

February 28, 2006

LONG-TERM CARE HOSPITALS PROPOSED MEDICARE RULE FOR RY 2007

AT A GLANCE

The Issue:

The Centers for Medicare & Medicaid Services (CMS) published in the Jan. 27 *Federal Register* the long-term care hospital prospective payment system (LTCH PPS) proposed rule for rate year 2007, which begins July 1, 2006. **CMS' proposal recommends significant reductions in Medicare payments to LTCHs and would have an estimated net impact of negative 11.1 percent.** The proposed rule is open for public comments through March 20 and available at www.cms.hhs.gov/LongTermCareHospitalPPS/ under "Regulations and Notices."

Our Take:

We are extremely concerned that this proposal goes too far and would harm patients. The most critical problems are CMS' proposed omission of the 3.6 percent market basket update and the provisions to change the short-stay outlier policy, which would cut LTCH payments by 11.4 percent. We strongly oppose this proposed rule and will present a fair alternative that preserves access for patients who need LTCH care.

What You Can Do:

- Share this advisory with your senior management team, chief financial officer, billing and coding staff, nurse managers and key physician leaders.
- Calculate the impact of these changes on your expected 2007 Medicare payments.
- Develop comments for CMS that emphasize the proposed rule's impact on your patients. Submit them by March 20 either electronically at www.cms.hhs.gov/eRulemaking; or via mail (original and two copies) to CMS, Dept. of HHS, ATTN: CMS-1485-P, PO Box 8012, Baltimore, MD 21244-8012; or via overnight delivery to CMS, Dept. of HHS, ATTN:CMS-1485-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Further Questions:

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BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) published in the Jan. 27 *Federal Register* the long-term care hospital prospective payment system (LTCH PPS) proposed rule for rate year (RY) 2007, which begins July 1, 2006. **CMS is proposing significant reductions in Medicare payments to LTCHs and estimates the proposed rule's net fiscal impact to be negative 11.1 percent.**

CMS is accepting public comments on this proposal through March 20. The AHA is preparing comments and collaborating with other national organizations to analyze this proposal and develop policy alternatives for CMS. A final rule is expected in April with an effective date of July 1. The proposed rule is available at www.cms.hhs.gov/LongTermCareHospitalPPS under "Regulations and Notices."

AT ISSUE

LTCH PPS Phase-in

CMS estimates that 97 percent of LTCHs have fully transitioned to the LTCH PPS. For LTCHs transitioning to PPS, the final year of the transition will begin for cost reports beginning on or after October 1, 2006, with payments paid at 100 percent under the LTCH PPS. The agency plans to postpone until July 2008 the one-time adjustment to ensure that payments during the transition to the LTCH PPS are budget neutral to the amount of payments that would have been paid under the cost-based system. CMS will continue to collect and analyze data to determine if this adjustment should be proposed in the future.

Proposed New Market Basket

CMS proposes to implement a new market basket methodology for LTCHs – the rehabilitation, psychiatric and long-term care (RPL) market basket. The RPL market basket would replace the current "excluded hospital with capital market basket" which is based on 1997 Medicare cost report data and includes children's and cancer hospitals. The new RPL market basket is based on a more

targeted group of hospitals which CMS feels are more homogeneous than the broader group captured in the current market basket. This change would both revise the market basket by changing the methodology and rebase the market basket by moving to a new base year of data – the 2002 cost reports. The RPL market basket includes both capital and operating costs based on new cost categories, weights and price proxies, as detailed in Table 2 of the proposed rule.

Update to Standard Payment

Although CMS calculated the rate of inflation and growth for LTCHs in 2007 to be 3.6 percent (as measured by the RPL 2007 market basket), the agency is not recommending that this inflationary update be applied. As a result, CMS is proposing to hold the RY 2007 LTCH standard payment at the current level of \$38,086.04. Under federal statute, CMS is not mandated to include the market basket update in its annual rate payment update. In failing to include a market basket update in the proposed rule, CMS ignores the real cost of inflation associated with the cost of providing health care services. The AHA strongly disagrees with the agency's recommendation to omit the market basket update which is intended to preserve the ability of providers to ensure access to appropriate patient care.

Part of CMS' rationale for providing no payment update lies in steady increases in the case mix index (CMI). CMS analysis indicates that from FY 2003 to FY 2004, the LTCH CMI increased 6.75 percent. CMS estimates that 4.0 percent of this change was due to changes in coding practice, called "apparent CMI increase," and the remaining 2.75 percent change was caused by increases in patient acuity, called "real CMI increase." CMS states that "a zero percent update factor would... account for the increase in apparent case mix in the prior period." The proposed rule also notes CMS' concerns that case-mix index increases have led to Medicare payment increases in the cost of treating patients and that LTCHs are "treating patients that do not require hospital-level care."

