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Title: Medigap Bulletin Series – INFORMATION

Subject: Medigap Issuers' Payment Responsibilities Under the Long-term Care Hospital PPS

Market: Medigap

I. PURPOSE

The purpose of this bulletin is to clarify the responsibility of a Medicare supplement (Medigap) issuer for paying claims when an insured individual exhausts Medicare hospital benefits while an inpatient in a long-term care hospital (LTCH) that is paid under the Medicare long-term care hospital prospective payment system (LTCH PPS). The LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002.[i] The LTCH PPS replaces a reasonable cost-based payment system.

The final rule implementing the LTCH PPS was published in the *Federal Register* on August 30, 2002 (67 FR 55954).[ii] During rulemaking, the Centers for Medicare & Medicaid Services (CMS) received comments on the proposed LTCH PPS rule related to a Medigap issuer's payment responsibilities under the new payment system. This bulletin clarifies Medigap issuers' payment responsibilities under the LTCH PPS when the policyholder has exhausted all Medicare hospital coverage.

II. BACKGROUND

A. Medicare Hospital Benefits

Hospital services are covered for up to 90 days during a Medicare-defined benefit period, which is a period that begins with admission as an inpatient to any acute care or other hospital certified by Medicare and ends when the beneficiary has spent 60 consecutive days outside of an inpatient facility. There are 60 additional covered lifetime reserve days that a beneficiary may elect to use over the beneficiary's lifetime after the individual has exhausted the 90 days of Medicare coverage in any benefit period. If a beneficiary ends a benefit period and commences a new benefit period, even after having exhausted all lifetime reserve days, the beneficiary will receive up to 90 more days of hospital care for that new benefit period.

Medicare covers inpatient hospital care in various types of hospital facilities: acute care hospitals that are subject to the "regular" inpatient hospital PPS; inpatient rehabilitation hospitals that are subject to another type of PPS designed specifically for these types of hospitals, and certain other types of "excluded" hospitals such as psychiatric hospitals, children's hospitals, and, prior to October 2002, LTCHs. Hospitals that are excluded from one prospective payment system or

another are generally paid on the basis of reasonable costs. Days spent in any combination of Medicare-certified inpatient hospital facilities within the same benefit period accrue against the day limits for Medicare hospital care within that benefit period.

Regardless of the type of hospital facility in which the beneficiary is receiving care, the beneficiary is responsible for payment of the inpatient hospital deductible as of the first day of hospital coverage that begins a new benefit period. A patient in any Medicare-certified hospital facility is subject to a coinsurance payment for days 61 through 90 that is equal to one-quarter of the inpatient hospital deductible amount. Medicare is responsible for the remainder of the cost for the care provided to the beneficiary during a covered day. Unless the individual begins a new hospital benefit period, Medicare will pay nothing after exhaustion of the 90 days in the current benefit period, plus any remaining lifetime reserve days.[iii]

B. *Medigap Benefits for Hospital Services*

Section 8.B(1)-(3) of the NAIC Model Standards for Regulation of Medicare Supplemental Insurance (NAIC Model), incorporated by reference into section 1882 of the Social Security Act, sets forth the core benefits a Medigap issuer must pay for Medicare Part A eligible hospital expenses under any standardized Medicare supplement policy.[iv] Under section 8.B(3), an issuer of a Medicare supplement policy must provide the following as part of the core benefits:

> Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the diagnostic [sic] related group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. (Emphasis added to identify the addition made to the benefit description in 1991).[v]

Section 5.G of the NAIC Model defines "Medicare eligible expenses" as "expenses of the kinds covered by Medicare, to the extent recognized as reasonable and necessary by Medicare."

Until October 1, 2002, care that was provided in a LTCH was, as noted above, paid on a reasonable cost basis. Now that these stays will be subject to LTCH PPS, the Medigap issuer's payment obligation is determined by "[an]other appropriate standard of payment," under the new LTCH PPS. Nevertheless, the Medigap issuer is still responsible for paying whatever amount Medicare would have paid if Medicare were covering the stay.

III. LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM

Generally, under a Medicare inpatient hospital prospective payment system, a hospital knows in advance the standard rate it will be paid for a Medicare patient admitted with a particular diagnosis. (Each patient is classified into a "diagnosis related group" (DRG) for payment purposes.) However, in certain cases the standard rate will be adjusted for that stay. LTCHs are generally distinguished from acute care inpatient hospitals because they have an **average** length of stay (ALOS) that is significantly higher than in acute care hospitals, and therefore the payment systems reflect this difference. In an acute care hospital, the standard DRG amount is paid regardless of how long the patient remains in the hospital. However, under the LTCH PPS the actual length of the hospital stay is taken into account. While the acute care hospital and LTCH prospective payment system makes additional payments for stays that are unusually costly ("high cost outliers"), the final LTCH PPS regulation provides for adjusting the standard rate in two other

situations: “short stay outliers” and “interrupted stays.” A short stay outlier is a hospital stay in which the patient leaves the hospital earlier than expected (the stay is less than 5/6ths of the ALOS for that LTC-DRG). In an interrupted stay, the patient is discharged to an acute care hospital, an inpatient rehabilitation facility, or a skilled nursing facility, but is then readmitted to the LTCH within a specified period of time. If an admission occurs shortly before the point at which the patient exhausts his or her lifetime reserve days, the stay is classified as a short stay for Medicare payment purposes. Medicare will not make the full LTC-DRG payment.

A. Medigap Payment Under LTCH PPS

As noted above, the NAIC Model prescribes that a Medigap issuer provide coverage of the Medicare Part A eligible expenses for hospitalization paid at the DRG day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days. CMS (formerly the Health Care Financing Administration (HCFA)) has consistently interpreted this language to require that the Medigap issuer make payments at the rate Medicare would have paid, had Medicare Part A hospital days not been exhausted. Thus, while Medicare no longer pays “day” outliers, the reference to “other appropriate standard[s] of payment” encompasses the LTCH PPS, including any short stay outliers or interrupted stays.

Under the acute care hospital inpatient PPS, even if a patient has only one day of Medicare coverage remaining at the time of admission, Medicare pays the full DRG amount. Accordingly, after a patient’s Medicare covered inpatient hospital days are exhausted, a Medigap issuer would not be responsible for paying any more with respect to the basic stay. It would simply be responsible for high cost outliers, if any. If the patient’s stay is already in high cost outlier status when Medicare coverage is exhausted, the Medigap issuer’s responsibility is simply to continue paying what Medicare had been paying on the last day of coverage (i.e., the high cost outlier amount).

However, under the LTCH PPS, the amount of payment is based, in part, on how long the patient is expected to stay in the hospital. The fiscal intermediary, upon receipt of a discharge bill, determines the amount of payment the LTCH will receive for the stay. The discharge bill provides data to allow for reclassifying the stay from payment at the full LTC-DRG rate to payment for a case as a short stay outlier or as an interrupted stay, or to determine if the case will qualify for a high cost outlier payment.

B. Short Stays

If a patient with a Medigap policy exhausts Medicare covered days before being discharged from a LTCH, the only way to determine the “appropriate standard of payment” for which the Medigap issuer is responsible is to use the same methodology used by Medicare. If Medicare benefits are exhausted while the patient is still within the period of time considered to be a “short stay outlier,” Medicare will make payment to the hospital as if it were a short stay, regardless of the actual length of time the patient ultimately stays in the LTCH. This means that the payment that happens to be attributed to the last day of Medicare coverage is not an accurate basis for calculating the Medigap issuer’s responsibility. It may be more, or less, than the LTC-DRG payment that is ultimately applicable to the full LTCH stay. The Medigap issuer’s payment obligation is to pay what Medicare would have paid, but for the fact that the individual exhausted Medicare covered days before the patient’s entire stay (covered and non-covered days) is completed.

To determine its payment obligation, a Medigap issuer should use the LTCH PPS methodology, based on the individual's LTC-DRG classification at the time of discharge, to determine the amount Medicare would have paid for the full LTCH stay. Once the full LTC-DRG rate has been determined, the Medigap issuer should deduct the amount paid by Medicare for the days prior to exhaustion of Medicare benefits. The remaining amount is the Medigap issuer's payment responsibility. In other words, the Medigap issuer is responsible for paying the full LTC-DRG payment, *less* what Medicare has already paid at the short stay outlier rate for the Medicare-covered portion of the stay.

