LONG-TERM CARE HOSPITALS PAYMENT SYSTEM

*payment***basics**

Revised:
October 2007

Patients with clinically complex problems, such as multiple acute or chronic conditions, may need hospital care for relatively extended periods of time. Some are admitted to long-term care hospitals (LTCHs), which must have an average Medicare length of stay greater than 25 days. Payments to LTCHs were about $4.6 billion in 2006; Medicare beneficiaries accounted for about 70 percent of these hospitals' revenues. In 2005, 119,000 Medicare beneficiaries had 134,000 discharges from LTCHs, and 392 facilities were Medicare certified. LTCHs are not distributed evenly through the nation.

Beneficiaries transferred to an LTCH from an acute care hospital pay no additional deductible. However, beneficiaries admitted from the community are responsible for a deductible—$992 in 2007—as the first admission during a spell of illness, and for a copayment—$248 per day—for the 61st through 90th days. Beneficiaries treated in LTCHs are covered for 90 days of hospital care per illness, with a 60-day lifetime reserve.[1]

Beginning in October 2002, LTCHs are paid predetermined per discharge rates based primarily on the patient's diagnosis and market area wages.[2] Before then, LTCHs were paid for furnishing care to Medicare beneficiaries on the basis of their average costs per discharge, as long as they did not exceed the facility-specific limit that was adjusted annually.

Under the PPS, discharges are assigned to case-mix groups containing patients with similar clinical problems that are expected to require similar amounts of resources. Each case-mix group has a national relative weight reflecting the expected costliness of treatment for a patient in that category compared with that for the average LTCH patient.

Defining the long-term care hospital product Medicare buys

Under the prospective payment system (PPS) for care in LTCHs, Medicare pays for the operating and capital costs associated with hospital inpatient stays in LTCHs. Medicare sets per discharge payment rates for different case-mix groups called long-term care diagnosis related groups (LTC–DRGs) based on the expected relative costliness of treatment for patients in the group. Patients are assigned to these groups based on their principal diagnosis, up to eight secondary diagnoses, up to six procedures performed, age, sex, and discharge status. On October 1, 2007, Medicare will begin to use case-mix groups called the Medicare Severity LTC–DRGs (MS–LTC–DRGs), which comprise base DRGs that have been subdivided into one, two, or three severity levels.[3] As with the current LTC–DRG system, the MS–LTC–DRGs will be the same groups used in the acute inpatient PPS but will have relative weights specific to LTCH patients, reflecting the average relative costliness of cases in the group compared with that for the average LTCH case.[4]

Setting the payment rates

The PPS payment rates cover all operating and capital costs that LTCHs would be expected to incur in furnishing covered services. The initial payment level (base rate) for a typical discharge is $38,356 for the 2008 rate year (July 2007 through June 2008).

The base rate is adjusted to account for differences in market area wages (Figure 1). The labor-related portion of the base payment amount—76 percent—is multiplied by a version of the hospital wage index and the result is added to the nonlabor portion.[5] For LTCHs in Alaska and Hawaii, the nonlabor portion is

This document does not reflect proposed legislation or regulatory actions.

