



**WISCONSIN HOSPITAL
ASSOCIATION**

**SUMMARY OF THE MEDICARE
LONG-TERM CARE HOSPITAL
PROSPECTIVE PAYMENT SYSTEM
PROPOSED FFY 2011 RULE**

**INCLUDING PROVISIONS CONTAINED IN
THE AFFORDABLE CARE ACT (ACA) OF 2010**

June 2010

SUBMISSION OF COMMENTS

The Centers for Medicare and Medicaid Services (CMS) published the proposed federal fiscal year (FFY) 2011 Long-Term Care Hospital Prospective Payment System (LTCH PPS) rule in the May 4, 2010 *Federal Register*. Subsequently, CMS released a supplemental proposed LTCH PPS rule in the June 2, 2010 *Federal Register*, which contains provisions enacted under the final health care reform legislation – the Patient Protection and Affordable Care Act as modified by the Health Care and Education Affordability Reconciliation Act, known together as the Affordable Care Act (ACA) of 2010. Additional information regarding the LTCH PPS is available on the CMS Web site at <http://www.cms.hhs.gov>.

CMS must receive comments on both proposed rules by June 18 at 5 p.m. CMS requests that comments reference the file code CMS-1498-P (May 4, 2010 *Federal Register*) or CMS-1498-P2 (June 2, 2010 *Federal Register*).

Comments on both proposed rules can be submitted electronically at <http://www.regulations.gov>. Click on the “Submit Electronic Comments on CMS Regulations With an Open Comment Period” link (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-1498-P (or CMS-1498-P2)
P.O. Box 8011
Baltimore, MD 21244-1850

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

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1498-P (or CMS-1498-P2)
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: Call (410) 786-7195 to
schedule the delivery if you
use the Baltimore address.

I. PAYMENT RATE

Marketbasket Update

May 4 *Federal Register* page 24044 amended by June 2 *Federal Register* page 30969

CMS' Proposal: For FFY 2011, CMS proposes to reduce the projected rehabilitation, psychiatric, and long-term care (RPL) marketbasket to conform with the provisions of the ACA such that “...*the proposed market basket update under the LTCH PPS for FY 2011 is 1.9 percent (that is, the most recent estimate of the LTCH PPS market basket of 2.4 percent minus the 0.50 percentage points required in section 1886(m)(4)(B) of the Act.)*”

Documentation and Coding Adjustment

May 4 *Federal Register* pages 24045 – 24046

CMS' Proposal: For FFY 2011, CMS proposes to reduce the LTCH PPS standard federal rate by 2.5% to recoup what the agency claims are accumulated program payment increases in the 2008 and 2009 rate years (RYs) that were due to coding practice changes and not due to increases in patient severity.

Standard Federal Rate

May 4 *Federal Register* page 24089 amended by June 2 *Federal Register* page 30980

CMS' Proposal: For FFY 2011, CMS is proposing a standard federal rate of \$39,560.16, reflecting the marketbasket increase of 2.4% minus the ACA-mandated 0.50 percentage points and a 2.5% reduction for the proposed 2008-2009 documentation and coding adjustment. The net result is a standard federal rate that is 0.6% less than the prior year's rate.

Note: The FFY 2010 standard federal rate has been revised to incorporate a 0.25 percentage point marketbasket reduction, effective April 1, 2010, per the ACA. The revised FFY 2010 LTCH PPS standard federal rate is \$39,794.95. The 0.6% net reduction is compared to this reduced FFY 2010 amount.

Wage Indexes and Labor Share

May 4 *Federal Register* page 24085

CMS' Proposal: For FFY 2011, CMS proposes to use the same data collected from cost reports submitted by Inpatient PPS hospitals for periods beginning during FFY 2007 that were used to compute the proposed FFY 2011 acute care hospital inpatient wage indexes, without taking into consideration geographic reclassifications or rural floors. The proposed LTCH wage indexes for FFY 2011 are published in the Addendum, Tables 12A and 12B of the May 4 *Federal Register* (pages 24266 - 24286).

Based on the most recent data, but retaining its previously established methodology for calculating the labor-related share, CMS is proposing to reduce the labor-related portion of the federal rate from 75.779 percent to 75.407 percent for FFY 2011.

