American Hospital Association

Regulatory Advisory

AHA's Regulatory Advisory, a service to members, is produced whenever there is a significant development that affects the job you do in your community.

CMS Issues Two Rules Affecting Long-Term Care Hospitals

A Message to AHA Members:

Recently, the Centers for Medicare & Medicaid Services (CMS) issued two rules concerning Medicare payments to long-term care hospitals (LTCH) under the prospective payment system (PPS). First, on May 9, CMS published the final rule on LTCH PPS payments for rate year 2005, which begins July 1, 2004. Besides the market basket update, this final rule includes changes to the calculation of average length of stay and new definitions of interrupted stays. Second, on May 18, CMS published the inpatient PPS proposed rule for fiscal year 2005 that contained LTCH provisions concerning Medicare separateness and governance criteria, re-calibration of the LTCH diagnostic-related groups (DRG), and payments to "crossover patients," who are undergoing treatment when an LTCH receives Medicare certification.

The AHA is concerned about the proposed changes related to the LTCH separateness and governance criteria, and we'll voice our opposition to these and other proposed provisions in our comment letter to CMS. We encourage LTCH members and affected short-term acute hospitals to also submit comments by the July 12 deadline – describe the barriers to accessing appropriate levels of care that the proposed rule would create for the Medicare beneficiaries and community you serve.

After reviewing this advisory, check off the following items from your to-do list:

- ✓ Share the advisory with your senior management team, medical director and discharge planner; the LTCH administrator and medical director; physicians who commonly refer to your facility; and other key partners.
- ✓ Submit your comment letter to CMS by July 12. In your letter, emphasize the reduced access to care resulting from the IPPS proposed rule's LTCH provisions. Be specific in describing how your patients, community and local health care continuum would be affected if your LTCH would be forced to close or reduce services due to CMS' proposal.

The AHA will continue to work vigorously on behalf of long-term care hospitals.

Sincerely,

Rick Pollack
Executive Vice President

June 14, 2004

American Hospital Association

Regulatory Advisory

June 14, 2004

CMS Issues Two Rules Affecting Long-Term Care Hospitals

In recent weeks, the Centers for Medicare & Medicaid Services (CMS) issued two rules pertaining to long-term care hospitals (LTCH). The first is the May 7 final rule that concerns changes to the LTCH prospective payment system (PPS) for the 2005 rate year. The second is the proposed rule on the inpatient prospective payment system (IPPS), published in the May 18 *Federal Register*, which includes several significant LTCH provisions.

Several years ago, CMS introduced the concept of a "rate year" in order to stagger rule changes over a 12-month period. However, this policy is disruptive. Rate changes take effect July 1 and DRG adjustments take effect October 1. The AHA will continue urge CMS to issue LTHC changes in a more uniform manner.

This advisory summarizes the LTCH provisions in the IPPS proposed rule and the LTCH final rule.

Major LTCH Changes included in the IPPS Proposed Rule for FY 2005

The May 18 IPPS proposed rule includes several provisions related to LTCH hospital in a hospital[1] (HIH) certification and payment, and proposed revisions to the LTCH diagnosis-related group (DRG) weights. These proposed changes would take effect for cost reporting periods beginning on or after October 1, 2004. **Comments on this proposed rule must be received by CMS by July 12, 2004.** In our comment letter to CMS, the AHA will strongly oppose many of the LTCH provisions.

Background on Governance and Separateness Criteria. Under current law, to be eligible for Medicare certification an LTCH HIH must satisfy several regulatory standards that demonstrate organizational and functional separateness from the host hospital or campus. Two key requirements are briefly summarized:

- *Governance*: Although a host hospital and HIH may not be under a common control arrangement, a common ownership relationship is allowable, which requires separate governing bodies, chief executive officers, chief medical officers and medical staff.
- *Separateness*: An HIH must satisfy <u>one</u> of the following requirements:
    - Not more than 15 percent of an HIH's operating costs may be services purchased from the host hospital.

[1] An LTCH hospital in a hospital describes a long-term care hospital that exists as a wing or floor within an acute care hospital (host). An HIH is not a freestanding facility.

- ♦ The HIH purchases virtually no medical services from the host hospital.
- ♦ Not more than 25 percent of an HIH's admissions may be referrals from the host hospital.

Most HIHs satisfy the separateness requirement through the 15 percent limitation on the purchase of services from the host hospital.

