

PROPOSED LEGISLATION TO PROTECT PATIENT ACCESS TO LONG TERM HOSPITAL CARE

Stephen M. Sullivan, JD, MPH

Long-term care hospitals (LTCH) provide hospital-level care for medically complex, long stay patients which may include patients requiring respiratory failure with ventilator dependency, infections, patients with complex wounds, and trauma patients. LTCHs must meet the same regulatory requirements as general acute hospitals but have a significantly longer average length of stay greater than 25 days. Recently the Centers for Medicare and Medicaid Services (CMS) published payment regulations that limit patient access to LTCH services.

To address the current regulatory instability which threatens LTCHs' ability to continue caring for Medicare beneficiaries and other patients, the American Hospital Association, the Federation of American Hospitals, NALTH, and ALTHA have jointly developed a unified, common sense approach to define the appropriate role for LTCHs in treating medically complex, long-stay Medicare patients and ensure regulatory stability.

The proposed legislation, to be known as the "Long-Term Care Patient Safety and Improvement Act of 2007", has not yet been introduced and at this stage, the likelihood of it being adopted by Congress is not known. I recommend that all interested parties prepare a letter of support to their Congressional Representatives.

Under this bill, LTCHs would be required to maintain the current Medicare criteria of an average length of stay for Medicare patients greater than 25 days and meet the hospital conditions of participation. In addition, they would be required to implement a patient assessment tool for determining the medical necessity of admission and continued stay as well as meeting other staffing requirements. The bill directs the Secretary to implement patient certification criteria to ensure the majority are severely ill and can be classified into one of seven major diagnostic categories (MDCs) and lays out the two-year timeline for implementation by the Secretary. For example, an enactment date of October 1, 2007 (FY 2008) would mean that LTCHs would have to meet the certification requirements developed by the Secretary beginning October 1, 2009 (FY 2010).¹

Furthermore, only LTCHs having accreditation by the Commission on Accreditation of Rehabilitation Facilities in 2004 would be eligible to open a distinct and separate rehabilitation unit.¹

The bill requires the Secretary to design a medical necessity review program that would capture 65 percent of overpayments to LTCHs using the quality improvement organizations (QIOs). Currently QIOs review only a small portion of all LTCH claims, so this provision is a significant change. According to CMS, in 2005 QIO reviews found only 7.9 percent of claims reviewed to be inappropriate.¹

Another crucial change would limit the certification of new LTCHs for three years after enactment unless the LTCH met one of two exceptions. An LTCH could be certified during the moratorium if it can prove it was under development before the enactment date or if it is in an area without an LTCH and the Secretary deems it would be in the best interest of Medicare beneficiaries to provide access to LTCH services in that area.¹

In the final rule for RY 2008, CMS extended the 25 Percent Rule to all LTCHs. The bill contains a provision that would not allow the Secretary to extend to freestanding LTCHs a policy that pays for a portion of LTCH cases under the inpatient PPS (IPPS) rather than under the LTCH PPS when the portion of those cases coming from a single source exceeds a threshold set by the Secretary. The 25 Percent Rule thresholds for LTCHs co-located with other hospitals (hospitals within hospitals (HwHs)) would be frozen at the current transition-level thresholds, which are 50 percent for urban HwHs and 75 percent for rural LTCHs and LTCHs located in a MSA-dominant hospital.¹

CMS would be barred from implementing a change in payment policy for certain short-stay outlier (SSO) cases that CMS finalized for RY 2008. The policy would affect LTCH SSO cases with lengths of stay below the IPPS average length of stay plus one standard deviation (the inpatient comparable threshold). Furthermore, the Secretary would be prohibited from making a one-time budget neutrality adjustment to ensure that payments under the PPS are not less than or more than payments would have been under the previous payment system.¹

Finally the bill would require the Secretary to study appropriate quality measures for LTCH patients and choose three measures to be reported by LTCHs. The bill allows the Secretary to augment the number of quality measures as appropriate. LTCHs which do not participate in the quality data reporting program would lose a percent of the market basket update.¹

¹ Alexis Ahlstrom, Jon Blum, Avalere Health LLC, *Cost Estimate for "Long-Term Care Patient Safety and Improvement Act of 2007"*, June 20, 2007 Memorandum to ALTHA