

**Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007  
Proposed Annual Payment Rate, Updates, Policy Changes, and Clarification**

**The proposed rule contains provisions which:**

- Provide for no FY 2007 update and freeze the LTCH-PPS standard amount at the FY 2006 level of \$38,086.14
- Significantly reduce payments under the short-stay outlier policy.
- Significantly reduce payments for cost outliers by raising the cost outliers threshold from the FY 2006 amount of \$10,501 to \$18,489 in FY 2007.
- Eliminate the surgical DRG exception to the Interruption of Stay Policy.
- Attempts to clarify how payments will be determined under the 25% rule and new short-stay outlier policy under rates that are “equivalent” to those paid under short-term acute hospital IPPS.
- Sets forth findings contained in a preliminary report made by the Research Triangle Institute (RTI)
- Proposes adoption of the Rehabilitation and Long-term Care (RPL) market basket to replace the current excluded hospital and capital market basket.
- Defers the look back for a one time adjustment to the standard amount until FY 2008.

**Detailed Summary** (p. 1-541)

**D. Update of LTC-DRG:** *The next update to the LTC-DRGs and relative weights for FY 2007 will be presented in the FY2007 IPPS proposed and final rules.* (p. 39-45)

**Section IV: Proposed Changes to the LTCH PPS Payment Rates for the 2007 LTCH PPS Rate Year (p.63)**

**A. Overview of the Development of the Payment Rates:** *Discussion of proposed factors that will be used to update the LTCH PPS standard Federal rate for the 2007 LTCH PPS rate year that would be effective for LTCHs discharges occurring on or after July 1, 2006 through June 30, 2007.*

**B. Proposed LTCH PPS Market Basket (p.68):**

Proposed Market Basket Estimate for 2007 LTCH PPS Rate Year: Proposing to adopt the FY 2002- based **RPL market basket** as the appropriate market basket of goods and services under the LTCH PPS for discharges occurring on or after July 1, 2006. This will replace the excluded hospital with capital market basket that is currently used as the measure of inflation for calculating the annual update to the LTCH PPS federal rate. Also, the proposal is to exclude childrens, cancer hospitals, and religious non-medical healthcare institutions (RNHCIs) from the RPL market basket because their payments are based entirely on reasonable costs subject to rate-of-increase limits. The most recent estimate of the RPL market basket for July 1, 2006 through June 30, 2007 is **3.6%**. This proposal to adopt the RPL market basket would also result in an increase in labor share, from 72.885% to **75.923%**, which is used in the adjustment for area wages.

**Proposed Update to the Standard Federal Rate for the 2007 LTCH PPS Rate Year: (p. 108-123)**

Proposing to revise and to specify that, for discharges occurring on or after July 1, 2006 and on or before June 30, 2007, the standard Federal rate from the previous year would be updated by a factor of **zero percent**.

CMS is proposing to revise the annual update to the LTCH PPS standard Federal rate for the 2007 LTCH PPS rate year to adjust the payment amount for LTCH inpatient hospital services to eliminate the effect of coding or classification changes that do not reflect real changes in LTCHs case-mix. This adjustment being proposed to eliminate the effect of coding or classification changes that do not reflect real changes in LTCHs' case-mix would reduce the amount that RY 2007 LTCH PPS payments would have been absent this adjustment so that payments would become more aligned with the true costs of treating LTCH patients. (p.112)

Payments under the LTCH PPS are updated annually. Since the implementation of the LTCH PPS in FY 2003 (when there were approximately 280 LTCHs), the number of LTCHs has increased by about 32 percent. Based on CMS projections, Medicare payments under the LTCH PPS will be **\$5.27 billion** for 2007, an increase of approximately 70 percent since FY 2003.

**Proposed Standard Federal Rate for the 2007 LTCH PPS Rate Year (p.124)**

Based on the proposed zero percent update, the proposed standard Federal rate for RY 2007 would be **\$38,086.04**. This proposal is based on an analysis of the LTCH case-mix index and margins before and after implementation of the LTCH PPS and the latest available LTCH cost reports, which indicate that LTCH Medicare margins were 8.8% for FY2003 and 11.7% for FY 2004. This proposed Federal rate is consistent with MedPAC's recent update recommendation for the LTCH PPS.

Since the proposed standard Federal rate for the 2007 LTCH PPS rate year has already been adjusted for differences in case-mix, wages, cost-of-living, and high-cost outlier payments, CMS would not propose to make any additional adjustments in the proposed standard Federal rate for these factors.

**Calculation of Proposed LTCH Prospective Payments for the 2007 LTCH PPS Rate Year (p.125)**

For cost reporting periods beginning on or after October 1, 2006 (FY2007), Medicare payment to LTCHs will be determined entirely (100%) under the LTCH PPS Federal rate.

The wage index adjustment will be completely phased-in beginning with cost reporting periods beginning on or after October 1, 2006, the applicable LTCH wage index value will be the full (five-fifths) LTCH PPS wage index value. (p.128)

CMS adjusted for area wage differences for estimated proposed 2007 LTCH PPS rate year payments by computing a weighted average of a LTCH's applicable wage index during the period from July 1, 2006 through June 30, 2007. For cost reporting periods that began on or after October 1, 2005 and on or before September 30, 2006 (FY 2006), the labor portion of the Federal rate is adjusted by four-fifths of the applicable LTCH PPS wage index. For cost reporting periods beginning on or after October 1, 2006, the labor portion of the Federal rate is adjusted by the full (five-fifths) applicable LTCH PPS wage index. CMS adjusted for area wage differences for estimated proposed 2007 LTCH PPS rate year payments using the proposed LTCH PPS labor-related share of **75.923%**.