C. Interrupted Stays

Under the LTCH PPS Final Rule, all patients who are discharged to either an acute care hospital, an inpatient rehabilitation facility (IRF) or a skilled nursing facility (SNF) and admitted back to the LTCH within a fixed period of time will be treated as an interrupted stay. The fixed period for each type of discharge and return to the LTCH is as follows: 9 days for acute care hospital stays; 27 days for IRF stays; and 45 days for SNF stays. Payment will be made at the full LTC-DRG rate for these cases.

Once an individual has exhausted Medicare benefits, the interrupted stay policy will be the basis for determining the Medigap issuer's payment responsibility. In other words, the Medigap issuer will be responsible for paying what Medicare would have paid for the interrupted stay, based on the assigned LTC-DRG at discharge.

IV. EXAMPLES

Scenario 1: Medicare covered portion of the stay is a "short stay" due to exhaustion of Medicare-covered days

Description of LTCH Stay

Assume that the LTC-DRG assigned to the beneficiary has an average length of stay (ALOS) of 30 days. Also assume that the beneficiary exhausts Medicare-covered days (including lifetime reserve days) on day 5 of the stay. In this case, the Medicare-covered portion of the stay does not reach 5/6ths of the ALOS for the assigned LTC-DRG (5/6ths of 30 days equals 25 days), which means that Medicare does not make the full LTC-DRG payment. The beneficiary's stay in the LTCH extends beyond the point where Medicare is responsible for payment for the stay. Instead of making the full LTC-DRG payment, Medicare pays for the Medicare-covered portion of the stay under the short-stay outlier policy. However, the beneficiary remains in the LTCH an additional 30 days and, therefore, exceeds 5/6ths of the ALOS for the assigned LTC-DRG. Note that this stay would have generated a full LTC-DRG payment from Medicare *if* the patient had a sufficient number of remaining Medicare-covered days.

Medicare Payment Obligation

Medicare pays for the Medicare-covered portion of the stay (5 days) at the short stay outlier rate. Under the short stay outlier policy Medicare will pay the least of: (1) 120 percent of the cost of the case; (2) 120 percent of the specific LTC-DRG per diem amount multiplied by the LOS; or (3) the full LTC-DRG payment.

Medigap Payment Obligation

Under the facts set forth under "Description of LTCH Stay," the Medicare-covered portion of the stay was classified as a short-stay for Medicare payment purposes because the beneficiary exhausted Medicare-covered days prior to reaching 5/6ths of the ALOS for that LTC-DRG. Since the beneficiary's stay ultimately exceeded 5/6ths of the ALOS for the LTC-DRG, the Medigap issuer is responsible for paying the full LTC-DRG payment, less what Medicare has already paid under the short-stay outlier policy.[vi]

Scenario 2: Both Medicare and Medigap pay for stay under "short stay" outlier policy

Assume the LTC-DRG assigned to the beneficiary has an ALOS of 30 days and that the beneficiary's entire stay in the LTCH is 6 days (including Medicare-covered and non-covered days). The stay is considered a short stay and will be paid under the short stay outlier policy because the stay does not exceed the short stay outlier threshold of 25 days (5/6ths of 30 days). The beneficiary exhausts Medicare-covered days (including lifetime reserve days) on Day 3 of the stay. So, 3 days of the stay are Medicare-covered days and 3 days are non-covered days.

Medicare Payment Obligation

Medicare pays for the Medicare-covered portion of the stay (3 days) at the short stay outlier rate. Medicare will pay the least of: (1) 120 percent of the cost of the case; (2) 120 percent of the specific LTC-DRG per diem amount multiplied by the ALOS; or (3) the full LTC-DRG payment.

Medigap Payment Obligation

The Medigap issuer would also pay at the short stay outlier rate for the remaining noncovered days of the stay (i.e., the 3 days remaining in the stay after Medicare benefits are exhausted).

[Note that under very rare circumstances, a LTCH discharge that is classified as a short stay outlier case could also be a high cost outlier case, in which case the Medigap issuer would begin paying the high cost outlier rate at the same point that Medicare would have begun paying the high cost outlier rate after the fixed loss period].

