 percent, or $135 million, in FY 2006. Specifically, CMS proposes a new re-weighting method that would remove statistical outliers (cases that are more than three standard deviations from the mean for charges per case and charges per day) and short stays (cases with a length of stay (LOS) up to seven days) from the re-weighting calculation. In the proposed rule, CMS said that outlier cases were removed from the calculation because they "may represent aberrations in the data that distort the measure of average resource use" and that short-stay cases were removed since they "do not belong in a LTCH because these stays do not fully receive or benefit from treatment that is typical in a LTCH stay, and full resources are often not used in the earlier stages of admission to a LTCH." The AHA is concerned that the proposed methodology will inappropriately remove selected categories of LTCH patients from the calculation. By narrowing the pool of cases used to determine the relative weights for LTCH DRGs, the agency would erode a fundamental feature of the prospective payment system – the principle of averaging. The re-weighting of the

DRGs also raises concerns about CMS' requirement to implement the LTCH PPS in a budget neutral manner when compared to what Medicare payments would have been under the former reasonable cost-based system. We question CMS' interpretation that budget neutrality only applies to the annual rate update and are analyzing the statutory guidelines to determine how the budget neutrality principle applies to other components of the LTCH PPS such as the annual re-weighting of the LTCH DRGs.

Final LTCH PPS Changes for Rate Year 2006

Market Basket Update and Aggregate Impact

The final rule provides a full market basket update of 3.4 percent as required by law, which would produce a standard payment amount of $38,086.04 beginning July 1. The final standard amount is higher than the standard amount originally proposed due to more recent labor market data.

Budget Neutral Implementation of LTCH PPS

In the final rule, CMS makes no budget neutrality adjustment since it estimates that 98 percent of all LTCHs will be fully phased in to LTCH PPS for the next rate year. Yet, the final rule also notes that CMS lacks sufficient cost report and claims data under the LTCH PPS to conduct a comprehensive reevaluation of budget neutrality calculations conducted during the initial implementation of the LTCH PPS in rate year 2003. The final year of the five-year transition to the new PPS will be completed in FY 2007. LTCHs that have not yet fully converted to the LTCH PPS will be reimbursed with a blended payment based 80 percent on the LTCH PPS and 20 percent on the former reasonable cost payment.

Outlier Threshold Substantially Lowered

The rule also substantially lowers the fixed loss amount for high cost outliers to $10,501 from the FY 2005 amount ($17,864) and the original amount proposed for FY 2006 ($17,864). The AHA applauds this reduction since more cases now will be eligible for outlier payments. The reduction is due to CMS' use of newly available LTCH-specific cost to charge ratios used for calculating outlier projections. The outlier threshold amount then is set at a level to produce estimated total outlier payments equal to eight percent of total projected LTCH PPS payments.

Wage Index Adjustment and New Geographic Classifications

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, which will be applied at a rate of 60 percent until October 1, 2005, when the rate transitions to 80 percent.

As with recent changes for short-term acute hospitals, the proposed rule will replace Metropolitan Statistical Area (MSA) boundaries with Core-Based Statistical Areas (CBSA) to distinguish labor markets for wage index adjustments to LTCH Medicare payments. CBSAs will be fully implemented on July 1 and not phased in as was the case for general acute hospitals.

CMS stated that since the LTCH PPS wage index presently is being phased-in and will be applied at 80 percent in FY 2006, the impact of the new CBSA labor market definitions will not be as severe.

A CBSA, based on 2000 U.S. Census data, is "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 comprise 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.

LTCHs will continue to be assigned to urban and rural labor market areas. CBSAs in metropolitan areas (including new "New England MSA, Metropolitan Division" designations) would be treated as urban labor market areas. CBSAs in micropolitan areas and "outside CBSAs" will 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) of the final rule.

Extension of Additional Payment for LTCH Patients Needing Surgery

A "three-day or less interrupted stay" occurs when a patient is discharged from an LTCH to a short-term acute hospital, inpatient rehabilitation facility, skilled nursing facility or home, and then is readmitted within three days to the same LTCH. In this situation, only one Medicare payment is made to the LTCH and the LTCH is responsible for paying for services received in other care settings, except for surgeries. The exemption for surgeries initially was approved for one year, but this final rule extends the exemption for an additional year. Under this exemption, the acute care hospital providing the surgery receives a separate payment from Medicare. CMS noted that it will conduct additional analysis to determine if this exception should be extended even further.

New Reporting Requirements

Under the final rule, LTCHs configured as a hospital in hospital (HIH) or satellite (including "grandfathered" HIHs) must notify their CMS regional offices and fiscal intermediaries 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. Beginning July 1, LTCHs must provide this information in writing, on an on-going, prospective basis when a change in co-located status occurs. While LTCHs are not penalized currently for failing to provide such a notice, CMS said the agency will monitor compliance and consider penalties if it determines that LTCHs are not complying with this requirement.

Ongoing 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 staffing, patient evaluation and review processes, and mix of patients. According to MedPAC, patient criteria 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) to analyze claims data, clinical outcomes, lengths of stay, resource utilization throughout an episode of care, patient admission criteria, diagnosis frequency variations by provider, and other data to identify and distinguish the role of LTCHs as a Medicare provider. In addition, RTI will evaluate 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 on to the definition and oversight of LTCHs.

In addition to summarizing the RTI research project, CMS said it intends 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 LTC-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 who stay in an LTCH for six months or longer to determine if skilled nursing care may be more appropriate, especially for those long-stay LTCH patients who generated an outlier payment for a general acute hospital;
- 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;
- The need to assess and build a quality measurement program for the LTCH setting;
- Lengths of stay for a sample of LTCH patients in Texas, Massachusetts and Louisiana to determine if patients are being maintained too long to meet the minimum requirement; and
- Quality measurement for public reporting of LTCH outcomes.

CMS said it will publish preliminary research findings in Spring 2007. The agency also notes that it may lack the statutory authority to implement some of RTI's recommendations. The AHA is disappointed that CMS did not act on the recommendation from us and others that proposed establishing a technical advisory panel to work with RTI on its LTCH research, especially given the scope and significance of current and planned CMS research initiatives.