#### **Proposed Labor-Related Share (p. 131-138)**

Proposing to revise the **LTCH PPS labor-related share** from 72.885% to **75.923%** based on the relative importance of the labor-related share of operating costs and capital costs of the proposed market basket based on FY 2002 data.

*Calculation: The proposed labor-related share for the 2007 LTCH PPS rate year would be the sum of the relative importance of each labor-related cost category, and would reflect the different rates of price change for these cost categories between the base year (FY2002) and the 2007 LTCH PPS rate year. Based on the most recent available data, the sum of the proposed relative importance for 2007 LTCH PPS rate year for operating costs would be 71.845. The portion of capital that is influenced by the local labor market is estimated to be 46%. Since the relative importance for capital would be 8.866% of the proposed FY 2002-based RPL market basket for the 2007 LTCH PPS rate year based on the latest available data, we are proposing to multiply the estimated portion of capital influenced by the local labor market (46%) by the relative importance for capital of the proposed FY 2002-based RPL market basket (8.86 %) to determine the proposed labor-related share of capital for the 2007 LTCH PPS rate year. The result would be 4.078% (0.46 x 8.866%), which is added to 71.845% for the operating cost amount to determine the total proposed labor-related share for the 2007 LTCH PPS rate year.*

#### **Proposed Wage Index Data (p.138-144)**

For the 2007 LTCH PPS rate year, CMS proposes that the same data used to compute the FY 2006 acute care hospital inpatient wage index data without taking into account geographic reclassification, would be used to determine the applicable wage index values under the LTCH PPS because these data (FY 2002) are the most recent complete data.

CMS proposes to continue to use IPPS wage data as a proxy to determine the proposed LTCH wage index values for the 2007 LTCH PPS rate year because both LTCHs and acute-care hospitals are required to meet the same certification criteria to participate as a hospital in the Medicare program and they both compete in the same labor markets, and therefore experience similar wage-related costs.

- Specifically, for a LTCHs cost reporting period beginning during FY 2006, for discharges occurring on or after July 1, 2006 through June 30, 2007 the applicable wage index value would be four-fifths of the full FY 2006 acute care hospital inpatient wage index data, without taking into account geographic reclassification. (p.141) *Note: During the 2007 LTCH PPS rate year, for a LTCH with a January 1<sup>st</sup> FY, the four-fifths wage index will be applicable for the first 6 months of the 2007 LTCH PPS rate year (July 1, 2006 through December 31, 2006) and the full (five-fifths) wage index will be applicable for the second 6 months of the 2007 LTCH PPS rate year (January 1, 2007 through June 30, 2007).*

#### **Proposed Adjustment for High-Cost Outliers (p.144)**

##### **Cost-to-Charge Ratios (pp.146)**

Proposing to revise methodology for determining the annual CCR ceiling under the LTCH PPS for discharges occurring on or after October 1, 2006

For discharges occurring on or after October 1, 2006, the proposal would be to determine the single "total" CCR ceiling, (operating & capital) CCR for each hospital and then determine the average total CCR for all hospitals. The ceiling would then be established at 3 standard deviations from the mean total CCR rather than determining the LTCH total CCR ceiling by adding the separate IPPS operating CCR and capital CCR ceiling.

"Medicare will pay a hospital an additional amount for unusually high cost cases under the high-cost outlier policy. To be eligible for this payment, the hospital's estimated costs in treating the case must exceed the LTC-DRG payment by an outlier fixed-loss amount. The proposed outlier fixed-loss amount for rate year 2007 would be **\$18,489**, compared with \$10,501 in rate year 2006. The primary reason for this proposed increase is because estimated aggregate outlier case payments are limited to **8%** of total estimated LTCH payment. Since CMS believes the proposed revisions to the short stay outlier policy would result in reduced total LTCH payments, it is necessary to increase the fixed loss amount in order to maintain the **8%** limit on total estimated LTCH payments."

CMS is proposing that for discharges occurring on or after October 1, 2006, the CCR applied at the time a claim is processed would be based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period.

CMS is proposing to state that CMS may specify an alternative to the CCR computed, that is the CCR computed from the most recent settled cost report of the most recent tentative settled cost report, whichever is later, or a hospital may also request that its FI use a different (higher or lower) CCR based on substantial evidence presented by the hospital.

CMS is proposing to specify that the FI may use a statewide average CCR, which would be established annually by CMS, if it is unable to determine an accurate CCR for a LTCH in one of the following 3 circumstances:

1. New LTCHs that have not yet submitted their first Medicare cost report (for this purpose, consistent with current policy, a new LTCH would be defined as an entity that has not accepted assignment of an existing hospital's provider agreement);
2. LTCHs whose CCR is in excess of the LTCH CCR ceiling (3 standard deviations above the corresponding national geometric mean total CCR); and
3. Other LTCHs for whom data with which to calculate a CCR is not available (ex. Missing faulty data). (p.155)

Specifically, under this proposed policy, the same IPPS CCR data would be used to annually establish the separate IPPS operating and capital Statewide CCRs (that is added together under the current policy to determine the applicable "combined" Statewide average CCR for LTCHs) to compute Statewide average total CCRs by first calculating the total (operating and capital) CCR for each hospital and then determining the average total CCR for all hospitals in each state rather than adding together the separate applicable IPPS operating and capital Statewide average CCRs (which is the current policy) (p.156)

#### **Reconciliation of Outlier Payments Upon Cost Report Settlement (p.171 & 247)**

CMS is proposing to specify that for discharges occurring on or after October 1, 2006, any reconciliation of outlier payments would be based on the CCR calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. In addition, CMS is proposing to specify that for discharges occurring on or after October 1, 2006, at the time of any reconciliation, outlier payments may be adjusted to account for the time value of any underpayments or overpayments.

