MSB 18-07-23-A: Per Diem Reimbursement for Long Term Acute Care and Rehabilitation Hospitals

Classifications*: Long Term Acute Care and Rehabilitation Hospitals are divided into three (3) classes to determine the per diem the Hospital will be reimbursed: **(MSB 18-07-23-A pg. 6)**

1. **Long Term Acute Care (LTAC/LTCH) Hospitals:** Licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital which primarily serves an Inpatient population requiring long-term care services including but not limited to respiratory therapy, head trauma treatment, complex wound care, IV Antibiotic Treatment and pain management.

2. **Rehabilitations (IRF):** Licensed and CMS-certified as a Rehabilitation Hospital which primarily serves an Inpatient population requiring intensive rehabilitative services including but not limited to stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur, brain injury, and other disorders or injuries requiring intensive rehabilitation

3. **Spine/Brain Injury Treatment Specialist (IRF or LTAC/LTCH):** Licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital OR CMS-certified as a Rehabilitation Hospital and is a Not-for Profit Hospital as determined by the CMS Cost Report for the most recent fiscal year. A Spine/Brain Injury Treatment Specialty Hospital primarily serves an inpatient population requiring long term acute care and extensive rehabilitation for recent spine/brain injuries. Hospital's discharges by calendar year for cases which received payments from Medicaid, spine/brain injury treatment claims (previously grouped to APR-DRG 40, 44, 55, 56, 57) must account for at least fifty (50) percent of the annual discharges. The minimum of fifty (50) percent must exist from the previous calendar year of the classification and continue with each calendar year to keep designation.

Current Methodology for Inpatient Reimbursement

- APR-DRG Grouping Logic
- Base Rates: vary hospital to hospital
- Interim billing allowed if
  - Reimbursed charges over $100,000
  - Medicaid is the only insurance
- Medicare Crossover – 'Lesser of' logic
  - Coinsurance + Deductible
  - Medicare Paid Allowed Amount – Medicare Paid Amount
- Base Rates increase/decrease by Annual approved State Budget Percentage

Hospital Type	APR-DRG	Severity	Description	Weight	Average Length of Stay	Trimpoint
LTAC**	130	4	Ventilator Support 96+ Hours	6.7266	21.62	62
IRF**	860	3	Rehabilitation	2.1410	15.36	39
SPINE**	40	3	Spinal Disorders and Injuries	1.6653	6.46	20

*Classifications were determined by case dynamics, Colorado State licensure by Colorado Department of Public Health and Environment (CDPHE) and Medicare Certification.

Why a Per Diem? (MSB 18-07-23-A pg. 3-4)

- Majority of Medicaid programs surveyed, 17 out of 30, currently reimburse similar hospitals with a per diem
- Per diem would create an equal reimbursement for each classification of Specialty.
- Decreases Department costs on short stays while increasing reimbursement to Hospitals for higher severity cases that result in longer stays.
- Under APR-DRG methodology, hospitals receive the same payment regardless of length of stay from day 1 to the Trimpoint day.
- Unchanging amount of payment between ALOS and Trimpoint impacts our smaller hospitals ability to accept higher severity patients, who have longer stays and greater Trimpoints.
- Inconsistent Base Rates provide a few hospitals an advantage in accepting Medicaid clients versus those hospitals with lower base rate.
- Easier to calculate a payment expectancy versus APR-DRG methodology that requires grouping, severity of illness, average length of stay, Trimpoint and Outlier payment. (Providers are currently having to estimate their payment using a grouper and then determine if they can take patient. A per diem expedites that process and allows for a clear picture of reimbursement.
- Better foundation to build for additional components such as quality measures and case mix index (Severity component).

Per Diem Methodology Components (MSB 18-07-23-A pg. 23-24)

- Each **Tier** represents the amount of days paid at a designated per diem. Each classification receives four sections consisting of a stepdown methodology based on a calculation customized for each class.
- **Stepdown methodology** was developed to address longer stays. As the stay enters a new **Tier** a decrease is applied to the start of each new tier. This still allows Hospitals to gain a higher reimbursement in the long run for its services to higher severity patients but also disincentives patients staying longer than needed as the reimbursement per day decreases with time. It also reflects the reduction of care as the patient is recovering. Stepdown of 5% was confirmed by the equation of the line created by graphing the Hospital's billed amount divided by the covered days reflected in a scatterplot graph.
- **Interim Billing** will be allowed every 30 days. This provides all Long-Term Acute Care and Rehabilitation Hospitals a chance to receive interim payments at the same frequency.

FINAL RATE								
CLASSIFICATION	T1 Days	Tier 1 Rate	T2 Days	Tier 2 Rate	T3 Days	Tier 3 Rate	T4 Days	Tier 4 Rate
LTAC	1-21	$2,176.81	22-35	$2,067.97	36-56	$1,964.57	>56	$1,866.34
REHAB	1-6	$1,009.50	7-10	$959.03	11-14	$911.08	>14	$865.52
SPINE	1-28	$2,875.38	29-49	$2,731.61	50-77	$2,595.03	>77	$2,465.28

*Classifications were determined by case dynamics, Colorado State licensure by Colorado Department of Public Health and Environment (CDPHE) and Medicare Certification.