Long-Term Care Hospitals' Response to the 25-Percent Threshold Rule: Did Bed Size Increase?

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In June 2011, KNG Health Consulting, LLC prepared a study for the National Association of Long Term Hospitals (NALTH) entitled "An Analysis of Referral Patters to Long-Term Care Hospitals and Implications for the 25% Threshold Rule." The purpose of the study was to assess whether or not referral patterns changed in ways that would reduce the potential savings generated from a fully-implemented 25% Rule. We also examined the extent to which LTCHs moved locations, which could reflect an attempt to facilitate changes in referral patterns. The study was conducted using Medicare claims data for a 5 percent sample of beneficiaries. Changes in referral patterns to LTCHs and LTCH location were compared between 2003, the year in which the 25% Threshold Rule ("25-percent rule") was proposed, and 2009 (we used 2011 data on LTCH location). The study's main findings were that:

- Approximately 19% of LTCHs moved between 2003 and 2011, with more co-located LTCHs moving (23%) than non-co-located LTCHs (15%).

- Co-located proprietary hospitals were twice as like to move than co-located voluntary hospitals (28% vs. 14%).

- The overall estimated percentage of cases subject to the 25% Rule fell from 34% to 24% between 2003 and 2009. This reductions represents an approximately 29% decrease in the number of cases subject to the payment reductions in the 25% Rule for our consistent panel of LTCHs.

The study concluded that LTCHs appeared to have responded to the 25-percent rule by taking steps to mitigate its impact if fully implemented. While the study noted that a number of LTCHs moved and that those that moved were more likely to be co-located with an acute care hospital, it did not examine changes in LTCH bed size, which could be one strategic response to a 25-percent rule. An increase in number of cases allowed through bed expansion could reduce, and potentially eliminate, the impact of the 25-percent rule on an LTCH if an LTCH is able to fill those beds from acute care hospitals other than its primary referral source(s).

KNG Health examined changes in bed size for LTCH "movers" and "non-movers" between 2003 and 2011. The results are shown in Table 1. Among the 207 hospitals in our analysis that did not move, the number of certified beds increases by 179 or 0.9 beds per LTCH between 2003 and 2011. This represents an average increase of 1.2 percent in certified beds for LTCHs that did not relocate between 2003 and 2011. For non-movers, the (interquartile) range for the percent change in certified beds was -54 percent at the 25th percentile to 0 percent at the 75th percentile (i.e., 75 percent of the non-movers either did not change or reduced their bed size). By comparison, the number of certified beds increased by 308 or 6.2 beds per LTCH for the 50 LTCHs that did move between 2003 and 2011. This represents an average increase of 13.8 percent in certified beds for LTCHs that did relocate. For movers, the (interquartile) range for the percent change in certified beds was from -29 percent at the 25th percentile to 98 percent at the 75th percentile.

We next stratified hospitals into quartiles based on their percent of cases that would be subject to a fully-implemented 25-percent rule in 2003 and examined the average changes in beds for hospitals in each quartile. The results are shown in Table 2. Those hospitals with the smallest percent of cases that would be subject to a 25 percent rule reduced Medicare certified beds by an average of 1.7 (or -1.7%), while those with the largest percent of cases increased beds by an average of 4.5 per LTCH (or 9.4%). Similarly, those hospitals in quartiles 2 and 3 also increased beds, by 4.1 and 0.5 per LTCH, respectively.

Table 1. Changes in Number of LTCH Certified Beds by "Mover" Status

		# of Medicare Certified Beds				
Mover	**# LTCHs**	**2003**	**2011**	**Total Change in Beds**	**Average Change per LTCH**	**% Change In LTCH Beds**
No	50	14639	14818	179	0.9	1.2%
Yes	207	2239	2547	308	6.2	13.8%
All	257	16878	17365	487	1.9	2.9%

Source: KNG Health analysis of 2003 and 2009 5% Standard Analytic Inpatient File, 2003 and 2011 Provider of Service file

The overall findings indicate that LTCHs that moved locations between 2003 and 2011 increased bed size, while those LTCHs that did not move reduced bed size, on average. Moreover, those LTCHs that would have been impacted the most by a fully-implemented 25 percent rule increased bed size by 4.6 beds per LTCH, on average by 2011. These findings are consistent, although not conclusive, that some LTCHs increased bed size as a way, in part, to mitigate the effects of the 25 percent rule. To the extent these bed size changes was a response to the 25 percent rule, the policy could encourage growth of some existing LTCHs which could have reduced the potential savings of the policy.

