

A blurred background image of a person in a suit, possibly a lawyer, standing in a courtroom or office setting. The image is faded and serves as a decorative backdrop for the slide.

LTCH PPS: 2005 Annual Payment Rate Updates & Policy Changes

Mark Rich, FHFMA
Feeley & Driscoll, PC

www.fdcpa.com
888.875.9770

- Overview of Proposed Changes:
 - July 1 changes
 - October 1 changes
- Implementation Issues
- Other Current Issues

- Issued January 30, 2004 [FR Doc. 04-01886]
- Covers: LTCH Rate Year 2005
 - July 1, 2004 through June 30, 2005
 - Some elements still change on October 1, 2004
- Comment period ends 5pm March 23, 2004

- Base Rate inflation:
 - Change in *base rate*: **2.9%**
 - Increase from **\$35,726.18** to **\$36,762.24**
- Wage Index *Values*:
 - Updated from 2003 IPPS rate to 2004 IPPS rate
 - Based on Federal Year *2000 data*
 - Boston, *full rate*: 1.1233 (Prior 1.1229)
 - Springfield, *full rate*: 1.0543 (Prior 1.0927)

- Labor share remains at 72.885%
- Outlier threshold increases by **11.61%**
 - From **\$19,950** to **\$21,864**
 - Variable % remains at 80% of RCC
- Budget neutrality decreases from **6%** to **3%**
 - Lower than originally anticipated for LTCH RY '05 (4.6%)
 - CMS estimates:
 - 2006: 2.2%
 - 2007: 1.1%
 - 2008: 0.1%

Proposed Changes: October 1, 2004

Changes



- Grouper:
 - Remain on V.21 through September 30, 2004
 - Post October 1, 2004 tied to IPPS 2005 Final
- DRG Weights:
 - Remain as is through September 30, 2004
 - Federal FY 2004 based on 2002 MedPar
 - Post October 1, 2004 tied to next grouper

Proposed Changes: October 1, 2004 Changes



- Transition blending:

Cost Reporting Periods Beginning On or After	Prospective Payment Federal Rate Percentage	Cost-Based Reimbursement Rate Percentage
October 1, 2002	20	80
October 1, 2003	40	60
October 1, 2004	60	40
October 1, 2005	80	20
October 1, 2006	100	0



Proposed Changes: October 1, 2004 Changes



- Wage index *blending*:
 - Continuing on 5 year phase-in
 - Percentages change on October 1
 - July 1 – September 30, 2004: 40%
 - Boston: **1.0493** (increase from 1.0371)
 - Springfield: **1.0217** (decrease from 1.0371)
 - October 1, 2004 – June 30, 2005: 60%
 - Boston: **1.0740**
 - Springfield: **1.0326**

Proposed Changes: Rate Summary

	Oct 1, 2003 - June 30, 2004	July 1, 2004 - Sept 30, 2004	Oct 1, 2004 - June 30, 2005
•Boston payment rate:			
-Federal rate:	\$35,726.18	\$36,762.24	\$36,762.24
-Labor %	0.72885	0.72885	0.72885
-Labor portion	26,039.03	26,794.16	26,794.16
-AWI (phase-in)	1.0492	1.0493	1.0740
-Adj labor portion	27,320.15	28,115.11	28,776.93
-Non-labor portion	9,687.15	9,968.08	9,968.08
-Boston base rate	37,007.30	38,083.19	38,745.01
-Budget neutrality	0.94	0.97	0.97
-Adj Boston rate	\$34,786.86	\$36,940.70	\$37,582.66
Effective Rate Change		6.19%	1.74%

- Average Length of Stay:
 - Proposed regulation offers a “clarification”
 - Under the TEFRA system: (aka “Census Days”)

“Under the reasonable cost-based reimbursement system, the number of patient days that occurred during a cost reporting period and the costs associated with those days were reported on the hospital’s cost report (Hospital and Hospital Health Care Complex Cost Report, CMS Form 2552-96), as were the number of patient discharges that occurred during that same period. This method of reporting and reimbursement did not require that all of the days of care to a patient be counted as occurring in the cost reporting period during which the patient was discharged. Under this method of reporting and reimbursement the days of care to a patient are counted in the cost reporting period in which it occurred.”

