What is a Long-Term Care Hospital ("LTCH")?

- Provides hospital-level care for medically complex patients.
- Has an average Medicare inpatient length of stay of greater than 25 days.
- Meets same Conditions of Participation as an acute hospital (see 42 C.F.R. Part 482) and maintains a contract with a Quality Improvement Organization ("QIO") (see 42 C.F.R. § 476.78).
LONG TERM CARE HOSPITALS

- Historically all hospitals paid on the basis of “Reasonable Costs”.
- 1983 Congress decrees cost of care in acute hospitals must get divorced from payment. Cost and payment will never re-marry.
- Exceptions for rehabilitation hospitals, psychiatric hospitals, cancer hospitals and long term care hospitals.
- LTCHs are only hospital in history of the world created by reimbursement exception rather than type of care.

STATISTICS

- 33 LTCHs in 1983
  - TB Hospitals
  - State owned sanitariums with ALOS above 25 days
- 105 LTCHs in 1993
  - 300% growth
  - Cause = HwHs and Satellites
- 318 LTCHs in 2003
- Over 450 LTCHs today
  - Growth has finally stopped.
PAYMENT

- In the decade from 1993 to 2003 LTCH reimbursement increased 500% from less than $400 million to $1.6 billion.
- Currently about $5 billion.

LTCH — FUNDAMENTAL ISSUES

- Medicare certification requirements for hospitals
- Expiration of LTCH moratorium under MMSEA
- Minimum six-month compliance period and 25-day average-length-of-stay ("ALOS") requirement
- Hospital-within-hospital requirements
- Satellite facility requirements
- Remote location requirements
- LTCH inpatient PPS ("LTCH-PPS") and LTCH payment rules
MEDICARE, MEDICAID AND SCHIP EXTENSION ACT of 2007 (“MMSEA”)

- MMSEA effective December 29, 2007
- Established new LTCH criteria
- Imposed 3-year Moratorium on LTCHs

MMSEA MORATORIUM

- Effective for Cost Reporting Years beginning after December 29, 2007; Initially for 3 year period.
- No new LTCHs, satellites or bed increases.
- The Affordable Care Act (“ACA”) extended another two years, through December 28, 2012.
- Moratorium now expired.
LTCH — 25-DAY ALOS REQUIREMENT

- 25-day ALOS requirement (42 C.F.R. § 412.23(e)):
  - Divide the total number of covered and noncovered days of stay of Medicare inpatients (less leave or pass days) by the number of total Medicare discharges for the hospital’s most recent complete cost reporting period.
  - Only Medicare beneficiaries are considered.
  - Total number of covered and noncovered days of stay of Medicare inpatients, even if not claimed.
  - Situation of beneficiary discharged in cost period subsequent to his/her admission → total days considered to have occurred in cost period inpatient is discharged.

Medicare Administrative Contractors (“MACs”) measure compliance with the ALOS requirement.

MAC reviews the hospital’s discharge data from its most recent cost period, or if a change in the hospital’s ALOS is indicated, the hospital may provide the MAC with the hospital’s ALOS for the immediately preceding six-month period.

Implications of failure to comply? Hospital will be subject to IPPS in its next cost period.
LTCH — MINIMUM SIX-MONTH COMPLIANCE PERIOD

- Minimum six-month compliance period (42 C.F.R. § 412.23(e)).
- Prospective LTCH must comply with 25-day ALOS requirement over a minimum six-month period before the facility can be paid under the LTCH-PPS.

