



**WISCONSIN HOSPITAL  
ASSOCIATION**

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**SUMMARY OF THE PROPOSED  
RY 2009 MEDICARE LONG-TERM  
CARE HOSPITALS ANNUAL  
PAYMENT UPDATE AND POLICY  
CHANGES**

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**February 2008**

## SUBMISSION OF COMMENTS

This document provides an overview of the Medicare proposed rule for the Long Term Care Hospital Prospective Payment System (LTCH PPS) for the 2009 Rate Year. Additional information regarding the LTCH PPS is available on the Centers for Medicare and Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/LongTermCareHospitalPPS/>.

Comments on this proposed rule must be received by CMS no later than 5:00 pm on March 24, 2008. CMS requests that comments reference the file code CMS-1393-P and the specific “issue identifier” that precedes the section on which you choose to comment. Each section of this summary provides the appropriate issue identifier for referencing in comments.

Comments on the proposed rule can be:

Submitted electronically to the CMS web address <http://www.regulations.gov>.

Follow the instructions for “Comment or Submission” and enter the file code (CMS-1393-P) to find the document accepting comment.

(Attachments should be in Microsoft Word, WordPerfect, or Excel format.)

**-OR-**

Regular Mail (an original and two copies):

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1393-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

Express/Overnight Mail (an original and two copies):

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1393-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**-OR-**

Hand-Delivered (an original and two copies):

Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

**OR**

7500 Security Boulevard  
Baltimore, MD 21244 -1850  
Note: If you intend to deliver your comments to the Baltimore address, please call (410) 786-7195 in advance to schedule your arrival with a CMS staff member.

## I. OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) published its Rate Year (RY) 2009 Proposed Annual Payment Rate Updates, Policy Changes, and Clarifications for Long-Term Care Hospitals in the January 29, 2008 *Federal Register*. In addition to annual rate updates, the proposed rule implements certain provisions of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) that relate to LTCHs. All proposed changes are to be effective for discharges beginning on or after July 1, 2008 unless noted otherwise.

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

## II. ANNUAL UPDATE SCHEDULE

Reference for comments: “PROPOSED CHANGES TO LTCH PPS PAYMENT RATES FOR THE 2009 LTCH PPS RATE YEAR”

### **Consolidation of the Annual Updates for Payment with MS-LTC-DRG Weights Updates** (*Federal Register* page 5351)

CMS is proposing to change the annual update schedule for LTCH PPS payments to coincide with the schedule for Inpatient PPS payments because the MS-LTC-DRG weights are recalibrated at the same time as the weights for the Inpatient MS-DRGs. This proposal would eliminate the need to update LTCH payments twice each year – once for the July 1 rate year and again for the October 1 weights update.

For 2009, CMS is proposing to establish a 15-month rate period that would be effective from July 1, 2008 through September 30, 2009, after which the rate years would commence on October 1.

## III. PAYMENT RATE

Reference for comments: “PROPOSED CHANGES TO LTCH PPS PAYMENT RATES FOR THE 2009 LTCH PPS RATE YEAR”

### **Marketbasket Update** (*Federal Register* page 5352)

The most recent estimate for the Rehabilitation, Psychiatric and Long-Term Care (RPL) marketbasket for the LTCH 2009 Rate Year is 3.5 percent; however, CMS is proposing to update the LTCH PPS federal rate by only 2.6 percent to incorporate a negative adjustment for coding increases in the 2006 rate year. According to CMS, there was a 0.9 percent increase in case-mix during RY 2006 that is attributable to coding practice changes and not due to a true increase in patient severity. The net 2.6 percent update reflects a 15-month rate period.

### **Standard Federal Rate** (*Federal Register* pages 5361 - 5362)

The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) mandates that, for the last 3 months of the 2008 RY, the federal base rate for LTCH PPS be the same as the base rate for RY 2007. CMS has implemented this freeze to the RY 2008 federal base rate and, therefore, proposes a standard federal rate for RY 2009 of \$39,076.28, which reflects the 2007 standard federal rate (\$38,086.04) increased by the 2.6 percent update factor described above.

### **One-Time Prospective Adjustment to the Standard Federal Rate** (*Federal Register* pages 5353 - 5360)

Since the implementation of the LTCH PPS in RY 2002, CMS has maintained that it has the statutory authority to apply a one-time prospective adjustment to the standard federal rate in order to neutralize for any increase in LTCH payments that may have occurred due to the change in payment methodology. In its final RY 2008 LTCH PPS rule, CMS noted that it has; “.. *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.”* The MMSEA provides that CMS shall not apply any one-time adjustment to the LTCH PPS rates for this purpose for the 3-year period that commenced on the date of the enactment of the Act.