Update to Labor-Related Share

Under this proposed rule, the labor-related share would be updated to become aligned with the new RPL market basket. The labor-related share would be revised from 72.885 percent to 75.923 percent, which reflects a larger share of labor-related costs (such as wages/salaries and benefits) relative to other operating and capital costs for LTCHs.

Outlier Threshold

CMS would substantially increase the outlier threshold in RY 2007 from the current level of \$10,501 to \$18,489, which would result in reduced outlier payments to LTCHs. The significant scale of this change reflects the statutory mandate that CMS maintain outlier payments at 8 percent of Medicare payments to LTCHs, while Medicare payments to LTCHs would decrease by 11.1 percent. This change would increase the amount of loss that an LTCH experiences before a case qualifies as a high-cost outlier.

CMS also proposes a series of changes related to cost-to-charge ratios (CCRs) used to determine whether an LTCH case is an outlier. These changes take effect October 1, since LTCH CCRs are based on general acute hospital data that are updated on a fiscal year cycle. First, rather than calculating separate CCR ceilings for operating and capital costs/charges and adding them together, CMS would calculate a combined LTCH CCR. Second, for LTCHs with CCRs above the LTCH CCR ceiling (three standard deviations above the national geometric mean total CCR), the fiscal intermediary would be allowed to use a statewide average CCR. Individual LTCHs would maintain the option of petitioning to use a different CCR with substantial evidence that the alternate CCR would more accurately reflect the hospital's actual costs and charges. These changes also apply to short-stay outlier cases that qualify for high-cost outlier payment. CCRs would be based on the most recent settled cost report or the most recent tentative settled cost report, whichever is later.

Short-Stay Outliers

The proposed changes to the LTCH short-stay outlier (SSO) provision are the largest fiscal impact in this proposed rule – an 11.4 percent reduction in payments. SSOs have a duration that is up to 5/6 of the geometric average length of stay (ALOS) for a particular LTCH diagnosis-related group (DRG). CMS estimates that SSOs account for 37 percent of all LTCH cases – a decrease from 48 percent, the rate of SSOs at the outset of the LTCH PPS. Data (MedPAR 2004) indicate that the ALOS for SSOs is 12.7 days. Currently, SSO cases are paid the lesser of the following:

- the full LTCH DRG payment;
- 120 percent of the LTCH DRG per diem; or
- 120 percent of the cost of the SSO case, calculated using an LTCH's CCR.

CMS implemented the SSO policy to discourage LTCHs from admitting short-stay cases. In the proposed rule, the agency restates its concern that the high incidence of SSOs “may indicate a premature discharge from the acute-care hospital and an unnecessary admission to the LTCH.”

CMS proposes to modify the current SSO policy in two ways:

- lower the SSO reimbursement based on cost from 120 percent to 100 percent; and
- add a new, and substantially lower, payment alternative – an amount “comparable” to the general acute hospital rate for a given diagnosis.

Under this proposal, all SSO cases would continue to be eligible for a high-cost outlier payment under the LTCH PPS. However, SSOs paid the amount comparable to the general acute hospital rate, based on the inpatient PPS, would be ineligible to have an inpatient PPS outlier payment added.

The new payment adjustment would be comparable to inpatient PPS rates including adjustments for area wages (based on the wage index for non-reclassified hospitals); for cost of living for LTCHs in Alaska and Hawaii; for

treatment of low-income patients; outliers and for being a teaching hospital. LTCHs with an approved residency teaching program would be eligible for an adjustment based on the ratio of the number of residents to the number of available beds. Due to data limitations, CMS proposes to use an LTCH's graduate medical education cap to establish eligibility for this adjustment since it is "the best available data on residency programs at LTCHs." LTCHs treating a disproportionate share (DSH) of low-income patients would be eligible for a DSH adjustment, which is a percentage add-on. DSH eligibility is established through two means, as described in Attachment A.

Interrupted Stay Policy

CMS proposes to eliminate the surgical DRG exception for interrupted stays of three days or less. This category of interrupted stays does not result in a second payment for the LTCH. In addition, the LTCH must pay "under arrangements" for treatments provided to the patient during the interruption. Currently, interruptions due to surgery are exempt from this policy and CMS makes a separate payment to the surgery provider. According to CMS analysis, approximately 50 percent of interrupted cases include surgical care. The agency suggests that some of these claims may include surgical procedures performed during the prior acute stay, which would result in the LTCH patient being grouped to a surgical LTCH DRG, which is a higher payment. For these reasons, CMS expects this proposed change would not have a "strong negative impact on the LTCHs."

In addition, CMS is considering changing the three-day threshold for the interrupted stay policy to a four-day threshold.

