LONG-TERM CARE HOSPITALS PAYMENT SYSTEM

*payment***basics**

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Patients with chronic critical illness—those who exhibit metabolic, endocrine, physiologic, and immunologic abnormalities that result in profound debilitation and often ongoing respiratory failure—frequently need hospital-level care for relatively extended periods. Nationwide, most chronically critically ill (CCI) patients are treated in acute care hospitals, but some are admitted to long-term care hospitals (LTCHs). These facilities can be freestanding or co-located with other hospitals as hospitals-within-hospitals (HWHs) or satellites. To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay greater than 25 days for certain Medicare patients.[1] Medicare payments to LTCHs were about $5.4 billion in 2014; Medicare beneficiaries accounted for about two-thirds of these hospitals' revenues. In 2014, about 118,000 Medicare beneficiaries had roughly 134,000 LTCH stays.[2] LTCHs are not distributed evenly through the nation.

Beneficiaries transferred to an LTCH from an acute care hospital pay no additional deductible. However, beneficiaries admitted from the community are responsible for a deductible—$1,288 in 2016—as the first admission during a spell of illness. An additional copayment is required if the beneficiary's hospital stay (whether in an acute care hospital, an LTCH, or combined) extends beyond 60 days during a spell of illness. In 2016, the copayment is $322 per day for the 61st through 90th days. Beneficiaries treated in LTCHs are covered for 90 days of hospital care per illness, with a 60-day lifetime reserve.[3]

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

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

Medicare began paying differently for some cases in LTCHs starting in fiscal year 2016. The Pathway for SGR Reform Act of 2013 establishes a dual payment structure and requires that Medicare pay "site-neutral" rates, based on what Medicare pays for similar cases in acute care hospitals, unless the LTCH case meets certain criteria.

Defining the long-term care hospital product Medicare buys

Beginning in 2016, LTCH cases that immediately follow an acute care hospital stay which included three days or more in an intensive care unit, or LTCH cases for which the LTCH stay includes mechanical ventilation services for at least 96 hours are paid under the LTCH PPS. LTCH discharges not meeting these criteria are paid an amount based on Medicare's acute care hospital payment rates under the inpatient PPS or 100 percent of the cost of the case, whichever is lower.

Under the LTCH PPS, Medicare pays for the operating and capital costs associated with hospital inpatient stays in LTCHs. Medicare sets per discharge payment rates for different case-mix groups called Medicare severity long-term care diagnosis related groups (MS–LTC–DRGs) based on the expected relative costliness

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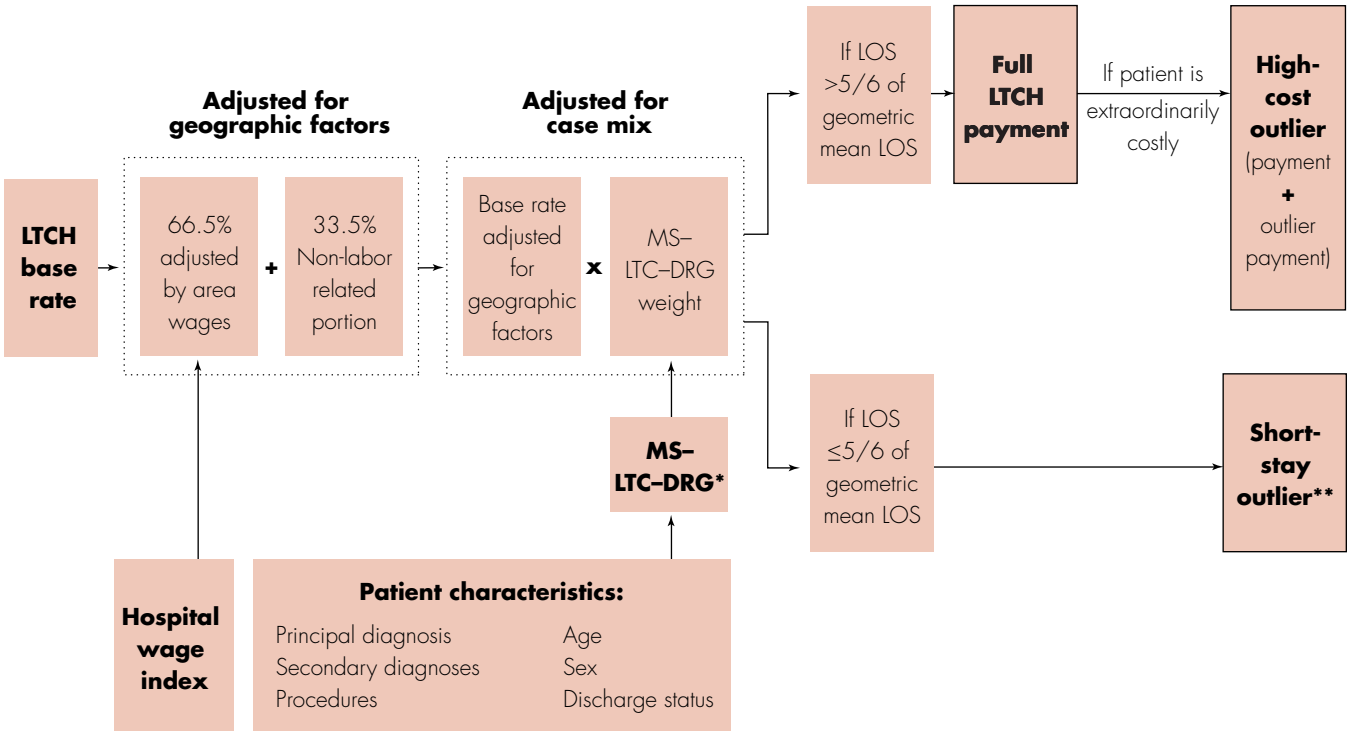
Figure 1 Payment for cases paid under the long-term care hospital prospective payment system



