Long Term (Acute) Care Hospitals

State of the Industry

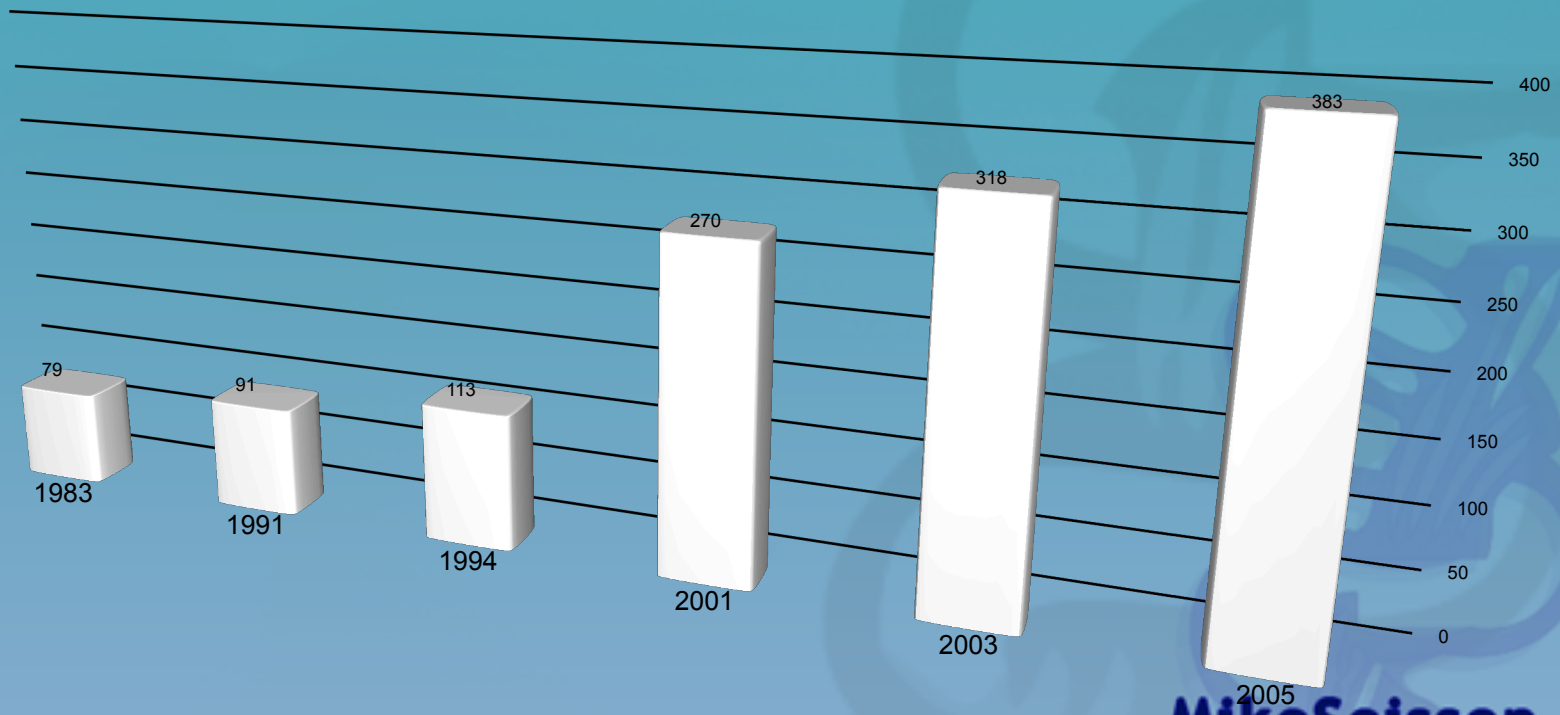
2007

MikeSoisson Consulting Inc.

Background

- LTCH Criteria:
  - Medicare 25 + day ALOS
- LTCH Base Payment for FY 2007 = $38,086
  - Acute Care base payment = $5,308
  - Rehab base payment = $12,952
- CMS estimates the total Medicare Payment to LTCHs for rate year 2007 at $5.27 billion (From Marwood Group Report).
- MedPAC (June 2005 report to Congress) estimates 33% of Medicare pts receive Post Acute Services:
  - 13% SNF
  - 11% Home Health
  - 5% either LTCH, IRF, or Psych
  - 4% multiple services