- During the minimum six-month compliance period, most prospective LTCHs are subject to the IPPS, although some certify their prospective compliance with the rehabilitation hospital requirements and are paid under the inpatient rehabilitation PPS (IRF-PPS).
- Implications for selecting initial short cost period and subsequent first full cost period.
MMSEA – ADDITIONAL LTCH CRITERIA

- An LTCH is a hospital that:
  - Is primarily engaged in providing inpatient services to Medicare beneficiaries whose medically complex conditions require a long hospital stay and programs provided by a LTCH;
  - Has a patient review process that screens patients prior to admission for appropriateness of admissions, validates patients’ admissions within 48 hours, regularly evaluate patients during their stay, and assesses available discharge options when patients fail to continue to meet stay criteria;
  - Has active physician involvement with patients;
  - Has an interdisciplinary team treatment for patients to prepare and carry out an individualized treatment plan; and
  - Has consultants available at bedside in a moderate amount of time to be defined by the Secretary.

LTCH FACILITIES

- LTCHs can exist as:
  - Freestanding Hospitals;
  - Hospitals-within-hospitals (“HwHs”);
  - Satellite Facilities; or
  - Remote Locations.
Hospital-Within-Hospital ("HwH") requirements (42 C.F.R. § 412.22(e)):

- Do not apply if LTCH is located in a Nursing Facility.
- Concept formerly applied only to LTCHs but now also applies to rehabilitation hospitals and psychiatric hospitals.
- Definition — Hospital occupying space in a building also used by another hospital or in one or more separate buildings located on same campus as buildings used by another hospital.

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An LTCH HwH is exempt from IPPS (i.e., it is paid higher rates under LTCH-PPS) if it meets the conditions for an LTCH and:

- Has a governing body that is:
  1. separate from the governing body of the hospital occupying space in the same building or on the same campus; and
  2. not under the control of the hospital occupying space in the same building or on the same campus, or of any third entity that controls both hospitals.
• Separate governing body (cont).
  o The prohibition on common “control” is defined as the ability to influence significantly. 42 C.F.R. § 412.22(g). This is the same definition as in the related party rule. 42 C.F.R. § 413.17(b)(3).
  o Common ownership is allowed.

• Has a separate chief medical officer, medical staff and chief executive officer, which are not under the control of the co-located hospital.

• Provides written notice of its co-located status to its MAC and CMS.

_gtch - HwHs (cont.)_

➢ Grandfathered HwH exemption:

• An HwH is exempt from the above criteria if it meets grandfathering provisions under 42 C.F.R. §412.22(f). (See § 4417(a) of the Balanced Budget Act of 1997, as codified at 42 U.S.C. § 1395ww(d)(1)(B)).
LTCH - HwHs (cont.)

- In order to be grandfathered, an HwH must:
  - Have been excluded from PPS on or before September 30, 1995; and
  - Continue to operate under the same terms and conditions in effect on September 30, 2003:
    - Can *increase or decrease square footage* any time without losing grandfathered status; and
    - Can *decrease bed number, and subsequently increase bed number*, as long as resulting total does not exceed bed number on September 30, 2003.

LTCH - SATELLITE FACILITIES

- A satellite facility is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.
- Satellites must comply with the provider-based rule, 42 C.F.R. § 413.65. (See Slides 27 - 30).
A hospital that has a satellite facility is exempt from IPPS (i.e., it is paid higher rates under LTCH-PPS) if it meets the conditions for an LTCH and complies with other requirements of 42 C.F.R. § 412.22(h):

- Satellite facility independently complies with all LTCH certification requirements, including the 25-day ALOS requirement;
- Notification of co-located status — same as for a hospital-within-a-hospital;

Requirements (cont.):

- Satellite facility is not under the control of the governing body or the chief executive officer of the host hospital;
- Effective for cost reporting periods beginning on or after October 1, 2009, the governing body of the hospital of which the satellite is a part is not under the control of any third entity that controls both the hospital of which the satellite is a part and the hospital with which the satellite is co-located;
  - Note: Hospitals and satellites excluded prior to October 1, 2009 are exempt from compliance with respect to that satellite, but must comply with respect to any additional satellites.
LTCH - SATELLITE FACILITIES (cont.)

