

## **Weathering the Reimbursement Crunch**

*Are long-term care hospitals still a good idea?*

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Healthcare providers today face the dual challenge of providing specialized patient services while coping with an increasingly restrictive reimbursement system. This challenge can be addressed through the utilization of post acute service venues such as long-term care hospitals (LTCHs). LTCHs generally treat chronically ill and rehabilitation patients whose average length of stay exceeds 25 days.

LTCH patients typically require long lengths of acute stay with access to technologically advanced therapies. Common conditions of LTCH patients include ventilator dependency, respiratory care, stroke, general debilitation and cardiac care. LTCHs are exempt from the DRG-based prospective payment system. Under the Balanced Budget Act of 1997, LTCHs are cost-based reimbursed up to a TEFRA cap. The cap is set at the 75<sup>th</sup> percentile of the target amounts for LTCHs with cost-reporting periods ending during fiscal year 1996. This amount is updated annually. For fiscal year 1998, the caps for established LTCHs were limited to \$37,688. New LTCHs (those receiving their first payment as a PPS-exempt provider on or after October 1, 1997) will be capped at \$21,494. The target limits for fiscal year 1999 are \$38,593 and \$22,010, respectively.

The HCFA-imposed caps will result in a decline in reimbursement for those LTCHs which had established caps greater than the 75<sup>th</sup> percentile. However, LTCHs with caps below the 75<sup>th</sup> percentile will remain limited to their facility-specific rate. This system of reimbursement will be utilized through, at least, fiscal year 2002. At that point it is envisioned that HCFA will attempt to gradually phase LTCH Medicare reimbursement to a prospective payment system. Despite the changes in reimbursement, LTCHs will continue to occupy an important role in health systems.

## **The Benefits of LTCHs**

The inclusion of a LTCH within a health system serves two important purposes. First, long-term care patients are provided with an appropriate venue of care for their type of illnesses and levels of acuity. Second, healthcare systems can avoid sustaining losses through the provision of uncompensated care under the Medicare system. Despite these advantages, some health systems have still not explored the opportunities LTCHs offer to improve both patient care and the bottom line. Meanwhile, the number of LTCHs nation-wide has increased over the past 18 months from 185 LTCHs to approximately 250.

A common misconception within the healthcare community has dissuaded some health systems from investigating LTCH utilization. The misconception is that health systems may not own and control LTCHs. However, there is no prohibition against health systems owning LTCHs. And, in many instances, health systems may control LTCHs as well. However, this issue is dependent on whether the LTCH is free-standing or a hospital-within-a-hospital.

LTCHs may generally be established in one of two ways. They may be started as free-standing facilities and occupy an entire building off the campus of another provider. They also may be established as a hospital-within-a-hospital. The hospital-within-a-hospital model involves a LTCH being based in a host hospital. For example, an LTCH could exist within a 40-bed wing of its host hospital or a building on the campus of its host hospital. This model allows health systems to establish LTCHs of an appropriate size for patient demand. It also reduces the duplication of hospital services as the LTCH can contract with the host hospital for various services. However, the hospital-within-a-hospital model LTCH poses governance and control issues which do not have to be addressed when establishing a freestanding LTCH.

## **The LTCH Governing Body and Control**

The host hospital is generally the owner of the building and leases space to the LTCH. To comply with federal regulations, the LTCH must have a governing body that is separate from the governing body of the host hospital. To be separate from the governing body of the host hospital, under the

regulations, means that the governing body of the LTCH cannot be under the control of the host hospital or of any third party that controls both hospitals. The Medicare regulations define control as the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.

The Health Care Financing Administration (HCFA) has provided scant definitive guidance in regards to what constitutes "control." The boundaries of permissible conduct, however, are more easily identifiable. If the "owner" (i.e. the holder of the stock of a for-profit corporation, holder of the partnership interest in a general partnership, holder of the interest in a limited liability company, sponsor or corporate member of a not-for-profit corporation) of the LTCH organization has the ability to appoint the governing body of the LTCH, it most likely exerts the requisite control under the Medicare definition and fails to meet the Medicare criteria for a separate governing body. At the opposite end of the spectrum is the situation where there is no "ownership" interest in the LTCH and no power to appoint any governing body members of the LTCH.

As seen above, a host hospital or its parent may not "control" the LTCH. However, health systems are reluctant to establish and own LTCHs at the other end of the spectrum which are completely free from their influence and, therefore, the mission of the health system. Another common misconception is that a health system may have no input regarding the affairs of a long-term care hospital-within-a-hospital it owns. As indicated in the spectrum of control chart accompanying this article, long-term care hospital-within-a-hospital owners may still play a carefully limited role in the LTCH. Health system may even, in some circumstances, retain the right to appoint a minority number of governing body members.

A health system also will not violate the control prohibition by leasing space to its LTCH in an acute care hospital also owned by the system. HCFA has designed the LTCH regulations to create a degree of separation between the host hospital and the LTCH. Their goal was to prevent acute care hospitals from setting up "paper hospitals" which had no operational substance. Common ownership of the host hospital and the LTCH will not prevent the LTCH from being excluded from the prospective payment system. HCFA has stated that a "separately operated hospital is not ineligible for exclusion solely because it and the host facility are under common ownership."

There are strategies which can be implemented when a health system owns both the host hospital and the LTCH to ensure the LTCH remains separate from its host facility. Because the LTCH must have a “separate governing body,” board members of the host hospital should not serve on the governing body of the LTCH. The LTCH board should include members of the community at large and not the members of the host hospital or health system boards. The LTCH’s articles of governance could be drafted to prevent the possibility of host hospital or health system directors from serving on its governing body. And most importantly, the actual operational practices and day-to-day management of the LTCH cannot be controlled by the host hospital in fact and circumstance.

By carefully complying with the control requirements, health systems are in a unique position to utilize LTCHs which are established as hospitals-within-hospitals. As such, these venues can offer significant economies of scale because many hospital services will not have to be duplicated and a physical plant will not have to be purchased or wholly constructed. Providers may then realize the significant advantages of LTCHs. Patients will be offered an extended continuum of care and the provision of uncompensated acute care will be reduced. This allows health systems to be fiscally prudent and yet remain competitive in today’s healthcare market.

***Sample Issues***  
**SPECTRUM OF "CONTROL"**

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**AS PER REGULATORY COMPLIANCE**

<b>GREEN ZONE</b>	<ul style="list-style-type: none"> <li>• Ethical and religious directives input</li> <li>• Mission and purpose statements consultation</li> <li>• Patient quality of care consultation</li> <li>• Assistance in patient transfer</li> <li>• Joint educational programming</li> </ul>
<b>YELLOW ZONE</b>	<ul style="list-style-type: none"> <li>• Minimal number of governing body board members</li> <li>• Involved with long term strategic plan</li> <li>• Joint case management</li> <li>• Sharing of information</li> </ul>
<b>RED ZONE</b>	<ul style="list-style-type: none"> <li>• Approval of administration / management / staff</li> <li>• Determining reporting relationship within operations</li> <li>• Influences short term operational plan</li> <li>• Appoints significant number of board</li> <li>• Power hire / fire line staff</li> <li>• Prepares / approves operating or capital budget</li> <li>• Cross utilizes same space without appropriate allocation</li> <li>• Program specific decisionmaking</li> <li>• Joint records</li> </ul>