

**STATEMENT OF WORK
LONG TERM CARE HOSPITAL
PAYMENT SYSTEM REFINEMENT/EVALUATION**

I. SCOPE:

The contractor shall provide a wide variety of statistical, data and policy analysis to support the CMS need to further examine the LTCH PPS and its effect on overall Medicare payments. These efforts will also assist CMS in evaluating and determining the feasibility of implementing recommendations 5A and 5B of the June 2004 Medicare Payment Advisory Commission (MedPac) Report To The Congress (RTC), Chapter 5, "Defining Long-Term Care Hospitals" (LTCHs). The MedPac recommended that Congress and the Secretary define LTCHs by facility and patient criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement. In addition, they recommend the expansion of the statement of work for the QIOs in order for them to monitor LTCH compliance with the newly-established hospital and patient criteria.

A. Background

Long term care hospitals (LTCHs) are certified under Medicare as short-term, acute care hospitals which have been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under section 1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average length of stay of greater than 25 days. The LTCH PPS replaces the reasonable cost-based payment system under which the LTCHs were paid.

The BBRA and BIPA, which mandated the development of a PPS for LTCHs, conferred extremely broad authority on the Secretary in designing the LTCH PPS, specifying only that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002. Payment rates under the LTCH PPS are updated on a July 1 through June 30 cycle, a LTCH rate year (RY). The relative weights for the LTC-DRG patient classification system remain linked to the October 1 through September 30 schedule of the acute inpatient PPS, and are therefore published in the annual IPPS final rule by August 1.

According to the 2003 and 2004 MedPAC Reports to Congress, since 1993, the number of LTCHs has increased from 109 to over 300 facilities, an increase of greater than 275 percent. CMS data reveals that annual Medicare LTCH spending has jumped from \$398 million in 1993 to \$1.9 billion in 2001, an increase in over 475 percent. Medpac estimates that spending for LTCHs in 2004 will be \$2.8 billion.

Although the numbers are rapidly increasing, geographically, LTCHs are unevenly distributed throughout the nation. For example, more than 35 percent of LTCHs are located in Louisiana, Massachusetts, and Texas together but only 10 percent of Medicare beneficiaries reside in those states. Given the relatively few LTCHs nation-wide, patients who fit the typical profile of a LTCH patient, (i.e., seriously ill patients with multi-comorbidities requiring long-stay hospital-

level care) generally receive care at acute care hospitals, often as high cost outliers. Following treatment at an acute care hospital, such patients may be admitted to skilled nursing facilities (SNFs) for additional non-hospital-level care.

The calculation of the average length of stay (ALOS) for LTCHs, includes all inpatient days for Medicare patients in the calculation, not just days paid for by Medicare. Accordingly, while under the LTCH prospective payment system, Medicare will pay for only covered days in a LTCH, we will count the total number of days of a Medicare patient's stay for purposes of LTCH designation.

Presently, other than a cost-of living (COLA) adjustment for LTCHs in Alaska and Hawaii and a 5-year phase-in of awage-index adjustment, there are no other facility-level adjustments because of the lack of empirical evidence from regression analysis to support those adjustments. As additional data on the LTCH PPS is gathered, these determinations will be revisited. Case-level adjustments include:

- Payment adjustments for short-stay outliers (SSO) that are cases with considerably shorter lengths of stay than the average length of stay for specific LTC-DRGs.
- High cost outlier payments for cases that have unusually high costs that exceed a fixed loss threshold.
- Interrupted stay adjustments for LTCH patient hospitalizations during which a patient is discharged from the LTCH and subsequently readmitted within a specified period of time for a continuation of the same episode of care. Medicare will make one payment for both segments of the LTCH stay. Medicare will make no additional payments if the patient returns to the LTCH within 3-days and receives any outpatient or inpatient care at an acute care hospital, inpatient rehabilitation facility (IRF) or skilled nursing facility (SNF). Such care will be deemed “under arrangements” (i.e., treatment that is included in the LTCH care but unavailable at that setting) and paid for by the LTCH. (For RY 2005, Medicare will pay for treatment delivered at an acute care hospital that is grouped to a surgical DRG separately.) Medicare will make a separate payment to an acute care hospital, IRF, or a SNF, if the patient stay exceeds 3 days and if the stay at the intervening site of care exceeds the applicable threshold for each provider-type. In such a case, the readmission to the LTCH will also be paid as a separate episode of care.
- LTCHs that share a building with another hospital or are located on the same campus with another hospital or part of a hospital such as HwHs, satellites, and units, are subject to the policies of the interrupted stay policy for all cases of patient movement from the LTCH to other on-site providers, regardless of the length of stay at the intervening provider, if the number of such cases exceed 5 percent of all discharges during a cost reporting period. The establishment of hospitals-within-hospitals (HwHs) represent the greatest growth in the LTCH universe.

An additional payment adjustment related to co-location of a LTCH HwH or satellite and a host hospital was implemented in the IPPS final rule for FY 2005. This payment policy is based on our concern that despite a statutory preclusion, many LTCH HwHs may be actually functioning

as LTCH units of their host hospitals (particularly, but not limited to, an acute care hospitals). Under this policy, if the number of patients who are discharged from the LTCH HwH or satellite within a cost reporting period were admitted from the host hospital in excess of 25 percent or an applicable percentage threshold specified for special situations, i.e., rural, single urban or MSA dominant hospitals, Medicare makes an adjusted payment under the LTCH PPS for each discharge beyond the threshold. This adjustment, which will be phased-in over 4 years, is based on the lesser of the otherwise unadjusted LTCH PPS payment or an amount equivalent to what would have been paid under the otherwise unadjusted IPPS. Additionally, payments for a patient originating at the host hospital that attained high cost outlier status at the host, would be determined as if the patient had been admitted to the LTCH HwH from an off-site provider.