Table 2. Changes in Number of LTCH Certified Beds by Quartile of Cases Subject to a Fully-Implemented 25 Percent Threshold Rule

		# of Medicare Certified Beds				
Quartile	**# LTCHs**	**2003**	**2011**	**Total Change in Beds**	**Average Change per LTCH**	**% Change In LTCH Beds**
1	65	6467	6357	-110	-1.7	-1.7%
2	64	4121	4385	264	4.1	6.4%
3	63	3114	3148	34	0.5	1.1%
4	65	3176	3475	299	4.6	9.4%

Source: KNG Health analysis of 2003 and 2009 5% Standard Analytic Inpatient File, 2003 and 2011 Provider of Service file

Notes: Quartile 1=LTCHs with less than approximately 21 percent of cases subject to a fully-implemented 25% rule, Quartile 2= between 22 and 38 percent of cases, Quartile 3= between 39 and 52 percent of cases, Quartile 4=More than 52 percent of cases

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STATEMENT

American Hospital Association Proposed Legislation on New Long-Term Care Hospital Certification Criteria and Patient and Facility Criteria

It is the practice of NALTH to issue a "Statement" when matters of importance arise which may have an effect on long-term care hospitals (LTCHs) and the patients they serve. NALTH Statements are used to inform the NALTH membership, the general public, and policy makers on matters which NALTH believes may be "significant" regarding the delivery of LTCH services.

Current law requires that, in order to participate in the Medicare program as a LTCH, a hospital not only must meet the same certification requirements that are applicable to other hospitals, but also must serve Medicare patients who have an average length of stay (ALOS) of greater than 25 days. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) required the Secretary of the Department of Health and Human Services (DHHS) to "conduct a study on the establishment of national long-term care hospital facility and patient criteria for the purposes of determining medical necessity, appropriateness of admission, and continued stay at, and discharge from, long-term care hospitals." The law required the Secretary to make a report to Congress no later than July 1, 2009. On January 19, 2011, February 3, 2011, and February 22, 2011, the American Hospital Association (AHA) provided NALTH with drafts of legislation containing new LTCH certification criteria and patient and facility criteria. As a general matter NALTH supports the development of criteria which better identify patients who should receive care in LTCHs in accordance with Congress' directive in MMSEA. NALTH understands the purpose of these criteria is to better define LTCHs and patients who are appropriate to receive services in LTCHs.

In March of 2011 the Secretary of the DHHS fined with the Congress a report and study required by Congress in the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) In this report the Secretary advised Congress that it is "not possible (nor desirable)" to develop LTCH specific criteria. In her report the Secretary indicated that she is investigating new payment methods which my involve payment for patients with similar resource use requirements at the same rate regardless of the provider type (acute hospital, LTCH, IRF or SNF) in which they receive services.

NALTH has reviewed the AHA's proposed legislation. NALTH has identified a number of issues in the proposal which it believes warrant further review. These issues are discussed below.