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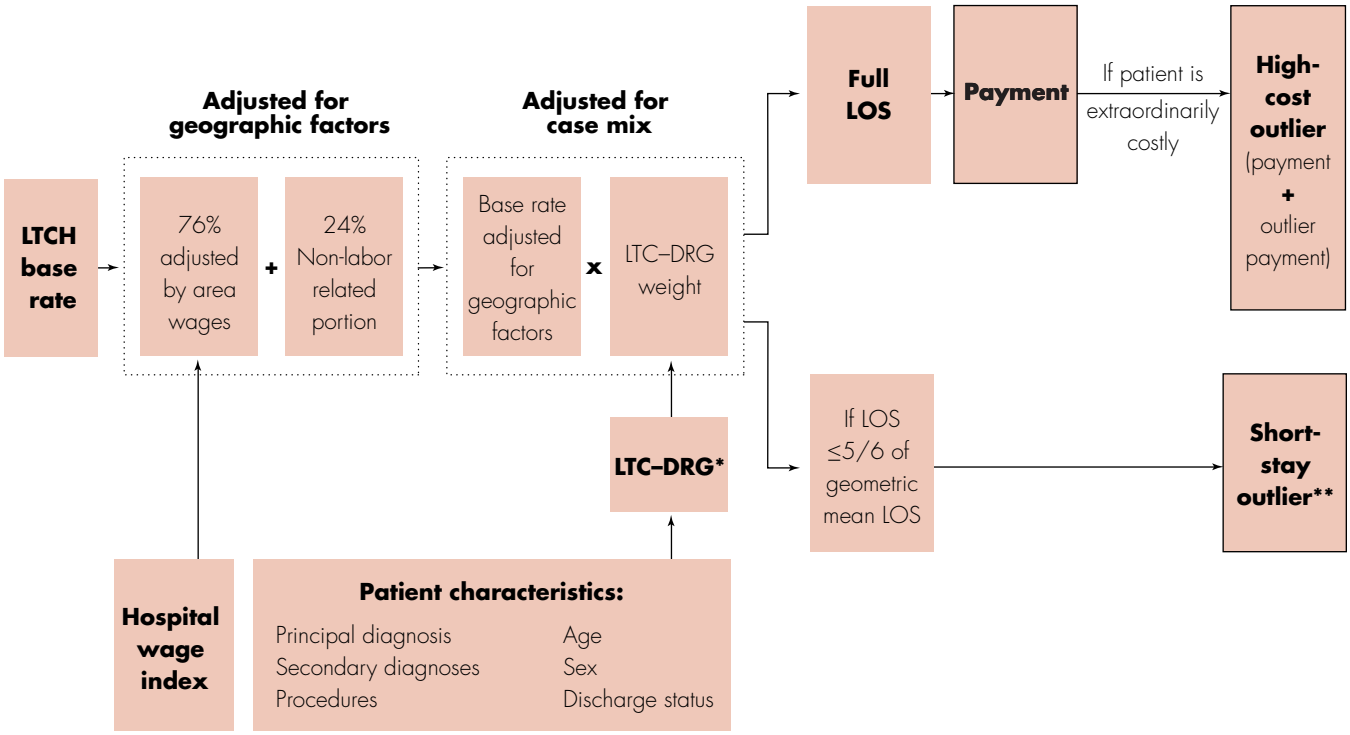
Figure 1 Long-term care hospital prospective payment system



Note: LTCH (long-term care hospital), LTC–DRG (long-term care diagnosis related group), LOS (length of stay).
* On October 1, 2007, Medicare will begin to adjust payments using Medicare Severity LTC–DRGs (MS–LTC–DRGs), which comprise base DRGs subdivided into one, two, or three severity levels.
** Payments generally are reduced for short-stay patients.

adjusted by a cost of living adjustment (COLA) and added to the labor-related portion.[6] The adjusted rate for each market is multiplied by the relative weights for all LTC–DRGs to create local PPS payment rates.

Short-stay outliers—LTCHs are paid adjusted PPS rates for patients who have short stays. Short-stay outliers (SSOs) are cases with a length of stay up to and including five-sixths of the geometric average length of stay for the LTC–DRG. For SSOs, LTCHs are paid the least of:

- 100 percent of the cost of the case,
- 120 percent of the LTC–DRG specific per diem amount multiplied by the length of stay for that case,
- the full LTC–DRG payment, or
- an amount that is a blend of the inpatient PPS amount for the DRG and the 120 percent of the LTCH per diem payment amount. As the length of stay for the SSO increases, the portion of payment attributable to the LTCH per diem increases.

Medicare applies a different standard for the shortest SSO cases. These cases are those in which length of stay is less than or equal to the average length of stay for the same DRG at acute care hospitals paid under the inpatient PPS (IPPS) plus one standard deviation. For SSO cases that meet this "IPPS comparable threshold," LTCHs are paid the least of:

- 100 percent of the cost of the case,
- 120 percent of the LTC–DRG specific per diem amount multipled by the length of stay for that case,
- the full LTC–DRG payment, or
- the IPPS per diem amount multiplied by the length of stay for the case, not to exceed the full IPPS payment amount.

High-cost outliers—LTCHs are paid outlier payments for patients who are extraordinarily costly. High-cost outlier cases are identified by comparing their costs to a threshold that is the MS–LTC–DRG payment for the case plus a fixed loss amount. In 2008 the fixed loss amount is $20,738. Medicare pays 80 percent of the LTCHs' costs above the threshold. High-cost outlier payments are funded by reducing the base payment amount for all LTCHs by 8 percent.