Satellite facilities and remote facilities of hospitals that spin off as separate hospitals and seek LTCH status will have to qualify based on ALOS data gathered following hospital certification unless the spin-off was compelled by enforcement of the provider-based mileage requirements. In those cases, data compiled prior to hospital certification may be utilized for LTCH qualification.

B. Purpose

This Statement of Work seeks protect the integrity of the Medicare program by insuring that Medicare is a prudent purchaser of LTC services. This will be accomplished by obtaining professional and technical services for the purpose of: 1) Performing policy and analytic analysis of LTCH patients and LTCHs for purposes of evaluating the feasibility of both patient and facility-level criteria to assure appropriate and cost-effective utilization of LTCHs as a provider category as recommended in MedPac's June 2004 RTC; 2) Designing specific patient and facility-level criteria; This shall include an implementation approach, timelines, and estimated costs. 3) Developing a plan to implement improvements to the LTCH PPS. This shall include short-term and long-term actions/recommendations, defining monitoring and refinement techniques, and the like. The Medpac recommendations focus on development and monitoring of patient and facility criteria. They also raise several long-term and short-term questions for consideration and provide suggested patient and facility criteria. Medicare costs for episode of care at LTCHs are the highest for any provider type and therefore, it is vital that we establish an appropriate measure of what patients can best be treated at these hospitals and what the hospitals be required to provide. CMS needs to evaluate these suggestions, as well as alternatives, and develop a short-term and long-term plan for assuring that the LTCHs, are being appropriately

II REQUIREMENTS

A. Tasks to be performed

The work shall be performed in two phases. At the completion of phase 1, CMS will evaluate the LTCH Project Approach and provide written comments within 30 days. The contractor shall not begin work on phase 2 until receiving written instructions from CMS to proceed, regarding the chosen approach. Tasks include the following:

PHASE 1

- 1) Develop a Project Management Plan.
- 2) Perform data collection and analysis to examine the current status of the LTCH PPS and to further analyze the MedPac recommendations.
- 3) Develop a LTCH Project Approach, to include objectives and recommended actions.

PHASE 2

- 3) Develop a LTCH Enhancement Plan to accomplish CMS objectives.

B. Report Requirements

All written documents for this project shall be delivered via a single hard copy plus an electronic version via email, 3.5-inch diskette, or compact disk. The GTL may request additional hard copies as necessary. All electronic files shall be submitted in a format that is compatible with Microsoft Word (*). This is subject to change, and the contractor shall be prepared to submit deliverables in any new CMS standard.

The GTL shall provide the contractor with comments on draft reports within two (2) weeks of receipt. If no response is received within two (2) weeks, the contractor shall assume that the draft report is approved for development of final reporting. The contractor will not proceed with Phase 2 until written instructions are provided regarding the chosen method of approach.

Project Management Plan: The project management plan shall cover each requirement in this Task Order and shall highlight each step of Task Order implementation. The project plan shall include, at a minimum, descriptions of methods for satisfying requirements of the SOW including the following information (not necessarily in the order presented here):

- Resource planning by activity (description of the activity, anticipated results, activity implementation schedule and delivery schedules/completion dates)
- Activity interdependency and critical path for completion of all tasks
 - Key staff types devoted to each task or activity, if appropriate, and time allocation for each
 - Key milestones signifying successful completion of each task and periodic internal assessment/progress reports planned

LTCH Project Approach: LTCH Project Approach shall include

- A full description of assumptions and constraints under which each type of analysis shall be performed.
- Analysis/evaluation of the MedPac Report recommendations.
- Alternatives for developing facility and patient criteria, including those recommended by MedPac.

- Recommendations regarding which criteria should be adopted, as well as other long-term and short-term recommendations for improving the LTCH PPS and assuring that beneficiaries are receiving care in appropriate settings.

Final Report (LTCH Enhancement Plan): The contents of the Final Report shall be defined by the GTL and during the course of the contract. This report shall include:

- A detailed plan of action and resources required to achieve appropriate, efficient use of the LTCHs.
- Statement of the goals/objectives to be achieved.
- Timeline for implementing both short-term and long-term recommendations.
- Plan for ongoing monitoring and refinement of the PPS.

Other items as identified by the CMS.

C. Period of performance: 9/15/04-9/15/05

D. Government Property – None

E. Key Personnel Requirements:

At a minimum, at least one of each of the following key personnel shall be identified in the proposal:

- Project Director – Experience on with prior study with expert familiarity with Medicare policies, techniques and processes for data analysis, and review of medical records involving therapy claims;
- Statistician - Ph.D., with experience and expert familiarity with prior study, techniques for patient profiling;
- Project Coordinator – Experience and expert familiarity with Medicare policies, techniques and processes for data analysis, and familiarity with the LTCH PPS.

Section F:

SCHEDULE OF DELIVERABLES

PHASE 1

- 1) Kick-off meeting – within one week after contract award.
- 2) Project Management Plan – within 30 days after contract award.
- 3) LTCH Project Approach – presented at an on-site meeting within 6 months of contract award.

PHASE 2

- 4) Draft LTCH Strategic Plan - 60 days prior to the end of the contract.
- 5) Final LTCH Strategic Plan - at the completion of the project.
- 6) Data and Analytic Files – at the close of the project.

THROUGHOUT ENTIRE PROJECT

- 7) Monthly Progress Reports – on the eighth day of each month.
- 8) On site meetings - at least quarterly, to present findings/approaches to date and confer with CMS on project direction.

Deliverables shall be sent to:

Government Task Leader:

Government Task Leader
CMM/HAPG/DPS
7500 Security Blvd Mail Stop C4-03-06
Baltimore 21244-1850
410-786-2590