

## **IN ABEYANCE – THE STATUS OF LTACH**

**By:**

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Long Term Acute Care Hospitals (LTACH) have been around for nearly 20 years, but they may soon become extinct in American healthcare. First created to fill a vacuum in the continuum of care between the short term acute care hospital and other post-acute care venues, LTACH's have provided a much-needed supplement to patient care, particularly the medically-complex, long-stay patients that the venue was legislatively-intended to serve. Now, after several years of chipping away at LTACH's by the Centers for Medicare and Medicaid Services (CMS), Congress has imposed a three-year moratorium on new LTACH's and additional LTACH beds. Is this the end of LTACH as we know it?

### The Beginning

Since the creation of the Long Term Care Prospective Payment System (LTC-PPS) in 2002, CMS has targeted hospital-within-hospital (HwH) LTACH's that serviced primarily a Medicare patient-population referred from their host hospital. In fact, CMS has been concerned about LTACH's serving simply as a "step-down unit" for short term acute care hospitals since the FY 1995 Inpatient Prospective System Final Rule (59 FR 45389). CMS first acted to limit the relationship between HwH LTACHs and the host hospital with the 15% Rule, allowing no more than 15% of their operation costs on goods and services purchased from the host hospital and having a board of directors independent from the host hospital. Despite the beneficial intentions of most HwH LTACH's, CMS in 2004 imposed financial restrictions on the source of LTACH patients, creating the "Threshold Rule." Unlike the 75% Rehabilitation Threshold Rule, the LTACH Threshold Rule would create a restriction allowing the HwH LTACH to admit only a certain percentage of their Medicare patients from their host-hospital. Freestanding LTACH's had been exempt from these payment restrictions, until the Final LTC-PPS Rule was published May 2, 2007, applying similar

restrictions on freestanding LTACH's that admit high percentages of their Medicare patients from a particular source.

Despite financial penalties on LTACH's, in essence restricting LTACH's from caring for the patients most in need of this venue of care (particularly for Rural or Single-Urban LTACH's), CMS continued to support the concept of the LTACH. Between FY 2003 and FY 2008, the LTACH Base Rate increased from \$34,956 to \$38,356, a nearly 10% increase. Although LTACH's only represent 7% of total hospitals in the US, the LTACH industry also grew to satisfy the demand for this type of patient care, from 103 facilities in 1993 to approximately 400 today.

### Legislative Efforts

Beginning in 2006, a group of HwH LTACHs impacted by the Threshold Rule began contacting their legislators to prevent a full phase-in of the Threshold Rule (at full phase-in, excluding Rural, MSA-dominant and single urban LTACH's, up to 25% of their Medicare patients could come from the host hospital without suffering a financial penalty). The group of predominately not-for-profit HwH LTACHs were unable to find traction in their legislative efforts until 2007, when both Chambers of Congress introduced separate bills that would have frozen the Threshold Rule at it's current levels before full phase-in. With the introduction of the May 2007 Final Rule that applied the Threshold Rule to Freestanding LTACHs, set to be effective July 1, 2007, a new sense of urgency was found to protect LTACH's from the implications of the Threshold Rule. In order to present bills that were budget-neutral, the proponents of the legislation needed to find savings to balance the additional costs of rolling back parts of the Threshold Rule. This is when the LTACH moratorium was first introduced; a remedy that had far-flung ramifications to those hospitals in the planning stage who believed that this venue was essential to their continuum of care. With its immediate implementation date, the moratorium was to deny others the benefit of this venue.

First introduced in May 2007 as a method to protect existing LTACH's, the moratorium initially was proposed for 4 years, then modified to 3 years. Neither the House nor the Senate LTACH bill was expected to pass, until the issue of CMS Physician

reimbursement cuts and the extension of the State Children's Health Insurance Program (SCHIP) took center stage. The extension, and possible expansion, of the SCHIP program consumed Congress and President Bush for months, vehemently disagreeing about whether to expand the scope of coverage under the SCHIP program. All the while, HwH and freestanding LTACH's, relatively small in the health care continuum, anxiously awaited whether they would be spared the costs of hundreds of thousands of dollars in reimbursement cuts likely to accompany the full phase-in of the Threshold Rule.

#### Medicare, Medicaid and SCHIP Extension Act of 2007

In December 2007, after President Bush had twice vetoed the significant expansion of SCHIP urged by both Chambers of the Democrat-controlled Congress, legislators sought a compromise. There were two pressing issues – SCHIP was set to expire at the end of 2007 unless the program was either extended or expanded, and physicians were set to receive a significant financial hit starting January 1, 2008. The physician reimbursement issues was the result of the 2008 Medicare Physician Fee Schedule Final Rule, published November 1, 2007. Within the Final Rule was a 10.1% cut in the conversion factor for physician-related services, which is required by law, under the sustainable growth rate formula (SGR). As President Bush made clear he would not sign into law any expansion of the SCHIP Bill, but had indicated that relief for physicians is on the table, Congress quickly got to work.

On December 13, 2007, President Bush delivered his second veto of the SCHIP expansion. Two business days later, December 17, 2007, the Medicare, Medicaid and SCHIP Extension Act of 2007 was introduced in the U.S. House, passed by the Senate the following day, and signed into law by President Bush December 29, 2007 (Public Law 110-173). When the smoke had settled, LTACH proponents had inserted the provisions of the previous House and Senate LTACH bills (including the moratorium) into the Act signed by the President. The Congressional Budget Office estimated that the reinsertion of the 10.1% cut that had been planned for physicians, only for a six month period, would cost \$6.4 billion over 10 years. This cost was offset by approximately \$1.2 billion in savings resulting from the LTACH moratorium.

