CMS finally published the long-awaited proposed rule that would establish a prospective payment system (PPS) for long-term care hospitals (LTCHs). The payment system would replace the reasonable cost-based payment system under which LTCHs are currently paid. The proposed PPS would use information from LTCH patient records to classify patients into distinct diagnosis-related groups (DRGs) based on clinical characteristics and expected resource needs. Separate payments would be calculated for each DRG. The PPS will be phased-in over five years, starting with cost reporting periods that begin on or after October 1, 2002.

Veterans Administration hospitals, hospitals that are reimbursed under state cost control systems, hospitals that are reimbursed in accordance with demonstration projects, and nonparticipating hospitals furnishing emergency services to Medicare beneficiaries would not be subject to the proposed LTCH prospective payment system rules.

Patient Classification

CMS is proposing a patient classification system called Long-Term Care Diagnosis-Related Groups (LTC-DRGs). The LTC-DRGs would classify patient discharges based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. Upon the discharge of the patient from a LTCH, the LTCH would assign appropriate ICD-9-CM diagnosis and procedure codes. The LTCH would then enter these codes on the current Medicare claims form and submit the completed claims form to its Medicare fiscal intermediary. Each claim would be classified into the appropriate LTC-DRG by the Medicare LTCH GROUPER. Following the LTC-DRG assignment, the fiscal intermediary would determine the prospective payment by using the Medicare PRICER program, which accounts for hospital-specific adjustments.

Payment Rate

The proposed standard Federal payment rate is **$27,649.02**. Payment rates would encompass both inpatient operating and capital-related costs of furnishing covered inpatient LTCH services, including routine and ancillary costs, but not the costs of bad debts, approved educational activities, blood clotting factors, anesthesia services furnished by hospital-employed nonphysician anesthetists or obtained under arrangement, or the costs of photocopying and mailing medical records requested by a PRO, which are costs paid outside the prospective payment system.

In this proposed payment system, relative weights for each LTC-DRG would be a primary element used to account for the variations in cost per discharge and resource

utilization among the payment groups. A relative weight is assigned for each LTC-DRG that represents the resources needed by an average inpatient LTCH case in that LTC-DRG. After applying the relative weights, reimbursement would range from a low of $7,680.90 to a high of $88,803.12.

Adjustments

Additional adjustments will also be made to the payment rates for:

- Very short-stay discharge
- Short-stay outlier
- Interrupted stay
- Outlier payment

Most surprisingly, an **Area Wage Adjustment** is **NOT** being proposed because statistical analysis did not show a significant relationship between LTCHs' costs and their geographic location. I can't recall any other major program that is not wage adjusted. While this is great for Louisiana facilities, I have my doubts that this will make it pass the final rule without change.

Also, **no** adjustments are proposed for Rural Area Adjustment, Geographic Reclassification, Disproportionate Share, and Indirect Teaching. Obviously, since there would be no purpose for LTCHs to reclassify to another area, there would be no need for adjustment for geographic reclassification.

In addition, **no** separate policy is proposed for cases that are **transferred** (except for those that are encompassed by the proposed interrupted stay policy) or for patients who **expired**. CMS believes the proposed very short-stay discharge policy, the proposed short-stay outlier, and the proposed interrupted stay policy would adequately address these circumstances.

Criteria to Qualify as LTCH

Presently to qualify for LTCH status, the Average Length of Stay (ALOS) must exceed 25 days. ALOS is currently determined by dividing TOTAL Days by TOTAL Discharges. CMS is proposing to change this rule to include only MEDICARE days and discharges instead of Total days and discharges. This could impact you if you have a significant number of non-Medicare patients driving the average over 25 days.

There will be a 60-day comment period before the Final rules are to be released. The proposed regulation is subject to significant modification, and the proposed payments may be adjusted.

Glen Langlinais