American Hospital Association

Regulatory Advisory

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Long Term Care Hospital Changes for FY 2005 and Beyond

A Message to AHA Members:

On August 11, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* the final rule implementing fiscal year (FY) 2005 changes to the hospital inpatient prospective payment system (PPS). The attached advisory describes the long-term care hospital (LTCH) provisions contained in this final rule. The AHA's comment letter on the LTCH provisions of the proposed rule may be found at: www.aha.org/aha/key_issues/longterm/advocacy/070704commentltr.html. The final rule can be found at www.hospitalconnect.com/aha/advocacy-grassroots/advocacy/register/arfedregister.html.

The final rule modifies several policies affecting long-term care hospitals (LTCH) located within another hospital. While the AHA is pleased that CMS deferred action on significant LTCH policy changes for one year, we're still concerned that appropriate clear patient and facility criteria for LTCH care have not been identified. As we requested, the rule does not change the current guidelines regarding common ownership; however, we're disappointed that CMS will impose a downward payment adjustment for certain patients referred from a "host hospital." This change inappropriately interferes with clinical decision-making and the ability to provide the right care in the right place.

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

- ✓ Share this advisory with your entire LTCH management team.
- ✓ Determine how changes to the LTCH PPS will affect your FY 2005 Medicare revenue.
- ✓ If your facility is a hospital-within-hospital, determine your host hospital referral percentage and the impact of the new payment adjustment.
- ✓ If you are a hospital-within-hospital, discuss these changes with the management of your host hospital.
- ✓ If you are a host hospital, analyze the implications of these changes and possible future changes on your facility.

The AHA will continue to work with Congress and the administration to ensure that LTCHs have the resources needed to provide quality health care to America's communities.

Sincerely,

Rick Pollack
Executive Vice President

August 26, 2004

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Long Term Care Hospital Changes for FY 2005 and Beyond

Background

On August 11, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* the final rule implementing fiscal year (FY) 2005 changes to the hospital inpatient prospective payment system (PPS) which included changes to the long term care hospital (LTCH) prospective payment system. While the AHA is pleased that CMS deferred action on significant LTCH policy changes for one year, we're still concerned that appropriate, clear patient and facility criteria for LTCH care have not been identified.

Hospital-Within-Hospital Requirements to Demonstrate Separation from a Host Hospital
The final rule implements significant changes to the regulations that require an LTCH located in an acute care hospital (hospital-within-hospital) to demonstrate its separateness from its host hospital. Beginning with cost report periods on or after October 1, 2005, LTCHs that are hospitals-within-hospitals no longer will be required to satisfy the current separateness criteria, which demonstrates functional separateness from their host hospitals. Instead, hospitals-within-hospitals and satellites will be subject to a new payment adjustment for certain patients. This adjustment will apply to existing LTCH hospitals-within-hospitals, LTCH satellites, and acute hospitals that are in the process of becoming certified as LTCHs.

In addition to other Medicare certification requirements, an LTCH hospital-within-hospital currently must satisfy one of three criteria to demonstrate functional separateness from the host hospital in which it is located. Each hospital-within-hospital 1) must not exceed the 25 percent cap on host hospital referrals; 2) must not exceed the 15 percent cap on services purchased from the host hospital; or 3) must not purchase any medical services from the host hospital. Most hospitals-within-hospitals satisfy this requirement by complying with the 15 percent cap.

In the proposed rule, CMS had proposed changing the qualification criteria for LTCH hospitals-within-hospitals to address the agency's concern that they are providing care that should be delivered in the acute hospital setting. The proposal would have eliminated two of the three separateness qualification options for hospital-within-hospital certification – the limitations on the purchase of services and the purchase of medical services requirements. The sole remaining means of meeting the hospital-within-hospital separateness criteria would have been to satisfy the requirement that no more than 25 percent of the LTCH's admissions are referrals from its host hospital. CMS proposed paying a lower amount to hospitals-within-hospitals that exceeded

the 25 percent referral cap, and requested comments on three options for reducing Medicare payments.

CMS changed its approach in the final rule. The separateness criteria will remain in effect for cost reports beginning in FY 2005, however, beginning on October 1, 2005, hospitals-within-hospitals no longer will be required to satisfy *any* of the three separateness criteria. Instead, hospital-within-hospitals and satellites will be subject to a new payment adjustment for certain patients. The new payment adjustment will be phased in and apply to existing LTCH hospitals-within-hospitals, LTCH satellites, and acute hospitals that are in the process of becoming certified as LTCHs, as defined below.