Note: LTCH (long-term care hospital), MS–LTC–DRG (Medicare severity long-term care diagnosis related group), LOS (length of stay). Beginning in fiscal year 2016, cases in LTCHs must meet certain criteria to receive payment under the LTCH prospective payment system. This includes cases that are admitted immediately following an acute care hospital stay and (a) that stay included at least three days in an intensive care unit or (b) the LTCH discharge receives a principal diagnosis indicating the receipt of mechanical ventilation services for at least 96 hours. All other cases are paid an amount based on Medicare's acute care hospital payment rates under the inpatient prospective payment system (IPPS) or 100 percent of the cost of the case, whichever is lower.

* MS–LTC–DRGs comprise base DRGs subdivided into one, two, or three severity levels.

** Payments generally are reduced for short-stay patients. CMS classifies cases with a length of stay that is less than or equal to the average length of stay for the corresponding IPPS MS–DRG plus one standard deviation as very short-stay outlier cases.

of treatment for patients in the group. Patients are assigned to these groups based on their principal diagnosis, secondary diagnoses, procedures performed, age, sex, and discharge status. The MS–LTC–DRGs are the same groups used in the acute inpatient PPS but have relative weights specific to LTCH patients, reflecting the average relative costliness of cases in the group compared with that for the average LTCH case.[4]

LTCH cases paid under the site-neutral rate will be assigned the same diagnosis related group based on their principal diagnosis, secondary diagnoses, procedure performed, age, sex, and discharge status. However, the relative weights will reflect those used in the acute inpatient PPS (IPPS).

Setting the LTCH PPS payment rates

The LTCH PPS payment rates cover all operating and capital costs that LTCHs would be expected to incur in furnishing covered services. The initial payment level (base rate) for a typical discharge in fiscal year 2017 is $42,476. Payments to LTCHs that fail to provide data on specified quality indicators are reduced by 2 percent.

The base rate is adjusted to account for differences in market area wages (Figure 1). The labor-related portion of the base payment amount—66.5 percent—is multiplied by a version of the hospital wage index and the result is added to the nonlabor portion.[5] For LTCHs in Alaska and Hawaii, the nonlabor portion is adjusted

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

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

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

Medicare applies a different standard for the shortest SSO cases. These cases are those in which length of stay is less than or equal to the average length of stay for the same MS–DRG at acute care hospitals paid under the IPPS plus one standard deviation. These cases are also paid the lowest of four payment amounts: the first three listed previously or an amount comparable with the IPPS payment rate, rather than a blended amount.

High-cost outliers—LTCHs are paid outlier payments for patients who are extraordinarily costly. High-cost outlier cases are identified by comparing their costs to a threshold that is the MS–LTC–DRG payment for the case plus a fixed loss amount. In FY 2017 the fixed loss amount is $21,943. Medicare pays 80 percent of the LTCHs' costs above the threshold. High-cost outlier payments are funded by reducing the base payment amount for all cases paid under the LTCH PPS by 8 percent.

