

The ABCs of PPS and LTACHs

By

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On Friday, March 22, 2002, the Centers for Medicare and Medicaid Services (“CMS”) published the proposed rule outlining a prospective payment system for long-term acute care hospitals (“LTACH”). The 60-day comment period for the proposed rule ended on May 21, 2002, and CMS expects the proposed rule to become final and effective for cost reporting periods beginning on or after October 1, 2002. The new rules are very positive as they relate to existing and future LTACHs, and they reinforce the significant benefit of this post acute venue as a “through source” of patient care along a seamless continuum. This article will review the highlights of the proposed rule.

OVERVIEW – MAJOR COMPONENTS

The proposed rule contains 13 major components:

- A 25-day average length of stay will be calculated using only Medicare patient days, rather than all patient days.
- The system is based on the inpatient PPS DRG system, but the DRGs are re-weighted to account for increased resource utilization in LTACHs.
- LTACH DRGs are referred to as “LTC-DRG”.
- The Prospective Federal Payment rate for FY 2003 is proposed to be \$26,238.92, which includes a budget neutrality adjustment.
- There is a five-year transition provided on an elective basis. A hospital may elect the full Federal payment rate in any year. Once made, an election may not be withdrawn.
- TEFRA payments during the phase-in period will include restoration of full allowance to 100% of allowable capital cost re-instating the 15% reduced by the BBA of 1997.

- CMS included special rules for “very short-stay discharges,” defined as those patients with a length of stay of 7 days or less.
- CMS also included special rules for “short-stay outliers,” defined as those patients whose length of stay is between 8 days and two-thirds of the published length of stay for each LTC-DRG.
- A special payment for high-cost outliers is included.
- There are also special rules for interrupted stays
- In the final rule, CMS is considering eliminating the bed-limit requirements for old LTACHs with satellites, if the facility is paid completely under the federal rate, and is seeking comments on the appropriateness of maintaining current hospital within hospital requirements.
- New medical review requirements and physician acknowledgement concerning LTC-DRG assignments are established.
- No area wage adjustments or disproportionate share payments were proposed, although CMS requested comments on these issues. This is a positive for all regions under 1.0

PATIENT CLASSIFICATION SYSTEM

CMS is proposing a prospective payment system consisting of 501 LTC-DRGs. The 501 LTC-DRGs are comprised of 497 used in the current acute hospital PPS, and two very short stay discharge LTC-DRGs and two error LTC-DRGs. All LTC-DRGs, and related average length of stays are reported in the Federal Register.

PAYMENT

Except for “special cases”, which will be outlined below, payments are made on a per discharge basis. LTC-DRG payments include all operating and capital-related costs. Certain costs will continue to be paid on a Medicare reasonable cost basis, in addition to the LTC-DRG payments. These pass-through costs are:

- Costs of approved medical education
- Bad debts of Medicare beneficiaries
- Payment for blood clotting factor used by hemophilia patients
- Anesthesia services furnished under arrangement or by a hospital employed physician anesthesiologists
- Cost of photocopying and mailing records requested by a PRO.

TRANSITION PERIOD

As noted above, the LTACH PPS will be implemented over a five-year transition period. CMS projects that 58% of LTACHs will elect to be paid immediately at the full Federal Payment rate. The remaining hospitals are expected to elect a five-year phase-in, implemented as follows:

<u>Year</u>	<u>PPS Federal Rate</u>	<u>Cost-based Reimbursement Per Discharge</u>
10-1-02	20%	80%
10-1-03	40%	60%
10-1-04	60%	40%
10-1-05	80%	20%
10-1-06	100%	0%

Hospitals can elect to be paid fully under the federal rate at any time during the five-year transitional period. Capital pass through is a significant factor in the decision whether to elect the full PPS or the phase-in.

SPECIAL RULES FOR VERY SHORT STAY DISCHARGES

Very short stay discharges are defined as patient who are discharged (including death) within 7 days or less of inpatient services. These cases will be paid a per diem amount, determined by dividing the applicable Federal payment rate by 7 days.

SPECIAL RULES FOR SHORT-STAY OUTLIERS

Short stay outliers are defined as those patients with a length of stay between 8 days and two-thirds of the arithmetic ALOS for each LTC-DRG. These cases will be paid the least of:

1. 150% of the LTC-DRG specific per diem payment
2. 150% of the cost of the case, or
3. The full LTC-DRG payment

SPECIAL RULES FOR HIGH COST OUTLIERS

Additional payments will be made for “outlier” cases. High Cost Outliers are defined as cases that have unusually high costs exceeding the LTC-DRG payment, plus a fixed cost amount. In FY 2003, this amount is proposed to be \$29, 852. CMS proposes to pay an outlier case 80% of the difference between the estimated cost of the case and the sum of the adjusted Federal PPS rate for the LTC-DRG plus \$29,852.

SPECIAL RULES FOR INTERRUPTED STAYS

One of the most difficult concepts to implement that is created by this proposed rule is that of the interrupted stay. An interrupted stay is defined as those cases in which a LTACH patient is discharged to an inpatient acute care hospital, an inpatient rehabilitation facility or a SNF for treatment or services not available at the LTACH for a period that is defined as follows:

*** For Patients Transferred to Acute Care Hospitals:**

For a period that is within one standard deviation from the arithmetic ALOS for the DRG assigned at the acute care hospital.

*** For Patients Transferred to an IRF:**

For a period that is within one standard deviation from the arithmetic ALOS for the CMG and comorbidity tier assigned for the IRF stay.

