

## **SAVING THE HOSPITAL-WITHIN-HOSPITAL LTACH**

**By**

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Congress has long recognized the distinct services provided by long term acute care hospitals (LTACHs) and has provided that they should not be reimbursed as acute care hospitals. However, CMS has recently altered its reimbursement methodology for hospital-within-hospital LTACHs according to referral patterns. This article summarizes the history of long term care hospital reimbursement and CMS' policy regarding reimbursement of hospitals within hospitals. It also discusses the impact of CMS' policy and examines proposed alternatives that would better serve the long term care hospital industry, patients and families.

### **Medicare Reimbursement and Regulatory History of LTACHs**

LTACHs are based on one of two models: freestanding LTACHs and hospitals-within-hospitals (HWH). Freestanding LTACHs, as the label implies, are self-contained hospitals that are not located in or on the campus of another hospital. Freestanding LTACHs dominated the LTACH market in the 1980's. Hospitals-within-hospitals ("HWHs") are hospitals that are separate and distinct from, but located within, leased space in a host hospital. HWHs typically purchase some services from the host hospital, but the two entities must maintain the requisite degree of separateness (see below).

Both models share a common history in terms of Medicare reimbursement. When CMS (formerly HCFA) first implemented the prospective payment system (PPS), which provides a fixed payment for each acute care hospital for each patient in a given diagnosis-related group (DRG), for acute care hospitals in 1983, Several post-acute venues, including rehabilitation hospitals, psychiatric hospitals, and LTACHs were exempted from that system. Instead, payment for LTACHs was based on average per-discharge costs, subject to limits established under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Under TEFRA, LTACHs that existed prior to 1997 were reimbursed at higher rates than hospitals that began providing service on or after October 1, 1997.

Pursuant to The Balanced Budget Act of 1997 (BBA) CMS implemented the current LTC-DRG system, which provides a fixed payment to LTACHs for a given DRG. The LTC-DRG system is applicable to cost reporting periods beginning on or after October 1, 2002.

While the development and implementation of the LTC-DRG system has been eminently fair, CMS has exhibited a continuing distrust of the HWH LTACH venue, often voicing the fear (but presenting no evidence) that providers were treating the HWH LTACH as a “disguised” unit of the host hospital. In 1994, in an attempt to deter providers from this perceived manipulation, CMS established separateness and control regulations for HWHs. CMS’ policy rationale was that an entity that could not be separately identified would effectively be functioning as a mere unit of the host that could not appropriately be exempted from the PPS system.

The 1994 regulations required the host hospital and the HWH to have a separate governing body, chief medical officer, medical staff and CEO. Additionally, HWH’s were required to comply with one of the following rules:

- The “basic services rule”, which required that the HWH perform its basic functions using employees or contracted entities other than the host hospital or an entity that owns both the host and the HWH;
- The 15% Rule, which required that the cost of the services obtained from the host hospital or a third entity that owns both the host and the HWH not exceed 15% of the HWH’s inpatient operating costs;
- or
- The 75% Rule, which requires that at least 75% of the HWH’s referrals come from a source other than the host hospital.

Hospitals-within-hospitals in existence before September 30, 1995 were exempted from these rules.

### **The New Patient Admission Threshold**

In its August 11, 2004 final Rule, CMS eliminated the requirement that HWH LTACHs comply with the basic services rule, the 15 percent rule or the 75 percent rule. CMS instead finalized a regulation that will reduce HWH LTACH reimbursement based on the number of beneficiaries referred by the host hospital. CMS set patient admissions thresholds on the number of referrals that HWH LTACHs and satellites may obtain from their hosts before a reimbursement adjustment is made. The threshold level is scheduled for phase-in for existing HWH LTACHs and LTACH satellites, and is based solely on Medicare patients. While the patient admission threshold affects Medicare reimbursement, compliance with the threshold is not a condition of certification as an LTACH. Generally, Medicare reimbursement for beneficiaries who are admitted from the host hospital and who cause the HWH LTACH or LTACH satellite to exceed the 25 percent threshold for discharges of patients from the host hospital is the lesser of the amount payable under the LTACH PPS or the acute care PPS.

