



American Hospital  
Association

## Regulatory Bulletin

### LTCH Report Released by CMS

January 4, 2007

Below is a summary of a long-term care hospital (LTCH) report by the Research Triangle Institute, Inc. (RTI) that was released by the Centers for Medicare & Medicaid Services (CMS) in late December. This report was commissioned by CMS to help ensure the appropriate use of long-term care hospitals (LTCH) in the Medicare program. This report sought to identify feasible patient and facility criteria that would further distinguish LTCHs from other acute-care hospitals. This summary covers the key patient and facility recommendations in the RTI report. The full report can be accessed online at [http://www.cms.hhs.gov/LongTermCareHospitalPPS/Downloads/RTI\\_LTCHPPS\\_Final\\_Rpt.pdf](http://www.cms.hhs.gov/LongTermCareHospitalPPS/Downloads/RTI_LTCHPPS_Final_Rpt.pdf).

We anticipate that the pending proposed rule on the LTCH prospective payment system for Rate Year 2008 will discuss the report and include some of the recommendations below. Overall, even these recommendations are only partially implemented, they would reduce and slow Medicare spending on LTCHs by limiting the types of patients admitted to LTCHs. Some of these recommendations would require authorizing legislation from Congress.

#### Overview of RTI's Patient and Facility Recommendations

1. All LTCH patients should have a primary medical diagnosis (rather than a rehabilitation or psychiatric diagnosis) and be medically complex, with a wide range of medical complications, co morbidities, or system failures that cumulatively constitute a severely ill patient.
2. LTCH patients should meet the acute hospital standard of having an expectation for improvement or being admitted for a diagnostic procedure. Therefore, LTCH patients should be monitored with continuing stay criteria to assess progress and long-term ventilator patients who fail weaning should be transferred from an LTCH to a less-intensive setting.
3. Clinical criteria that identify LTCH patients based on clinical acuity should be developed.

4. RTI will establish a technical expert panel comprised of clinicians and operational representatives from general acute hospitals and post-acute settings to identify key clinical characteristics that distinguish LTCH patients from other patient populations.
5. Coding requirements should be modified to collect clinical data that indicate a patient's level of medical acuity.
6. LTCHs should be required to submit functional and physiologic measures on all patients receiving physical, occupational, and/or speech-language therapy. Such measures should be consistent with those used by other Medicare providers to allow comparisons across sites.
7. LTCHs should satisfy additional conditions of participation such as specific staffing requirements appropriate for medically complex cases.
8. To retain the LTCH emphasis on treating long-stay patients, keep the 25-day average length of stay (ALOS) requirement.
9. Allow LTCHs, to operate distinct-part rehabilitation and psychiatric unit in cases where access for these patient populations is restricted.
10. Discourage "inappropriate" transfers to other settings through two payment reductions -- reduce payments for 1) LTCH patients discharged to a post-acute setting; and 2) patients discharged following a "very short" LTCH stay. Very short stays could be defined as being within one standard deviation ALOS for general acute hospitals and would be paid at the lower rate for general acute hospitals.
11. CMS should support further research to understand the distinct costs and margins for each component the entire episode of care for medically-complex patients.

To discuss any concerns or questions containing to this bulletin or the full RTI report, please call Rochelle Archuleta, senior associate director of policy, at 202-638-1100.