



**WISCONSIN HOSPITAL
ASSOCIATION**

**SUMMARY OF THE RY 2008
MEDICARE LONG-TERM CARE
HOSPITALS ANNUAL PAYMENT
UPDATE AND POLICY CHANGES**

May 2007

I. OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) published its final Rate Year (RY) 2008 Annual Payment Rate Updates and Policy Changes for Long-Term Care Hospitals in the May 11, 2007 *Federal Register*.

These annual changes to payment amounts and policy changes are effective for discharges beginning on or after July 1, 2007. Because the Long-Term Care Hospital PPS (LTCH PPS) utilizes the same DRGs as are used under the inpatient PPS (IPPS), the LTC DRGs will not be finalized until the IPPS rule is finalized and implemented. Hence, any changes to LTC DRGs will be made at the same time as the hospital IPPS update and will be effective October 1, 2007.

This summary does not address the proposed changes to Graduate Medical Education payments, which were also published in this final rule.

Note: Text in italics is extracted from the *Federal Register*.

II. PAYMENT RATE

Marketbasket Update (*Federal Register* page 26886)

The most recent estimate for the Rehabilitation, Psychiatric and Long-Term Care (RPL) marketbasket for the LTCH 2008 Rate Year is 3.2 percent; however, CMS is proposing to update the LTCH PPS federal rate by only 0.71 percent to incorporate an adjustment for a case-mix increase in the 2005 rate year. According to CMS, there was a 2.49 percent increase in case-mix during RY 2005 that is attributable to coding practice changes and not a true increase in patient severity. CMS has reduced the projected marketbasket by the 2.49 percent to arrive at the 0.71 percent rate increase.

Standard Federal Rate (*Federal Register* pages 26886 - 26890)

This is the final year of the five-year transition to LTCH PPS. All facilities with cost reporting periods beginning on or after October 1, 2006 will receive a total LTCH PPS payment based on 100 percent of the federal rate. Facilities with cost reporting periods beginning prior to October 1, 2006 will receive a LTCH PPS payment based on 20 percent reasonable cost and 80 percent standard federal rate for that portion of the Rate Year that is still within the 2007 Cost Report period. The standard federal rate for RY 2008 is \$38,356.45, which reflects the 2007 standard federal rate (\$38,086.04) increased by the 0.71 percent update factor described above.

Budget Neutrality Offset to Account for the Transition Methodology (*Federal Register* page 26900)

There is no budget neutrality (BN) adjustment for transition per CMS: “. . . we continue to estimate that nearly all (over 98 percent) LTCHs are currently being paid based on 100 percent of the Federal rate (rather than the transition blend methodology).” “Accordingly, in this final rule, based on updated data and using the same methodology established in the August 30, 2002 final rule . . . we are not implementing a transition BN offset to all LTCH PPS payments for discharges occurring on or after July 1, 2007 through June 30, 2008 . . .”

One-Time Prospective Adjustment to the Standard Federal Rate (*Federal Register* pages 26901 - 26904)

According to CMS: “. . . we have provided for the possibility of making a one-time prospective adjustment to the LTCH PPS rates by July 1, 2008, so that the effect of any significant difference between actual payments and estimated payments for the first year of the LTCH PPS would not be perpetuated in the LTCH PPS rates for future years.”

“. . . we believe that we still do not have sufficient new data to enable us to conduct a comprehensive reevaluation of our FY 2003 BN calculations. Accordingly, in this final rule, we are not making a one-time adjustment . . .”

This does not preclude CMS from implementing this one-time adjustment for RY 2009.

Wage Index and Labor Share (*Federal Register* pages 26891 - 26894)

The area wage index is applied to the labor-related portion of the standard federal rate to adjust for differences in area wage levels. For RY 2008, CMS is increasing the labor-related portion of the federal rate from 75.665 percent to 75.788 percent “. . . based on the relative importance of the labor-related share of operating costs (wages and salaries, employee benefits, professional fees, and all other labor-intensive services) and capital costs of the FY 2002-based RPL market basket from the 1st quarter of 2007 . . .”