Scenario 3: Medicare pays full LTC-DRG and makes no additional payments during "fixed loss period"

Description of LTCH Stay

Assume that the beneficiary's stay exceeds 5/6ths of the ALOS for the LTC-DRG, which means that the full LTC-DRG payment will be made to the LTCH. In addition, assume that the costs of the case are estimated to exceed the "high cost outlier threshold," which is the LTC-DRG payment amount plus the fixed loss amount (i.e., $24,450 for FY 2003). The hospital-specific cost-to-charge ratio determines whether or not the costs of a particular stay are expected to exceed the high cost outlier threshold. The period of time between that portion of the stay that is covered by the LTC-DRG payment and the point (the day) at which the costs exceed the high cost outlier threshold is known as the "fixed loss period." No Medicare payment is made during this fixed loss period.

Assume that the beneficiary in this scenario exhausts Medicare covered days (including lifetime reserve days) during the fixed loss period.

Medicare Payment Obligation

Medicare pays the full LTC-DRG for this beneficiary's stay. Once the beneficiary's stay exceeds the short stay outlier threshold and the full LTC-DRG payment is made, the remaining "inlier" days of the stay are considered covered under this payment until the high cost outlier threshold is reached. Medicare does not make any payment during the fixed loss period. Payment of high cost outliers has not started because the patient is in the fixed loss period at the time the patient exhausts Medicare-covered days. Note that Medicare does not make any additional payments during the fixed loss period even if the beneficiary had additional Medicare-covered days.

Medigap Payment Obligation

The Medigap issuer pays nothing during the fixed loss period (because Medicare pays nothing during the fixed loss period). High cost outlier payments do not begin until the day the costs of the stay exceed the outlier threshold. Once the fixed loss period ends (the day the costs of the stay exceed the high cost outlier threshold), the Medigap issuer pays at the high cost outlier rate (i.e., the same rate Medicare pays if the patient has Medicare-covered days).

High cost outlier cases are paid at 80 percent of the difference between the estimated cost of the case (based on the LTCH's overall cost-to-charge ratio) and the outlier threshold. The high cost outlier threshold is the sum of the payment for the LTC-DRG and the current fixed loss amount. The fixed loss amount for FY 2003 is $24,450.

Scenario 4: Medicare is paying the high cost outlier rate at the time Medicare coverage is exhausted

Description of LTCH Stay

The beneficiary's LOS is greater than 5/6ths of the ALOS for the LTC-DRG and the costs of the case are estimated to exceed the high cost outlier threshold (the LTC-DRG payment plus the fixed loss amount). The beneficiary exhausts Medicare covered days (151st day) after Medicare has already begun paying at the high cost outlier rate.[vii]

Medicare Payment Obligation

Medicare has paid the full LTC-DRG and has already begun paying the high cost outlier rate at the time the beneficiary exhausts Medicare covered days. Consistent with the policy under the acute care hospital PPS, Medicare makes high cost outlier payments only for Medicare covered days; that is, days for which the beneficiary has either regular benefit days or lifetime reserve days.

Medigap Payment Obligation

The Medigap issuer pays at the high cost outlier rate until the beneficiary reaches the coverage limit of 365 days, dies, or is transferred to another facility or discharged home.

Scenario 5: Medigap pays under the "interrupted stay" policy

Description of LTCH Stay

Assume the beneficiary is outside of a Medicare-covered stay and the patient's Medigap policy is responsible for paying for the continued stay. The patient is then discharged to an acute care hospital and returns to the LTCH 4 days later. The patient remains in the LTCH long enough for the stay to qualify for the full LTC-DRG payment. For example, the LTC-DRG assigned to the patient has an ALOS of 30 days and the patient stays 27 days.

<u>Medicare Payment Obligation</u>

Not applicable. In this example, the beneficiary is outside of a Medicare-covered stay (because the beneficiary has exhausted all Medicare-covered days, including lifetime reserve days prior to the beginning of this stay).

<u>Medigap Payment Obligation</u>

The patient's stay is considered an "interrupted stay" because the patient is discharged to an acute care hospital and returns to the LTCH within the fixed time period (9 days) established for discharges to the acute hospital setting. Therefore, the patient's stay in the LTCH is considered a single discharge from the LTCH. The Medigap issuer pays the hospital one full LTC-DRG payment for this stay (since the entire stay exceeded 5/6ths of the ALOS for this specific LTC-DRG).

