Medlearn Matters
Information for Medicare Providers

Related Change Request (CR) #: 3335
Related CR Release Date: June 18, 2004
Related CR Transmittal #: 208
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Medlearn Matters Number: MM3335

Long Term Care Hospital Prospective Payment System (LTCH PPS) Annual Update

Provider Types Affected

Long Term Care Hospitals paid under Medicare's Long Term Care PPS

Provider Action Needed

This article provides the annual LTCH PPS payment updates and also conveys some Medicare policy changes for the LTCH PPS based on the final rule published on May 7, 2004 for the LTCH PPS (69 FR 25674).

Background

Long term care hospitals (LTCHs) are certified under Medicare as short-term, acute care hospitals that have been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under section 1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average length of stay of greater than 25 days. The LTCH PPS replaces the reasonable cost-based payment system under which the LTCHs were paid.

The BBRA and BIPA, which mandated the development of a PPS for LTCHs, conferred extremely broad authority on the Secretary in designing the LTCH PPS, specifying only that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002.

Payment rates under the LTCH PPS are updated on a July 1 through June 30 cycle, a LTCH rate year (RY). The relative weights for the LTC-DRG patient classification system remain linked to the October 1 through September 30 schedule of the acute inpatient PPS, and are therefore published in the annual IPPS final rule by August 1. CMS is required to update the payments made under this PPS annually, and for the LTCH PPS Rate Year (RY) 2005, the following applies:

- Standard Federal rate is $36,833.69;
- Fixed loss amount is $17,864.00;
- Budget neutrality offset is 0.5%;

- Wage index phase-in percentage for cost reporting periods beginning on or after October 1, 2004 is 3/5th (60 %);
- Labor-related share is 72.885 %;
- The non-labor related share is 27.115%; and
- The short-stay outlier percentage for "subsection II" LTCHs is 193% for this second transition year.

Other Medicare policy changes include the following:

1. Expanding the existing interrupted stay policy

Under the existing interrupted stay policy, implemented at the beginning of the LTCH PPS for cost reporting periods beginning on or after October 1, 2002, if an LTCH patient is discharged to an acute care hospital, an inpatient rehabilitation facility (IRF), or a skilled nursing facility (SNF) and then is readmitted to the LTCH within a fixed period of time, the entire LTCH hospitalization, both before and after the interruption, will be viewed as one episode of care and will generate one LTC-DRG payment. There has been no such policy with regard to LTCH patients discharged and subsequently readmitted if during the interruption they were not inpatients at one of the above inpatient settings.

Effective July 1, 2004, CMS is expanding its interrupted stay policy to include a discharge and readmission to the LTCH within three days, regardless of where the patient goes upon discharge. This means that if a patient is readmitted to the LTCH within three days of discharge, Medicare will pay only one LTC-DRG.

This policy is intended to cover:

- Discharges and readmissions following an outpatient treatment;
- Three (3) -day or less inpatient stays; and
- Discharge and readmission with an intervening patient-stay at home.

Furthermore, Medicare payment for any test, procedure, or care provided on an outpatient basis or for any inpatient treatment during the "interruption" would be the responsibility of the LTCH "under arrangements" with one exception RY 2005 (July 1, 2004 – June 30, 2005): if treatment at an inpatient acute care hospital would be grouped to a surgical DRG, a separate Medicare payment would be made under the Inpatient PPS for that care. (Existing regulations specify that tests or procedures unavailable where a patient is hospitalized should be provided "under arrangement," and paid for by the original hospital with no additional beneficiary liability.)

Therefore, any tests or procedures that were administered to the patient during that period of time, other than inpatient surgical care at an acute care hospital, will be considered to be part of that single episode of LTCH care and bundled into the payment to the LTCH. The LTCH will be required to pay any other providers without additional Medicare program payment liability.

NOTE: CMS will be implementing this policy in a separate CR in January 2005; however, CMS will make these changes retroactive to July 1, 2004.

2. Satellite facilities and remote facilities of hospitals that spin off as separate hospitals and seek LTCH status

If a satellite or remote location of multi-campus LTCHs "spins-off" to become an independent LTCH, such a facility must comply with existing requirements for LTCH designation by first being certified as an independent hospital and then presenting discharge data to its fiscal intermediary indicating that once it became separate an independent hospital, it met the Average Length of Stay (ALOS) requirement for Medicare patients for at least five of the next six months.

CMS is distinguishing "voluntary" separation from a parent LTCH from a separation mandated by the mileage requirement of the provider-based rules. In the latter case, CMS is establishing an exception in situations where the satellite facility or remote location of the hospital is required to become separately certified as a result of failing the mileage requirement of the provider-based regulations.

Under the exception, once these satellite facilities or remote locations become separate independent hospitals, they can immediately be paid as an LTCH if they submit to their fiscal intermediaries discharge data gathered during five months of the immediate six months preceding the facility's separation from the main hospital. The data must document that they meet the ALOS requirement.

A satellite that is being "voluntarily" spun-off from a parent LTCH, however, will be paid under the IPPS for at least six months. During this time, it must gather data to demonstrate that as a hospital, it complies with the ALOS requirement.

3. Determining ALOS based on the number of days of care for only the patients that were discharged during the hospital's fiscal year

An LTCH's ALOS will be calculated by using days and discharge data for only those patients discharged during the cost reporting period.

Presently, the days in the hospital and the discharge dates are reported in the cost reporting period when they occurred, as under the TEFRA system. An example of this change is as follows:

For a hospital on a calendar year cost report, the data for the patient that was admitted on 12/15 and discharged on 1/15 would have no impact on the first cost- reporting period, but would include 31 days and one discharge in calculating the ALOS for the second cost-reporting period.

This change for cases that crosses cost reporting periods would make the methodology for data collection for ALOS purposes consistent with the payment determinations, which under the LTCH PPS are discharged-based.

No LTCH will lose its designation should it fail to meet the ALOS requirement under the new regulations for the first year because of a one-year grandfathering provision that will allow an extra cost reporting period for compliance with the change. Therefore, for cost reporting periods starting between July 1, 2004 and July 1, 2005, for a LTCH that fails to meet the ALOS requirement under new methodology, the fiscal intermediary has been instructed to calculate the ALOS under the previous methodology in order to determine compliance.

Implementation

The implementation date for this instruction is July 6, 2004.

Related Instructions

The Centers for Medicare & Medicaid Services has several fact sheets related to the LTCH PPS and those fact sheets have been revised to reflect this annual update. The fact sheets are available at:

http://www.cms.hhs.gov/medlearn/ltchpps.asp

The Medicare Claims Processing Manual, Pub 100-04, Chapter 3, Section 150 (Long Term Care Hospitals (LTCHs) PPS), is being updated and the following Sections are being revised. The updated manual instructions are included in the official instruction issued to your carrier which can be found by going to:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

On that web page, look for CR3335 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:

http://www.cms.hhs.gov/medlearn/tollnums.asp.