

Payment

Long-Term Care Hospital
Prospective Payment System

Objectives

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

Payment Part I

Background and Components

Statutory Requirements

- 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
 - Payments based on standardized amount per patient discharge

LTCHs Defined

- Certified as short-term acute care hospitals excluded from IPPS
- Meet State licensure for acute care hospitals
- Identified by last four digits of Medicare Provider Number “2000” through “2299”
- Average length of stay greater than 25 days
- No LTCHs units
 - Can be free-standing or hospital-within-a-hospital, and may establish satellite facilities within other providers’ facilities

Not Subject To LTCH PPS

- Veterans Administration hospitals
- Reimbursed under State cost control system
- Reimbursed in accordance with demonstration projects
- Foreign hospitals
- Non-participating Medicare hospitals

Average Length Of Stay

- Cost reporting periods prior to October 1, 2002
 - Average length of stay based on hospital's total inpatients' total days
 - Including covered and non-covered days
 - Including non-Medicare patients' days

- Cost reporting periods on or after October 1, 2002
 - Average length of stay based on hospital's **Medicare** inpatients' total days
 - Including covered and non-covered days
 - Excludes **non-Medicare** patients' days

Medical Necessity And ALOS

- Days of a stay failing medical review
 - Excluded from the provider's 25-day average length of stay computation for the LTCH's cost reporting period

Determine And Maintain LTCH Status

- ALOS is based on discharge data from the most recently filed cost reporting period
 - Or most recent six-month period, if:
 - No previous cost report or
 - Current cost report does not accurately reflect current ALOS

Qualifying LTCHs Under PPS For ALOS

- Same procedures as existing policy
- Fiscal Intermediary (FI)
 - Determine whether existing LTCHs qualify for payments
 - According to revised criteria after October 1, 2002
 - FI notifies LTCH if they qualify for payment under LTCH PPS
 - Prior to start of LTCH's next cost reporting period

Payment Provisions

- Part A costs not included in LTCH PPS:
 - Medical education program
 - Bad debts
 - Blood Clotting Factors
 - Certain anesthesia services
 - Photocopying and mailing records to QIO

Payment Provisions (2)

- LTCH PPS applies to inpatient hospital services provided in LTCHs
 - Including operating and capital costs
- After 5-year transition, payments calculated based solely on standardized amount per patient discharge
 - Standard Federal Rate

Budget Neutrality

- Requires
 - Total payments equal amount that would have been paid if PPS had not been implemented
- Budget neutrality
 - Accounts for behavioral changes following implementation
 - Additional offset

Calculation Of Unadjusted Payment Rate

- Factors

- Patient classification (LTC-DRG)
- Relative weight of LTC-DRG
- Federal payment rate

- Calculation

$$\frac{\text{LTC-DRG relative weight} \times \text{Standard Federal rate}}{\text{Unadjusted Federal PPS rate}}$$



Payment Classification System

- LTC-DRGs
 - Based on existing acute care hospital PPS case-mix grouped DRGs
 - Case-mix grouped based on clinical characteristics

GROUPER And PRICER

- Same GROUPER software as acute care hospital PPS
 - LTCH-specific relative weights
 - Relative weights updated annually
- PRICER program calculates Medicare payment rate
 - Short-stay outliers determined in PRICER logic

Relative Weights

- Each LTC DRG is assigned a specific value representing relative resource use
- Methodology normalizes charges
- Relative weights will be updated annually

Payment Rate

- Single standard Federal rate
 - Includes operating and capital-related costs
 - Does not include certain pass-through costs
 - Bad debts, medical education, etc.
 - FY2003 LTCH PPS unadjusted standard Federal Rate = \$34,956.15
 - Updated annually by excluded hospital with capital market basket index

Payment Rate (2)

LTC-DRG relative weight

X Standard Federal rate

Unadjusted Federal PPS rate

Payment Part II

Case-Level Adjustments

Case-Level Adjustments

- Three types
 - Short stay outliers
 - Interrupted stays
 - High cost outliers
- One case can have multiple applicable case-level and/or facility-level adjustments
 - Examples
 - Short stay and interrupted stay
 - Interrupted stay and high cost outlier



Short Stay Outliers



Short Stay Outliers (2)

- Patient receives less than the full course of treatment and therefore would generally be overpaid if full LTC-DRG payment was made
 - Case with length of stay between one day and up to and including $\frac{5}{6}$ of the geometric average length of stay of the LTC-DRG