The area wage indexes are computed using wage data from inpatient acute care hospitals (excluding reclassifications, adjustments, and rural floors). The wage data used to generate the proposed wage indexes for LTCHs is from FY 2003: “. . . we are using the same data (generated in cost reporting periods beginning during FY 2003) used to compute the FY 2007 acute care hospital inpatient wage index data without taking into account geographic reclassification . . . to determine the applicable wage index values under the LTCH PPS because these data (FY 2003) are the most recent complete data.”

This is also the final year of the five-year transition to full use of the area wage index. Facilities with cost reporting periods beginning on or after October 1, 2006 will receive a full wage index adjustment to the standard federal rate. Facilities with cost reporting periods beginning prior to October 1, 2006 will receive a four-fifths (80 percent) wage index adjustment to the federal portion of their LTCH PPS payment rate for that portion of the 2008 RY that is within their 2007 Cost Report year. The proposed wage indexes (at full and four-fifths values) are published in Addendum A, Tables 1 and 2 of the *Federal Register* (pages 26996 - 27019).

III. LTC DRGs

LTCH DRG Classifications (*Federal Register* pages 26876 - 26880)

“We propose to modify the existing LTC-DRGs so that they reflect the changes made to the CMS DRGs under the proposed IPPS notice.” Since the IPPS DRGs will not be finalized for payment until October 1, 2007, LTCHs will continue to be paid based upon the RY 2007 LTC-DRGs and weights until then: “. . . Version 24.0 of the DRG GROUPEER software established in the FY 2007 IPPS final rule will continue to be effective until October 1, 2007. Moreover, the LTC-DRGs and relative weights for FY 2007 established in Table 11 of that same IPPS final rule . . . will continue to be effective until October 1, 2007 . . .”

Long Term Care Hospitals have until June 12th to comment on the proposed MS-LTC-DRGs as presented in Table 11 of the proposed IPPS rule for FY 2008. Please refer to that rule for the appropriate submission information.

Budget Neutrality (*Federal Register* pages 26880 - 26883)

There is no requirement that revisions to LTC-DRG relative weights be done in a budget neutral manner; however, CMS has broad discretion to implement a BN adjustment to LTC-DRG weights, should it deem necessary. For RY 2008 CMS states that: “. . . because we believe that the observed annual CMI increase is primarily ‘real’ and not ‘apparent,’ it is no longer necessary to update the LTC-DRGs in a non-budget neutral manner.” “In this final rule, under the broad authority conferred upon the Secretary under section 123 of the BBRA as amended by section 307(b) of the BIPA to develop the LTCH PPS, beginning with the LTC-DRG update for FY 2008. . . the annual update to the LTC-DRG classifications and relative weights will be done in a budget neutral manner such that estimated aggregate LTCH PPS payments will be unaffected, that is, will be neither greater than nor less than the estimated aggregate LTCH PPS payment that would have been made without the LTC-DRG classification and relative weight changes.”

For the proposed MS-LTC-DRGs that would become effective on October 1, 2007, the weights will be normalized by a factor of 1.020302, which is applied to each MS-LTC-DRG relative weight, then a BN factor of 1.003924 will be applied to the relative weights after normalization.

Behavioral Offset (*Federal Register* pages 26883 - 26884)

Similar to the proposal in the FY 2008 IPPS proposed rule, CMS proposes to apply a negative 2.4 percent adjustment for anticipated case-mix increases resulting from coding practice changes under MS-LTC-DRGs in both FY 2008 and FY 2009. Unlike the proposal under IPPS, CMS is proposing to reduce the DRG relative weights for LTCHs (the proposed offset is applied to the federal standard amount in the IPPS rule). *“Accordingly, each of the proposed MS-LTC-DRG relative weights in Table 11 of the Addendum to the FY 2008 IPPS proposed rule reflects this proposed adjustment. That is, each proposed MS-LTC-DRG relative weight was multiplied by a factor of 0.976 to account for changes in coding or classification of discharges resulting from the proposed adoption of the new patient classification system.”*

Long-Term Care Hospitals have until June 12th to submit comments to CMS on the proposed Behavioral Offset. Please refer to that rule for the appropriate submission information.