- Requirements (cont.):
  - Satellite facility furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or chief executive officer of the host hospital;
  - Satellite facility admission and discharge records are separate from the host hospital;
  - Satellite facility beds physically separate and not commingled;
  - Satellite facility has same MAC as the main facility; and
  - Satellite facility is treated as a separate cost center of the main facility.

LTCH - SATELLITE FACILITIES (cont.)

- NOTE: For cost reporting periods beginning on or after October 1, 2006, a satellite facility may increase or decrease square footage or decrease bed number, and subsequently increase the bed number, at any time without losing its grandfathered status as long as the resulting total bed number does not exceed the bed number on September 30, 1999.
LTCH – REMOTE LOCATIONS

- A remote location is usually a freestanding facility that is owned by a hospital (the main provider) and which furnishes inpatient hospital services under the same name, Medicare provider number, ownership and financial & administrative control of the main provider.
- The Medicare conditions of participation do not apply to a remote location of a hospital as an independent entity.
- Remote locations, like satellite facilities, must comply with the provider-based rule, 42 C.F.R. § 413.65. (See Slides 27 - 30).

PROVIDER-BASED RULE

- Any facility for which provider-based status is sought must meet the following requirements to have provider-based status:
- Requirements applicable whether facility is located On or Off Main Campus:
  - Is operated under same license as main provider;
  - Clinical services are integrated with main provider’s;
    - Professional staff at facility have clinical privileges at main provider; medical records are integrated; and inpatient and outpatient services are integrated.
  - Has financial integration with main provider; and
  - Public is aware of its relationship with main provider.
PLEASE CALL DR. FRANKENSTEIN

- CMS views growth in LTCHs like a scary movie.
- CMS combats growth in spending.

LTCH - PPS

- October 1, 2002 - CMS implemented an LTCH prospective payment system (“LTCH-PPS”) (See 42 CFR § 412.500-541).
- Payments are based on long-term care diagnosis-related groups (“LTC-DRGs”).
  - Each patient stay is grouped into an LTC-DRG based on diagnosis (principal and secondary), procedures performed, age, gender, and discharge status.
  - These are the same DRGs as are used in the short-term acute inpatient hospital PPS (“IPPS”).
  - Weights are applied to the IPPS DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCHs.
Upon a patient’s discharge, the LTCH assigns appropriate diagnosis and procedure codes from the ICD-9-CM.

Medicare payment is made at a predetermined specific rate for each discharge; that payment varies by the LTC-DRG to which a beneficiary’s stay is assigned.

CMS created LTCH specific market basket for determination of LTCH federal standard payment rate. (See 77 Fed. Reg. 53467-53479, 08/31/2012).

Following DRG assignment, the MAC determines the prospective payment by using Medicare PRICER program, which accounts for hospital-specific adjustments.

Standard federal PPS rate is adjusted by the LTC-DRG relative weights in determining payment for each case.

Standard federal LTCH-PPS rate for 2013 — $40,397.96

Any payment adjustments are then applied for a final payment, including adjustments for interrupted stays and short-term stays, and special rules for co-located hospitals.
ONE-TIME PAYMENT ADJUSTMENT

- One-time payment adjustment to account for inaccuracies at PPS implementation.
- MMSEA moratorium on payment adjustment.
- Adjustment is approximately a 3.5% payment reduction, to be phased in over 3 years beginning for discharges on December 29, 2012 (upon expiration of MMSEA moratorium).

MOST CONVOLUTED PPS SYSTEM EVER!

- Interrupted Stay Rules
  - 9-day Acute
  - 27-day IRF
  - 45-day SNF
- Short Stay Outlier
- 72-hour Interrupted Stay
- Two 5% Re-admission rules
- 25% Rule
SHORT STAY OUTLIERS ("SSOs")

- A short-stay outlier ("SSO") is an adjustment to the federal payment rate for LTCH stays that are considerably shorter than the ALOS for an LTC-DRG. (See 42 C.F.R. § 412.529).
- A patient’s stay qualifies for SSO if the Length of Stay ("LOS") ranges from 1 day through 5/6 of the ALOS for the LTC-DRG to which that patient’s case is grouped.
- An LOS that exceeds 5/6 of the ALOS for the LTC-DRG to which the patient’s case is grouped exceeds the SSO threshold and is paid the full LTC-DRG payment.