Short Stay Outliers (3)

- Paid the least of
 - Full LTC-DRG payment
 - 120% of the LTC-DRG specific per diem amount
 - 120% of cost of case
- Payment determined in PRICER logic

Short Stay Outliers (4)

- Calculation of per diem amount for each LTC-DRG
 - Divide the full LTC-DRG payment (adjusted by the relative weight, wage index and COLA) by the geometric mean length of stay of the LTC-DRG
- Cost of case determination
 - Hospital specific cost-to-charge ratio and Medicare allowable charges for case

Short Stay Outliers (5)

- Medicare will not pay a full LTC-DRG when:
 - The patient is discharged before the number of days required to generate a full LTC-DRG payment, or
 - The patient lacks Medicare-covered days to generate a full LTC-DRG payment
 - Will be discussed further in Billing section



Short Stay Outliers (6)

- No retroactive adjustments to payments for changes in LTCHs hospital-specific cost-to-charge ratio



Short Stay Outlier Example

- Example assumptions
 - Length of stay = 10 days
 - Charges = \$13,870.33
 - LTC-DRG = 113
 - LTC-DRG 113 relative weight = 1.4103
 - LTC-DRG ALOS 113 = 36.9
 - Cost-to-charge-ratio (CCR) = 0.8114

Short Stay Outlier Example (2)

- Determine the least of
 - Full LTC-DRG payment
 - 120% of the LTC-DRG specific per diem payment
 - 120% of cost of case

Short Stay Outlier Example (3)

- Determine Full LTC-DRG payment

$((\text{Standard Federal Rate} \times \text{Labor percentage}) \times$
 $(1/5 \text{ Wage Index Value}) + \text{Non-labor Share}) \times$
 LTC-DRG Weight

- \$50,380.19

–See Training Guide for full computation

Short Stay Outlier Example (4)

- Determine 120% of the LTC-DRG specific per diem amount

$$\left[\frac{\text{Full LTC-DRG Payment}}{\text{ALOS LTC-DRG}} \right] \times \text{LOS of case} \times 1.2$$

• \$16,383.80

–See Training Guide for full computation

Short Stay Outlier Example (5)

- Determine 120% of cost of case

$((\text{Charges} \times \text{Cost-to-charge-ratio} = \text{Cost}) \times 1.2))$

- \$13,505.27

–See Training Guide for full computation

Short Stay Outlier Example (6)

- Answer

- ✗ Full LTC-DRG payment

- \$50,380.19

- ✗ 120% of the LTC-DRG specific per diem payment

- \$16,383.80

- ★ **120% of cost of case**

- **\$13,505.27**

Interrupted Stays



Interrupted Stays (2)

- 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



Not Interrupted Stays

- Readmission to the LTCH generates a separate discharge payment when:
 - Length of stay at “receiving” site of care exceeds fixed period
 - “Receiving” site of care not an acute care hospital, IRF, Swing Bed or SNF
 - Patient admitted to more than one facility or goes home before returning to LTCH



Not Interrupted Stays (2)

- Length of stay at “receiving” site of care exceeds fixed periods
 - Return to LTCH equals new admission
 - Example
 - Patient discharged and admitted to acute care hospital
 - Returns to same LTCH in 10 or more days
 - Return to LTCH is a new admission
 - LTCH submits new claim for admission
 - Treated as discharge for payment purposes
 - Two separate payments made to LTCH

Not Interrupted Stays (3)

- “Receiving” site of care not an acute care hospital, IRF or SNF

– Example

- Patient discharged from LTCH and admitted to HHA
- Return to LTCH is new admission
- LTCH submits new claim for admission
- Treated as discharge for payment purposes
- Two separate payments made to LTCH

Not Interrupted Stays (4)

- Patient admitted to more than one facility or goes home between LTCH stays
 - Example
 - Patient discharged from LTCH and admitted to IRF
 - IRF discharges patient to acute care hospital
 - Acute care hospital discharges patient to original LTCH
 - Return to LTCH is new admission
 - LTCH submits new claim for admission
 - Treated as discharge for payment purposes
 - Two separate payments made to LTCH

Interrupted Stays

- **If** length of stay at receiving provider falls within fixed periods of time
 - Medicare beneficiary did not go home
 - To another facility before returning to LTCH
- **Then** original LTCH stay and second LTCH stay meet interrupted stay criteria
 - Bill as one Medicare claim
 - Claim must reflect period of time at other facility

Interrupted Stays (5)