Interrupted stays—LTCHs receive one payment for "interrupted-stay" patients. An interrupted stay is when an LTCH patient is discharged to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), or a skilled nursing facility (SNF), stays for a maximum specified period, then goes back to the same LTCH. The maximum specified period of time is 9 days for an acute care hospital, 27 days for an IRF, and 45 days for a SNF. For interrupted stays lasting three days or less, the LTCH is responsible for paying for the services provided by the intervening acute care hospital, IRF, or SNF.

Setting the payment rate for site-neutral cases

Cases that do not meet the specified criteria—including any discharges assigned to psychiatric or rehabilitation MS–LTC–DRGs, regardless of intensive care use—will be paid an amount comparable to Medicare's IPPS rate for the same type of case, including any applicable outlier payments, or 100 percent of the cost of the case, whichever is lower. These site-neutral payments will be phased in over a two-year period. Beginning with cost reporting periods starting in fiscal years 2016 and 2017, cases that do not meet the specified criteria will receive a blended rate of one-half the standard LTCH payment and one-half the site-neutral payment. These cases receive 100 percent of the site-neutral payment rate beginning with cost reporting periods starting on or after October 1, 2017.

High-cost outliers—LTCHs are paid outlier payments for site-neutral cases that are extraordinarily costly. Site-neutral high-cost outlier cases are identified by comparing their costs to a threshold that equals the site-neutral payment amount plus the IPPS fixed loss amount. In FY 2017, the IPPS fixed loss amount is $23,570. Medicare pays 80 percent of the LTCHs' costs above the threshold. High-cost outlier payments are funded by reducing the payment amount for cases paid under the site-neutral rate by 5.1 percent.

Interrupted stays—Medicare will apply the same interrupted stay policy to LTCH

cases paid the site-neutral payment rate as under the LTCH PPS payment rate.

The 25 percent rule

The 25 percent rule is intended to help ensure that LTCHs do not function as units of acute care hospitals and that decisions about admission, treatment, and discharge in both acute care hospitals and LTCHs are made for clinical rather than financial reasons. The rule sets a limit on the share of an LTCH's cases that can be admitted from certain referring acute care hospitals and reduces payments for some LTCHs that exceed the threshold. After the threshold is reached, the LTCH is paid the lesser of the LTCH PPS rate or an amount equivalent to the acute care hospital PPS rate for patients discharged from the host acute care hospital.[7]

The Medicare, Medicaid, and SCHIP Extension Act of 2007—as amended by the Patient Protection and Affordable Care Act of 2010 (PPACA), the Health Care Education Reconciliation Act of 2010, and the Pathway for SGR Reform Act of 2013—substantially changed the implementation of the 25 percent rule. Together, these laws roll back the phased-in implementation of the 25 percent rule for HWHs and satellites to 50 percent until cost reporting periods beginning on or after October 1, 2016, and prevent application of the rule to freestanding LTCHs until cost reporting periods beginning on or after July 1, 2016. In addition, The Pathway for SGR Reform Act of 2013 also permanently exempts certain co-located LTCHs from the 25 percent rule. In its fiscal year 2017 final rule, CMS consolidated the 25 percent threshold under one policy. CMS will apply the 25 percent threshold for discharges occurring on or after October 1, 2016, in cost reporting periods beginning on or after July 1, 2016, for LTCHs that do not include any co-located facilities or in cost reporting periods beginning on or after October 1, 2016, for LTCHs that include at least one co-located facility.

Payment updates

CMS updates the LTCH PPS payment rates annually based on the applicable market basket index (which measures the price increases of goods and services LTCHs buy to produce patient care). PPACA requires that any annual update to the LTCH payment rates beginning in fiscal year 2012 be reduced by an adjustment for productivity. PPACA also requires that the any update is further reduced by an additional adjustment through 2019. Payments to LTCHs for cases not meeting the patient-level critieria based on Medicare's acute care hospital payment rates will be updated statutorily by the inpatient market basket index as adjusted by productivity and the additional PPACA adjustment, as applicable. ■

1 Under the Pathway for SGR Reform Act of 2013, beginning in fiscal year 2016, the LTCH average length of stay is calculated only for Medicare fee-for-service cases that are not paid the site-neutral rate. Starting in fiscal year 2020, an LTCH must have no more than 50 percent of its cases paid at the site-neutral rate to receive the LTCH prospective payment system payment rate for eligible cases.

2 Medicare beneficiaries enrolled in Medicare Advantage plans are not included in these aggregate totals.

3 Beneficiaries are liable for a higher copayment for each lifetime reserve day—$644 per day in 2016.

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

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

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

7 During the year, the facility will be paid the LTCH rate. During retrospective settlement at the end of an LTCH's cost report year, if the facility is determined to be overpaid, CMS will collect the overpayments from future payments.