New Hospital-Within-Hospital Payment Adjustment. Medicare will reimburse hospitals-within-hospitals or satellites under the LTCH PPS for three categories of patients: 1) patients who are not referred by the host hospital; 2) patients who were Medicare high-cost outliers at the host hospital prior to being transferred to a hospital-within-hospital or satellite; and 3) certain host-referred patients. Host-referred patients up to a specified threshold (25 percent under full implementation) for hospital-within-hospital or satellite discharges during a cost report period will be paid under the LTCH PPS. LTCH PPS payments will be adjusted for those hospital-within-hospital or satellite patients who exceed the threshold for host hospital referrals. For such patients, reimbursement will be the lesser of the unadjusted LTCH PPS payment or the correlating IPPS payment. Only Medicare patients will be counted in the assessment of a facility's status relative to this threshold.

Transition to New Payment Adjustment. A host hospital referral threshold of 25 percent will be phased in over four years:

- FY 2005: During FY 2005, hospitals-within-hospitals and satellites must satisfy one of the current three separateness criteria described above. During FY 2005, the percentage of host hospital referrals may not exceed the FY 2004 referral rate.
- FY 2006: The current LTCH hospital-within-hospital separateness policies expire. The host hospital referral threshold will be set at 75 percent.
- FY 2007: The host hospital referral threshold will be set at 50 percent.
- FY 2008 and beyond: The host hospital referral threshold will be set at 25 percent. Rural and certain urban hospitals-within-hospitals will receive exceptions from this policy as noted below.

    - ***Rural Hospitals-Within-Hospitals.*** For FY 2008 and beyond, reimbursement for rural hospital-within-hospital and satellite discharges above a 50 percent threshold on host hospital referrals will be adjusted to the lesser of the unadjusted LTCH PPS or IPPS payment. Payments for patients who were Medicare high cost outliers at the host hospital and then transferred to a hospital-within-hospital or satellite will not be included in the assessment of a facility's status relative to the threshold and will be reimbursed under the LTCH PPS.

    - ***Urban Hospitals-Within-Hospitals.*** An urban hospital-within-hospital or satellite will be eligible for an exception if it is located in an urban hospital that:
        - Is the only acute hospital in the metropolitan area, or
        - Is the dominant hospital of the metropolitan area (defined as having more than 25 percent of all Medicare inpatient acute care hospital discharges).

For these hospitals, in FY 2008 and beyond, between 25 and 50 percent of patients referred from the host hospital will be paid at the LTCH PPS rate. The particular percentage is determined by the host hospital's percentage of total Medicare discharges in the labor market area. That is, the larger the host hospital's proportion of Medicare discharges, the higher the allowed percentage of hospital-within-hospital referrals from the host hospital, up to a 50 percent ceiling.

"LTCHs-Under-Formation." Under the final rule, acute hospitals in the process of seeking certification as an LTCH hospital-within-hospital, referred to as "LTCHs-under-formation," may be eligible for the four-year phase-in if two criteria are met. Such hospitals must be certified as an acute care hospital on or before October 1, 2004, and designated as an LTCH before October 1, 2005. Any new LTCH hospital-within-hospital that opens without qualifying as an "LTCH-under-formation" must operate under the 25 percent threshold and will not benefit from the transition.

Hospital-Within-Hospital Common Ownership

As the AHA strongly urged, the rule does not change current criteria regarding the governance of hospitals-within-hospitals. Under current regulations, a host hospital and hospital-within-hospital may not be under a common control arrangement; however, a common ownership relationship is allowed. The common ownership provision requires that the hospital-within-hospital have a distinctly separate governing body, chief executive officer, chief medical officer and medical staff from those of the host hospital. Primarily not-for-profit hospitals have chosen to incorporate an LTCH into their continuum of care through a common ownership arrangement to avoid the tremendous capital investment associated with establishing an LTCH as a freestanding facility.

The proposed rule would have prohibited certification of new hospitals-within-hospitals under a common ownership arrangement on or after July 1, 2004. This proposal would have disproportionately affected not-for-profit LTCHs, which frequently operate under a common ownership model.

The final rule did not change the current LTCH common ownership guidelines; however, CMS does plan to continue monitoring patient referral patterns and utilization at LTCHs organized in a common ownership arrangement.

CMS Research of LTCH Facility and Patient Criteria

During the three-year transition, CMS will assess the feasibility of developing LTCH facility and patient/clinical criteria. CMS intends to discuss any short-term findings regarding the development of these criteria in the forthcoming FY 2006 LTCH PPS notice of proposed rulemaking, expected to be released in January 2005.