Interrupted stays—LTCHs receive one payment for "interrupted-stay" patients. An interrupted stay is when a LTCH patient is discharged to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), or a skilled nursing facility (SNF), stays for a specified period, then goes back to the same LTCH. The specified period of time is 9 days for an acute care hospital, 27 days for an IRF, and 45 days for a SNF. Any LTCH discharge readmitted within three days is also considered an interrupted stay.

LTCHs that are co-located with other Medicare providers are subject to the interrupted-stay policy unless their readmissions exceed 5 percent of the LTCH's total discharges. If this limit is exceeded, the LTCH receives only one payment for each interrupted-stay patient regardless of the amount of time spent at the intervening facility. (A separate 5-percent threshold applies to cases transferred to co-located SNFs, IRFs, and psychiatric facilities.)

The 25 percent rule

In FY 2005, CMS established a new policy—the so-called 25 percent rule—to help ensure that LTCHs do not function as units of host hospitals and that decisions about admission, treatment, and discharge are made for clinical rather than financial reasons. Originally affecting only LTC "hospitals-within-hospitals" (HWHs) and LTCH satellites, the rule limits the proportion of patients who can be admitted from a HWH's host hospital during a cost-reporting period to no more than 25 percent. HWHs and satellites are paid LTCH PPS rates for patients admitted from the host acute care hospital when those patients are below the 25 percent threshold that year. After the 25 percent threshold is reached, the LTCH is paid the lesser of the LTCH PPS rate or the acute hospital PPS rate for patients discharged from the host acute care hospital.[7]

There are some exceptions to the 25 percent rule. For rural HWHs, the applicable percentage is 50 percent. Urban single HWHs or those located in metropolitan statistical areas (MSAs) with dominant hospitals—those with one-fourth or more of acute care cases for the MSA—also have a threshold of 50 percent of cases.

For 2008, CMS has extended the 25 percent rule to apply to all LTCHs, limiting the proportion of patients who can be admitted to a LTCH from any one acute care hospital during a cost-reporting period. The policy will be phased in over three years. The applicable threshold for non-HWHs and non-satellites is:

- 75 percent for rate year 2008,
- 50 percent for rate year 2009, and
- 25 percent for rate year 2010.

Rural LTCHs, urban single LTCHs, and LTCHs located in MSAs with dominant hospitals will have a threshold of 50 percent of cases.

Payment updates

There is no mechanism in law for updating payments to LTCHs. CMS has stated that it intends to update LTCH PPS payment rates based on the most recent estimate of the Rehabilitation, Psychiatric, and Long-Term Care (RPL) market basket index (which measures the price increases of goods and services inpatient rehabilitation facilities, inpatient psychiatric facilities, and LTCHs buy to produce patient care). In recent years, CMS has adjusted the market basket increase downward to account for improved coding practices that result in higher case-mix indexes (and higher payments) without correlative increases in patient severity of illness. ■

1 Beneficiaries are liable for a higher copayment for each lifetime reserve day—$476 per day in 2006.

2 LTCHs began receiving payments under the new PPS at the beginning of their 2003 cost reporting periods. During a five-year transition period, they are paid a blend of the PPS rate and their updated facility-specific rate. For example, in the first year of PPS, payments were made up of 20 percent PPS rates and 80 percent facility-specific rates; in the second year, payments were made up of 40 percent PPS rates and 60 percent facility-specific rates. LTCHs also could choose to be paid at 100 percent of the PPS rate; CMS estimates that more than 90 percent of LTCHs have chosen this option.

3 To ease the transition to the new case-mix groups, 50 percent of the relative weight for each MS–LTC–DRG in FY 2008 will be based on the applicable relative weight under the old LTC–DRG system.

4 As with the LTC–DRGs, MS–LTC–DRGs with fewer than 25 cases are grouped into 5 categories based on their average charges; relative weights for these 5 case-mix groups are determined based on the average charges for the LTC–DRGs in each of these groups.

5 The wage index used to adjust LTCH payments is calculated from wage data reported by acute care hospitals without the effects of geographic reclassification.

6 The COLA is intended to reflect the higher costs of supplies and other nonlabor resources in Alaska and Hawaii. It increases the nonlabor portion of the payment by as much as 25 percent.

7 Patients who are transferred to the LTCH after being high-cost outliers in the acute care hospital do not count toward the threshold and continue to be paid at the LTCH PPS rate even if the 25 percent threshold has been reached.