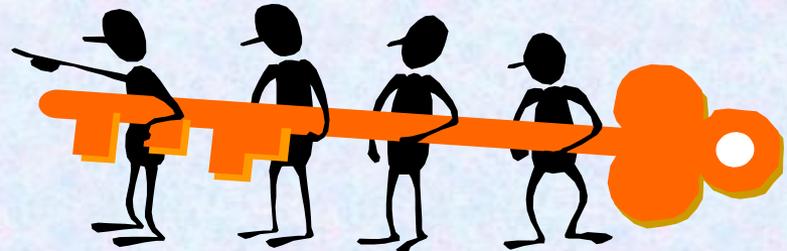


Introduction

Long-Term Care Hospital
Prospective Payment System

LTCH PPS Training Resources

- Today's agenda and slides
- Training Guide
- CMS's Medicare Learning Network
 - www.cms.gov/medlearn/ltchpps.asp
- Key training points identified



Overview

Long-Term Care Hospital
Prospective Payment System

Overview (2)

- Objectives

- Identify statutory basis for the implementation of the LTCH PPS
- Identify impacted hospitals
- Gain a high-level understanding of the LTCH PPS components and how they interrelate

Payment

- Objectives
 - Payment Part I
 - Understand background and components
 - Payment Part II
 - Understand case-level adjustments
 - Payment Part III
 - Understand facility-specific adjustments

Clinical Issues

- Objectives
 - Highlight clinical-related background
 - Emphasize importance of correct coding
 - Identify responsibility for medical review
 - Explore interrupted stay impact on medical record

Billing

- Objectives

- Identify LTCH PPS billing effective date
- Identify requirements not affected by LTCH PPS
- Understand applicable acute care hospital PPS requirements
- Introduce new billing requirements
- Understand transition period billing

Background

- BBRA of 1999 amended by BIPA of 2000
 - Implement budget neutral, per discharge PPS for LTCHs based on DRGs
 - Cost reporting periods beginning on or after October 1, 2002
 - Replaces reasonable cost-based TEFRA payment system

Affected Medicare Providers

- LTCHs

- Certified as short-term acute care hospitals excluded from IPPS
- Having an average length of stay greater than 25 days
- Identified by last four digits of Medicare provider number “2000” through “2299”
- Meet State licensure for acute care hospitals

Hospitals Not Affected

- Hospitals not subject to LTCH PPS
 - Veterans Hospitals
 - Reimbursed under State cost control system
 - Reimbursed in accordance with demonstration projects
 - Two of four Maryland demonstration hospitals
 - Non-participating Medicare hospitals
 - Foreign Hospitals

New Average Length of Stay

- Cost reporting periods on or after 10/01/02
 - Average length of stay based on LTCH Medicare inpatients' total days
 - Continues to count covered and non-covered days
 - Excludes non-Medicare (other payers') covered days

Payment Provisions

- Per discharge Federal rates
 - Based on average LTCH costs in a base year updated for inflation
 - Updated annually
- Three primary payment drivers
 - Patient classification into LTC-DRG
 - Relative weight of the LTC-DRG
 - Federal payment rate



Payment Provisions (2)

- Secondary payment drivers
 - Case-level adjustments
 - Short stay outliers
 - Interrupted stays
 - High cost outliers
 - Facility-level adjustments
 - Area wage index
 - COLA
 - Co-located provider policy



Payment Classification System

- LTC-DRGs
 - Based on the existing IPPS DRGs
 - Grouped using ICD-9-CM codes
- Relative weights
 - Assigns a specific value representing the relative resource use
 - Normalizes charges
 - Will be updated annually

Payment Adjustments

- LTCH PPS case-level adjustments
 - Short-stay outliers
 - Interrupted stays
 - High Cost Outliers
- LTCH PPS facility-level adjustments
 - Area wage adjustment
 - COLA
- Co-located providers

Short Stay Outliers

- Length of stay less than or equal to $\frac{5}{6}$ of LTC-DRG geometric average length of stay
- Paid least of
 - 120% cost of case
 - 120% LTC-DRG specific per diem amount
 - Full LTC-DRG payment
- No retroactive adjustments for cost-to-charge ratio changes



Interrupted Stays

- Admitted upon discharge to inpatient acute care hospital, IRF or SNF/Swing Bed and returns to same LTCH within a fixed period of time
 - Becomes one discharge and one payment

Facility Type	Days
Inpatient Hospital	≤ 9
IRF	≤ 27
SNF/Swing Bed	≤ 45



High Cost Outliers

- Additional payment for exceeding outlier threshold
 - LTC-DRG payment + Fixed-loss amount
- Paid at 80% of costs above outlier threshold
 - Costs determined using charges from claim and hospital-specific cost-to-charge ratio
 - No retroactive adjustments for changes to cost-to-charge ratio



Facility-Level Adjustments

- LTCH PPS does not include the following “typical” facility-level adjustments found in other PPS
 - Rural location
 - Geographic reclassification
 - Disproportionate share (DSH)
 - Indirect medical education (IME)



Facility-Level Adjustments (2)

- Labor and Wage
 - Area wage index
 - Cost of living adjustment (COLA) for Alaska and Hawaii

Co-located Provider Policy

- Hospital-within-hospitals
- Satellite facilities
- Onsite SNFs, IRFs, etc.

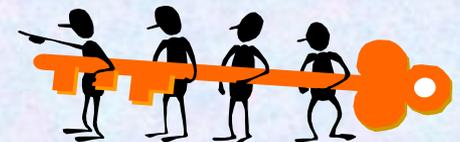
Budget Neutrality

- Total payments must equal the amount that would have been paid if the PPS had not been implemented

Implementation Phase-in

- 5-year phase-in period
- Irrevocable opportunity to elect payment based on 100% of Federal rate
- *New* providers are not eligible for blended transition payments

Year	TEFRA Rate	Federal Rate
1	80%	20%
2	60%	40%
3	40%	60%
4	20%	80%
5	0%	100%



Beneficiary Liability

- Cannot be billed for difference between cost and payment if a full LTC-DRG payment is made
- Can be charged for
 - Deductibles
 - Coinsurance
 - Noncovered services

Benefit Utilization

- Beneficiary must have covered benefit days at time of admission
- Medicare will pay only for covered days
 - Until the length of stay exceeds “short-stay outlier” threshold
 - »Generates a full LTC-DRG payment
 - At that point, the stay will be covered by Medicare until the high cost outlier threshold is reached

Billing Changes

- Use new coding at transition
 - One claim per stay
 - Interim billing and high cost outliers similar to acute care hospital PPS
 - Stays crossing transition may need cancels and/or adjustments
 - Use coding for interrupted stays
 - Most other requirements unchanged

Billing Implementation

Examples:

Cost Report Period Start Date on	New Coding Applicable to Discharges on and after
10/01/02	01/01/03
10/01/02	01/01/03

Standard System Delay

- FI and CWF processing will not be ready until at least January 1, 2003
 - Submit claims with required new coding or hold
 - Mass adjustments will be done by FI at a later date
- Providers must still comply with HIPAA Administrative Simplification Compliance Act
 - Unless exemption obtained

Medical Review

- Provider must have an agreement with QIO
 - Quality and admission review
- Also subject to FI medical review
 - Targeted through Progressive Corrective Action (PCA)
- Days failing medical review will be excluded from the qualification for meeting the 25-day ALOS