SSOs (cont.)

- SSO payment is now the lower of the following four options:
  1) 100% of estimated patient costs using hospital’s Cost-to-Charge Ratio;
  2) 120% of the LTC-DRG per diem amount;
  3) the full LTC-DRG payment; or
  4) This option depends upon the date of discharge...
4) Fourth payment option continued:

- For discharges occurring on or before December 28, 2012, a blend of the following:
  - An amount comparable to what Medicare would otherwise pay under IPPS – this is calculated as a per diem and is capped at the full IPPS comparable amount (“Step 1”); and
  - 120% of the LTC-DRG per diem amount (“Step 2”).
  - The amounts calculated under Step 1 and Step 2 are added together to get the blended SSO payment amount under this fourth option.

4) Fourth payment option continued:

- For discharges occurring on or after December 29, 2012:
  - For cases with an LOS that is greater than the “IPPS comparable threshold”: use the same blend payment calculation as for discharges occurring on or before December 28, 2012; and
  - For cases with an LOS that is equal to or less than the “IPPS comparable threshold”: use an IPPS comparable amount – calculated as a per diem and capped at an amount comparable to (but not exceeding) what would have been a full payment under the IPPS.
**VERY SHORT STAY OUTLIERS**

4) Fourth payment option continued:
   - For discharges occurring on or after December 29, 2012:
     - The “IPPS comparable threshold” referred to is the IPPS comparable amount that is included as this additional payment option for SSO stays with LOS equal to or less than one standard deviation from the geometric ALOS for the same DRG under the IPPS.
     - This additional option for SSO payment, referred to as the “Very Short Stay Outlier” option was announced in Rate Year 2008, but was suspended for 5 years (under MMSEA, then under ACA).

**HIGH COST OUTLIERS (“HCOs”)**

- A high cost outlier is an adjustment for LTCH stays that exceed the typical cost for a particular LTC-DRG.
- A particular case qualifies for HCO adjustment if the LTCH’s estimated costs to treat the case exceeds the HCO threshold.
- The HCO threshold is LTCH-PPS adjusted Federal payment for the particular case plus a fixed-loss amount.
  - The LTCH-PPS adjusted payment could be either the full LTC-DRG payment or the SSO payment.
  - Fixed-loss amount for FY 2013 = $15,408.00
**HCOs (cont.)**

- Medicare pays an HCO payment in addition to the LTC-DRG (or SSO payment if applicable) payment.
- The HCO payment is equal to 80% of the difference between the following:
  - The estimated cost of the case; and
  - The outlier threshold.

**INTERRUPTED STAY POLICY**

- There are two interrupted stay policies:
  1. Long interrupted stays (greater than 3 days); and
  2. Short interrupted stays (3 days or less).
- An “interruption of stay” occurs when an LTCH discharges a patient for treatment and services not available at the LTCH and the patient is readmitted to the same LTCH within a certain number of days from the day of discharge. (See 42 C.F.R. § 412.531).
“3-Day or Less Interruption of Stay” Policy:
- This applies when a patient is discharged from an LTCH to an acute care hospital, IRF or SNF or to the patient’s home and is subsequently readmitted to the same LTCH within 3 days or less of the discharge from the LTCH.
- Any services provided to the patient during the 3 days, such as home health care, are “bundled” with LTCH-PPS payments and may not be billed by another provider.
- The LTCH is responsible for paying another provider for any services rendered during the interruption.