#### **Application of Outlier Policy to Short-Stay Outlier (SSO) Cases (p.176)**

For a SSO case in the 2007 LTCH PPS rate year, the high-cost outlier payment would be **80%** of the difference between the estimated cost of the case and the proposed outlier threshold (the sum of the proposed fixed-loss amount of **\$18,489** and the amount paid under the SSO policy).

#### **Proposed Budget Neutrality Offset to Account for the Transition Methodology (p.178)**

Specifically, CMS reduces all LTCH Medicare payments during the 5-year transition by a factor that is equal to 1 minus the ratio of the estimated TEFRA reasonable cost-based payments that would be made if the LTCH PPS was not implemented, to the projected total Medicare program PPS payments (payments made under the transition methodology and the option to elect payment based on 100% of the Federal rate).

CMS projects that approximately **97%** of LTCHs would be paid based on 100% of the proposed standard Federal rate rather than receive payment under the transition blend methodology during the 2007 LTCH PPS rate year. *\*This projection, which used updated data, is based on our estimate that either: 1. a LTCH has already elected payment based on 100% of the Federal rate prior to the beginning of 2007 LTCH PPS rate year (July 1, 2006); or 2. A LTCH would receive higher payments based on 100% of the proposed standard Federal rate compared to the payments they would receive under the transition blend methodology. (p.182)*

CMS projects that the remaining **3%** of LTCHs would choose to be paid based on the transition blend methodology because those payments are estimated to be higher than if they were paid based on 100% of the proposed standard Federal rate. *\*This projection is slightly lower than the projection that 98% of LTCHs would be paid based on 100% of the proposed standard Federal rate rather than receive payment under the transition blend methodology during the 2006 LTCH PPS rate year.*

CMS projects that for the RY 2007 LTCH PPS rate year, the applicable transition blend methodology payments to those LTCHs would be greater than payment based 100% of the Federal rate, and therefore, those LTCHs would not be included in the number of LTCHs that are estimated to be paid based on 100% of the Federal rate in RY 2007. Based on the policies presented in this proposed rule, CMS is projecting two things; (1) a decrease in their estimated payments based on 100% of the Federal rate in RY 2007 payment as compared to their estimated payments based on 100% of the Federal rate in RY 2006 primarily as a result of the proposed changes to the SSO policy and the proposed increase in the outlier fixed-loss amount, and (2) the estimated RY 2007 payments based on the applicable transition blend methodology are now higher than their estimated RY 2007 payments based on 100% of the Federal rate. *\*CMS does not project that these LTCHs' would elect payment based on 100% of the Federal rate for RY2007. Therefore the slight decrease in CMS's projection in the number of LTCHs that would be based on 100% of the Federal rate for the 2007 LTCH PPS rate year is appropriate. (p.185)*

*CMS projects that in absence of a transition budget neutrality offset, the full effect of the final full year of the transition period (including the election option) as compared to payments as if all LTCHs would be paid based on 100% of the Federal rate would result in a cost to the Medicare program of approximately **2.8 million**. P.185*

Based on updated data and the policies and rates presented in this proposed rule, CMS proposes a **0.1% reduction** (a budget neutrality offset of **0.999**) to all LTCHs' payments for discharges occurring on or after July 1, 2006 and through June 30, 2007 to account for the estimated cost of the transition period methodology (including the option to elect payment based on 100% of the Federal rate) of approximately **\$2.8 million** for the 2007 LTCH PPS rate year. *\*Note: This proposed offset for the 2007 LTCH PPS rate year is slightly larger than the 0.0 percent reduction (a budget neutrality offset of 1.000) established for the 2006 LTCH PPS rate year. (p.186 & 298: see Table 12 for further explanation)*

### **One-time prospective adjustment to the standard Federal rate (p.187-206)**

CMS is proposing to extend the deadline for making the adjustment to July 1, 2008. *Detail:* CMS has provided for the possibility of making a one-time prospective adjustment to the LTCH PPS rates by October 1, 2006 so that the effect of any significant different between actual payments and estimated payments for the first year of the LTCH PPS would not be perpetuated in the LTCH PPS rates for future years.

- *Further Detail:* CMS estimated that total Medicare program payments for LTCH services over the next 5 LTCH PPS rate years would be \$3.32 billion for the 2006 LTCH PPS rate year and **\$3.38 billion** for the 2007 LTCH PPS rate year; 3.48 billion for the 2008 LTCH PPS rate year etc. *See table 9 on p. 189 for estimated payments from 2007-2011 LTCH PPS Rate Years.*
- *Further Detail:* CMS considered OACT's most recent projections of changes in Medicare beneficiary enrollment that there would be a change in Medicare fee-for-service beneficiary enrollment of **-2.3%** in the 2007 LTCH PPS rate year, -1.0% in the 2008 LTCH PPS rate year etc. *Note: OACT is projecting a slight decrease in Medicare fee-for-service Part A enrollment for the 2007 and 2008 LTCH PPS rate years. This is because they are projecting an increase in Medicare managed care enrollment as a result if the implementation of several provisions of the MMA of 2003.*