LTCH Growth



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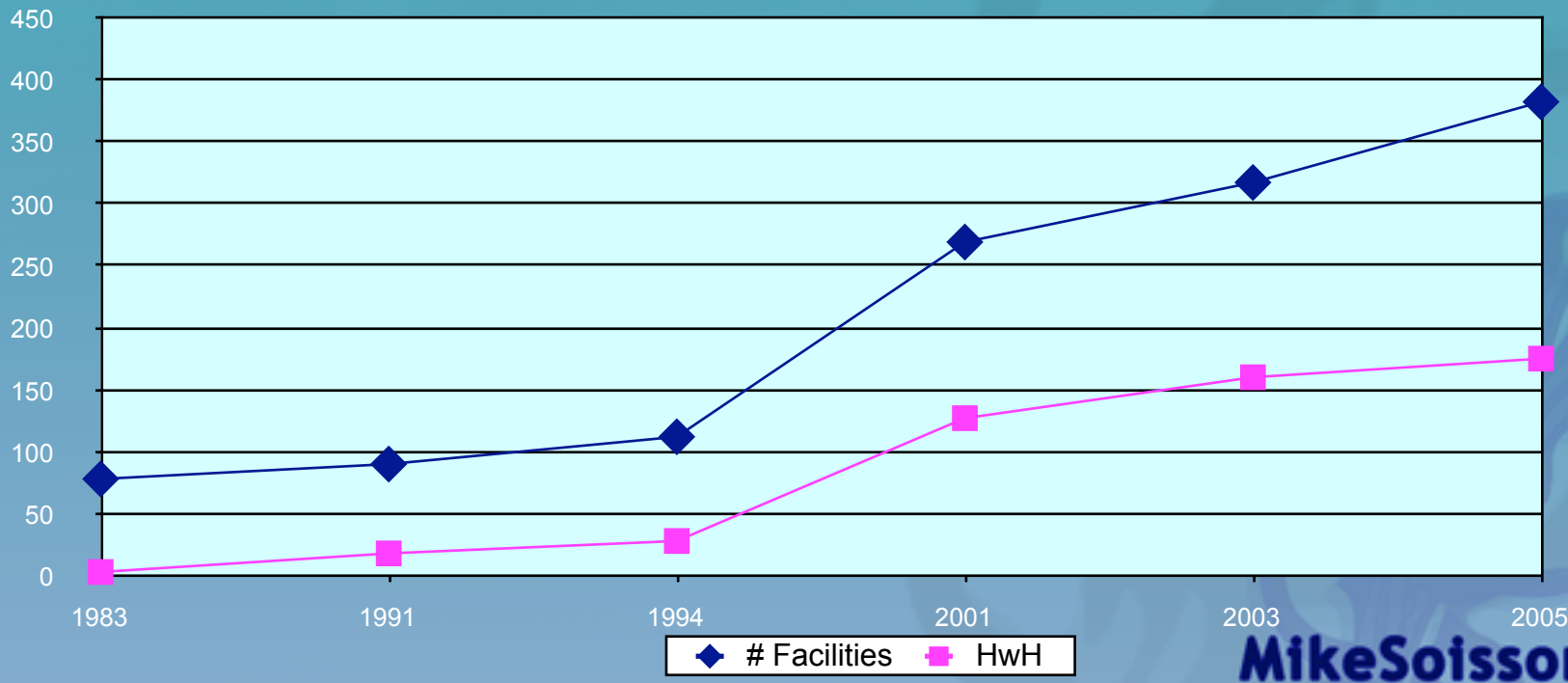
Hospital within Hospital Growth



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Top LTCH DRGs

DRG	Description	Volume	Percent
475	Respiratory System Dx w Vent Support	10140	8.7%
462	Rehab	7131	6.2%
12	Degenerative Nervous System Disorder	5846	5.0%
271	Skin Ulcers	5348	4.6%

Research Triangle Institute (RTI)

- RTI engaged by CMS for "Long-Term Care Hospital Payment System Refinement/Evaluation".
- Designed to assist CMS develop a criteria for assuring appropriate and cost-effective use of LTCHs following the MedPAC recommendations.
- Phase I: Background
- Phase II:
  - Examine tools used by QIOs and the industry to assess patient appropriateness for admission;
  - Analysis of claims to understand variation between LTCH pts and pts staying in acute care for longer stays/outliers;
  - Site visits to 8 LTCHs and 1 acute care hospital to interview providers regarding differences between LTCH and acute care patients.

RTI Findings

- 80% of LTCH patients are admitted from acute care hospitals.
- LTCHs patients had:
  - Shorter inpatient stays and lower outlier payments
  - Fewer SNF admissions
  - Lower payments for trach patients
  - Lower hospital readmission rates
- While discharging patients to LTCH does not save money for Medicare, for patients with higher severity of illness, it does not cost anymore than keeping the patient in acute care and in certain diagnoses (Trach patients), discharging to LTCH does save money.
- Severity index has the highest correlation with patients admitted to LTCH. 71% of patients admitted to LTCH had an APR-DRG severity index of 3 or 4.
- 37% (Marwood Group estimate) - 43% (RTI report) of all LTCH admissions receive payment adjustments for having shorter than average stays in LTCH.