Prohibition of Common Ownership Governance. CMS is proposing to prohibit LTCH HIH governance under a common ownership arrangement with a host hospital. Commonly-owned HIHs in existence on June 30, 2004 would be exempt. This proposal would disproportionately affect not-for-profit LTCHs, which frequently operate under a common ownership model. The AHA opposes this provision, and we are concerned that it is inconsistent with other common ownership arrangements that are allowed by Medicare for facilities such as children's and cancer hospitals.

Restriction of HIH Separateness Standard. CMS proposes to eliminate two of the three "separateness" qualification options for LTCH HIH certification – the 15 percent expenditure requirement and the purchase of medical services requirement. Under the proposed rule, the sole means of meeting the HIH separateness criteria would be to satisfy the requirement that no more than 25 percent of its admissions are referrals from its host hospital. An HIH that exceeds the 25 percent referral cap would not be decertified, but would be reimbursed under one of the payment methods put forth in the proposed rule, which are summarized below. (NOTE: due to an exemption provided in the Balanced Budget Act of 1997, the proposed changes would not apply to the approximately 18 HIHs that were certified prior to September 30, 1995.)

Payment Methodologies for Facilities that Fail to Meet Proposed Separateness Criteria. CMS put forth the proposals changing governance and separateness requirements as a disincentive to LTCH HIHs that provide services the agency views as a continuation of care provided by the host hospital, and which, CMS believes, are already adequately reimbursed through the IPPS DRG payment. CMS views a subsequent, additional payment to an LTCH HIH for post-acute care as an inappropriate payment for an unbundled acute hospital service, which distorts cost averaging under the IPPS. CMS is considering the following reimbursement methods for these HIHs, and is seeking comment from the field on these alternative payment methods:

- Medicare would reimburse the HIH under the short-term acute IPPS for all patients, which would reduce the standardized amount from $36,834 to approximately $5,000 per case. (The proposed rule is silent on whether existing IPPS adjustments would apply, such as disproportionate share, rural, etc.)
- Medicare would pay the HIH under the LTCH PPS for patients referred from a source other than the host hospital. For patients transferred from the host hospital, no payment would be made to the LTCH.
- Medicare would pay the HIH the lesser of the IPPS payment or the LTCH PPS payment for patients received from a host hospital. For other patients, the HIH would be paid under the LTCH PPS.

Given the high cost of LTCH patients, it is anticipated that under these proposed qualification and payment scenarios, significant numbers of LTCH HIHs would be forced to close their doors.

Potential Impact on non-LTCH HIHs. The proposed rule does not mention LTCH satellite facilities when discussing governance and separateness provisions. However, as currently

written, the proposed changes would apply to freestanding, co-located facilities[2] that are exempt from the IPPS such as inpatient rehabilitation facilities (IRF), psychiatric hospitals and perhaps other types of co-located institutions.

The AHA is concerned about the separateness and governance provisions in the IPPS proposed rule because they could cause reduced access to needed care for patients of affected LTCHs, IRFs and psychiatric facilities.

FY 2005 DRG Weights. CMS' proposed FY 2005 DRG weights are, overall, lower than the FY 2004 weights. The reduction in DRG weights is projected to reduce aggregate payment to LTCHs in FY 2005 by approximately $55 million. The proposed rule attributes the change in weights to the increases in the volume of cases being assigned to higher-weight DRGs. The AHA is concerned that the proposed recalculation of the LTCH DRG relative weights for FY 2005 would reduce overall payments. This process should be budget neutral and should result in the same overall net payment to LTCHs.

Payments to Converting LTCHs. Most hospitals operate as an acute hospital for the six-month period prior to certification as an LTCH in order to demonstrate compliance with the 25-day average length of stay (ALOS) requirement. Currently, inpatients at the time of conversion to an LTCH are technically "discharged" from the acute hospital and admitted to the newly established LTCH. This results in two episodes of care for services provided by the same facility – one under its pre-LTCH status and then one under its new LTCH status – and the facility receives two Medicare payments. Under the proposed rule, Medicare would recognize and pay only for one LTCH episode. For such cases, a single LTCH PPS payment would be made and *all* days would count toward the LTCH's 25-day ALOS calculation for the cost report.

LTCH PPS Final Rule

The May 7 LTCH PPS final rule implements several provisions pertaining to the 2005 rate year including the statutorily-required update of the market basket rate, a reduced outlier threshold, a modified method for calculating ALOS and new definitions for interrupted stays. These and other changes are described below. The final rule takes effect July 1.

Market Basket Update. In the final rule, the inflation update for the 2005 rate year is 3.1 percent, which exceeds the 2.9 percent estimated increase in the proposed rule. As a result of this full market basket rate increase, the LTCH standardized rate for the 2005 rate year will be $36,834.