### **Section V: Proposed Adjustments for Special Cases (p.206-238)**

*"The proposed rule would make the LTCH payment system more efficient and consistent with Medicare's other payment systems for similar patients by revising the payment adjustment formula for short-stay outlier (SSO) patients, who comprise approximately 37% of LTCH PPS discharges. These are cases where the patient is discharged early and the hospital's costs are significantly below average. Currently, payment for these patients is based on the least of (1) 120% of patient costs; (2) 120% of the per diem of the Long Term Care Diagnosis Related Group (LTC-DRG); or (3) the full LTC-DRG payment. The proposed rule would reduce the part of the current payment formula that is based on costs, to ensure that payments would not substantially exceed costs. It would also add a fourth component to the current formula that would allow payment under the LTCH PPS based on an amount comparable to what would be paid to an acute care hospital under the inpatient prospective payment system (IPPS). Under this proposed policy, LTCHs, which are certified as acute care hospitals, could be paid by Medicare under the LTCH PPS at a rate that is more consistent with the rate paid to acute care hospitals when the LTCHs treat shorter stay patients."*

In order to address these concerns, CMS proposes *two specific changes* to the existing SSO payment methodology (under 412.529). 1. To reduce current adjustment and; 2. Add a 4<sup>th</sup> payment method. (p. 215)

1. CMS is proposing to reduce the current adjustment which is based on 120% of the costs of the case to 100% of the costs of the case for discharges occurring on or after July 1, 2006. CMS is not proposing to change the payment option of 120% of the per diem for a specific LTC-DRG multiplied by the LOS for that case because of the specific calculations. *Note: By reducing the Medicare payment to the LTCH for a specific SSO case so that it would be equal to but not exceed the estimated costs incurred for that case, CMS believes that they could be removing a financial incentive that the current policy has established to treat short stay cases in LTCHs. P. 216-218.*

2. To discourage LTCHs from behaving like acute care hospitals by having a significant number of cases with lengths of stay commensurate with acute care hospitals and also to discourage LTCHs from admitting patients that could be premature discharges from acute care hospitals. Therefore, CMS proposes to add a fourth payment method to the three alternatives for SSO cases. Specifically, CMS proposes to provide that for discharges from LTCHs occurring on or after July 1, 2006, payment for a SSO case would be the least of the following: 1. 120% of the per diem amount for a specific LTC-DRG multiplied by the LOS of the discharge; 2. 100% of the estimated costs of the case; 3. the full LTCH PPS payment for the LTC-DRG; or a LTCH PPS payment comparable to the payment that would otherwise be paid under the IPPS. P.219

Under this proposed revision to the LTCH PPS SSO payment adjustment, CMS is proposing that in the case of a LTCH that is a teaching hospital, CMS would determine the IME payment for the LTCH by imputing a limit on the number of full-time equivalent (FTE) residents that may be counted for IME (IME cap) based on the LTCHs direct GME cap (which would already have been established for an LTCH which had residency programs, thus calculating an IME payment for this LTCH that is in accord with the IPPS payment formula. P. 227

CMS proposes that an amount under subpart 0 that is comparable to an amount that otherwise would be paid under the IPPS would be calculated including the applicable differences in resource use (IPPS DRG relative weights), differences in area wage levels (wage index), cost-of-living adjustment for hospitals located in Alaska and Hawaii, the treatment of a disproportionate share of low income patients (DSH), and an adjustment for indirect medical education (IME). P. 225 Additionally, CMS is proposing that this proposed revised payment adjusted alternative (an amount comparable to what would otherwise be paid under the IPPS for the costs of inpatient operating services) would also include a DSH adjustment, if applicable, for discharges.

Under this proposed LTCH PPS payment adjustment, an amount payable under subpart 0 comparable to what would otherwise be paid under the IPPS would also include payment for the costs of inpatient capital-related costs based on the capital Federal rate, which would be adjusted by the applicable IPPS DRG weighting factors. This amount would be further adjusted by the applicable geographic adjustment factors, including wage index, (based on the CBSA where a LTCH is physically located and derived from the IPPS wage index for non-reclassified hospitals, large urban location, if applicable, and the IPPS COLA factor used under the IPPS for LTCHs located in Alaska and Hawaii. P.229

### **Proposed Changes to the Determination of Cost-to-Charge Ratios (CCR) and Reconciliation of SSO Cases (p.238)**

CMS proposes that for discharges occurring on or after October 1, 2006, if, among other things, a LTCHs CCR is in excess of the LTCH CCR ceiling (which would be calculated as 3 standard deviations above the corresponding national geometric mean CCR, the FI may use a Statewide average CCR. Similar to CMS current policy, it is also proposed that the FI may use a statewide average CCR in two other circumstances (See p.144 & 241)

Specifically, CMS proposes under the SSO policy, to use the same IPPS CCR data that they currently use to annually determine the separate IPPS operating CCR and capital CCR ceilings (that CMS adds together under their current policy to determine the annual CCR ceiling for LTCHs) to compute the single LTCH “total” CCR ceiling based on IPPS hospital-specific total (operating and capital) Medicare costs and charges.

