

LTACH Hospitals within Hospitals – A New Challenge

By

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Introduction

In May of this year, when CMS proposed onerous restrictions on long term acute care hospitals (“LTACHs”) that are located within other hospitals,¹ the provider community rose to the challenge with a strong effort that educated and informed both Congressional and CMS officials of the many problems with the proposed rule. As a result, the final rule, which was published in the Federal Register on August 11, 2004,² removes one of the most inequitable provisions of the proposal—the preclusion of common ownership of the host hospital and the LTACH—and contains provisions that will make compliance with the new requirements somewhat easier. Unfortunately, in the final rule, CMS chose to leave intact the proposal’s most arbitrary provision—the limitation on referrals from the host hospital to 25 percent of the LTACH’s Medicare patient population.

As we shall see, however, CMS has also placed in the new rule a transition period for existing LTACHs. This transition period should give the provider community an opportunity to continue dialogue with CMS and Congress so that ultimately LTACH hospitals within hospitals (“HwHs”) can operate under a set of rules that ensures appropriate admissions, but avoids arbitrary restrictions that have the ultimate effect of diluting both patient choice and patient care.

Ownership Restriction Removed

CMS’ proposed rule would have prohibited newly-developed HWHs from operating under the direct or indirect ownership of an individual or entity that had any ownership interest in a hospital on the same campus or that shared a building. In the final rule, CMS has elected not to finalize the proposed policy which would have precluded common ownership. In the commentary to the final rule, CMS does not elaborate on its reasons for removing the proposed prohibition, other than to state that it believes that the percentage restriction on referrals from the host hospital will be a sufficient check on inappropriate admissions. CMS also acknowledged, however, that it had received several comments pointing out that the proposed restriction would have unfairly benefited

¹ See Cherilyn G. Murer, “Of Two Minds,” *Rehab Management* (July, 2004).

² 69 Fed. Reg. 48916 (Aug. 11, 2004).

investor-owned LTACH chains at the expense of non-profit hospitals and systems. It is reasonable to assume that these comments had at least some effect on CMS' ultimate decision to drop the restriction.

End of the 15 Percent Rule

With its decision to rely on the 25 percent referral limitation as the sole determinant for payment under the LTACH prospective payment system, CMS has also finalized its proposal to drop the criterion known as the "15 percent rule." Under the 15 percent rule, a HwH qualified for LTACH payment status, if the cost of the services that the LTACH obtained under contracts or other agreements with the host hospital, or with a third entity that controlled both hospitals, was no more than 15 percent of the hospital's total inpatient operating costs. Perhaps the most distressing aspect of CMS' decision is its conclusion that host hospitals and LTACHs were using the 15 percent rule to manipulate admissions through "creative corporate configurations."

In response to the several commentators who pointed out that CMS had cited no evidence in its proposal to back up this claim, CMS replied that it had relied upon "anecdotal evidence" from fiscal intermediaries, providers, and state survey agencies. Unfortunately CMS again chose not to share these anecdotes with the public in the commentary, so it impossible to evaluate their accuracy. As a result, the many LTACHs that not only have not attempted to manipulate the system, but expended considerable time and effort (not to mention considerable additional monies as a result of foregoing the more favorable contracts available from the host hospital) have been tarred with the same brush as the unknown number of those that sought to take unfair advantage.

The New 25 Percent Rule

As noted above, in the final rule, CMS has set a threshold of 25 percent on the number of Medicare referrals that LTACHs within hospitals may obtain from their hosts. Thanks to the efforts of the provider community, the harshness of this rule is somewhat alleviated by a phase-in period that was not included in the proposed rule. Moreover, in the final rule, the patient admissions requirement is applicable to LTACHs and not to other excluded hospitals, such as rehabilitation or psychiatric hospitals. The community effort has also resulted in a rule that will affect the *amount* of Medicare reimbursement, but will not implicate a provider's *status* as a LTACH excluded from the general inpatient prospective payment system.

The patient admissions criterion applies only to Medicare beneficiaries at LTACHs within hospitals and their LTACH satellites. Generally, effective with the

LTACHs first cost reporting period beginning on or after October 1, 2004, Medicare reimbursement for beneficiaries who are admitted from the host hospital and who cause the LTACH or LTACH satellite to exceed the 25 percent threshold for discharges of patients from the host hospital will be the lesser of the amount payable under the LTACH PPS or the general inpatient acute care PPS. All patients up to and including the 25 percent threshold will continue to be reimbursed at the LTACH PPS rate.

Also thanks to the efforts of the provider community, the final rule adds a phase-in period for patient admissions that applies to existing HwH LTACHs and to LTACHs 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 they obtain designation as an LTACH before October 1, 2005. “New” LTACHs, i.e., those not certified as hospitals before October 1, 2004, and not certified as LTACHs before October 1, 2005, will be reimbursed under the 25 percent admissions policy as soon as they are certified as LTACHs.

