Prospective Payment System for Long Term Care Hospitals: RY 2008 Proposed Rule

On January 25, 2007, the Centers for Medicare and Medicaid (CMS) put on public display the proposed rule for the prospective payment system for long term care hospitals' rate year (RY) 2008, which starts July 1, 2007. The notice of proposed rule making (NPRM) is scheduled to be published in the *Federal Register* on February 1, 2007. The NPRM has a 60-day comment period from the display date.

Note: The proposed RY 2008 LTC-PPS rule also includes proposed revisions to direct graduate medical education (GME) and indirect medical education (IME) policies. A separate summary will cover these proposed GME and IME changes.

Impact. According to CMS, the cumulative impact of expanding the "25 percent" policy (see below), along with other proposed payment changes in the rule, would result in an estimated 2.9 percent reduction (approximately $117 million) overall in aggregate LTCH prospective payment system (PPS) payments. CMS projects such payments to be $4.4 billion for RY 2008. The change in the 25 percent rule accounts for 2.2 percent of the 2.9 percent figure. CMS provided the following table showing the break down of this impact.

Estimated Impact of the Provisions of this Proposed Rule[1]

Proposed Policy	**Estimated Percent Change in Estimated Aggregate LTCH PPS Payments**
Proposed Payment Rate and Policy Changes	
Proposed Changes to the Federal Rate	0.61%
Proposed Changes to the Area Wage Adjustment	-0.49%
Approach Discussed for SSO Policy	-0.91%
Subtotal	-0.7%
Expansion of the "25 Percent" Policy -2.9%	-2.9%
Total (-0.7% + -2.2%)	-2.9%

I. **Long Term Care Diagnostis-Related Groups (LTC-DRG) Classification and Relative Weights Update.** The LTC-DRGs used as the patient classification component of the LTCH PPS correspond to the hospital inpatient DRGs in the hospital inpatient prospective payment system (IPPS). Updates to the LTCH PPS (for relative weights and the creation or deletion of DRGs) are made in the annual IPPS proposed and final rules and are effective each October 1. Thus, the next update of the LTC-DRGs will be effective on October 1, 2007, the start of the IPPS FY 2008.

A. **Proposed Budget Neutrality Adjustment.** Currently, there are no statutory or regulatory requirements that the annual update to the LTC-DRG classifications and relative weights be done in a budget neutral manner. As a result, updates to the LTC-DRGs and relative weights could result in a decrease in aggregate payments. This happened in FY 2007—estimated aggregate payments decreased 1.4 percent. In response, past commenters, including MedPAC, have urged the adoption of a budget neutrality policy. After assuring itself that payment fluctuations were resulting from real changes in LTCHs' true costs of treating patients rather than changes in coding practices, CMS is proposing that, beginning with the LTC-DRG update for FY 2008, the annual update to the LTC-DRG classifications and relative weights would be done in a budget neutral manner. The proposed methodology for calculating the budget neutrality factor would be similar to the one used for the hospital inpatient PPS.

II. **Proposed Changes to the LTCH PPS Payment Rate for RY 2008.** The most recent estimate of the market basket[1] increase for RY 2008 is 3.2 percent. CMS, however, is proposing an update of 0.71 percent for RY 2008. The difference, according to CMS, is to adjust for the increase in case-mix in the prior period that resulted from changes in coding practices rather than an increase in patient severity. The update factor for RY 2007 was zero percent. That is, CMS froze the RY 2007 payment rate at the RY 2006 level, i.e., $38,086.04. Noting that MedPAC recommended a zero percent update for RY 2008, CMS is asking for comments on the recommendation. The proposed standard Federal rate for RY 2008 would be $38,356.45 subject to the availability of more recent data.

A. **Proposed Adjustment for Area Wage Levels—Labor Share.** The applicable LTCH PPS wage index is computed using wage data from inpatient acute care hospitals without regard to geographic reclassification. Based on more recent data, CMS is proposing to revise the LTCH PPS labor-related share from 75.665 percent to 75.511 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 Rehabilitation, Psychiatric, Long-Term Care (RPL) market basket from the third quarter of 2006.

B. **Proposed Adjustment for High Cost Outliers.** CMS pays an outlier case 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the adjusted Federal LTCH PPS payment for the LTC-DRG and the fixed-loss amount).The LTCH PPS fixed-loss amount was $14,887 for the 2007 LTCH PPS rate year. CMS is proposing a fixed-loss amount of $18,774 for the 2008 LTCH PPS rate year. CMS

noted that the proposed fixed-loss amount of $18,774 is lower than the FY 2003 fixed-loss amount of $24,450 and the 2004 LTCH PPS rate year fixed-loss amount of $19,590, and only slightly higher than the 2005 LTCH PPS rate year fixed-loss amount of $17,864. The outlier pool would remain set at 8 percent of total estimated payments.

