LONG TERM ACUTE CARE HOSPITALS:
"A Good Idea Just Got Better"

by

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Introduction

Since the early 1980's, the long term acute care hospital (LTACH) has been an integral part of the continuum of care for many hospitals and healthcare systems. Originally developed as tuberculosis hospitals or as settings focusing on ventilator patients, LTACHs today provide an ideal venue in which to treat patients with complex medical conditions requiring an extended stay in an acute setting.. In addition to ventilator dependency, LTACHs now treat a variety of patients that require long lengths of stay with access to technologically advanced therapies, including respiratory care, stroke, general debilitation, wound management, and cardiac care. Until recently, payment for long term acute care hospitals was administered under the cost-based reimbursement system known as TEFRA. Although the limit on TEFRA payments— "TEFRA Cap"—for most LTACHs was favorable when compared to payments under the acute care inpatient prospective payment system (Acute PPS), payment rates under the newly established prospective payment system for LTACHs (LTC-PPS), together with other features of the regulations establishing the LTC-PPS, mean that for most providers who serve patients in need of an extended stay in an acute venue, the LTACH is even more firmly established as a key venue within its comprehensive continuum of care.

From TEFRA to LTC-PPS

Prior to the passage of the Balanced Budget Act of 1997 (BBA), LTACHs had extraordinarily high TEFRA caps, often ranging from $50,000 to $80,000 per patient discharge. Since the BBA, however, TEFRA caps for both existing and new providers have been significantly lower. Nevertheless, today most long term acute care hospitals have TEFRA payments in the low to mid $20,000 range. However, this remains a favorable reimbursement rate when the LTACH reimbursement is considered together with the fact that without a long term acute care hospital these same patients would remain in the short term acute hospital and would generate no additional payment except for the original DRG payment. In most cases the DRG payment covers only the first few days of inpatient care. Extended stay patients would continue to occupy the hospital acute bed but no new monies would be available to cover their stay. Thus, TEFRA payments aside, LTACHs were "a good idea" under the TEFRA system because they provided significant reimbursement for patients who otherwise would have generated none while at the same time occupying an acute care bed that

otherwise could have been occupied by a short-term patient for whom reimbursement *was* available.

With CMS' publication of the final rules on August 30, 2002,[1] the importance of the LTACH in the continuum of care became even stronger. LTACHs with cost reports beginning on or after October 1, 2002, will be paid under the new LTC-PPS. Existing LTACHs may elect to be reimbursed under the full PPS immediately at the beginning of their cost reporting period.[2] Otherwise they will be phased into the LTC-PPS over a five-year period as follows:

Year	PPS Federal Rate	Cost-Based Reimbursement Per Discharge
10-1-02	20%	80%
10-1-03	40%	60%
10-1-04	60%	40%
10-1-05	80%	20%
10-1-06	100%	0%[3]

Advantages of the LTC-PPS

Although the LTC-DRG Payment System operates in a manner similar to the short term acute DRG payment system, the LTC-DRGs have higher weights and payments to compensate for longer stay patients. For example, in the acute care hospital, DRG 87, Pulmonary Edema and Respiratory Failure has a geometric mean length of stay (GMLOS) of 4.8 days with a payment of $6,046.[4] Under LTC-PPS, this DRG has a GMLOS of 32.3 days with a payment of $54,187.[5] Also, under the TEFRA payment system, an LTACH could anticipate a per diem of $800-$900 based on the hospital's interim rate. Under the LTC-PPS, on the other hand, a typical diagnosis has an average per diem of $1,300-$1,700.

DRGs that are specific to LTACH patients also have quite favorable reimbursement. LTC-DRGs range from DRG 21, Viral Meningitis with a payment of $13,000 to DRG 483, Trach w/Vent with a payment of $105,000. Many LTC-DRGs fall within an average range of $30,000-$60,000.