RTI Findings (cont)

- The majority of LTCH pts are severely ill (medically complex), however, a small percentage are less medically complex and have longer than expected LOS.
  - "These less intensive patients may resemble those otherwise treated in rehabilitation facilities or psychiatric hospitals."
  - "However, the Medicare program does not currently restrict LTCH admissions to the medically complex."
  - "Because of the lack of clinical admissions criteria, LTCH patients could be treated at other acute-level facilities for all or part of the care they receive at an LTCH."
- "LTCH rates, on the other hand, may be set too high for the services they are providing as shown in higher average PPS margins for cases in LTCHs. While aggregate LTCH inpatient PPS margins were at 8% in 2003, this varied by type of case.
  - For DRG 475, (10% of all LTCH admissions), we estimate an aggregate LTCH PPS margin of 18%."

RTI Findings (Financial Performance)

LTCH Hospitals	*Pre - PPS*		*Post - PPS*	
	FY 2001	**FY 2002**	**FY 2003**	**FY 2004**
Median Cost/case	$25,560	$24,219	$26,207	$26,904
Median Payment/case	$24,826	$24,372	$29,139	$30,909
Median CMI	N/A	N/A	1.0632	1.0744
Medicare Margin	-0.30%	1.90%	8.30%	12.80%
Facility Margin	1.40%	4.90%	8.90%	7.50%

RTI Recommendations

RTI Makes 15 Recommendations broken into four sections:

- Patient Level Recommendations
- Facility Level Recommendations
- Recommendations to improve consistency b/w general acute and LTCH payment and certification policies.
- Administrative Recommendations

Patient Level Recommendations

1. Restrict LTCH admissions to cases that meet certain medical conditions, including a primary dx that is medical in nature, (not function or psych) and meets a certain level of medical complexity that reflects severely ill populations.
2. Require LTCH admissions to be discharged if not having diagnostic procedures or showing improvement.
3. Develop a list of criteria to measure medical severity.
4. Establish a Technical Advisory Group to assist:
   - Recommend criteria for medical complexity
   - Recommend measurement levels.
5. Establish a data collection mechanism to collect this information.
6. Require LTCHs to collect functional measures as well as physiologic measures on all pts receiving PT, OT, SLP.

Facility Level Recommendations

7. Standardize conditions of participation and set staffing requirements to ensure appropriate staff for treating medically complex cases. (see Conditions of Participation recommendations)
8. Keep the 25 day ALOS requirement in place to limit LTCH incentives to unbundle and clearly delineate between general and LTCH patients.

Recommendations to improve consistency b/w general acute and LTCH payment and certification policies.

9. Allow LTCHs to open certified, distinct-part rehab and psych units if CMS finds that restricting LTCH admissions to medically complex cases results in access problems for IRF or psych populations.
10. Require LTCHs to meet same regulatory restrictions as general acute by limiting allowance to only one of each type of distinct-part unit.
11. Establish payment rules that provide a disincentive for LTCHs to transfer cases early to other post acute settings.
12. Conduct additional research on costs associated with different segments of a acute episode for medically complex patients. This should include an examination of the IPPS margins for common types of LTCH cases.

Administrative Recommendations

13. Establish a provider identification code for satellite facilities and hospitals in hospitals.
14. Strengthen the requirement for parent facilities to report satellite locations by requiring them to be identified on the cost report.
15. Clarify QIO roles in overseeing appropriateness of admissions of LTCHs. (QIO = Quality Improvement Organization)

Conditions of Participation Recommendations

- Require the delivery of multi-disciplinary care
- Require daily physician on-site review
- Require specialized nurse training
- Standardized staffing levels higher than general medical/surgical units.

Next Steps

- RTI recommends Phase III to look at variance between markets that have LTCHs and those that do not.
- CMS to issue Proposed FY08 LTCH regulations in January – February 2007.
  - Extension of the 25% cap from single source to free standing LTCHs?
  - Diagnostic based admission criteria as a Condition of Participation?
  - Adjustment of some case weights to reduce profitability?
  - Add other Condition of Participation Requirements?

Other Key Issues

- Deficit Reduction Act of 2005 mandated demonstration project for post acute payment reform will be initiated with:
  - Development of a comprehensive assessment tool to be used at time of acute care discharge to determine appropriate post acute placement.
  - Gather data on fixed and variable costs for each individual patient and on care outcomes in various post acute care settings.
  - Use a standardized assessment instrument to measure functional status and other factors during treatment and at discharge across post acute settings.
- Impact of the expanded Transfer DRGs in FY 2007, particularly those that discharge high volume to LTCH.

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