“Greater than 3-Day Interruption of Stay” Policy:
- This applies when a patient is discharged from an LTCH to any of the following provider types and is subsequently readmitted to the same LTCH (after 3 days) within the corresponding fixed-day period:
  - An acute care hospital: Between 4 and 9 days;
  - An IRF: Between 4 and 27 days; or
  - A SNF: Between 4 and days.
- The LTCH will receive one LTCH-PPS payment based on the initial admission and the intervening provider will receive a separate payment from Medicare.
INTERRUPTED STAY POLICY (cont.)

“Greater than 3-Day Interruption of Stay” Policy (cont):

- In addition to readmission within the appropriate fixed-day period, the patient must be discharged directly from the LTCH and admitted directly to one of the above providers.

- If a patient does not meet Interruption of Stay criteria, then the subsequent readmission to the LTCH is treated as a new and separate admission and the LTCH will receive two LTCH-PPS payments.
  - Example: The patient is readmitted after the appropriate fixed-day period or a patient is discharged to a different type of facility or to the patient’s home.

[Interrupted Stay Policy (cont.)]

INTERRUPTED STAY POLICY (cont.)

Implication on patient’s length of stay (“LOS”) at LTCH:

- The interrupted stay begins on day of LTCH discharge.

- **Greater than 3-day:** The days up to the initial discharge from the LTCH are added to the number of day following the subsequent readmission to determine the total LOS for the patient’s episode of care at the LTCH.

- **3-Day or Less:** If the patient is discharged home and is subsequently readmitted within 3 days without receiving additional care while discharged, those days not in the LTCH do **not** count toward the patient’s LOS. If additional care is received, LOS includes days during interruption.
5% READMISSION RULE

- Special Interrupted Stay rule for co-located facilities called the 5% Readmission Rule.
- There are two 5% Readmission Rules:

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<thead>
<tr>
<th>LTCH</th>
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<tbody>
<tr>
<td>Onsite IRF</td>
<td>Onsite Acute Care Hospital</td>
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<tr>
<td>Onsite SNF</td>
<td></td>
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<tr>
<td>Onsite Psychiatric Facility</td>
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5% READMISSION RULE (cont.)

- 5% Readmission Rule is applicable to HwHs and satellite facilities. (See 42 C.F.R. § 412.532).
  - If, during a cost reporting period, an LTCH (including a satellite) discharges patients to its co-located acute hospital and subsequently readmits more than 5.0% of the total number of its Medicare inpatients discharged from that acute hospital, all such discharges (including prior to and after the threshold is exceeded) to the co-located hospital and the readmissions to the LTCH will be treated as one discharge for that cost reporting period and one LTC-DRG payment will be made based on initial principal diagnosis.
  - The second separate 5% rule applies in the same manner for discharges to, and readmissions from, an onsite IRF, an onsite SNF, or an onsite psychiatric hospital or unit, or an onsite SNF, or a combination of the facilities.
PERCENTAGE THRESHOLDS (25% RULE)

- LTCH-PPS implementation did nothing to slow growth!
- Considering that the Base Rate per discharge is at almost 4 times IPPS, LTCHs continued to multiply.
- Growth rate of HwHs and satellites soared between 2002 to 2004.
- Bring on percentage thresholds…
- The 25% Rule establishes payment reductions for LTCHs that discharge more than a threshold percentage from other hospitals. (See 42 C.F.R. § 412.534, 412.536).

PERCENTAGE THRESHOLDS (25% RULE) (cont.)

- 42 C.F.R. § 412.534 versus 412.536:
  - 412.534 applies on a location-specific basis and applies only to co-located facilities (i.e. those located in the same building or on the same campus).
  - 412.536 applies on a provider number basis, and includes admits to an LTCH or satellite from any location covered under a referring hospital’s provider number.
    - Does not include any admissions governed by 412.534.
2004 - CMS establishes first 25% rule (42 C.F.R. § 412.534):

- Initially, rule established a payment adjustment for HwHs and satellites, but not grandfathered HwHs or satellites, effective October 1, 2004.
- If more than 25% of a HwH or satellites discharges for a cost reporting period are admitted from its co-located hospital, then payment to the LTCH for those discharges exceeding the 25% threshold will be the lesser of the payment applicable under LTCH-PPS or an amount equivalent to what would be paid under IPPS.
- Rural and MSA-dominant hospitals payment threshold was 50%.