General Overview

Legislation proposed by the AHA would install new mandatory LTCH specific Medicare patient selection, continued stay and accreditation standards a hospital would be required to meet as a condition of Medicare payment and retention of classification as a LTCH. LTCHs would remain subject to the current 25 day average length of stay Medicare certification requirement. The legislation specifies "core services"' as well as detailed patient admission processes which are different than current medical utilization review standards. The proposed standards are modeled, in part, on the Inpatient Rehabilitation Hospital (IRF) Medicare 60% rule and, when fully implemented would require, as a condition of retention of Medicare classification as a LTCH, that 70% of all Medicare beneficiaries who receive services under the Medicare Part A fee-for-service program meet one or more of four criteria. Unlike the thirteen broad conditions (e.g. amputation, stroke) which populate the IRF 60% rule, none of the four criteria contained in the AHA's proposal are known to LTCH clinical staff at the time of admission of a Medicare beneficiary. As is the case with the IRF 60% rule, the proposed LTCH 70% rule would be applied retroactively. NALTH does not agree that Medicare qualification for hospital classification as a LTCH should be determined on the basis of a percentage rule, under a similar process as is applicable to IRFs. Many LTCH patients have broad a spectrum of multifaceted clinical and programmatic medical resource needs that are not properly reflected by a finite list of LTCH criteria or the 70% test contained in AHA proposal. These proposed criteria were not derived from an empirically based study of their effect on patient care outcomes or payment efficiency. As the AHA's proposal was competed before the Secretary filed her report with Congress in March of 2011 it is not responsive to issues raised by the Secretary with Congress in her report. There are no provisions related to LTCHs and LTCH patients located in small communities or rural areas. NALTH is concerned that implementation of this proposal may have unknown effects on access of patients to LTCH services and programs.

NALTH did not participate in the formulation or approval of the proposed 70% policy or other proposed LTCH facility and patient criteria policies contained in the AHA legislation.

Restriction on Beneficiary Freedom of Choice

Section 1802(a) of the Social Security Act guarantees Medicare beneficiaries the freedom to receive covered services at any willing provider. The Secretary of Health and Human Services has issued a Clarification of Policy for Use of Screening Criteria (QIO TOPS 2004-12) which contains instructions to Medicare contractors that the guarantee of freedom of choice includes the right for Medicare beneficiaries to receive traditional inpatient rehabilitation services in a LTCH. Section 2 of the AHA legislation would require LTCHs to deny access for patients for whom rehabilitation services are the primary purpose for their admission.

NALTH is concerned this provision may interfere with Medicare beneficiaries' access to hospital services. NALTH does not support this restriction on Medicare beneficiary freedom of choice.

Feasibility of Retrospective LTCH 70% Rule

The legislation establishes a 3-year phase-in of the 70% rule under which at least 70% of a LTCH's Medicare patients are required to meet one of the following criteria instead of the 25% rule or the very short stay outlier:

1. the discharge has a length of stay of greater than 25 days.

2. the discharge applies to an inpatient who was an outlier of a short-term acute care hospital immediately prior to admission to the LTCH.

3. the discharge includes the furnishing of ventilator services.

4. the discharge had 3 or more Medicare Severity LTCH Related Group complications and comorbidities or major complications and comorbidities.

Government owned and operated LTCHs are subject to a 65% rule in the third year of the 3-year phase-in instead of a 70% rule. However, after the third year of the phase-in these LTCHs are subject to a 70% rule.

Administrative Feasibility. It is not administratively feasible for LTCHs to know at the time of admission whether patients will meet any of the 4 LTCH certification criteria upon discharge. For example, LTCHs do not have access to data on the cost outlier status of a patient in a discharging short-term acute care hospital and cannot determine whether a patient will meet the average length of stay criterion on admission. The criteria are likely to be subject to criticism by CMS due to the potential for LTCHs to control length of stay and coding.

Payment Ramifications and Potential Decertification

The criteria for retrospective review discussed above are "Requirements for Retention of Medicare Payment Classification as a Long-Term Care Hospital." Under the legislation LTCHs are to be paid as short–term acute care hospitals if they do not meet the criteria for retrospective review. Although there is an opportunity to cure a finding of noncompliance and an expedited appeal to the PRRB, a determination of noncompliance and retroactive recovery of payment is not stayed during the appeal. It is clear that if a LTCH fails to meet any one of 8 preadmission screening criteria or to validate at least 5 criteria within 24 hours of admission, payment is not available under either Medicare Parts A or B. For example, payment is not available for an admission if a patient has one secondary diagnosis. Also, even though the criteria to be applied on retrospective review are no longer under the heading "Requirements for Retention of Medicare Certification," it appears that the Secretary is authorized to subject the LTCH to decertification proceedings if all of the requirements of Section 2 and Section 3 are not met by virtue of the fact that the legislation amends Section 1861 of the Social Security Act. That Section is incorporated by reference in the regulations governing Medicare-Medicaid Conditions of Participation (CoP) for Hospitals. *See* 42 C.F.R. §482.00 *et seq.* If the Medicare-Medicaid CoP are not met, hospitals are subject to decertification proceedings.