C. **Proposed Budget Neutrality Adjustment to Offset Transition Methodology.** The implementation of the LTC-PPS on October 1, 2002 allowed a LTCH[2] to elect a 5-year transition that ends with cost reporting periods beginning on or after October 1, 2007 or to go immediately to being paid based on 100 percent of the Federal rate. CMS said that about 98 percent of all LTCHs elected to go with the latter option. Because so few LTCHs opted for the 5-year transition period, CMS said it was not proposing any budget neutrality adjustment in regard to the transition methodology.

D. **One Time Prospective Adjustment to the Standard Federal Rate.** In prior rule making, CMS 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. While still a probability, CMS, because of the lack of appropriate and timely data analysis, is not proposing any such adjustment for RY 2008.

III. **Other Proposed Policy Changes for the 2008 LTCH-PPS Rate Year**

A. **Proposed Adjustments to the Short-Stay Outlier (SSO)[3] Policy.** Under the current SSO policy, CMS adjusted the per discharge payment under the LTCH PPS by the least of:

1. 100 percent of the estimated cost of the case;
2. 120 percent of the LTC-DRG specific per diem amount multiplied by the covered length-of-stay (LOS) of that discharge;
3. The full LTC-DRG payment; or
4. A blend of an LTCH PPS amount that is comparable to the IPPS per diem payment amount, and 120 percent of the LTC-DRG per diem payment amount.

CMS said it continued to be concerned about appropriate payment for SSO cases under the LTCH PPS, and therefore, was considering a policy change for the purpose of differentiating between those SSO cases that the agency believed are more appropriately admitted and treated at LTCHs as distinguished from those with a LOS that resemble cases typically treated at acute care hospitals. Consistent with this concern, for the shortest

SSO cases (that is, if the LTCH patient's covered LOS is less than or equal to the "IPPS-comparable threshold"), CMS is considering using, as the fourth payment option (replacing the blend option), the IPPS comparable per diem amount, capped at the full IPPS-comparable amount.

If adopted, this revised policy would not apply to LTCHs that primarily treat patients with a principal diagnosis of neoplastic disease (so-called Type II LTCHs).

B. **Proposed expansion of special payment provisions for LTCH hospitals within hospitals (HwHs) and LTCH satellites: Proposed expansion of the 25 percent rule to certain situations not currently covered.** Current policy provides that if a LTCH HwH or LTCH satellite's discharges that were admitted from its host hospital exceed 25 percent (or an applicable percentage[4]) of its total Medicare discharges for the LTCH HwH or LTCH satellite's cost reporting period, an adjusted payment would be made at the lesser of the otherwise payable amount under the LTCH PPS or the amount payable under the LTCH PPS that would be equivalent to what Medicare would otherwise pay under the IPPS. The policy, effective October 1, 2004, came with a 4-year transition period.

Notwithstanding the above policy, the relationship between a receiving provider and any referring hospital has remained a CMS issue, even in the absence of co-location. CMS does not believe that either common ownership or co-location are the only circumstances under which financial incentives exist for acute care hospitals to prematurely discharge Medicare patients to LTCHs for additional treatment during the same episode of patient care. CMS believes that additional regulation in this area is both necessary and appropriate in order to protect the Medicare program. Accordingly, CMS is proposing that the policy provisions of the existing 25 percent (or applicable percentage) payment adjustment would apply to any LTCH or LTCH satellite (excluding Type II LTCHS) regardless of the physical proximity to the hospital from which it is accepting admissions. The proposed payment adjustment would be synchronized with the phase-in of the current transition policy adjustment for LTCH HwHs and LTCH satellites.

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1. Effective July 1, 2006, CMS adopted the "Rehabilitation, Psychiatric, Long-Term Care (RPL)" market basket as the appropriate market basket of goods and services under the LTCH PPS.

2. A LTCH that had its first cost reporting period beginning on or after October 1, 2002 is considered a "new LTCH" and does not have the option of a transition.
3. Short-stay outliers were defined to include cases with a covered LOS that is less than or equal to five-sixths of the geometric average LOS for each LTC-DRG.
4. For rural hospitals the "applicable percentage" is 50 percent. In addition for a LTCH or LTCH satellite facility that was co-located with the only other hospital in the MSA or with an MSA-dominant hospital CMS provides a payment threshold that the agency believes responds to "the unique needs of these communities." The "applicable percentage" also applies to the transition period.