2007 - CMS established next 25% rule (42 C.F.R. § 412.536):

- CMS expanded 25% rule to apply to freestanding and grandfathered HwHs, effective July 1, 2007.
- If more than 25% of a HwH or satellites discharges for a cost reporting period are admitted from any hospital other than a hospital with which it is co-located, then payment to the LTCH for those discharges exceeding the 25% threshold will be the lesser of the payment applicable under LTCH-PPS or an amount equivalent to what would be paid under IPPS.
PERCENTAGE THRESHOLDS (25% RULE) (cont.)

- **2007** – MMSEA granted relief under 25% Rule (See MMSEA, § 114(c)):
  - Exempted “freestanding” and grandfathered HwHs from application of 412.536.
  - Exempted grandfathered HwHs (but not grandfathered satellites) from application of 412.534.
  - Revised the percentage threshold from 25% to 50% for hospitals subject to original 25% rule (but not including grandfathered satellites).
  - Revised the percentage threshold from 50% to 75% for rural and MSA-dominant hospitals.
  - ACA continued relief until December 29, 2012.

PERCENTAGE THRESHOLDS (25% RULE) (cont.)

- So, where is 25% Rule today?
  - Grandfathered HwHs – exempt from 412.534 and 412.536;
  - Grandfathered satellites – subject to revised percentage thresholds under 412.534; fully subject to 412.536;
  - Freestanding hospitals – exempt from 412.536 (412.534 not applicable because not co-located);
  - Non-grandfathered HwHs and satellites subject to 25% transition rules (i.e. paid as an LTCH as of 10/01/2004) – subject to revised percentage thresholds under 412.534; fully subject to 412.536.
  - New LTCHs and satellites post-moratorium – fully subject to 25% rules under 412.534 and 412.536 (not revised percentage).
LTCH QUALITY REPORTING PROGRAM ("LTC-QRP")

- ACA established quality reporting program for LTCHs.
- LTCHs must begin reporting quality data for discharges on or after October 1, 2012 or face a 2 percentage point reduction in their annual payment update beginning FY 2014 and each subsequent year.
- 3 Quality Measures for FY 2014:
  1. Catheter-Associated Urinary Tract Infection (CAUTI);
  2. Central Line-Associated Blood Stream Infection (CLABSI); and
  3. Percent of Residents with Pressure Ulcers that are New or Worsened.
- More quality measures to come in subsequent years.

HEALTH REFORM AND FUTURE OF LTCHs

- Role of LTCHs in “Bundling” and “Continuing Care Hospital” demonstrations.
- Growth of LTCHs following expiration of MMSEA moratorium.
SOMETHING HAS GOT TO GIVE!

- 10% of Medicare patients are “medically complex” (5 or more chronic conditions)
- Complex patients consume 70% of expenditures.
- Beginning in 2011 over 10,000 Americans turn 65 every month.

CMS ADMINISTRATIVE MORATORIUM

- ACA § 6401(a) granted CMS sweeping authority to impose administrative moratoria on new providers [42 U.S.C. § 1395cc(j)(7)].
- Administrative Moratorium set forth in 42 C.F.R. § 424.570:
  - CMS can impose a moratorium on the enrollment of new Medicare providers of a particular type, or on the establishment of new practice locations of a particular type in a particular geographic area within CMS’ discretion.
  - The temporary moratoria are for six (6) month periods. CMS, however, may renew any given moratorium in its sole discretion.
  - CMS does not have to provide advance notice of its decision to issue an administrative moratorium.
  - Temporary moratoria will not apply to any newly enrolled provider that has been approved, but not yet entered into PECOS.