Changes in ALOS Calculation. Under the final rule, CMS will assess compliance with the 25-day ALOS requirement by counting all days of a patient's stay in the cost reporting period in which the patient is discharged. This method is consistent with the counting methodology used for payment purposes. For existing LTCHs, noncompliance with this requirement will be enforced beginning July 1, 2005. If an LTCH fails to meet the 25-day standard based on the most recent cost reporting period, it may maintain Medicare certification if it can demonstrate that the standard was met during at least five months of the preceding six-month period. If an LTCH changes ownership at the start of a cost reporting period or within five months of the preceding six-month period, the hospital may maintain Medicare certification if during at least

[2] Co-located facilities are defined as facilities that have the same parent company and are located on the same campus.

five of the immediately preceding six months the hospital met the ALOS standard and continuously operated as a hospital under Medicare.

Interrupted Stay Policy Modifications. Responding to concerns raised by the AHA and others, the final rule establishes two categories of interrupted stays based on the number of days the patient is not in an LTCH. For the first category, "greater than three-day interrupted stays," the existing provider-specific limits will continue to apply – a maximum of nine days for an acute care hospital, 27 days for an IRF and 45 days for a skilled nursing facility (SNF). Interruptions longer than three days and within these provider-specific limits will be treated as part of one stay for the LTCH and eligible for one LTCH payment. Services provided during the interrupted period will be eligible for separate reimbursement by Medicare under the appropriate PPS. Interrupted stays that exceed these provider-specific limits and are followed by a readmission to the same LTCH will continue to be treated as two LTCH stays that are each eligible for a separate Medicare reimbursement. For "greater than three-day interrupted stays," the days that a patient is away from an LTCH are not included in the ALOS calculation.

For the second category, "three-day or less interrupted stays," a single LTCH stay will be designated for the LTCH beneficiary discharged to a short-term acute hospital, IRF, SNF or home and then readmitted within three days to the same LTCH. Thus, only one LTCH PPS payment is made to the hospital. For this category of interruptions, the LTCH is responsible for paying for patient services received in other care settings with an exception for surgeries, through an "under arrangement" basis. Services provided under arrangement are the financial responsibility of the LTCH (including hospital outpatient services) and will not be paid separately by CMS, except for surgery provided from July 1, 2004 through June 30, 2005. The LTCH must negotiate payment and pay for the care delivered by the other providers. For this initial one-year period, short-term acute hospitals providing surgical care to LTCH patients during an interrupted period will receive a separate Medicare payment under the IPPS.

For "three-day or less interrupted stays," the days the beneficiary spends away from the LTCH are only included in the facility's ALOS calculation if inpatient or outpatient services are rendered during the interrupted period – excluding surgical days, which are not to be counted in the ALOS. The days of the "three-day or less interrupted stays" are subject to outlier rules, including the short-stay outlier rule payment reduction and the high-cost outlier add-on.

Outlier Threshold Reduced. CMS pays high-cost outlier cases 80 percent of the difference between the estimated cost of the patient case above and beyond the outlier threshold. For the 2005 rate year, LTCHs will have an outlier threshold of $17,864, which is $1,726 lower than the 2004 threshold. The threshold was reduced due to the availability of recently corrected data used by CMS to calculate the outlier threshold.

Separation of Satellite and Remote LTCHs. On July 1, 2003, CMS began prohibiting LTCH satellites (located in a different hospital or campus) and remote LTCH facilities (not located in another hospital or the same campus) beyond 35 miles from a host hospital's main campus. These facilities were *involuntarily* separated from their host facilities. These "new" facilities were granted an exemption from first operating as a short-term acute hospital to demonstrate compliance with the 25-day ALOS requirement independently from the hospital. Such facilities were allowed to submit discharge data for five of the immediately preceding six months to demonstrate compliance with the 25-day ALOS requirement prior to separation from the main hospital, and were eligible for operation as an independent LTCH on the first day of separation.

In the final rule, CMS clarifies the certification requirements for satellite and remote LTCHs seeking to *voluntarily* reorganize as an independent provider with its own Medicare provider number. A voluntarily separating satellite or remote location must first demonstrate that it meets the 25-day ALOS requirement by operating as a short-term acute hospital for six months and, if deemed eligible, may then begin Medicare participation as a new LTCH at the start of the next cost reporting period.

Ongoing CMS Monitoring. In the final rule, CMS announced it will continue to closely monitor growth, payments and other policy issues related to LTCH HIHs. The agency also noted its development of a system to track beneficiary movement to and from LTCHs including transfers to and from other Medicare providers.