

An Certain Future

Complying with the new regulations for long-term acute care hospitals

By

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Since the Balanced Budget Act of 1997, the regulatory activity on the health care landscape has increased greatly for all providers. Long term acute care hospitals will be particularly impacted by the eventual implementation of a prospective payment system (PPS) which is anticipated to be within the next three years. In the meantime, long term acute care hospitals must pay close attention to other developments which impact their operation and reimbursement. As described below, such developments may originate from various sources.

Recently, the Health Care Financing Administration finalized its regulations for obtaining provider-based status. These regulations must be carefully considered by long term acute care hospitals that wish to obtain provider-based designation for facilities or inpatient satellites that are located away from their campuses. In addition, the United States Court of Appeals recently decided that the Secretary of Health and Human Services is not required to reimburse new long term care hospitals under PPS during their initial cost reporting periods.

Complying with Provider-Based Requirements

While long term care hospitals have not typically utilized provider-based facilities to the degree that their general acute care hospital

counterparts have, provider-based entities do offer additional strategic options to long term care providers. For example, a long term care hospital may wish to operate a provider-based outpatient facility or have an inpatient satellite facility located away from its campus. In such instances, it is vital that the long term care hospital have a thorough understanding of the new provider-based regulations and competent legal guidance to navigate their requirements. These regulations are scheduled to become effective on October 10, 2000. *It should be noted that, according to informal communications with the federal government and other sources, the effective implementation date may be postponed until at least January 1, 2001.*

Long term care hospitals will now have to seek the approval of HCFA before establishing provider-based facilities that will seek Medicare reimbursement through the main provider. This includes inpatient satellite facilities that treat long term care patients. A primary concern inherent in HCFA's regulatory framework is that there is no mechanism in place to seek advanced determination of provider-based status. Therefore, long term care hospitals that establish new facilities or satellites that are not on the same campus face the risk of expending significant resources in development of the entities without knowing whether the entities will eventually be granted provider-based status.

The primary test for whether a facility or inpatient satellite is provider-based is whether it is within the "immediate vicinity" of the main provider. This standard requires that 75 percent of the patients that are served by the provider-based facility or satellite reside in the same postal zip codes as the patients served by the main provider. However, because some areas, particularly urban regions, have numerous zip codes, the regulations alternatively allow provider-based status if 75 percent of the patients served by the provider-based entity who require the type of care furnished by the main provider, received care from the main provider.

Even if the immediate vicinity standard is met, long term care hospitals wishing to establish provider-based entities must comply with other requirements. For example, the main provider and its entities must operate under the same license. The entity must be an integral part of the main provider and be owned and operated as part

of the provider in concert with other the provider's other departments under the same license. This requires that the administrative functions of the provider-based entity be integrated with those of the main provider. As such, the main provider and its subordinate facilities must share such services as billing services, medical records, human resources, and purchasing services and share a common medical staff.

The provider and its subordinate entities must also comply with a requirement that addresses public awareness. This entity must be presented to the public as part of the main provider. Patients must know that the entity is part of the main provider and that they will be billed as a patient of the main provider. Appropriate signage and patient admitting forms and other documentation can serve to apprise patients that they are being treated by the main provider even though they are treated in a subordinate facility.

Finally, if a provider is accredited, a provider's subordinate entities must be recognized as part of the provider by organizations that accredit the provider such as the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. Additionally, the provider's chief executive officer must supervise the operation of the subordinate facility on a day-to-day basis and have authority over the facility.

Clearly, the provider-based regulations present significant challenges to long term care hospitals that wish to establish provider-based facilities or inpatient satellite facilities. The outline of some of the requirements above suggests the complexity inherent in the regulations. In addition, a recently proposed rule of HCFA's has caused some long term care hospitals to question exactly where they fit into the provider-based regulatory scheme.

