

CMS Proposed Payment Revisions For LTACH

by

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Introduction

Over the past decade CMS has reviewed rules and regulations concerning key post acute care venues on an annual basis. These reviews are CMS's attempt to right size the continuum of care. On January 20, 2006 CMS proposed rules that apply to the Long Term Acute Care Hospital (LTACH). It is the opinion of this author that these proposed regulations are not devastating to the integrity of the LTACH, but rather challenges providers to assure the appropriate patient population is admitted to the LTACH. What remains of greater concern than the January 20th proposed rule change is the patient admission threshold that went into effect in 2004. The hospital within a hospital threshold rule which limits the number of referrals allowed from the host hospital has a draconian impact on the LTACH community. There is a need to continue to educate and advocate for a reversal of the 75% rule to allow continued existence of the very effective structure of hospital within a hospital. However, regardless of structure as hospital within a hospital or freestanding facility the proposed LTACH Prospective Payment System (PPS) update that CMS announced Friday, January 20, 2006 generally is as follows:

- The market basket proposed base rate for the LTACH would stay the same as the prior year, \$38,086.04.
- The proposal would change payments for short stay outliers;
 - Payment will be reduced to either 100 percent of costs; or,
 - A formula yet to be determined that would attempt to make the short-term outlier payment the similar as the payment that the patient would have received in a short-term acute care hospital
- The outlier threshold on high cost outlier cases would increase from \$10,501 to \$18,489.
- The proposal would eliminate the separate payment for the acute care hospital when a less than three day interrupted stay generates a surgical DRG in the short-term acute care hospital. The LTACH would have to cover those costs within its PPS payment under arrangement, as it does for other interrupted stays of less than three days.

Market Basket

The market basket proposed base rate is contemplated to be updated at 0% which means no change for a continued payment of \$38,086.04 in 2007. CMS reasoned that because the LTACH PPS was implemented just 3 years ago and there is a time lag in the availability of Medicare data there is not sufficient data to develop a Federal update framework. Therefore, previous increases were

arbitrary due to this Medicare data lag. CMS believes that the two full years of data generated under the LTACH PPS is sufficient data to begin the discussion of the development of a proposed framework for future Federal updates.

Short Stay Outlier

The change in payment rate for short stay outliers (SSO) is probably the most significant aspect of the proposal. This author has always counseled that short stay outliers are problematic for LTACHs and has always emphasized careful monitoring not only for purposes of satisfying the 25-day aggregate length of stay requirement, but also to assure admission of the appropriate patients.

The proposal recommends that the SSO be adjusted downward from 120% to 100%. Furthermore, it recommends an addition of a fourth alternative payment method that is reflective of what a short term acute care hospital would have received. Under existing CMS policy the SSO Medicare payment is the *least* of the following:

- 120 percent of the LTC-DRG per diem amount multiplied by the LOS of the discharge;
- 120 percent of the cost of the case; or,
- The full LTC-DRG.

The fourth proposed alternative would include an alternative payment method under the LTACH PPS SSO adjustment that could result in an LTACH PPS payment to the LTACH for a SSO stay that would be comparable to what Medicare would pay to an acute care hospital. According to MedPar over 80 percent of all LTACH patients are admitted from acute care hospitals. Many of these become a SSO which may have been a result of an acute care hospital's discharge of a patient who is still in need of acute-level care. CMS believes that this may indicate a premature and inappropriate discharge from the acute care hospital, an inappropriate admission to the LTACH, and results in an unnecessary Medicare payment to the LTACH. Therefore, providing payment under the SSO policy is appropriate since there is concern that LTACHs may be admitting patients that should otherwise be treated in acute care hospitals.

High Cost Outlier

The proposed fixed-loss amount for the 2007 LTACH PPS rate year is significantly higher at \$18,489 than the current fixed-loss amount of \$10,501. CMS explains that this proposed change in the fixed-loss amount would primarily be due to the projected decrease in LTACH PPS payments resulting from the proposed change in the SSO policy. CMS believes that an increase in the proposed fixed-loss amount is appropriate and necessary to maintain the requirement that estimated outlier payments would equal 8 percent of estimated total LTACH PPS payments. CMS reasons that maintaining the fixed-loss amount at the current level would result in high cost outlier payments that would significantly exceed the current regulatory requirement that estimated outlier payments would be projected to equal 8 percent of estimated total LTACH PPS payments. It should be noted that the proposed amount is still significantly less

than the current threshold for short-term acute hospitals which is about \$23,600 for 2006. CMS has consistently proposed to raise the threshold since the LTACH PPS was instituted in 2002.

DRG Surgical Exception

CMS is currently proposing not to renew the surgical-DRG exception to interrupted stay of 3 days or less policy. Presently treatment at an acute care hospital that was grouped to a surgical DRG would be considered part of the LTACH stay and paid for by CMS separately under the short term acute care hospital DRG. The proposed sun setting of this exception would require that those surgical services be provided by the LTACH "under arrangements." That is the LTACH would pay the short term acute care hospital separately for surgical services rendered and the short term acute care hospital could no longer bill Medicare.

CMS conducted an analysis of sample LTACH cases that included a 3 day or less interruption of stay that was governed by the surgical DRG-exception. It was found that at least one-half of the LTACH claims themselves included surgical care. The patient's discharge to the acute care hospital for treatment that was grouped to a surgical DRG and for which a separate claim was submitted to Medicare by the acute care hospital would have been inappropriate. Typically, LTACHs do not perform significant surgical procedures and it has been suggested that some of the LTACH claims may be including the surgical procedure performed during the prior acute care stay. CMS stated that if LTACHs are presently coding for the surgical procedures that are being delivered in the acute care hospital during a 3-day or less interruption of stay the LTACH should be paying for this treatment "under arrangements." Furthermore, Medicare may be paying twice for the same treatment in the cases where the same DRG is reported by both the LTACH and the acute care hospital treating the patient during the 3 day or less interruption. CMS reasons that the above scenarios are a direct result of poor documentation in the medical record, poor coding, or gaming of the Medicare system. Therefore, CMS is proposing to discontinue this policy because they do not believe that the surgical exception to the 3-day or less interruption of stay policy is actively accomplishing their goal. That goal is to reduce unnecessary Medicare payments and deter unnecessary and inappropriate Medicare payments while assuring beneficiary access to whatever service is medically necessary. Medicare's findings mirror those of this author's experience and the proposed rule affects very few cases.

Conclusion

In sum, the proposed changes are manageable. The most precarious proposed change relates to the ambiguity of the short term outlier methodology. CMS should take into consideration the rate of mortality which significantly skews the statistical reporting of SSOs. The LTACH is at a disadvantage because it is structured to serve a homogenous population of very critically ill patients. This type of specialty hospital will have a disproportionate rate of patients who will

expire due to the nature of their illness. The SSO methodology must take into consideration that, although appropriate for the LTACH at the time of admission a patient may expire due to the number of co-morbidities and complexity of illness which could result in a shorter than projected mean length of stay. This outlier status does not, in and of itself, indicate an inappropriate admission and the facility should not be unduly penalized by a significant reduction on reimbursement. The LTACH community should strategically plan for corrections to the Medicare proposed methodologies. However, the LTACH community should also continue to advocate for its rightful place at the epicenter of the continuum of care. The 75% rule effecting hospital within hospitals should remain of greatest concern and consideration with a more reasoned means to assure appropriate patient admissions to the LTACH.

About the Author:

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