



Office of External Affairs

MEDICARE NEWS

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MEDICARE ANNOUNCES PAYMENT CHANGES FOR LONG-TERM CARE HOSPITALS FOR RATE YEAR 2007

The Centers for Medicare & Medicaid Services (CMS) today issued a final rule designed to assure appropriate payment for services by long-term acute care hospitals (LTCHs) to severely ill or medically complex patients, while providing incentives for more efficient care for Medicare beneficiaries. Under this final rule, Medicare payments to LTCHs are expected to be \$5.3 billion for rate year (RY) 2007.

“Medicare’s goal is to ensure that those seriously ill beneficiaries who require hospital-level care to get the care they need with appropriate payments,” said CMS Administrator Mark B. McClellan, M.D., Ph.D. “The policies and payment rates in this final rule reflect the input we have received from all stakeholders to achieve high-quality, efficient care.”

Long-term care hospitals, in general, are defined as hospitals that have an average Medicare inpatient length of stay of greater than 25 days. These hospitals typically provide extended medical and rehabilitative care for patients who are clinically complex and may suffer from multiple acute or chronic conditions. Services typically include comprehensive rehabilitation, respiratory therapy, head trauma treatment and pain management.

The LTCH prospective payment system (PPS), which now sets payments for approximately 400 long-term care hospitals, was implemented in FY 2003, and is now updated annually, effective for discharges on or after July 1 of each year. An analysis of LTCH case-mix indices and margins after implementation of the LTCH PPS indicates that LTCH Medicare margins rose to 7.8 percent for FY 2003, and based on currently available data, to 12.7 percent for FY 2004. In conjunction with these growing differences between payments and costs, admissions to LTCHs have risen rapidly in certain areas of the country, and a significant number of admissions to these facilities are “short stay” transfers from acute care hospitals. With these trends, total estimated payments to LTCHs in RY 2007 are expected to be approximately 70 percent higher than payments in RY 2003.

In light of these data, the LTCH PPS Federal rate will remain at \$38,086.04 for RY 2007. The

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final Federal rate reflects the recommendation for the LTCH PPS update provided to Congress by the Medicare Payment Advisory Commission (MedPAC).

In addition, CMS is adopting the “Rehabilitation, Psychiatric and Long-Term Care (RPL)” market basket to replace the “excluded hospital with capital” market basket that is currently used as the measure of inflation for calculating the annual update to the LTCH PPS Federal rate. The RPL market basket is based on the operating and capital costs of inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), and LTCHs. Adopting the RPL market basket will result in an increase in the labor share, which is used in the adjustment for area wages, from 72.885 percent to 75.665 percent.

The final rule would also make the LTCH payment system more efficient by revising the payment adjustment formula for short-stay outlier (SSO) patients. These are cases where the patient is discharged early and the hospital’s costs may be significantly below average for the Long Term Care Diagnosis Related Group (LTC-DRG) assigned to the case. Currently, payment for these patients is based on the lesser of (1) 120 percent of patient costs; (2) 120 percent of the per diem of the LTC-DRG payment; or (3) the full LTC-DRG payment.

The final rule revises the existing payment adjustment formula for SSO patients by reducing the part of the current payment formula that is based on costs and adding a fourth component to the current formula, a blend of an amount comparable to the hospital inpatient PPS (IPPS) payment and the LTC-DRG per diem payment, such that payments for SSO cases would be the lesser of:

- 100 percent of patient costs,
- 120 percent of the per diem of the LTC-DRG payment,
- 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, capped at the full IPPS DRG comparable payment amount, and 120 percent of the LTC-DRG per diem payment. For each day, as the length of stay increases, the percentage of the IPPS comparable amount will decrease and the percentage based on 120 percent of the per diem LTC-DRG specific amount will increase. As the length of stay reaches the lower of the five-sixths SSO threshold or 25 days, the payment will no longer be limited by this fourth option.

In response to public comments, CMS substantially revised the fourth component of the payment formula from the version in the proposed rule. The final rule, by providing for the blend option, acknowledges that as the patient's length of stay increases, the course of their treatment is more reflective of the resources used in the applicable LTC-DRG.

Medicare will pay a hospital an additional amount for unusually high cost cases under the high-cost outlier policy. To be eligible for this payment, the hospital’s estimated costs in treating the case must exceed the LTC-DRG payment by an outlier fixed-loss amount. The outlier fixed-loss amount for rate year 2007 would be \$14,887, compared with \$10,501 in rate year 2006.

CMS will also discontinue the surgical DRG exception to the three-day or less interrupted stay policy. The three-day or less interrupted stay policy provides that where a LTCH patient is discharged to an acute care hospital, IRF, skilled nursing facility (SNF), or to the patient’s home and is readmitted to

the long-term care hospital within three days, Medicare makes only one LTCH PPS payment and does not provide for a separate payment for services provided during the three-day or less period. The surgical DRG exception allowed Medicare to make a separate payment to the acute care hospital if the care delivered during a three-day or less interruption was for inpatient surgery.

An analysis of claims data from cases which fell under the surgical DRG exception revealed that many of the surgical procedures performed during the three-day or less interruption were related to the patient's principle diagnosis at the LTCH. Furthermore, CMS data indicates that the cases that were eligible for payment under the surgical DRG exception represented only 0.37 percent of total LTCH discharges during RY 2005, a small fraction of LTCH hospitalizations. Therefore, these cases were neither numerous nor would they be significantly costly for LTCHs to cover "under arrangements." For these reasons, among others, CMS will sunset this exception. Under this finalized policy, the LTCH would be required to provide such services either directly or "under arrangements" (i.e. the LTCH would pay another entity for providing the service to its patient). No separate payment would be made by Medicare to the other entity.

The LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002, to replace the previous cost-based payment methodology. The new system was based on the hospital IPPS, but modified to reflect the relatively higher costs experienced by LTCHs in treating the most severely ill beneficiaries. During a five-year transition period which began with an LTCH's cost reporting periods beginning on or after October 1, 2002, CMS pays existing LTCHs under a blend methodology in which a percentage of the payment is based on cost-based reimbursement and a percentage is based on the standard federal payment rate. Existing LTCHs, however, have the option to elect payment based on 100 percent of the adjusted standard federal payment rate.

Because the base standard federal rate was determined as if all LTCHs are paid based on 100 percent of the federal rate, in order to maintain budget neutrality during the transition period, CMS reduces all LTCH payments to account for the additional costs of the transition period methodology. At this time, CMS estimates that 98 percent of LTCHs will be paid at 100 percent of the federal rate. Based on CMS estimates of a negligible cost to the Medicare program as a result of the transition methodology in RY 2007, the budget neutrality adjustment for the 2007 rate year is zero percent (i.e., a budget neutrality factor of 1.0).

Because the LTC-DRGs and their relative weights are related to the inpatient hospital DRGs, CMS is not revising the LTC-DRGs and relative weights at this time. Any changes will be made at the same time as the hospital IPPS update, on October 1, 2006. The proposed changes to the LTC-DRGs, relative weights and average length of stays for FY 2007 were presented in the FY 2007 IPPS final rule.

The final rule, which will appear in the May 12, 2006, *Federal Register*, will be effective for discharges occurring on or after July 1, 2006 through June 30, 2007.

Note: For more information, see the CMS web site at:

www.cms.hhs.gov/LongTermCareHospitalPPS/LTCHPPSRN/list.asp

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