A Different Standard for Some Long Term Care Hospitals' Satellites: More Confusion than Benefit

A proposed rule regarding provider-based status and long term care hospitals that was advanced by the Health Care Financing Administration has resulted in much confusion. The provision allows

specific long term care hospitals to establish satellite facilities without being required to meet the “immediate vicinity” standard. On initial viewing of the proposed rule, some health care executives, trade associations and attorneys believed that all long term care hospitals would be able to easily develop satellite facilities. However, the proposed rule, if finalized, is limited in scope and only applies to a small minority of long term care hospitals.

The proposed rule allows some long term care hospitals to establish satellites that qualify for PPS exclusion if the satellite is located within the same Metropolitan Statistical Area (MSA) as the hospital. Such satellites would not be required to meet the existing requirement of being located within the immediate vicinity of the hospital. However, this provision is only applicable to long term care hospitals which qualify for PPS exclusion under 42 CFR §412.23(e)(2); that is specializing in the treatment of cancer patients.

Long term care hospitals that qualify for PPS exclusion under 42 CFR §412.23(e)(2) constitute a small minority of long term care hospitals. The regulation addresses long term care hospitals that were first excluded from the PPS in 1986, have an average inpatient length of stay of greater than 20 days, and demonstrate that at least 80 percent of their annual Medicare inpatient discharges in the 12-month cost reporting period ending in fiscal year 1997 had a principal diagnosis that reflects a finding of **neoplastic disease**. Thus, the provider-based exception for satellite facilities of some long term care hospitals is not beneficial to the vast majority of these providers.

When Long Term Care Hospitals Are Eligible for Exclusion from the Prospective Payment System

Another significant development which impacts long term care hospital reimbursement is the decision reached by the United States Court of Appeals, District of Columbia Circuit, in *Transitional Hospitals Corporation, Incorporated v. Shalala*.¹ The plaintiffs in that case, two long term care hospitals, requested exclusion from PPS from the starting dates of their Medicare provider agreements rather

¹ 2000 WL 1133605 (D.C. Cir. Aug. 22, 2000).

than being reimbursed under PPS during their first six months of operation. The plaintiffs' request was denied by the Health Care Financing Administration and they brought suit to recover losses incurred during their six months of PPS reimbursement.

The plaintiffs argued that immediate exclusion from PPS was appropriate because the Medicare statute mandates exclusion for "a hospital which has an average inpatient length of stay of greater than 25 days." They contended that long term care hospitals should be reimbursed as long as the 25-day average length of stay is met, even during their first months of operation. Alternatively, the long term care hospitals argued that retroactive reimbursement was appropriate for long term care hospitals that meet the average length of stay requirement during their periods of PPS reimbursement.

The court found that the statute does not specify how the Secretary of Health and Human Services must determine whether the 25-day criterion is met. The court found the statutory language to be ambiguous. The court did note that the Secretary would not be precluded from reimbursing long term care hospitals for their reasonable costs incurred during the first six months of operation. However, the Secretary ultimately has the discretion to determine the manner in which long term care hospitals must meet the length of stay requirement to be excluded from PPS. Thus, it is likely that new long term care hospitals will continue to be required to undergo a six-month data collection with PPS reimbursement.

Conclusion

Long term care hospitals, like other health care providers, were significantly impacted by the Balanced Budget Act of 1997. In addition to limiting their TEFRA caps, the Act also prescribed other measures that continue to be put forth by HCFA. The provider-based regulations and subsequent proposed rule for long term care hospitals offer examples of recently finalized and proposed measures. However, the Balanced Budget Act's most significant change, PPS for long term care hospitals, has been delayed beyond its October 1, 2002 implementation date.

Long term care hospital developments have originated in the courts as well as with HCFA. The United States Court of Appeals for the District of Columbia Circuit found that the Secretary is not required to mandate that long term care hospitals operate under PPS for any period of time before exclusion may be sought. However, the Secretary has the discretion to determine whether new long term care hospitals must illustrate a 25-day average length of stay before exclusion or whether they may be immediately excluded.

Regardless of the existing and proposed regulations and restrictions applied, long term acute care hospitals remain a vital component of a health care system's continuum of care. The long term acute care hospital is a sound strategic option both financially and as a vehicle for effective and efficient patient care.

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