Inconsistency with Generally Accepted Standards of Care

The requirement for access to consults with an infectious disease specialist to treat patients requiring complex wound care is an inappropriate and unnecessary intrusion on medical practice, since all physicians and surgeons are qualified to treat extensive and complex wounds. Furthermore, not all infectious disease specialists provide wound care. In some areas of the Nation, general practitioners and surgeons provide these services. This provision would not allow a physician who is not an infectious disease specialist, who provided consulting services to a patient during an acute hospital stay which preceded the LTCH admission, from continuing to provide consulting services upon the patient's admission to a LTCH. Also, infectious diseases

specialists may not be readily available in some rural areas and small community settings. Some LTCHs employ certified wound specialists who are skilled in providing wound care.

Conflicts with Federal Requirements for Utilization Review and Determining Medical Necessity

Federal law currently requires that a physician certify that inpatient hospital services are medically necessary at the time a patient is admitted and (generally, not less frequently than every 30 days thereafter). The requirement that the physician apply the admission criteria set forth in Section 2 of the legislation to validate the admission is inconsistent with the exercise of medical judgment by physicians. Moreover, admission criteria historically have been applied by nurses, not physicians. In making utilization review determinations, physicians apply generally accepted medical practice, considerations of patient safety, and whether the care and services needed by the patient are actually available in an alternative setting. NALTH notes that the language which was added, "as well as any additional clinical rationale that the physician determines to be appropriate that established the reasonableness and necessity of furnishing care to the patient, " is in addition to, not instead of, the criteria.

Scope of Services

NALTH notes that the core services and items listed as furnished to inpatients of LTCHs (complex respiratory services, complex wound services, care for medically complex patients, and advanced cardiac life support) are proposed to be provided by all LTCHs. NALTH questions that these services may not be inclusive of those required by LTCH patients and notes the omission of rehabilitative services which is a core component of patient care provided by LTCHs. Additionally, there are no definitions for these services or basis to conclude that a hospital that may not provide all of these services does not provide high quality care to LTCH patients.

LTCH Nurse Staffing Requirements Should Not Be More Stringent than Nurse Staffing Requirements for Acute Care Hospitals

The requirements related to physician availability and nurse staffing are already addressed in Medicare regulations and Medicare-Medicaid CoP for hospitals. The requirement of on-site registered nurses 24 hours per day in the proposed legislation is more stringent than current Medicare-Medicaid CoP which require "24-hour nursing services furnished or supervised by a registered nurse," and a "licensed practical nurse or registered nurse on duty at all times, except for rural hospitals...." 42 C.F.R. §482.23(b)(1). NALTH does not deem it advisable to propose a more stringent standard for LTCHs than the standard currently applicable to all classes of hospitals, except for rural hospitals.

Omission of Assessment of Small Community and Rural Hospital Issues

NALTH is concerned there is no provision to assess the special needs and circumstances of LTCHs located in small communities and rural areas. Patient selection and resources often differ between these areas and large urban areas. For example, there is no indication of an assessment of the effect of the retrospective 70% rule on LTCHs located in rural areas.

Effect of CMS' Establishment of LTCH Specific Hospital Criteria on AHA Legislation

In November of 2010 the GAO reported, in a briefing report to the Senate Finance Committee staff on current LTCH quality standards, that in 2011 CMS intends to propose new regulations which will contain new LTCH specific "facility criteria." The GAO report indicates that CMS intends to propose this rulemaking as part of its existing authority to establish provider

conditions of participation in the Medicare program. The AHA draft legislation also contains proposals for new LTCH facility criteria. NALTH is concerned that Congress may be reluctant to adopt legislation that contains specific facility criteria when the Secretary is proceeding to do so under current statutory authority.

A Section by Section review of the draft legislation is attached and included as an integral part of NALTH's Statement.

For further information, please contact NALTH's General Counsel, Edward Kalman at ekalman@beharkalman.com or (617) 227-7660.