- Average length of stay (continued):
 - Under LTCH PPS: (aka “Discharge days”)

“...once a LTCH is subject to the LTCH PPS, that is, for its first cost reporting period starting on or after October 1, 2002, the “days follow the discharge,” which means that both days and costs are linked to the patient’s discharge, even when the days occurred in a previous cost reporting period.” [NOTE: applies to ALL calculations for hospitals subject to LTCH PPS, even those under the transition blending method.]

- Average length of stay (continued):
 - Presently:

“...presently, for a LTCH with a January 1 through December 31 cost reporting period, if a patient was admitted on December 1, 2002 and discharged on January 15, 2003, patient days would be counted one way for payment purposes [*I.e. discharge*] and another way for purposes of counting the average length of stay. [*I.e. census*]”
 - Proposed:

“...we are proposing to revise 412.23(e)(3)(i) of the regulations to specify that if a patient’s stay includes days of care furnished during two or more separate consecutive cost reporting periods, the total days of a patient’s stay would be reported in the cost reporting period during which the patient is discharged in calculating the average length of stay for hospitals that qualify as LTCHs”
 - CMS will continue to use MedPar data until the cost report form can be changed to capture “discharge days”

- Interrupted Stay:
 - New Category: “**3 day interrupted stay**”
 - Effective for discharges after July 1, 2004
 - Direct response to CMS’ belief that providers are “gaming the system” by “discharging” patients who require expensive treatment and then re-admitting those same patients subsequent to that treatment.
 - Proposal has 2 main components:
 - New timeframe for patients who are discharged to home
 - Requirement to ‘bundle’ services during THIS interrupted stay
 - Not requiring ‘bundling’ during ALL interrupted stays (*YET*)

- Interrupted Stay (continued):
 - **Under the proposed regulation, effective for discharges after July 1, 2004, all patients that are readmitted to an LTCH within 3 days of discharge (from the same LTCH) will be considered interrupted stays – regardless of where they were during the intervening 3 days.**

- Interrupted Stay (continued):
 - **CMS is proposing to apply “unbundling” provisions to services provided by any Part A or Part B provider during the 3-day absence from the LTCH.**
 - **The LTCH will be responsible for services provided during this period regardless of whether or not the services were related to the initial stay or the subsequent readmission and regardless of who provides the service.**
 - **As such, all such services will be required to be billed to the LTCH by the provider (rather than the provider billing CMS directly) as if they were provided "under arrangement".**
 - **CMS has indicated that this provision will require it to provide the FI's with detailed instructions on how to implement this policy**

- Interrupted Stay (continued):
 - For the new “3 day interrupted stay” only:
 - **the days during the interrupted stay will be considered in the calculation of the LTCH’s qualifying ALOS if the patient is an inpatient of another provider (LTCH, Acute Hospital, IRF, SNF) during the interrupted stay.**
 - **If the patient is not an inpatient of another provider during the stay (e.g. is at home), the days during the intervening will not be considered in the ALOS calculation.**

- Co-located satellites / Remote locations:
 - **Voluntarily “spun off” into new hospital**
 - Will be treated as a **NEW** provider
 - **At least 5 of 6 months at 25 ALOS subsequent to spin off**
 - **Involuntarily “spun off” into new hospital**
 - Will be treated as an **existing** provider
 - **At least 5 of 6 months at 25 ALOS prior to spin off**

- Billing Issues
- MedPac
 - January meeting: “Qualitative” Analysis
 - March meeting: “Policy Analysis: Defining LTCHs”
- DPH Hearing on Licensure
- House 1:
 - Proposed further reduction in AND supplement
 - From current rate of 90% of the difference to 80%
 - Effective July 1, 2004
 - MHA estimate: \$1.3 million state-wide
 - Not evenly distributed

A faint, semi-transparent image of a document or book cover is visible on the left side of the slide. It features a decorative border and some text, including the words 'MEMBERS OF THE' and 'GENERAL NOTES'.

Mark Rich, FHFMA
Partner