Specifically, CMS is proposing to specify that the FI may use a Statewide average CCR, which would be established annually by CMS, if it is unable to determine an accurate CCR for a LTCH in one of the following three circumstances: (1) New LTCHs that have not yet submitted their first Medicare cost report (for this purpose, consistent with current policy, a new LTCH would be defined as an entity that has not accepted assignment of an existing hospital’s provider agreement); (2) LTCHs whose CCR is in excess of the LTCH CCR ceiling (that is, 3 standard deviations above the corresponding national geometric mean total CCR); and (3) other LTCHs for whom data with which to calculate a CCR is not available (p. 144) either CMS or the hospital may request the use of different (higher or lower) CCR based on substantial evidence that such a CCR more accurately reflects the hospital’s actual costs and charges. (p.243)

Based on data analysis, CMS proposes NOT to renew the surgical-DRG exception to interrupted stay of 3-days or less policy for LTCH PPS RY 2007. (Pp.245-256 gives rationale for this decision.) With the proposed sunset of this exception for LTCH PPS RY 2007, treatment at an acute care hospital that was grouped to a surgical DRG would be considered part of the LTCH stay and paid for by the LTCH “under arrangements.”

**\*\*Different Information (e-mail)** “The proposed rule would also eliminate the surgical DRG exception to the three-day or less interrupted stay policy. The three-day or less interrupted stay policy provides that where a LTCH patient is discharged to an acute care hospital, inpatient rehabilitation facility (IRF), skilled nursing facility (SNF) or to the patient’s home and is readmitted to the long-term care hospital within three days Medicare does not provide for a separate payment for services provided during the three day or less period. The surgical DRG exception allowed Medicare to make a separate payment to the acute care hospital if the care delivered during a 3-day or less interruption was for inpatient surgery. Based on analysis of claims data from cases which fell under the surgical DRG exception during RY 2005, it was determined that many of the surgical procedures performed during the 3-day or less interruption were related to the patient’s principle diagnosis at the LTCH. Furthermore, CMS data indicates that the cases that were eligible for payment under the surgical-DRG exception represented only 0.003 percent of total LTCH discharges during RY 2005, a small fraction of LTCH hospitalizations. Therefore, these cases were neither numerous nor would they be significantly costly for LTCHs to cover “under arrangements.” For these reasons, among others, CMS has proposed to sunset this exception. Under this proposed policy, the LTCH would be required to provide such inpatient surgical services during a 3-day or less interrupted stay either directly or “under arrangements” with the facility that actually provides the service, and no separate payment would be made by Medicare.”

### **XII. Collection of Information Requirements (p. 358)**

#### **Section 412.525 Adjustment to the Federal Prospective Payment Provision for Short-Stay Outliers**

The burden associated with this requirement is the time and effort necessary for a hospital to gather, process and submit the necessary documentation to its FI to substantiate its request for the use of a different CCR by their FI. The estimated burden for this requirement is 8 hours per hospital. Therefore, CMS estimates that it would require 80 annual hours (8 hours x 100 facilities), to comply with this requirement

### **XIII. Regulatory Impact Analysis (p. 362)**

The impact from the proposed changes for the 2007 LTCH PPS rate year results in approximately 11% decrease in estimated payments in the 2007 LTCH PPS rate year on average to LTCHs (see Table 23). The majority of the approximately 11% decrease in estimated payments in the in the 2007 LTCH PPS rate year as compared to the 2006 LTCH PPS rate year is due to the proposed change in the payment formula for SSO cases. CMS does not believe that this proposed change would result in an adverse impact on affected LTCHs for the following reasons: The proposed changes to the SSO Policy would accomplish CMS’ stated goal of removing the incentive for LTCHs to admit patients for whom a long-term hospital stay is not necessary and therefore, for whom the LTCH would not be providing complete treatment.

CMS believes that the estimated **11.1%** decrease in LTCH payments per discharge for RY 2007 would only occur if LTCHs were to continue to admit the same number of SSO patients. Because the majority of the approximately **11% decrease** in estimated payments is due to the proposed change in the SSO policy and because CMS anticipates that LTCHs would no longer admit such a large percentage of SSO patients if such proposed changes are implemented, they believe that the actual decrease in LTCHs’ payments for RY 2007 would be considerably less than 11%. *\*\*Although CMS expects LTCHs to admit fewer cases under this proposed change, they believe that most of them would not experience an increase in cost per discharge as a result of unoccupied beds. Rather, they expect that LTCHs would make a commensurate reduction in available beds. LTCHs would lease fewer beds, and therefore, the LTCHs cost per discharge would not increase dramatically.* P.367

In addition, CMS’s Medicare margins analysis of the most recent LTCH cost report data, show that LTCH PPS payments for FY 2003 were **8.8%** higher than LTCHs’ Medicare costs, and preliminary cost report data for FY 2004 reveal an even higher Medicare margin of

**11.7%.** Because LTCH PPS payments appear to be more than adequate to cover the costs of the efficient delivery of care to patients at LTCHs, based on this analysis, CMS believes that even with an estimated decrease in LTCHs' payments per discharge for the 2007 LTCH PPS rate year, which may result from, among other things, the continued treatment of some short-stay cases and the estimated slight decrease in payments due to the proposed changes to the area wage adjustment LTCH PPS payments in RY 2007 would still be sufficient to compensate LTCHs for the costs of the efficient delivery of LTCH services to LTCH patients. Therefore, CMS does not expect that the provisions of this proposed rule would result in an adverse financial impact on affected LTCHs nor would there be an effect on beneficiaries' access to care.

