

CMS: Of Two Minds on Long Term Acute Care Hospitals?

By

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The Centers for Medicare & Medicaid Services' ("CMS") recent pronouncements on long term acute care hospitals ("LTACHs") could lead one to reasonably conclude that the agency is of two minds when it comes to LTACHs. On one hand, the rules for LTACHs operating as hospitals within hospitals ("HWH") that were proposed on May 11, 2004, if established, would have a negative impact on the operational characteristics of most HWH LTACHs. On the other hand, the agency's final Prospective Payment System ("PPS") update for 2005, effective July 1, 2004, is squarely in line with the traditional strong support for the LTACH venue, which is reflected by CMS' statement that accompanied publication of the proposed PPS update in January, 2004:

"[LTACHs] are designed to assure appropriate payment for services to the medically complex patients treated in these facilities, while providing incentives to hospitals to provide more efficient care of Medicare beneficiaries."

The Proposed Rule for Hospitals within Hospitals

While this article focuses on LTACHs, CMS's proposed regulations would also apply to other HWHs that are excluded from the short-term acute care PPS, such as psychiatric hospitals and rehabilitation hospitals. The proposal would require that all HWHs obtain at least 75 percent of patients from referral sources other than a hospital occupying space in the same building or on the same campus. In addition, CMS proposed that newly-developed HWHs may not be under the direct or indirect ownership of an individual or entity that has any ownership interest in a hospital on the same campus or that shares a building. The proposal would eliminate the ability of HWHs to comply with CMS' separateness requirements by spending no more than 15 percent of their operational costs on goods and services purchased from the host hospital and by having a board of directors that is independent of that of the host hospital, even if the two entities share common ownership.

CMS has proposed three options for reimbursing HWHs that fail to meet the 75 Percent Referral Rule:

1. The HWH would not be paid as an excluded hospital for any of its patients and would be reimbursed under the short-term acute care hospital PPS.
2. The HWH would be reimbursed as an excluded hospital only for patients referred from outside of the host hospital. No Medicare payments would be made for referrals from the host hospital. Rather, services provided by the HWH would be treated as provided “under arrangement” and only the host hospital would receive reimbursement.
3. The HWH would be reimbursed the lesser of what would be paid under the acute care PPS for the DRG or what would be paid to the HWH under the excluded payment system for patients referred from the host.

In its commentary to the proposed rules, CMS stated that the proposed changes were prompted by several concerns with compliance under the existing system. Although these concerns should not be lightly dismissed, it is fair to say that they are based on *assumptions* of non-compliance on the part of CMS rather than any hard evidence in the agency’s possession. For example, CMS states that under its proposal:

“[C]ostly, long-stay patients who could reasonably continue treatment in that setting would not be unnecessarily discharged to an onsite LTCH, a behavior that would skew and undermine the Medicare IPPS DRG system.”

CMS, however, cites no studies that have concluded that patients are being “unnecessarily” discharged to the LTACH. Similarly, the following statements in the commentary indicate that CMS’ proposal are prompted by a fear of non-compliance as opposed to actual case studies:

- “the hospital-within-hospital configuration could result in patient admission, treatment, and discharge patterns that are guided more by attempts to maximize Medicare payments than by patient welfare.”
- “the unregulated linking of an IPPS hospital and a hospital excluded from the IPPS could lead to two Medicare payments for what was essentially one episode of patient care.”
- “that the excluded hospital not function either as a vehicle to generate more favorable Medicare reimbursement for each provider or as a de facto unit.”

The lack of hard evidence is especially troubling given the serious impact that the proposals would have on HWH LTACHs. One major concern is that the proposed patient population requirement for HWHs will arbitrarily dictate patient admissions and referral choices for both Medicare and non-Medicare beneficiaries. CMS’ commentary states that “nowhere is a change in physician clinical

decisionmaking (sic) or a change in the manner in which a physician or hospital practices medicine intended. The policy options outlined in this proposed rule would simply address the appropriate level of payments once those decisions have been made.” The reality, however, is that loss of excluded status or significant reductions in payment for Medicare beneficiaries is not a result that providers will or can ignore. If the proposal is adopted, each physician referral to a HWH will be preceded by a calculation to determine where the HWH currently stands relative to the 75 Percent Rule. Therefore, individual patients (many non-Medicare) will have point of care decisions determined in part by a random threshold; in fact a QUOTA SYSTEM.