An additional positive reinforcement for LTACH reimbursement is contained in the addendum to the final rules published by CMS on March 7, 2003. This

[1] 67 Fed. Reg. 55954 (August 30, 2002).
[2] LTACHs electing full PPS reimbursement must inform their fiscal intermediaries in writing of their election no later than 30 days before the beginning of their cost reporting period.
[3] TEFRA payments during the phase-in period will include restoration of the full allowance for capital cost which had been reduced by 15 percent by the Balanced Budget Act of 1997.
[4] This is based on the 2003 DRG Payment with the standard Medicare Base Rate of $4,427.
[5] Based on the 2003 LTC-DRG Standard Federal Payment Rate of $32,649.

addendum calls for a 60-day commentary period in which CMS proposes to increase the standard Federal Base Rate for the long term acute care hospitals by approximately 2.2 percent from $34,956.15 to $35,726.64.[6]

The new LTC-PPS also provides quite favorable treatment for high cost "outlier" cases. High Cost Outliers are defined as cases that have unusually high costs exceeding the LTC-DRG payment, plus a fixed cost amount. In FY 2003, this amount is set at $24,450. An outlier case will be paid 80 percent of the difference between the estimated cost of the case and the sum of the adjusted Federal PPS rate for the LTC-DRG plus the fixed amount of $24,450. By comparison, for fiscal year 2003, the fixed loss amount for acute care hospitals under the Acute PPS is $33,560, meaning that acute care bed patients must incur over $9,000 more in expenses than LTACH patients before the outlier threshold is reached. Furthermore, the CMS proposed amendment would reduce the threshold for the LTACH outlier to $19,978.

Another advantage of the final LTC-PPS rules is that they limit the 25-day average length of stay requirement for LTACH patients to Medicare patients only. Patients under other payment systems, such as commercial insurance or worker's compensation, are not included in the average length of stay calculation for purposes of this Medicare condition of participation. This provides LTACHs more flexibility in determining length of stay for individual patients based on medical appropriateness rather than program directives. This aspect of the regulation, limiting the length of stay requirement to Medicare patients only, allows an LTACH to develop specialized programs such as bariatric surgery without putting in jeopardy its Medicare classification.

The final LTC-PPS rules also provide that certain expenses will continue to be paid on a Medicare reasonable cost basis, in addition to the LTC-DRG payments. These costs include:

- Costs of approved medical education
- Bad debts of Medicare beneficiaries
- Payment for blood clotting factor used by hemophilia patients
- Anesthesia services furnished under arrangement or by a hospital employed physician anesthetist
- Cost of photocopying and mailing records requested by a quality improvement organization (QIO).

These reimbursement advantages provided by the new LTC-PPS only serve to enhance the advantages already offered by the LTACH venue of care. When properly established and managed, the long term acute care hospital reflects the patient diagnostic population of the short term acute hospital in harmony with the

[6] 68 Fed. Reg. 11234, 11248 (March 7, 2003).

mission and philosophy of the health system and its medical staff. Together the long term acute and short term acute hospitals form the continuum of care with appropriate reimbursement reflective of each venue's purpose and anticipated length of stay. Under this continuum short-term acute care beds are no longer filled with patients who have exhausted their acute DRG payment. Instead, these patients are treated in a venue allowing the patient and the institution to benefit both clinically and financially.

Because most LTACHs are established as hospitals within hospitals, and therefore located within an existing acute care hospital, start-up costs in terms of construction generally are minimal when compared to new, free-standing facilities.[7] When coupled with the reimbursement benefits of the LTC-PPS, this cost savings provides the LTACH venue with a considerable financial advantage.

Conclusion

As a key element of the continuum of care that not only provided an appropriate venue for patients who needed acute services beyond those normally available in the general acute care hospital setting, the long term acute care hospital was always "a good idea." With the advent of the LTC-PPS and its considerable reimbursement benefits, the LTACH is, indeed, "a good idea that just got better."

About the Author:

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[7] It is a common misconception that the Medicare conditions of participation prohibit the host hospital or healthcare system from owning a hospital within a hospital LTACH. Although the host hospital or healthcare system is prohibited from controlling the LTACH, ownership of the LTACH by the host is *not* prohibited. See Cherilyn G. Murer, J.D., C.R.A., *Weathering the Reimbursement Crunch*, Rehab Management (December/January 1999).