LTACHs eligible for the phase-in period will have their referral thresholds set as follows:

- For discharges from Oct. 1, 2004 through Sept. 30, 2005- Reimbursement under the LTACH PPS is **unaffected**, effectively creating a one-year “hold harmless” period for all LTACH admissions.
- For discharges from Oct. 1, 2005 through Sept. 30, 2006- The percentage of Medicare patients that may be admitted from the host with no payment adjustment may not exceed the lesser of the percentage of patients admitted from the host in fiscal year 2004 or 75 percent.
- For discharges from Oct. 1, 2006 through Sept. 30, 2007- The percentage of Medicare patients that may be admitted from the host with no payment adjustment may not exceed the lesser of the percentage of patients admitted from the host in fiscal year 2004 or 50 percent.
- For discharges during cost reporting periods beginning on or after October 1, 2007, the percentage of Medicare patients that may be admitted from the host with no payment adjustment may not exceed 25 percent.

Also somewhat alleviating the harshness of the rule is that CMS has decided that patients on whose behalf an outlier payment was made to the host hospital will not be counted as referrals from the host hospital for purposes of calculating the 25 percent threshold. LTACH case managers will have to be extremely careful in utilizing this exception, however, because it potentially could create questions of medical necessity for the LTACH admission. For example, if it takes the patient several weeks in the acute care hospital to qualify for an outlier payment, the case manager, in consultation with the patient’s physician, will have to be

reasonably convinced that the patient continues to require an *additional* lengthy stay in an acute care setting before agreeing to admit the patient to the LTACH. This is so, because although the new 25 percent rule will affect only reimbursement, an aggregate average length of stay of 25 days in the LTACH for Medicare patients will continue to be a requirement for maintaining status as an LTACH. The outlier patient exception probably will be most applicable to post-surgical patients who tend to incur a large portion of their costs early in their acute care hospital stay.

Other Aspects of the Final Rule

Other aspects of the final rule that serve to reduce some of its harshness include a host hospital patient referral threshold of 50 percent, rather than 25 percent, for HWH LTACHs or their satellites located in rural areas and for LTACHs located in Urban Single or MSA Dominant Hospitals. CMS has also determined that inpatients who were admitted before the HWH achieved LTACH status, but were discharged after the HWH's certification as an LTACH, will be reimbursed under the LTACH prospective payment system for the entire length of their stay. Previously such overlapping patients had been reimbursed under the general inpatient acute care PPS for the portion of their stay prior to conversion and under the LTACH PPS for the remainder of their stay. Finally, CMS has removed the bed size restriction for LTACH satellites that are fully reimbursed on the LTACH PPS.

The Challenge Ahead

Due to the phase-in period, most HWH LTACHs will not be subject to reimbursement adjustments under the 25 percent rule until their 2006 or 2007 cost reporting periods. In addition, full implementation of the 25 percent rule will not be in place until most LTACHs' 2008 or 2009 cost reporting periods. While the delay in effective date is beneficial from a reimbursement standpoint, its greater importance lies in the opportunity it gives the provider community to once again rise to the challenge presented by the new rule. Providers and their representatives should be able to use this time to not only educate Congress, but CMS itself on the unfairness of 25 percent threshold, but to demonstrate that, if criteria other than the 15 percent rule are necessary to assure HWH LTACH compliance, that assurance should come from thoroughly developed, well-defined admission criteria and not from arbitrary percentage limits or quotas on referrals.

In that regard, CMS' conflicting response to MedPAC's June 2004 report on LTACHs is especially noteworthy. In that report, MedPAC declined to endorse CMS' approach of limiting the number of referrals from the host hospital, but instead recommended the development of standards that would identify the unique characteristics of an LTACH-eligible patient. Unfortunately, CMS, while saying that it welcomed MedPAC's recommendations, nevertheless decided to proceed with the referrals limits. CMS did say, however:

Prior to the end of the 4 year transition period, CMS will reevaluate the HwHs criteria to assess the feasibility of developing facility and clinical criteria for determining the appropriate facilities and patients to be paid for under the Medicare LTACH PPS. If, during that time period, data from well-designed studies (or other compelling clinical evidence) indicate that developing this criteria is feasible, we would consider revisions to the HwH regulations. We intend to analyze these issues and discuss any findings in the forthcoming FY 2006 LTCH PPS notice.³

The provider community should accept this challenge from CMS and ensure that HwH LTACHs, like all other Medicare providers, are free to operate under a system that does not impose unfair, arbitrary limits on providers, but instead works to achieve what CMS has always endorsed as its goal:

The right patient in the right bed for the right reimbursement.

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³ 69 Fed. Reg. At 49212.