



Long-Term Care Hospital Improvement Act of 2011

S. 1468

Section-by-Section Summary

Section 1. Short Title and Table of Contents

Section 2. Specification of Criteria for Patient Preadmission, Admission, and Continuing Stay Assessments

Pre-Admission Screening Criteria

- A screening must be conducted during the 36-hour window prior to admission by a clinical health care professional (physician, registered professional nurse, licensed practical or vocational nurse, physician assistant, respiratory therapist, or others defined by Secretary), and a physician must review and concur with the findings of the screening prior to LTCH admission.
- Specifies nine elements that must be included in a standardized preadmission screening process: 1) medical status of patient; 2) planned level of improvement; 3) expected length of stay; 4) evaluation of risk for clinical complications; 5) primary and secondary diagnosis; 6) identification of the primary treatment needed by the patient; 7) evaluation of whether there is appropriate treatment at a lower level of care; 8) anticipated post-discharge settings and treatments; and 9) any other clinical rationale for admission.

Admission Criteria

- A physician must examine all patients during the first 24 hours of admission.
- A patient meets LTCH admission criteria if he or she:
 - have 2 or more active secondary diagnoses;
 - are reasonably expected to require hospital level of care, benefit from LTCH care, and require an extended stay in a hospital that is typical of LTCHs; and
 - are not admitted for the primary purpose of intensive therapy (i.e., therapy typically provided at an inpatient rehabilitation facility).

Continued Stay Criteria

- By Day 7 following admission, and weekly thereafter, the physician must examine the patient to validate whether the patient continues to need inpatient hospital-level care.
- Patients who cease to need inpatient hospital-level care will be discharged.
- If a safe and appropriate discharge option is not available, the patient may remain in the facility as an LTCH patient if two conditions are met. First, the beneficiary must be notified that Medicare criteria for hospital-level care have not been satisfied; and second, the LTCH must continue to actively seek a safe, appropriate and available discharge option.
- The LTCH is paid at the lesser of the LTCH prospective payment amount for acute-care hospitals or its cost. The extended stay does count towards the facility's length of stay calculation for purposes of LTCH classification.

Section 3. Specification of Core Services and Patient Care Requirements

Core LTCH Services

- At a minimum, LTCHs must provide complex respiratory services, complex wound services, and services for patients with medically complex conditions.
- LTCHs must provide 24/7 physician on site or on call coverage. If physician is not on site 24/7, patients must be notified.
- LTCHs must provide 24/7 RN-level nursing.
- LTCHs must provide 24/7 advanced cardiac life support.
- LTCHs must provide 24/7 availability of respiratory therapists.

Patient Care Requirements

- Within 24 hours of admission, a physician must conduct a face-to-face evaluation and begin to develop a plan of care.
- By Day 7 of admission, a physician-led, inter-disciplinary team of providers establishes an individualized plan of care, updated through weekly team meetings.

Section 4. Additional Long-Term Care Hospital Payment Classification Criteria

- Requires LTCHs to comply with the “70% Rule” in order to retain Medicare payment classification as an LTCH. Non-compliance with the criteria results in loss of payment classification as an LTCH.
- The 70% Rule requires that not less than 70% of all Medicare fee-for-service discharges during a prior 12-month period meet, in the aggregate, any of the following four criteria:
 - An LTCH length of stay of 25 days or greater; or
 - A high cost outlier in the prior general acute hospital stay; or
 - An LTCH stay that included ventilator services; or
 - An LTCH stay with three or more complications or comorbidities (CC), or major complications or comorbidities (MCC).
- The policy is phased in over a three-year period: 50% in Year 1, 60% in Year 2; 70% in year 3. Government-owned LTCHs (approximately 26 organizations) have a four-year phase-in: 50% in Year 1; 60% in Year 2; 65% in Year 3; and 70% in Year 4.
- The criteria only apply to Medicare fee-for-service beneficiary discharges.
- LTCHs that fail to comply with the 70% Rule will be granted a cure period to demonstrate compliance.
- The proposed LTCH 70% Rule phase in begins 6 months after enactment.
- The future implementation of a “very short stay outlier policy” is prevented.
- The future application of a “one-time budget neutrality adjustment” is prevented.

Section 5. Application of Criteria for Certain Hospitals

- Consistent with current statutory treatment, this bill exempts from the proposed retrospective criterion the two Maryland LTCHs that are currently paid under a state-level rate-setting process, rather than through the LTCH PPS. (Section 1814(b)(3) of the Social Security Act) However, the bill would apply the new patient and facility criteria to these two LTCHs.
- In alignment with current statute, the bill completely exempts “category II” LTCHs (cancer hospitals that primarily treat neoplastic disease) from the new criteria. There is one LTCH with this designation.