Scenario 6: Medigap pays for entire stay because Medicare coverage exhausted prior to admission

Description of LTCH Stay

A beneficiary with a Medigap policy has exhausted all Medicare-covered days for this spell of illness (including all lifetime reserve days) prior to being admitted to the LTCH.

<u>Medicare Payment Obligation</u>

Medicare has no payment obligation for this LTCH stay because the beneficiary has exhausted all Medicare-covered days for this spell of illness and has exhausted all lifetime reserve days.

<u>Medigap Payment Obligation</u>

The Medigap issuer's payment obligation for the patient's stay would be determined by Medicare's payment rules under the LTCH PPS. If the patient's stay is less than or equal to 5/6ths of the ALOS for the LTC-DRG, then the Medigap issuer would pay at the short stay outlier rate, which is the least of (1) 120 percent of the cost of the case; (2) 120 percent of the specific LTC-DRG per diem amount multiplied by the ALOS; or (3) the full LTC-DRG payment. If the patient's stay exceeds 5/6ths of the ALOS for the LTC-DRG, then the Medigap issuer would pay the full LTC-DRG payment. The rules related to interrupted stays and high cost outliers would apply in the same manner as if Medicare were covering the stay.

Where to get more information:

If you have any questions regarding this bulletin, contact the Private Health Insurance Group at CMS via e-mail at *phigmedigap@cms.hhs.gov* or by telephone at (410) 786-1565 or toll free at 1-877-267-2323, extension 61565.

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[i] The LTCH PPS will be phased in over 5 years from cost-based reimbursement to Federal prospective payment. During this transition period, payment is based on an increasing percentage of the LTCH prospective payment and a decreasing percentage of each LTCH's cost-based reimbursement rate for each discharge. A LTCH may elect payment based on 100 percent of the Federal rate at the start of any of its cost reporting periods during the 5-year transition period.

[ii] For further details on the payment methodology and for definitions of terms, please see the final rule published in the *Federal Register* August 30, 2002. Additional information can also be obtained from the Program Memorandum entitled "Instructions for Implementing the Long-Term Care Hospital Prospective Payment System," that can be found on the CMS website at: www.cms.hhs.gov/manuals/pm_trans/A02093.pdf

[iii] Once the full LTC-DRG payment is made, the remaining "inlier" days of the stay are considered covered until the high cost outlier threshold is reached, even though the beneficiary may have already reached the 90th regular Medicare covered day within the benefit period. Once the beneficiary reaches the high cost outlier threshold, the beneficiary may choose to use the lifetime reserve days. The beneficiary has no coinsurance liability for the gap between the 90th day and the start of lifetime reserve days.

[iv] Section 7.B(1), (3), and (4) of the NAIC Model requires prestandardized policies to meet minimum benefit standards for Part A hospital expenses that are similar to the requirements in Section 8.B(1)-(3). Prestandardized policies are regulated under state law. Medigap policies issued prior to implementation of the 1991 NAIC standards generally were required to pay some portion of Medicare-eligible expenses for hospitalization for an additional 365 days after Medicare coverage was exhausted, including exhaustion of lifetime reserve days. The term "Medicare-eligible expenses" has always been the basis for calculating payment.

[v] The reference to "day outlier" payments was added to this requirement in the July 1991 version of the NAIC Model because there was some uncertainty as to what "Medicare eligible expenses" were under the acute care hospital PPS that was introduced in 1983. In 1991 most patients who exhausted all Medicare hospital coverage were being treated in acute care hospitals and were typically in day outlier status by the time lifetime reserve days were exhausted (in some cases, the patients would be in cost outlier status). Thus, in most cases, the appropriate standard of payment for the Medigap issuer would be a continuation of the day outlier payments. However, if Medicare was paying, or would have paid, on some other basis, then that other basis for payment would dictate the Medigap issuer's payment responsibility.

[vi] Once the beneficiary exceeds the 5/6ths short stay outlier threshold and the full LTC-DRG is paid to the hospital, the remaining "inlier" days of the stay are considered covered until and unless the high cost outlier is reached.

[vii] As noted in endnote 3 above, because a patient does not have to elect to use lifetime reserve days until the end of the fixed loss period (the point at which there will be high cost outlier payments), exhaustion of lifetime reserve days may occur later than the 151st day.