New HWH LTACHs will be reimbursed under the 25 percent admissions threshold. There is a phase-in for the patient admissions threshold that applies to existing HWH LTACHs and those that are already excluded or in development. HWH LTACHs are considered to be in development if they have certification as acute care hospitals on or before October 1, 2004 and obtain Medicare designation as an LTACH before October 1, 2005. The phase-in operates over a four year period. For instance, for cost reporting periods beginning on October 1, 2005, these hospitals will have to come below a 75% referral rate from the host hospital to avoid a payment reduction (receiving the short term acute care PPS). By October 1, 2007 those LTACHs will have to come below a 25% referral rate from the host hospital to avoid financial penalty. LTACHs certified by Medicare as acute care hospitals after October 1, 2004 are not eligible for the phase-in and are immediately subject to the 25% threshold.

In determining the number of beneficiaries referred from the host hospital, patients on whose behalf an outlier payment was made to the host hospital are not counted when calculating the 25 percent threshold.

There are also exceptions under CMS' policy for HWH LTACHs or satellites in rural areas and for HWH LTACHs or satellites located in MSA-dominant hospitals. HWH LTACHs or LTACH satellites located in rural areas have a threshold set at 50 percent after the phase-in. HWH LTACHs or satellites located in the only other hospital in the MSA or within an MSA-dominant hospital have a threshold set at 25 to 50 percent depending upon the host's percentage of Medicare discharges within the MSA.

### **Concerns Raised by the New Patient Admission Threshold**

CMS' patient admission threshold for HWH LTACHs and satellites raised a number of concerns. These concerns include, the fact that CMS offered no actual evidence that HWH LTACHs actually function as hospital units, or that the 15 percent rule is unworkable, the fact that imposing a reimbursement system designed for patients with a maximum length of stay of about 5 days on hospitals designed for patients with an aggregate length of stay of at least 25 days will force many LTACHs out of business, and that in many rural areas, there may be few or no referral sources other than the host hospital, precluding these areas from having LTACH care available.

### **Proposed Legislative Alternatives**

Several alternative models were discussed and debated by the Field. One such model would limit admissions from the host hospital to 75 percent instead of 25 percent. The 75 percent threshold would largely meet CMS' stated concerns relative to HWH LTACHs functioning as units of their respective host hospitals, because HWH LTACHs would still have a strong incentive to broaden their

respective admissions bases. HWH LTACHs that have traditionally relied on their hosts for 90-100 percent of admissions would seek to expand their referral sources and would be more likely to serve the entire Medicare patient community rather than a portion of the Medicare patient population which first receives care from the acute care host.

The National Association of Long Term Hospital (NALTH) has proposed that Congress pass legislation that would require CMS to suspend the patient admission thresholds for HWH LTACHs that had been certified as LTACHs on or before October 1, 2004. The NALTH proposal would allow the rule to operate for new LTACHs for a limited two year period. At the same time, CMS would be required to consider MedPAC's June 2004 recommendation to Congress that CMS establish patient-centered criteria that would assure the medical necessity of LTACH admissions. NALTH's proposal also would require CMS to report to Congress on its consideration of the MedPAC recommendations within one year, and require the admission thresholds rule to sunset at the end of two years when CMS adopts a new rule implementing the MedPAC recommendations.

The obvious benefits of the NALTH proposal are that, for existing LTACHs, it would prevent the arbitrary admission thresholds from ever going into effect, and it would replace those thresholds with appropriate medical necessity criteria. However, Murer Consultants initially opposed the NALTH proposal because it would not have protected either new HWH LTACHs or HWH LTACHs that were in the development process. NALTH, however, has recently amended its proposal to include in its "grandfathering" protection both new LTACHs and those that are in development. Given that developing, new, and existing LTACHs would all be protected, and that CMS officials have publicly stated that their ultimate goal is to replace the arbitrary admission thresholds with appropriate medical necessity criteria, Murer Consultants fully supports the NALTH proposal.

## **Conclusion**

HWH LTACHs provide a cost efficient (especially when compared with the expense of constructing a complete free-standing hospital) method of completing the continuum of care for many healthcare systems. Rather than allowing CMS' arbitrary percentage thresholds to undermine this valuable venue, providers should rally behind NALTH's revised proposal, which would replace percentage totally unrelated to patient care with what should be the basis of all inpatient admissions regardless of venue: medical necessity. Readers are strongly urged to contact their senators and representatives in support of the NALTH proposal.

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