It quickly became clear, however, that the final version of the Act did not match the details of the earlier legislation. What was quite unexpected to the LTACH community was that the final Bill did not provide immediate relief. Rather, a 3 year relief was to begin only upon the beginning of the LTACH's next cost reporting period (leaving many with up to a full year of continued Threshold Rule limitations depending upon their Medicare fiscal year end date). This caught many hospitals in a financial loop, especially freestanding hospitals that were once again exempted. It was the first time in recent memory that Congress, with the passage of this Bill, explicitly overturned a policy decision of CMS.

### LTACH Implications

The essential LTACH sections from the Medicare, Medicaid and SCHIP Extension Act of 2007 can be found below:

-Defines a "Long Term Care Hospital" as a hospital that:

1. Is primarily engaged in providing inpatient services, by or under the supervision of a physician, to Medicare beneficiaries whose medically complex conditions require a long hospital stay and programs of care provided by a long term care hospital;
2. Has an average Medicare inpatient length of stay of greater than 25 days
3. Institutes admission and patient-stay screening criteria, active physician involvement, and the participation of an interdisciplinary team

-Prohibits the application of the 25% Threshold to Freestanding LTACH's for a 3-year period, beginning with the LTACH's next cost reporting period.

-Freezes the Referral Threshold to 50% for hospital-within-hospital LTACH's (and up to 75% of Medicare Referrals from the co-located hospital for Rural and MSA-dominant LTACH's) for a 3-year period, beginning with the LTACH's next cost reporting period.

-Prevents applicability of "Very Short Stay Outlier" payments and application of a one-time adjustment to LTC-PPS rates for a 3-year period.

-Effective upon enactment of this Act, Institutes a 3-year moratorium on the establishment of new LTACH's, LTACH Satellites, and increased beds for LTACH's or LTACH Satellites.

1. The moratorium includes an exception for LTACH's "under development," defined as those:
  - i. Hospitals that have begun their 6-month data collection period;
  - ii. Hospitals that have a binding, written agreement with an outside, unrelated party for the actual construction, renovation, lease or demolition for a long-term care hospital, and has expended, before the date of the enactment of this Act, at least 10 percent of the estimated cost of the project (or, if less, \$2,500,000); or
  - iii. Has obtained an approved Certificate of Need (where required)

### The Aftermath

Although the Medicare, Medicaid and SCHIP Extension Act was intended to tie up some loose ends related to LTACH regulations, the Act has only raised new questions. How will CMS and Fiscal Intermediaries handle the discrepancy between LTACH's subjected to varying stages of the Threshold Phase-in, now subject to relief depending on their Cost Report Date? How does the moratorium address the relocation of previously licensed and certified LTACH beds? How will CMS define and limit the "amount expended" prior to December 29 for the second exception for the moratorium? Perhaps most importantly, what will happen to the LTACH industry in the next three years, and beyond?

### Future of the LTACH

Although the moratorium, in effect, will stymie growth of LTACH's, at least some facilities will qualify as "under development" meeting at least one of the three options for exception. However it is clear that new LTACH's will have to wait at least three years before even the potential for CMS reclassification. This will likely serve current LTACH's well – preventing additional marketplace competition, and allowing LTACH's to focus on better patient outcomes, as opposed to

compliance with the referral Threshold Rule. Still, the end game for LTACH's is far from certain. While MedPAC has consistently reaffirmed the value of LTACH's in the continuum of care, CMS administration has hardly articulated confidence in the venue. But where will LTACH-appropriate patients go?

Presently, an LTACH patient is inappropriate for the short term acute care venue. Not only does the inpatient prospective payment system insufficiently cover costs of an extended-stay medically complex patient, but the short term acute care hospital generally cannot absorb the LTACH patient that will occupy an in-demand bed for 18-35 days. Skilled Nursing Facilities (SNF) also fail to adequately provide for LTACH patients – with limited physician coverage, lower direct nursing hours and significantly lower reimbursement. LTACH patient care is expensive, requires high direct nursing hours, daily physician coverage, and does not fall within the 3-5 day average length of stay (ALOS) at a short term acute care hospital.

The U.S. population is growing older with exponentially increasing health care needs and costs. Economists for CMS recently projected that government spending on healthcare could nearly double by 2017, accounting for approximately 20% of the U.S. Gross Domestic Product. Medicare spending is expected to double, to \$884 billion in 2017, as compared to \$427 billion in 2007. But, what is the appropriate percent of ADP to spend on healthcare for the citizens of one's country? That debate has not been settled. Only the voice of the people will ultimately make that decision.

But, what is to be done now? Congress must now address the issue of what will happen with the long term acute care hospital venue after the expiration of the 3-year moratorium. Will Congress and CMS shift LTACH spending back into the Inpatient Prospective Payment System so that patients will now be treated at the short term acute care hospital, or will they reaffirm their commitment to the LTACH venue and the rightsizing of short term acute care hospitals; allowing the market to dictate the growth and scope of LTACH's?

One thing is for sure, stifling the growth of LTACH's through reimbursement limitations on the origin of the patient population fails to address the concern of LTACH's admitting appropriate patients.

Referral source is but an arbitrary factor and does not facilitate LTACH's treating clinically-appropriate patients. Healthcare policy regarding LTACH's should follow the recommendations of the Medicare Payment Advisory Committee (MedPAC). MedPAC rejected the idea of an LTACH moratorium that was proposed by Congress in 2004, and still today recommends CMS develop patient and facility level certification criteria for LTACH's.

The 1997 Balanced Budget Act reaffirmed the structure and value of the post acute continuum of care. What form will health care policy take without a sufficient number of long term acute care hospitals to meet the need and demand of patient care?

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