Although CMS is precluded from implementing a one-time budget neutrality adjustment at this time, the proposed rule details a methodology for determining whether a one-time budget neutrality adjustment may be appropriate. According to this methodology and the estimates it currently yields, the one-time adjustment, if applied in RY 2009, would be negative 3.75 percent. CMS notes that: “. . . *We expect to address the issue again when it is closer to the time section 114(c)(4) of the MMSEA permit us to implement a one-time adjustment . . . In the meantime, we welcome comments on the methodology that we have described.*”

**Wage Indexes and Labor Share** (*Federal Register* pages 5362 - 5368)

For the RY 2009, CMS proposes that “. . . *the same data (collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2004) used to compute the FY 2008 acute care hospital inpatient wage index data without taking into account geographic reclassification . . . would be used to determine the applicable wage index values under the LTCH PPS because these data (FY 2004) are the most recent complete data.*” The proposed wage indexes are published in Addendum A, Tables 1 and 2 of the *Federal Register* (pages 5386 - 5408).

This proposed rule would adopt two new and six revised CBSA-based labor market definitions for inclusion in the wage index methodology for LTCH PPS. CMS is also proposing a policy for determining a LTCH PPS wage index value for labor market areas in which there is no IPPS hospital (for cost report data). Currently, there are no LTCHs existing in such areas, but CMS is taking this opportunity to propose a policy/methodology in the event that such a situation arises in the future.

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 2009, CMS is increasing the labor-related portion of the federal rate from 75.788 percent to 75.920 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 4th quarter of 2007 . . .*”

## IV. LTC DRGs

Reference for comments: “MS-LTC-DRG CLASSIFICATIONS AND RELATIVE WEIGHTS”

**MS-LTC-DRG Classifications** (*Federal Register* pages 5346 - 5350)

The FY 2008 Inpatient PPS final rule adopted MS-DRGs, which are diagnosis and severity based. The MS-LTC-DRGs are structurally identical to the Inpatient MS-DRGs and, hence, patients are classified into these DRGs using the same methodology. Although the relative weights for MS-LTC-DRGs are different than those for Inpatient MS-DRGs; the weights are recalibrated for both Inpatient PPS and LTCHs at the same time. Weights are updated every year in order to reflect the current level of resources needed by the average patient in each MS-LTC-DRG. The weights for both sets of DRGs are updated in keeping with the IPPS payment update cycle. In prior years, that meant that the LTCH PPS payments were updated once at the beginning of the rate year, in July, and again in October when the DRG weights were recalibrated. In this proposed rule, CMS would change the LTCH PPS rate year to comport with the IPPS rate year by extending the 2009 rate year through September 30, 2009.

The MS-LTC-DRGs were adopted beginning October 1, 2007 (FY 2008) and are being transitioned over 2 years. For the first year of the transition, 50 percent of the relative weight for an MS-LTC-DRG is based on the average LTC-DRG weight and 50 percent is based on the MS-LTC-DRG weight. These weights will continue to apply for the first three months of the 2009 rate year. On October 1, 2008, when the weights are recalibrated, 100

percent of the weights will be based on the MS-LTC-DRGs. In future rate years, beginning on October 1, 2009, the MS-LTC-DRG weights would be recalibrated at the same time as the rest of the LTCH PPS payment updates.

**Budget Neutrality** (*Federal Register* page 5350)

For the current MS-LTC-DRGs, that became effective on October 1, 2007, the weights were normalized by a factor of 1.020302, which was applied to each MS-LTC-DRG relative weight, after which a Budget Neutrality factor of 1.003924 was applied.

Table 11 of the Addendum to the FY 2008 IPPS final rule lists the MS-LTC-DRGs and their respective transition blended budget neutral weights.

## V. OTHER ISSUES

**High Cost Outliers** (*Federal Register* pages 5368 - 5371)

Reference for comments: “PROPOSED CHANGES TO LTCH PPS PAYMENT RATES FOR THE 2009 LTCH PPS RATE YEAR”

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 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.

CMS is proposing a fixed loss amount of \$21,999 for the 2009 rate year, which is 6 percent higher than the 2008 rate year amount of \$20,738. 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**

No *Federal Register* reference, there are no proposed changes on this issue.

CMS established a special payment policy for Short Stay Outlier (SSO) cases to ensure that a LTCH 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 SSO payment policy applies to cases with a covered LOS of less than or equal to five-sixths of the geometric mean LOS. In its RY 2008 final LTCH PPS rule, CMS adopted a separate short stay threshold for the shortest stay cases (those with a LOS less than or equal to the mean LOS plus one standard deviation for that DRG under IPPS). Appendix A, Table 3 of the *Federal Register* (pages 5408 - 5419) shows the FY 2008 LTC-MS-DRGs, the applicable geometric mean LOS, the five-sixths (SSO) threshold, and the IPPS (shortest stay) threshold.

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-MS-DRG per diem; 3) the full LTC-MS-DRG case amount; or 4) a blend of the IPPS-DRG per diem and 120 percent LTC-MS-DRG per diem. For the shortest stay cases, the first three alternatives are the same, but the fourth alternative is 100 percent of the IPPS per diem (as opposed to a blend).

**The 25 Percent Rule**

No *Federal Register* reference, there are no proposed changes on this issue.

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 expanded 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*”. This expanded policy is being phased-in over 3 years.

The threshold is 50 percent for facilities located in rural areas.