*** For Patients Transferred to a SNF:**

For a period that is within 45 days.

One standard deviation from the arithmetic ALOS is a number published in the federal register for each acute care DRG and each rehab CMG.

If the patient remains in the transferred entity for the defined time or fewer days, the stay at the LTACH is an interrupted stay. If the patient remains in the transferred entity for more than the defined time, the LTACH stays are independent and the LTACH will receive two payments.

CMS has proposed standardizing the length of stay defining an interrupted stay for transfers to acute, at 9 days, and transfers to IRFs, at 27 days. They seek comments on how to define the interrupted stay in the final rule.

See the attached charts for an example of how the interrupted stay rules apply to a sample DRG.

CMS will have to review the standards created regarding interrupted stays, especially for those patients transferred to skilled nursing facilities. The practical implementation of such a standard is unworkable given the long length of time (45 days) that determines whether the subsequent stay at the LTACH is included

with the first stay as an interruption or whether it is a separate stay allowing for a separate payment.

SPECIAL RULES FOR ON-SITE TRANSFERS

This rule is very similar to the current 5% rule known to existing LTACHs. It outlines special rules for transfers between the LTACH and distinct-part SNFs, acute care hospitals, IRFs, or psychiatric hospitals when the LTACH and the other provider are co-located.

If an LTACH readmits more than 5% of its Medicare patients who are discharged to an on-site SNF, IRF, acute hospital, or psychiatric facility, only one LTC-DRG payment would be made to the LTACH for each discharge and readmittance during the LTACH's cost reporting period.

CMS further proposes to have separate 5% thresholds – one for discharges and readmits with a co-located acute care hospital, and another 5% threshold for all discharges and readmits with co-located SNFs, IRFs, and psychiatric facilities.

For purposes of these rules, there is no distinction made between a hospital within a hospital or a satellite. The rules apply to any LTACH that is “co-located” with another facility.

PHYSICIAN ACKNOWLEDGMENT STATEMENT

Under the new regulations, when a claim is submitted, the hospital must have on file a signed and dated acknowledgment from the attending physician that the physician has received the following notice:

Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical records. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

COMMENTS SOLICITED BY CMS

Because of the new proposed rules regarding patient transfers, patient transfers with co-located facilities, and interrupted stay rules, CMS requested comments on the possibility of changing the ownership and control requirements for hospitals within hospitals. CMS believes that the new rules may eliminate the need for many of the ownership and control requirements originally established for hospitals within hospitals.

CMS also solicited comments on the current regulations that limit the number of beds old LTACHs with satellites may have. CMS believes that the new LTACH regulations may make the old satellite rules obsolete. Whether these changes are incorporated into the final rule will largely depend on then number and persuasiveness of comments that CMS received on these questions.

CONCLUSION

The proposed payment rates for LTACH's are favorable, and long term care providers should be encouraged by the fact that CMS has chosen a patient classification system that takes into account the increased resource utilization incurred by long term acute care hospitals.

About the Author:

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Patient Stay - NO INTERRUPTION
DRG 127 - Heart Failure & Shock

Prepared By Murer Consultants Inc.

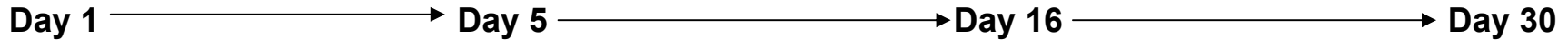
LTACH DRG
AMLOS = 25.8
2/3 AMLOS = 17.2
Payment = \$22,717.66

Short Acute DRG
AMLOS = 5.6
Payment = \$4,353.38
ALOS + one std. dev. = 10

LTACH STAY
4 Days

Acute Stay
11 Days

LTACH STAY
14 Days



LTACH PAYMENT

Payment One
 Short Stay 4 days x \$579.50 = \$2,318

Payment Two
 Short Stay Outlier (150% x per diem)
 \$1320.80 x 14 days = \$18,491

TOTAL PAYMENT TO LTACH
\$20,809

Acute PAYMENT

Payment
 Full DRG = \$4,353.38

TOTAL PAYMENT TO Acute
\$4,353,38

This stay is NOT an Interrupted Stay for the LTACH because the patient stayed in the acute hospital longer than the acute hospital ALOS plus one standard deviation (the determining factor for interruptions). The LTACH receives two separate payments.

LTACH DRG
AMLOS = 25.8
2/3 AMLOS = 17.2
Payment = \$22,717.66

Patient Stay - INTERRUPTED STAY
DRG 127 - Heart Failure & Shock
Prepared By Murer Consultants Inc.

Short Acute DRG
AMLOS = 5.6
Payment = \$4,353.38
ALOS + one std. dev. = 10

LTACH STAY
4 Days

Acute Stay
4 Days

LTACH STAY
14 Days

Day 1 → Day 5 → Day 9 → Day 23

LTACH PAYMENT

STAY ONE
4 days

STAY TWO
14 days

TOTAL STAY = 18 DAYS

FULL PPS PAYMENT TO LTACH
\$22,717.66

Acute PAYMENT

Payment
Full DRG = \$4,353.38

TOTAL PAYMENT TO Acute
\$4,353,38

This stay is an Interrupted Stay for the LTACH because the patient stayed in the acute hospital less than the acute hospital ALOS plus one standard deviation (the determining factor for interruptions). The LTACH receives only one payment.