III. OTHER CHANGES

High Cost Outliers (*Federal Register* pages 26894 - 26900)

High cost outlier cases are those that have extraordinarily high costs as compared to the costs of most LTCH discharges. CMS makes outlier payments for any discharges where the cost of the case exceeds the adjusted LTCH PPS payment plus a fixed-loss amount. Costs are determined by multiplying the facility’s overall Cost to Charge Ratio (CCR) by the allowable charges for the case. Costs determined to be in excess of the LTCH PPS payment plus the threshold are reimbursed at 80 percent. CMS has established a target of 8 percent of total LTCH PPS payments to be set aside for high cost outliers.

In this final rule, CMS sets a fixed loss amount of \$20,738 for the 2008 rate year, compared to \$14,887 for RY 2007. CMS justifies the increase in the fixed loss amount as necessary in order to maintain the requirement for estimated outlier payments to equal 8 percent of total LTCH PPS payments.

Short Stay Outliers (*Federal Register* pages 26904 - 26918)

CMS believes that length of stay (LOS) is the essential, defining characteristic for LTCHs and that, as such, many short stay cases could and should be treated in the acute care setting (and be paid for under the acute care Inpatient PPS). CMS established a special payment policy for Short Stay Outlier (SSO) cases to ensure that a payment rate that is based upon a long LOS is not inappropriately applied to a case where the patient may have received only partial treatment or should have been treated in a more appropriate setting.

The current SSO payment policy applies to cases with a covered LOS of less than or equal to five-sixths of the geometric mean LOS. The RY 2007 LTC-DRGs, the applicable geometric mean LOS, and five-sixths LOS are listed in Appendix A, Table 3 of the *Federal Register* (pages 27019 - 27029). The proposed MS-LTC-DRGs, their applicable geometric mean LOS, and five-sixths LOS are listed in Appendix A, Table 11 of the proposed IPPS rule.

Currently, payment for SSO cases is based on the lowest of four calculated amounts: 1) 100 percent of cost; 2) 120 percent of the LTC-DRG per diem; 3) the full LTC-DRG case amount; or 4) a blend of the IPPS-DRG per diem and 120 percent LTC-DRG per diem.

CMS is adopting as final its proposal to add another short stay threshold for the shortest stay SSO cases (those with a LOS less than or equal to the mean LOS plus one standard deviation for that DRG under IPPS). In these

cases, the fourth alternative under the SSO payment methodology will be 100 percent of the IPPS per diem (as opposed to the current blend). The average LOS plus one standard deviation, by DRG, is provided in the Addendum Tables referenced above. SSO cases with covered lengths of stay that exceed the comparable IPPS threshold, but are still below the old threshold of five-sixths of the LTC mean, will continue to be paid under the existing SSO policy.

The 25 Percent Rule (*Federal Register* pages 26919 - 26944)

Currently, LTCH Hospitals within Hospitals (HwHs) or LTCH satellites that admit more than 25 percent of their Medicare cases from their co-located, host hospitals receive an adjusted payment rate of the lesser of the LTCH PPS amount or the IPPS amount. For cost reporting periods beginning on or after July 1, 2007, CMS is expanding this policy to apply to any subclause (I) LTCH or LTCH satellite that admits more than 25 percent of Medicare patients from any individual hospital – thereby closing what CMS terms as the “*location-specific loophole*”.

“The payment adjustment . . . will be phased-in over 3 years for all LTCH discharges affected by the policies that we are finalizing beginning for cost reporting periods beginning on or after July 1, 2007.”

For facilities located in rural areas, CMS is increasing the percentage threshold to 50 percent.