II. MS-LTC-DRGs

MS-LTC-DRG Classifications

May 4 *Federal Register* pages 24021 – 24043 amended by June 2 *Federal Register* pages 30970 - 30971

Background: The Medicare Severity (MS)-Long-Term Care (LTC)-Diagnosis Related Groups (DRGs) are structurally identical to the Inpatient MS-DRGs; patients are classified into these MS-DRGs and relative weights are calculated for both IPPS and LTCHs using the same methodology at the same time. Weights are recalibrated every year in order to reflect the current level of resources needed by the average patient in each MS-LTC-DRG.

CMS' Proposal: Proposed weights for the FFY 2011 MS-LTC-DRGs were originally published in the May 4 *Federal Register*, but subsequently were revised and released in the June 2 *Federal Register*. The weights have been recalculated to reflect FFY 2009 claims data, using the methodology established in the final FFY 2010 rule, and recalibrated for a revised budget neutrality factor after the provisions of the ACA were incorporated into the standard federal amount. The MS-LTC-DRG weights are published in the Addendum, Table 11 of the June 2 *Federal Register* (pages 31078 – 31092)

III. OTHER ISSUES

High Cost Outliers

May 4 *Federal Register* page 24088 amended by June 2 *Federal Register* page 30981

Background: 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' Proposal: For FFY 2011, CMS proposes a high cost outlier fixed loss amount of \$19,254, which is higher than the 2010 adjusted (effective April 1, 2010 per ACA) amount of \$18,615. CMS states that the change to the fixed loss amount is necessary in order to maintain the requirement for estimated outlier payments equal 8 percent of total LTCH PPS payments.

IV. EXTENSION OF CERTAIN PAYMENT RULES

The American Recovery and Reinvestment Act (ARRA) of 2009 extended the applicability of several policy provisions related to LTCHs.

Short Stay Outlier Policy

June 2 *Federal Register* page 30966

Background: CMS established a special payment policy for short stay outlier (SSO) cases to ensure that LTCH payments, which are predicated on long lengths of stay, are not inappropriately applied to cases where the patient may have received only partial treatment or should have been treated in a more appropriate, short stay setting.

The SSO payment policy applies to cases with a covered length of stay (LOS) of less than or equal to five-sixths of the geometric mean LOS. Payments for SSO cases are 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.

In its RY 2008 final LTCH PPS rule, CMS adopted a 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) and a different fourth alternative for these shortest stay cases - 100 percent of the IPPS per diem (as opposed to the blended per diem). The implementation of this policy was delayed for three years, per legislative mandate in the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007, effective starting December 29, 2007.

Extension: The ARRA extends the delay in implementation of the change to the SSO policy for an additional two years.

One-Time Budget Neutrality Adjustment to the Standard Federal Rate

June 2 *Federal Register* pages 30966 – 30967

Background: 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 placed a three-year moratorium on CMS’ ability to implement this one-time adjustment, effective starting December 29, 2007.

Extension: The ARRA extends the moratorium on the implementation of the one-time adjustment for an additional two years.

New LTCHs and Satellite Facilities

June 2 *Federal Register* page 30968

Background: The MMSEA mandated and CMS implemented a three-year moratorium on the establishment of new LTCHs and LTCH satellite facilities and on increases in beds in existing LTCHs and LTCH satellite facilities. The moratorium is effective from December 29, 2007 through December 28, 2010 unless one of the following three exceptions has been met: 1) the LTCH began ‘its qualifying period for payment as a long-term care hospital on or before the date of enactment of the MMSEA; 2) the LTCH has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a LTCH and has expended, before December 29, 2007, at least 10 percent of the estimated cost of the project or, if less, \$2,500,000; or 3) the LTCH has obtained an approved certificate of need in a State where one is required on or before December 29, 2007.

Extension: The ARRA extends the moratorium on the establishment of new LTCHs and LTCH satellite facilities for an additional two years. The ARRA also added another exception to the moratorium on increases in the number of beds at existing LTCHs and LTCH satellites if: “. . . the hospital or facility obtained a certificate of need for an increase in beds that is in a State for which such certificate of need is required and that was issued on or after April 1, 2005, and before December 29, 2007. . .”

The 25 Percent Rule

June 2 *Federal Register* page 30967

Background: CMS had instituted a policy, in its RY 2008 LTCH PPS rule, that would have required certain LTCHs or LTCH satellites that admit more than 25 percent of their Medicare cases from their co-located, host hospitals (as opposed to the prior threshold of 50 percent) receive an adjusted payment rate of the lesser of the LTCH PPS amount or the IPPS amount. The MMSEA placed a three-year moratorium on CMS' ability to implement this policy, effective starting December 29, 2007.

Extension: The ARRA extends the moratorium on the implementation of the one-time adjustment for an additional two years.