- **If** length of stay at receiving provider is longer than fixed periods of time
 - Medicare beneficiary did not go home
 - To a third facility before returning to LTCH
- **Then** original LTCH stay and second LTCH are **separate**, not interrupted
 - Bill as two LTCH Medicare claims

Interrupted Stay

Example 1-A

- Inpatient acute care hospital scenario

Admission to LTCH	Discharge to Acute Care Hospital	Return No Later Than
10/05/02	10/10/02	10/18/02

Interrupted Stay

Example 2-A

- Inpatient Rehabilitation Facility scenario

Admission to LTCH	Discharge to IRF	Return No Later Than
10/05/02	11/30/02	12/26/02

Interrupted Stay Example 3-A

- Swing Bed/Skilled Nursing Facility scenario

Admission to LTCH	Discharge to IRF	Return No Later Than
10/05/02	10/10/02	11/23/02

High Cost Outliers

High Cost Outlier

- Payments made for cases with unusually high costs
 - Paid 80% of costs above outlier threshold
 - Costs determined using charges from claim and hospital-specific cost-to-charge ratio (CCR) computed from most recent cost report
 - No retroactive adjustments to payments for changes to CCR

High Cost Outlier Threshold

- High Cost Outlier Threshold =
 - LTC-DRG Payment + Fixed-Loss Amount
- If cost of the case exceeds high cost outlier threshold additional payment is added to LTC-DRG payment

Fixed-Loss Amount

- Fixed-loss amount is set such that projected outlier payments are equal to 8% of total national LTCH PPS payments
- FY 2003 fixed-loss amount = \$24,450

High Cost Outlier Payment

Outlier Payment =

Estimated cost of case minus outlier threshold

Cost-To-Charge Ratios

**Cost-To-Charge Ratio =
Medicare Costs ÷ Medicare Charges**

- Use the latest available settled cost report and associated data
- New providers use the sum of the operating and capital statewide averages under IPPS
- Includes operating and capital-related costs
 - Excludes bad debts, medical education, nurse anesthetist, and blood clotting factors

Payment Part III

Facility-Specific Adjustments
and Other Miscellaneous
Issues

Facility-Level Adjustments

- Based on individual LTCH characteristics
- Two basic types
 - Wage adjustment
 - COLA

Facility-level Adjustments (2)

- No adjustments necessary for
 - Geographic reclassification
 - DSH
 - IME adjustments
 - Rural Location

Wage Index

- Adjustment to standard Federal rate for differences in area wages
 - Wage index phased-in over 5 years
 - Multiply the labor-related share by applicable wage index value based on physical location of LTCH

Wage Index (2)

- FY 2003 applicable wage index value is 1/5 the value of pre-classification hospital inpatient wage index without regards to reclassification
- FY 2003 labor-related share is 72.885 percent

Wage Adjustment = Labor-Related Share of Standard Federal Rate * Wage Index Value

COLA

- Cost Of Living Adjustment (COLA)
 - Applicable to Hawaii and Alaska only
 - Multiply the non-labor-related portion of standard Federal rate by the applicable COLA factor
 - For FY 2003, the non-labor-related share is 27.115 percent

Co-location Policy

Co-located Providers

- Special payment policy
 - To discourage inappropriate patient-shifting among Medicare Providers that share a physical location
- Co-located providers
 - LTCH occupies space in a building used by another provider,
 - **Or**, in one or more entire buildings on the same campus of buildings used by another provider

Hospital-Within-A-Hospital

- LTCH located in or on the campus of an acute care hospital

Hospital-Within-A-Hospital

- Must meet criteria at CFR § 412.22 (e)
 - Separate governing body, CEO, CMO and medical staff
 - Perform basic functions independently from host hospital
 - Host hospital provides 15% or less of total inpatient operating costs supplied by host hospital, and
 - At least 75% of patients admitted from other than the host hospital

Satellite LTCH Provider

- Definition
 - Part of an LTCH that provides services in a building also used by another hospital

Satellite LTCH Provider (2)

- Must meet all the criteria in CFR §412.22(h) to be excluded from IPPS
 - Maintains separate admission/discharge records from host hospital
 - Cannot commingle beds with host hospital
 - Serviced by same intermediary as the parent hospital
 - Treated as a separate cost center of the parent hospital

Continued...