#### **1. Impact on Rural Hospitals**

The estimated **11.3% decrease** in LTCH PPS payments for RY 2007 for rural LTCHs was determined based on the current LTCH admission pattern of SSO cases (that is, currently about **37%** of all LTCH cases). The decrease would only occur if rural LTCHs were to continue to admit the same percentage of SSO patients. Because the majority of the 11.3% decrease in estimated payments for rural LTCHs is due to the proposed change in the SSO policy and since CMS anticipates that LTCHs (including rural LTCHs) would no longer admit such a large percentage of SSO patients if such proposed changes are implemented, CMS believes that the actual decrease in rural LTCHs' payments for RY 2007 would be considerably less than 11 percent. \*Even with the estimated decrease in LTCHs payments per discharge for the 2007 LTCH PPS rate year, LTCH PPS payments to rural LTCHs would still be sufficient to compensate LTCHs for the costs of the efficient delivery of LTCH services to LTCH patients. P. 371

**2. Budgetary Impact (p. 373):** CMS would apply a proposed budget neutrality offset to payments to account for the monetary effect of the 5-year transition period and the policy to permit LTCHs to elect to be paid based on 100% of the proposed standard Federal rate rather than a blend of proposed Federal Prospective payments and reasonable cost-based payments during the transition. The amount of the proposed offset is equal to 1 minus the ratio of the estimated payments based on 100% of the LTCH PPS Federal rate to the projected total Medicare program payments that would be made under the transition methodology and the option to elect payment based on 100% of the Federal prospective payment rate.

**3. Impact on Providers (p. 374):** In addition to the basic LTC-DRG payment (standard Federal rate x LTC-DRG relative weight), CMS makes adjustments for differences in area wage levels, cost-of-living adjustment for Alaska and Hawaii, and short-stay outliers. Furthermore, LTCHs may also receive high-cost outlier payments for those cases that quality based on the threshold established each year. During the 5-year transition period, payments to LTCHs are based on an increasing percentage of the LTCH PPS Federal rate and a decreasing percentage of payment based on reasonable cost-based methodology.

In order to understand the impact of the proposed changes to the LTCH PPS of this proposed rule on different categories of the LTCHs for the 2007 LTCH PPS rate year the following is necessary: (1) Estimate payments per discharge under the LTCH PPS rates, factors and policies established for the RY 2006 LTCH PPS final rule; (2) Estimate proposed payments per discharge that would be made under the proposed LTCH PPS rates, factors and policies for the 2007 LTCH PPS rate year; (3) Evaluate the percent change in the previous subjects. (p. 375)

*Prospective payments for the 2006 LTCH rate year were based on the standard Federal rate of \$38,086.04, the outlier fixed-loss amount of \$10,501, and the hospitals' estimated case-mix based on FY 2004 LTCH claims data. Estimated proposed prospective payments for the 2007 LTCH PPS rate year would be based on the proposed standard Federal rate of \$38,086.04 (based on the proposed zero percent update), the proposed outlier fixed-loss amount of \$18,489, the same FY 2004 LTCH claims data.*

#### **4. Calculation of Prospective Payments: (p. 378-386) Table 23 & 24: Impacts: (p. 387 & 388)**

To estimate payments under the LTCH PPS, CMS simulated payments on a case-by-case basis by applying the proposed payment policy for short-stay outliers, the proposed adjustments for area wage differences, for the cost-of-living for Alaska and Hawaii, and additional payments would also be made for high-cost outlier cases, (CMS is not proposing to make adjustments for rural location, geographic reclassification, indirect medical education costs, or a disproportionate share of low-income patients).

For those providers projected to receive payment under the transition blend methodology, CMS calculated payments using the applicable transition blend percentages. During the 2007 LTCH PPS rate year, based on the transition blend percentages, some of the providers that would be paid under the transition blend methodology may experience a change in the transition blend percentage during the period from July 1, 2006 through June 30, 2007. p.382

In estimating blended transition payments, CMS estimated payments based on the reasonable cost-based methodology. For those providers who have not already made the election to be paid based on 100% of the Federal rate, CMS compared the estimated blended transition payment to the LTCH's estimated payment if it would elect payment based on 100% of the Federal rate. If CMS estimated that the LTCH would be paid more based on 100% of the Federal rate, they assumed that it would elect to bypass the transition methodology and would receive payments based on 100% of prospective payment.

CMS applied the applicable budget neutrality offset to payments to account for the effect of the 5-year transition methodology and election of payment based on 100% of the Federal rate on Medicare program payments. In estimating 2007 LTCH PPS rate year payments, CMS applied the proposed **1.0%** (a budget neutrality factor of **0.999**) budget neutrality offset to payments to account for the effect of the 5-year transition methodology and election of payment based on 100% of the Federal rate on Medicare program payments to each LTCH estimated payments under the LTCH PPS for the 2007 LTCH PPS rate year. \*\*The impact, based on CMS' projection using

the best available data for **259 LTCHs** that approximately **3%** of LTCHs would be paid based on the transition blend methodology and **97%** of LTCHs would elect payment based on 100% of the Federal rate.

#### **5. Results (p. 393-411) ~ Summary of Impacts**

**Estimated payments per discharge** are expected to **decrease** approximately **11%** on average for all LTCHs from 2006 LTCH PPS rate year as compared to the 2007 LTCH PPS rate year as a result of the proposed changes in CMS' proposed rule.

Under proposed changes to the **SSO policy** for RY 2007, approximately **96%** of LTCH SSO cases (approximately 36% of all LTCH cases) would receive **lower** payment than under the current SSO policy.

