



Attention Long Term Care Hospitals!

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MLN Matters Number: MM5202

Related Change Request (CR) #: 5202

Related CR Release Date: June 15, 2006

Effective Date: July 1, 2006

Related CR Transmittal #: R981CP

Implementation Date: July 3, 2006

Note: This article was updated on November 8, 2012, to reflect current Web addresses. All other information remains unchanged.

Update - Long Term Care Hospital Prospective Payment System (LTCH PPS) Rate Year 2007

Provider Types Affected

Long term care hospitals paid under the LTCH PPS by Medicare fiscal intermediaries (FIs)

Provider Action Needed



STOP – Impact to You

Change Request (CR) 5202, from which this article is taken, updates the changes to LTCH PPS for Rate Year 2007 (July 1, 2006 - June 30, 2007). It also announces a policy change regarding payment for LTCH patients during a three-day or less interruption of an LTCH stay if the treatment was grouped to surgical diagnosis related groups (DRGs) in the acute care hospital. CR5202 also announces changes to short stay outlier (SSO) payment calculations.

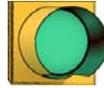


CAUTION – What You Need to Know

CR5202 provides updates to rates, budget neutrality factors, wage indexes, and so on, for the new rate year for LTCH PPS.

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GO – What You Need to Do

See the *Background* section of this article for further details regarding these changes.

Background

In accordance with provisions of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000), on October 1, 2002, CMS implemented a Medicare prospective payment system for LTCHs. Payments under this system are made on a per-discharge basis, using long-term care diagnosis-related groups (LTC-DRGs) that take into account differences in resource use of long-term care patients; and the most recently available hospital discharge data.

Annual Update

CMS is required to update the LTCH PPS payments annually: the Rate Year (RY) is updated each July, and the DRGs are updated each October.

CR5202, upon which this article is based, provides the LTCH PPS rates for RY 2007 (July 1, 2006 - June 30, 2007):

- The standard Federal rate is \$38,086.04.
- The fixed loss amount is \$14,887.00.
- The budget neutrality adjustment is 0%. (The PPS pricing software [PRICER] payment amount will include the adjustment factor as 1.00.)
- The wage index phase-in percentage for cost reporting periods, beginning on or after October 1, 2006, is 5/5^{ths} (100%). Note that the wage index table within PRICER will include three columns:
 - A 3/5^{ths} column for discharges occurring in LTCH cost report periods beginning during Fiscal Year 2005;
 - A 4/5^{ths} column for discharges occurring in LTCH cost report periods beginning during Fiscal Year 2006; and
 - A 5/5^{ths} column for discharges occurring in LTCH cost report periods beginning during Fiscal Year 2007.
- The labor-related share is 75.665%.
- The non-labor related share is 24.335%.

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Other Important Facts in CR5202

Short-Stay Outlier Cases

One notable policy change affects payments to short-stay outlier (SSO) cases. Currently, short-stay outlier (SSO) cases (i.e., cases with a length of stay less than or equal to 5/6^{ths} of the geometric average length of stay (ALOS) of the LTC diagnosis related groups (DRG)), are paid the least of:

- 1) 120% of the estimated cost of the case;
- 2) 120% of the LTC-DRG per diem amount; or
- 3) The full LTC-DRG payment.

However, in the RY 2007 LTCH PPS final rule, CMS revised the SSO case payment formula in two ways.

First, the current SSO payment formula option that is based on estimated costs has been reduced from 120% to 100% (effective for SSO discharges occurring on or after RY 2007). In addition, a fourth option is being added to the SSO payment formula. This option is a blended payment that is based on:

- A percentage of an inpatient prospective payment system (IPPS) comparable amount, computed as a per-diem and capped at the full IPPS comparable amount; and
- A percentage of the 120% of the LTC-DRG per diem amount.

Under this new blended fourth component of the SSO payment formula, as the length of the stay increases, it begins to resemble less of a short-term acute care IPPS hospital stay and more of a typical LTCH one.

Consequently, the LTCH PPS payment for the SSO case under this blend option is based on a **decreasing** percentage of the IPPS comparable per diem amount and an **increasing** percentage of the 120% of the LTC-DRG per diem amount as the LOS of the SSO case increases.

Therefore, effective for LTCH PPS discharges occurring on or after July 1, 2006, the adjusted payment for a SSO case will equal the lesser of:

- 100% of estimated cost of the case;
- 120% of the LTC-DRG per diem amount;
- The full LTC-DRG payment; or
- A blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem and capped at the full IPPS DRG comparable amount, and 120% of the LTC-DRG per diem amount.

Note: The IPPS comparable amount portion of the blend will be computed in the LTCH PRICER software program. In determining the IPPS comparable amount,

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appropriate IPPS adjustments will be made for DRG weights, wage index, cost-of living for LTCHs located in Alaska and Hawaii, and when applicable, the treatment of a disproportionate share of low-income patients (DSH) and the costs of indirect medical education (IME) (IPPS outlier payments are not included in this calculation).

As under the existing SSO policy, SSO cases are eligible for LTCH PPS high-cost outlier payments if the estimated cost of the SSO case exceeds the LTCH PPS outlier threshold (i.e., the SSO payment plus the fixed-loss amount).

CR5202 contains further details regarding the SSO calculations and also includes two very detailed examples of SSO calculations, one for a stay of 11 days and the other for a stay of 27 days. You may view these details by accessing CR5202 at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R981CP.pdf> on the CMS website.

Revised Payment Policy for Three-Day or Less Interruption of Stay

Another important subject addressed in CR5202 is the revised payment policy for a three-day or less interruption of stay. Currently, all inpatient and outpatient treatment and/or care delivered to LTCH patients by acute care hospitals, IRFs, and SNFs during a three-day or less interruption is the LTCH's responsibility "under arrangements," unless the patient's treatment during such an interruption was at an acute care hospital, and was grouped to a surgical DRG.

This means that the acute care hospital was allowed to submit a separate bill for these services (although the patient's re-admittance to the LTCH following the surgical procedure remained governed by the interrupted stay policy).

For RY 2007, this surgical-DRG exception to the three-day or less interruption of stay policy that was in effect for RYs 2005 and 2006 is discontinued, and LTCHs are required to cover such treatment "under arrangements" as they do for all other medical care or services provided to inpatients during a three-day or less interruption of stay.

Therefore, in these instances acute care hospitals will no longer be able to submit a separate bill to Medicare for such treatment but must turn to the LTCH for payment.

Additional Information

CR5202, the official guidance that CMS has provided to your FIs, is located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R981CP.pdf> on the CMS website.

If you have any questions, please contact your fiscal intermediary at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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