Payment Adjustment for Host Hospital Referrals

CMS is concerned about the "explosive growth in the number of freestanding LTCHs," and views this form of growth as replacing the prior growth of co-located LTCHs, which essentially halted upon the 2004 introduction of a payment reduction for LTCH admissions that exceed a cap on host hospital referrals. CMS is examining the proliferation of freestanding LTCHs and "considering appropriate adjustments." CMS cites MedPAC data that shows approximately 40 percent of referrals to freestanding LTCHs originate with a sole short-stay hospital, while approximately 60 percent of referrals to co-located LTCHs are derived from their host hospitals.

For co-located LTCHs, patients that exceed an established cap (currently 75 percent) on host hospital referrals are paid an amount equivalent to the inpatient PPS rate for the given diagnosis. In the proposed rule, CMS clarifies that in this case, "equivalent" means an amount that "closely replicates" the inpatient PPS rate.

In addition to monitoring the growth of freestanding LTCHs, the agency is reviewing patient transfer patterns between general acute hospitals and co-located and satellite LTCHs that appear to be designed to bypass this new policy for co-located LTCHs.

The AHA continues to oppose the referral cap, which moves to 50 percent beginning October 1, and we will continue to urge CMS to develop appropriate patient and facility criteria, rather than a blunt referral cap. We are very concerned with the proposed rule's discussion of applying the cap to freestanding LTCHs. This is a bad policy direction that we will oppose.

LTCH Research

CMS has contracted with the Research Triangle Institute (RTI) to analyze service utilization patterns for Medicare beneficiaries using 2003 data for LTCHs and other substitute providers including general acute hospitals, inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities and skilled nursing facilities (SNFs). RTI also is charged with assessing the feasibility of the September 2004 MedPAC recommendations on developing more specific facility and patient criteria for LTCHs. CMS expects that the final RTI report, due in late spring 2006, will have a "substantial impact on the LTCH policy and will contain specific criteria for LTCH patients and facilities." Below are some of RTI's key preliminary findings presented in the proposed rule.

- Table 14 in the proposed rule lists the Top 50 LTCH diagnoses and compares the frequency of these diagnoses for other Medicare providers. The top three LTCH diagnoses are respiratory system diagnosis with ventilator support, rehabilitation and degenerative nervous system disorders. RTI concludes that the majority of DRGs treated at LTCHs also are treated in alternative settings.
- A higher percentage of older patients discharged from general acute hospitals subsequently used an IRF or a SNF than patients discharged from LTCHs.
- The number of beneficiaries discharged from general acute hospitals to LTCHs more than doubled between 1996 and 2002.
- 79 percent of LTCH cases are preceded by an acute care stay and 12 percent are general acute hospital outlier cases.
- 36 percent of the LTCH cases were subsequently admitted to a SNF, an IRF or readmitted to a general acute hospital.
- LTCH cases were more likely to use home health than IRF or SNF services.
- Approximately 40 percent of all LTCH admissions are SSOs and the LTCH ALOS for all cases is 32.8 days.

AS IT STANDS

Patients who can benefit from LTCH care must have continued access to these services. This drastic proposal would threaten access for many LTCH patients. The LTCH field must collaborate on closely examining CMS' SSO proposal to develop a sound alternative that focuses on maintaining access to care and illustrates the excessive and imprecise nature of this provision.

NEXT STEPS

The AHA will continue to press CMS and Congress to pursue alternative changes to those in the proposed rule. In particular, we will work in conjunction with the other national LTCH organizations to share analysis and jointly develop a response strategy for the field. The AHA will prepare a written response to this proposal that emphasizes its potential impact on patients and provide policy options to improve the rule. We encourage AHA members to comment, and we'll post a sample letter in the near future.



LTCH Short-Stay Outliers

DSH-Like Adjustment for Selected Patients

To be eligible for the disproportionate share (DSH) adjustment, an LTCH must submit one of two criteria. The first is based on an annual DSH calculation for each LTCH, which consists of the two percentages below being calculated and added together. The combined percentages must equal 15 percent or greater for an LTCH to be eligible for a DSH adjustment.

$$\begin{array}{l} \text{Patients covered by both} \\ \text{Medicare Part A} \\ \text{and SSI days} \\ \text{Total Medicare Days} \end{array} + \begin{array}{l} \text{Medicaid-eligible percent} \\ \text{days not covered by} \\ \text{Medicare Part A} \\ \text{Total Patient Days} \end{array}$$

CMS acquires the LTCH's SSI data from the Social Security Administration and inpatient hospital stay data from its MedPAR files. The formula varies for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, and other hospitals. CMS states that the remaining types of data needed for the DSH calculation are already collected on the LTCH cost reports.

The second DSH methodology, known as the "Pickle Adjustment," would apply a 35 percent add-on to the inpatient PPS rate for urban LTCHs with more than 100 beds if more than 30 percent of its total net inpatient revenue comes from state and local governments (other than Medicare or Medicaid funds) and is designated for indigent care.