**Estimated outlier payments equal to 8%** of estimated total LTCH PPS payment, estimated **decrease** in LTCH PPS payments for RY 2007 resulting from the proposed changes to the SSO policy would require a proposed increase in the high-cost outlier fixed-loss amount in order to maintain that estimated outlier payments at 8% of the reduced estimated total LTCH PPS payments (resulting from the proposed changes to the SSO policy).

The proposed *increase* in the outlier fixed-loss amount and the proposed *slight increase* in the budget neutrality offset to account for the transition methodology are also factors contributing to the proposed decrease in payments per discharge from 2006 to 2007 LTCH PPS rate year. *\*\*Example: Many LTCHs are expected to receive a decrease in high-cost outlier payments, a result of the proposed increase to the fixed-loss amount from the 2006 LTCH PPS rate year (\$10,501) to the 2007 LTCH PPS rate year (\$18,489), fewer cases would qualify as outlier cases (the estimated cost of the case exceeds the outlier threshold). Since, many LTCHs would receive fewer outlier payments, total estimated payments per discharge would discharge.*

#### **Location (p. 395-397)**

Based on the most recent available data, the majority of LTCHs are in urban areas. Approximately 3.5% of the LTCHs are identified as being located in a rural area, and approximately 2.3% of all LTCH cases are treated in these rural hospitals. The analysis results indicate that the percent decrease in **estimated payments per discharge** for 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year for **rural** LTCHs would be **-11.3%**, and would be **-11.1%** for **urban** LTCHs. While rural LTCHs are expected to experience a lower decrease in payments due to the proposed changes in the SSO policy because they treat a smaller percentage of SSO cases, they are projected to experience a **higher decrease in payments per discharge** as a result of the proposed changes to the area wage adjustment.

**Rural LTCHs** are expected to experience a **higher decrease in payments per discharge** as a result of the proposed changes to the area wage adjustment because the wage index for all rural LTCHs is less than 1.0, and therefore, they would experience a decrease in payments per discharge as a result of the proposed increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment.

**Large urban LTCHs** are projected to experience a **12.8% decrease in payments per discharge** from 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year.

**Other urban LTCHs** are projected to experience a **11.8% decrease** (a higher than average decrease) in **payments per discharge** from 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year because of the proposed changes to the area wage adjustment in addition to the slightly higher percentage of SSO cases (a result of the proposed changes to the SSO policy). The majority of other urban LTCHs (over 80%) are located in urban areas that have a proposed wage index value of less than 1.0, and therefore, would experience a higher than average decrease in payments per discharge as a result of the proposed increase in the labor-related share and progression of the 5-year phase-in of the wage index adjustment.

#### **Participation Date (p. 397-398)**

LTCHs are *grouped by participation date* into **3 categories**: (1) Before October 1983; (2) between October 1983 and September 1993; and (3) between October 1993 and September 2002.

Based on the most recent available data, the majority, approximately 71.0%, of the LTCH cases are in hospitals that began participating between October 1993 and September 2002, and are projected to experience an **11.3% decrease in payments per discharge** from the 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year.

Approximately 22% of the cases are in LTCHs that began participating in Medicare between October 1983 and September 1993, and those LTCHs are projected to experience a **10.2% decrease in payments per discharge** from 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year (see Table 23 on page 387). CMS projects that this group would experience a lower than average decrease in payments for RY 2007 primarily because CMS is projecting that these LTCHs would experience a slight increase (0.1%) in payments per discharge due to the proposed changes to the area wage adjustment. In addition, many of these LTCHs are located in areas where the proposed RY 2007 wage index value would be greater than the RY 2006 wage index value. Also, several of these LTCHs are located in areas that have a proposed wage index value of greater than 1.0, and therefore, would experience a slight increase in payments per discharge as a result of the proposed increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment.

LTCHs that began participating before October 1983 are projected to experience a **12.0% decrease in payments per discharge** from the 2006 LTCH PPS rate year compared to the 2007 LTCH PPS rate year compared to the 2007 LTCH PPS rate year. This higher than

average **decrease** in payments for RY 2007 as compared to RY 2006 is primarily due to the higher than average percentage of SSO cases (resulting from the proposed changes to the SSO policy) (p.398)

#### **Ownership Control (p. 399)**

LTCHs are grouped into **3 categories** based on *ownership control type*: (1) Voluntary; (2) Proprietary (73%); and (3) Government (3.5%).

Based on the most recent available data, approximately 3.5% of LTCHs are **government owned and operated**. CMS expects that for this group, 2007 LTCH PPS rate year **payments per discharge would decrease 14.3%** (higher than average decrease) in comparison to the 2006 LTCH PPS rate year. This is primarily caused by the proposed changes to the SSO policy (since many of these LTCHs have a higher than average percentage of SSO cases. Another factor contributing to the projected higher than average decrease in payments in RY 2007 is the effect of the proposed changes to the area wage adjustment. Specifically, all but 1 of the 9 government-run LTCHs in CMS's database are located in areas where the proposed wage index value for RY 2007 is less than 1.0, and therefore would experience a higher than average decrease in payments per discharge as a result of the proposed increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment.