Satellite LTCH Provider (3)

- Must meet all the criteria in CFR §412.22(h) to be excluded from IPPS *continued*:
 - Accounting system allocates and maintains costs
 - Same fiscal period and method of apportionment of the parent hospital
 - Qualifies for exclusion from acute care hospital PPS
 - Complies with existing bed limit regulations

Co-location Payment Policy

- LTCH or LTCH satellite co-located with on-site acute care hospital
 - **If** more than 5% of LTCH patients discharged to an on-site acute care hospital and readmitted during cost reporting period,
 - **Then** one LTC-DRG payment made
 - For all such discharges and re-admits during entire cost reporting period

Co-location Payment Policy

- LTCH or LTCH satellite co-located with on-site SNFs/Swing Beds, IRFs or psychiatric facilities
 - **If** more than (a separate) 5% of LTCH patients discharged to an on-site SNF/Swing Bed, IRF or psychiatric facility and readmitted during cost reporting period
 - **Then** one LTC-DRG payment made
 - For all such discharges and re-admits during entire cost reporting period

Co-location Payment Policy (2)

- Limitation only applies to **onsite** readmissions
 - Once threshold is met for cost reporting period
- If **either** threshold met, paid as one discharge
 - Onsite acute care hospital
 - Onsite SNF/Swing Bed, IRF, or psychiatric facility

Co-location Notification Requirement

- Notify fiscal intermediary and CMS regional office that co-location exists
 - Within 60 days of first cost reporting period that begins October 1, 2002
 - Within 60 days of changes to status of co-location

Transitioning to the Federal Rate

Transition Period

- PPS payments are phased-in over 5 years
 - From blend of payments under TEFRA and Federal rate to full 100 percent Federal per-discharge LTC-DRG based PPS

Transition Period (2)

- 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
 - Paid based on 100% of Federal rate

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



Periodic Interim Payment (PIP)

- Providers may elect PIP, if qualified
- PIP based on transition blend
- PIP excludes outlier payments or estimated prospective payment
 - Outliers are paid on submission of discharge bill
- Providers not to receiving PIP payments can submit interim bills

Beneficiary Liability

Beneficiary Liability (2)

- Generally same as previous payment system
 - If Medicare pays below the LTCH's costs
 - Patient cannot be billed differences for covered days

Beneficiary Liability (3)

- Beneficiary is generally responsible for
 - Deductible
 - Coinsurance
 - Lifetime reserve days
 - Non-covered services
 - Services not covered due to benefit exhaustion
 - Inpatient services if no entitlement to Part A

Beneficiary Liability (4)

- If short stay outlier applies, also responsible for:
 - Any items and services not the basis for short-stay payment

Beneficiary Liability - Short Stay Outliers

- If stay **exceeds** short-stay outlier threshold
 - Entire stay paid up to the high cost outlier threshold
 - After high cost outlier threshold must have benefit days available for payment
 - *Same as IPPS*
- If stay **does not exceed** short-stay outlier threshold
 - Medicare pays only for benefit-covered days

Beneficiary Liability - Examples

AIDS of LTC-DRG	Short Stay Outlier Thresh. (5/6 of ALOS)	Actual Length of Stay	Short Stay Outlier	Benefit Days Available (Full/Co/LTR)	LTR Used	Medicare-Payable Days
30	25	25	Yes	0/15/30	0	15
30	25	24	Yes	0/15/0	0	15
30	25	20	Yes	0/15/30	5	20
30	25	29	No	0/27/0	0	29

Using LTR Days

- Beneficiary runs out of regular benefit days before the short-stay outlier threshold is exceeded
 - Remaining days of the patient's stay will be counted towards the beneficiary's lifetime reserve days for the remainder of the episode of care
 - Once a beneficiary starts using lifetime reserve days, must continue to use them

High Cost Outlier Benefit Days

- For Medicare coverage purposes:
 - Beneficiary must use either regular benefit days or lifetime reserve days for the period (or portion) of the stay beyond the high cost outlier threshold
 - Same as IPPS

Beneficiary Liability - Using LTR Days

AIDS of LTC-DRG	Short Stay Outlier Thresh. (5/6 of ALOS)	Actual Length of Stay	Short Stay Outlier	Benefit Days Available (Full/Co/LTR)	LTR Used	Medicare-Payable Days
30	25	35	No	0/26/30	0	35
30	25	45	No	0/26/30	0	45
30	25	35	No	0/10/30	25	35

Miscellaneous Payment Issues

- Current payment methodology continues to apply to Part B ancillary services
- Remittance advices, Medicare Summary Notices and Explanation of Benefits unchanged