Given the lack of evidence, CMS’ concern that a host hospital and HWH LTACH could receive two Medicare payments for what was “essentially one episode of patient care” also appears to be overstated. Significant controls are already in place to ensure that acute hospitals and collocated LTACHs do not receive inappropriate levels of reimbursement. These controls include in part:

- Requirement for LTACH to have 25-day average Medicare length of stay;
- Short-stay outlier provisions for LTACH;
- Discharge-transfer rule for acute care hospital; and
- LTACH PPS rules relative to interrupted stays and readmissions from onsite providers (which were recently strengthened in the 2005 PPS update).

Enforcement and refinement of the above policies would ensure that Medicare reimbursement is not disproportionate to a patient’s needs. Furthermore, the risk of making two Medicare payments for one episode of care, if the risk is accepted as valid, would exist with freestanding exempt hospitals as well as HWHs. Freestanding exempt hospitals in close proximity to acute care hospitals are not subject to any restrictions on patient admissions.

Among CMS’ reasons for proposing the 75 Percent Rule are that the 15 Percent Rule is difficult to enforce and their belief that “the 15-percent policy is being sidestepped through creative corporate reconfigurations.” Again, CMS has not cited any hard evidence to support this position. Without such evidence, it would seem that the loss of exclusion from the acute care PPS is enough of a threat that HWH LTACHs carefully comply with the requirement.

Furthermore, elimination of the 15 Percent Rule would effectively make it impossible for rural HWH LTACHs to comply. Many existing HWH LTACHs are located in rural areas with as few as one acute care hospital (the LTACH’s host hospital) within the area. Under such circumstances it would be impossible for these HWH LTACHs to meet the 75 Percent Rule, and LTACH services will become unavailable in many rural areas.

Although the concerns over the effects of the proposed 75 Percent Rule are very serious, CMS' unsubstantiated assumption that even an indirect ownership relationship in a HWH LTACH will dictate patient referral patterns is, perhaps, of even more concern. One of the most distressing aspects of this proposal is that it will disproportionately impact nonprofit hospitals and health systems. Nonprofit hospitals and health systems have previously been permitted to sponsor entities which control HWH LTACHs. Making such sponsorship illegal will effectively cede the field of HWH ownership to for-profit and/or investor owned entities.

Equally distressing is that CMS' proposal would "grandfather" host hospital ownership interests only for those LTACHs that were already exempt from the short-term acute PPS as of June 30, 2004. This severely limited proposal ignores both the length and expense of the development cycle for HWH LTACHs.

From the time a decision is made to develop an LTACH to the date that the LTACH is certified by CMS as exempt from the short-term acute PPS typically takes 18 – 24 months. During that time, the HWH LTACH's owners generally will have spent \$500,000 to \$1.5 million in costs that are specifically directed at compliance with CMS' current HWH rules. These costs include the legal and governmental fees associated with setting up a governance structure that is compliant with the current separateness rules. In addition, the current separateness rules mandate significant construction costs for any HWH developer, including the provision of a separate lobby and waiting area with disabled-accessible washrooms, fire wall separation from the host hospital, and separate signage. CMS' proposal to grandfather only already exempt LTACHs would force LTACH owners in the development process (many of whom are non-profit entities) to absorb significant losses in both time and money.

The PPS Update

In marked contrast to the HWH proposals, the final rule for its update to the LTACH PPS system, which becomes effective July 1, 2004, continues CMS' strong support for the LTACH venue. Instead of the 2.9 percent in LTACH payment rates that CMS had proposed in January, 2004, the actual increase will be 3.1 percent. This translates to a standard payment of \$36,762.24 per Medicare discharge, up from \$35,726.18 in 2004. Moreover, in January, CMS had proposed an increase in the fixed loss amount (the amount of losses the provider must absorb before it becomes eligible for high-cost outlier payments) from \$19,590 to \$21,864. In fact, the fixed loss amount, effective July 1, 2004, will be *reduced* to \$17,864.

These updated amounts indicate that, whatever conceptual problems CMS' staff have with the HWH format, the agency's support for LTACH venue as a key component of the continuum of care remains unwavering. It is to be hoped that during the comment period on the proposed HWH rules, which ends July 12, 2004, the provider and physician communities will convince CMS that its statement of support for LTACHs expressed in January, 2004, should remain as true for hospitals within hospitals as for freestanding LTACHs.

What is being proposed by CMS is bad public policy which would be, if taken in full context, injurious to community hospital providers, physicians, patients, and families.

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