CMS projects that 2007 LTCH PPS rate year **payments per discharge** for voluntary LTCHs would **decrease 13.2%** in comparison to the 2006 LTCH PPS rate year. CMS projects that voluntary LTCHs would experience a higher than average decrease in payments in RY 2007 primarily because of the proposed changes to the SSO policy, (since approximately two-thirds (40 LTCHs) of the voluntary LTCHs have a higher than average percentage of SSO cases. **\*\*ERROR on pg. 400 ~ "Similarly, we project that 2006 LTCH PPS rate year..."** The correct year is 2007, not 2006.

The majority of LTCHs are proprietary (approximately 73%). CMS projects that 2007 LTCH PPS rate year payments per discharge for these proprietary LTCHs would **decrease 10.4%** in comparison to the 2006 LTCH PPS rate year. This decrease in payments in lower than average due to the proposed changes to the SSO policy (since many of the proprietary LTCHs have a lower than average percentage of SSO cases)

#### **Census Region (p. 401-403)**

Payments per discharge for the 2007 LTCH PPS rate year are estimated to decrease for LTCHs located in all regions in comparison to the 2006 LTCH PPS rate year. Of the 9 census regions, CMS projects that the estimated decrease in proposed 2007 LTCH PPS rate year payments per discharge in comparison to the 2006 LTCH PPS rate year would have the **largest impact** on LTCHs in the **New England region (12.7%)**. LTCHs located in New England are expected to experience an **increase of 0.8% in payments** due to the proposed changes in the area wage adjustment, since all New England LTCHs are located in areas where the proposed wage index value for RY 2007 is greater than 1.0, thus experiencing an increase in payments per discharge as a result of the proposed increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment. However, because the vast majority of New England LTCH treat a higher than average percentage of SSO cases, CMS projects that these LTCHs would experience a higher than average decrease in payments in RY 2007 as a result of the proposed changes to the SSO policy.

CMS also projects that proposed 2007 LTCH PPS rate year payment per discharge would **decrease the least** for LTCHs in the **Pacific region** in comparison to the 2006 LTCH PPS rate year (**6.3%**). The projected decrease in payments per discharge for 2007 LTCH PPS rate year compared to the 2006 LTCH PPS rate year is less than the decreases projected for other regions because all LTCHs in this region are located in areas where the proposed RY 2007 wage index value is greater than the RY 2006 wage index value. In addition, all of the LTCHs located in the Pacific region are located in areas where the proposed wage index value for RY 2007 is greater than 1.0, and therefore, would experience an increase in payments per discharge as a result of the proposed increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment. Also, many of the Pacific LTCHs treat a lower than average percentage of SSO cases, and therefore, CMS projects that these LTCHs would experience a lower than average decrease in average payments as a result of the proposed changes to the SSO policy. (p.403)

#### **Bed Size (p. 403)**

LTCHs were grouped into 6 Categories based on *Bed Size*: 0-24 beds; 25-49 beds; 50-74 beds; 75-124 beds; 125-199 beds; and 200+ beds.

CMS projects a decrease in 2007 LTCH PPS rate year payments per discharge in comparison to the 2006 LTCH PPS rate year for all bed size categories. **Most LTCHs in bed size categories** where 2007 LTCH PPS rate year payments per discharge are projected to **decrease by at least 10.0%** in comparison to the 2006 LTCH PPS rate year.

Projecting that LTCHs with **200+ beds** would have the **smallest decrease (9.5%)** in estimated 2007 LTCH PPS rate year payments per discharge in comparison to the 2006 LTCH PPS rate year. Followed by LTCHs with **75-124 beds (10.3%)**. This lower than average decrease in projected payments per discharge for LTCHs with 200+ beds and for LTCHs with 75-124 beds is largely due to the proposed changes to the area wage adjustment.

Specifically for LTCHs with **75-124 beds**, the majority of these LTCHs are located in areas where the proposed change in the wage index value from RY 2006 to RY 2007 would be very small, therefore the proposed changes to the area wage adjustment would have a negligible impact on these LTCH's RY 2007 payments (0.0%) rather than decreasing their RY 2007 payments.

For LTCHs with **200+ beds**, the majority of these LTCHs are both located in areas where the **Proposed RY 2007 Wage Index Value > RY 2006 Wage Index Value**, and are located in areas where the **Proposed RY 2007 Wage Index Value > 1.0**, therefore, would experience an increase in payments per discharges as a result of the proposed increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment.

Payments per discharge for the 2007 LTCH PPS rate year for LTCHs with **0-24 beds** and projected to **decrease the most (13.5%)** in comparison to the 2006 LTCH PPS rate year, followed by LTCHs with **25-49 beds (11.8%)**. This higher than average decrease in projected payments per discharges for LTCHs with less than 49 beds is largely due to the proposed changes to the area wage adjustment. Specifically the majority of LTCHs with less than 49 beds are both located in areas where the **Proposed RY 2007 Wage Index Value < RY 2006 Wage Index Value** and are located in areas where the **Proposed RY 2007 Wage Index < 1.0**, therefore would experience a higher than average decrease in payments per discharge as a result of the proposed increase in the labor-related share and the progression of the 5-year phase-in of the wage index adjustment. In addition, LTCHs with 0-24 beds have a higher than average percent of SSO cases, therefore, would experience a higher than average decrease in payments per discharge as a result of the proposed change to the SSO policy.

**6. Effect on Medicare Beneficiaries (p. 409):** Under the LTCH PPS, hospitals receive payment based on the average resources consumed by patients for each diagnosis. CMS does not expect any changes in the quality of care or access to services for Medicare beneficiaries under the LTCH PPS, but they do expect that paying prospectively for LTCH services would enhance the efficiency of the Medicare program.