GreisGuide to LTACHs
Business and Legal Resources for Long Term Acute Care Hospitals

January 2009 Edition (Happy New Year!!!)

MedPAC Forecasts a 4.2% Decrease in Medicare Margins for LTACHs and Proposes 2010 Payment Rate Increase. On December 4, 2008 the Medicare Payment Advisory Committee (MedPAC) held a public meeting to review the adequacy of Medicare payments under the Long Term Care Hospital Prospective Payment System (LTCH-PPS) for services provided by LTACHs. Commissioners reviewed data related to Medicare payment and cost trends, access to capital, quality of care, access to care, and other factors. MedPAC predicts that average LTACH Medicare margins will decrease industry-wide from 4.7% in 2007 to 0.5% in 2009 primarily as a result of accelerating growth in the cost of care and recently enacted Medicare payment policy changes. As a result, MedPAC proposed a draft recommendation to Congress in favor of an increase to the Medicare payment rate for LTACH services for the 2010 Rate Year by the projected rate of increase in the market basket index, less adjustments for productivity growth.

LTACH Medicare profit margins grew rapidly after implementation of the LTCH-PPS in 2002. In 2005, the average industry-wide Medicare profit margin was 12%. In 2007, the average profit margin had decreased to 4.7% mainly as a result of Centers for Medicare and Medicaid Services payment adjustments. Medicare profit margins, however, varied greatly in 2007, with a quarter of hospitals having margins of -5.2% or less and another quarter of hospitals having margins of 13.1% or greater. MedPAC also noted that margins for for-profit LTACHs and freestanding facilities in 2007 were significantly higher than those for non-profits and hospitals-within-hospitals, respectively. Although MedPAC projections accounted for 2009 Medicare payment increases, it projected that the average industry-wide Medicare margin would decrease to 0.5% in 2009 as a result of accelerating growth in the cost of care and payment policy changes enacted in 2007 under the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA).

MedPAC noted that the impact of the current economy-wide credit crisis will vary across the LTACH industry, and that unlike in past years, access to capital is not a valid or reliable indicator of Medicare payment adequacy. Commissioners also commented on the unevenness of access to capital within the industry, noting that large public companies will be better able to weather the financial storm than smaller highly leveraged LTACH chains. MedPAC also observed that the MMSEA's three-year moratorium on the establishment of new LTACHs, LTACH satellite facilities, and increases in the number of LTACH beds (with certain limited exceptions) limits opportunities for expansion and, therefore, reduces the need for capital.

MedPAC reported that the quality of care provided in LTACHs was generally improving. It considered historical data on the percentage of patient deaths occurring in LTACHs, the percentage of patient deaths occurring within thirty days of discharge, and the percentage of patients readmitted to acute care hospitals for each of the top fifteen LTACH diagnoses (which account for 60% of all LTACH patient admissions). MedPAC found that readmission rates for virtually all diagnoses were stable or declined in 2007. LTACH death rates and deaths occurring within thirty days of discharge also declined for most diagnoses in 2007. Commissioners noted, however, that LTACHs experienced a large increase in the number of septicemia admissions and a correspondingly large increase in septicemia-related death rates.

MedPAC found it difficult to assess patient access to care since there are no fixed admission criteria for LTACH patients and because it is unclear in many cases whether patients treated in LTACHs require the acute level of care provided by such facilities. A CMS-commissioned study currently being performed by Research Triangle Institute that is scheduled to be presented to Congress by June 2009 will further examine and recommend LTACH patient admission and facility certification criteria.

Why Recessionary Pressures and State Medicaid Cuts Will Create a Challenging Environment for Many LTACHs in 2009. Conventional wisdom holds that hospital profitability follows income and revenue trends of the communities in which a hospital is located. If such wisdom holds true, 2009 could be a challenging year for LTACHs generally, and particularly for those LTACHs that rely heavily on state Medicaid reimbursement.

A recent front-page story in the Washington Post reported that "states from Rhode Island to California are being forced to curtail Medicaid spending" as they struggle to cope with decreasing tax revenue, rising unemployment rates and massive losses of private health insurance coverage. In fact, nineteen states and the District of Columbia have already decreased Medicaid reimbursement rates, and twenty-four more states are considering such cuts. Notably, New York Governor David Paterson released the State's budget proposal on December 16, 2008 that would significantly reduce New York's Medicaid spending, while raising more than one billion dollars in assessments on hospitals (including LTACHs), other health care providers, and health insurers. As a result of this financial crisis, governors and mayors from across the country have lined up to ask the new administration and Congress for hundreds of billions of dollars in stimulus package and emergency spending to plug holes in state budgets—arguing that the poorest and most disadvantaged communities will bear the brunt of health care service cuts, and joblessness will rise if Washington does not come to the rescue.

LTACHs and other post-acute care providers began "feeling the pinch" in the second half of 2008 as credit became increasingly scarce and costly, and as institutional investment portfolios racked up massive losses. A number of LTACHs have reportedly postponed or canceled plans to expand or open new facilities that were under development prior to enactment of the three-year moratorium on the establishment of new LTACHs, LTACH satellites, and increased beds for LTACHs and satellites. Even some LTACH facilities nearing completion have delayed opening as they attempt to gauge the magnitude of local payer mix shifts. Other LTACHs have delayed purchasing new equipment and planned capital spending (even spending on revenue generating services and equipment) until credit and general market conditions improve.

Even with the industry enjoying a period of Medicare reimbursement stability lasting through the end of the 2009 Rate Year (September 30, 2009), a favorable standard Federal payment rate in excess of $39,000 and anticipated modest admission growth, many LTACHs may be forced to cut staff and services and freeze or reduce salaries if an increasing number of patients obtain care under Medicaid and if the credit squeeze fails to moderate. General acute care hospitals across the country, including Loyola University Health System in Illinois, Commonwealth Medical Center in Pennsylvania and Santa Rosa Memorial Hospital in California have, respectively, cut jobs, closed down and halted a $68 million expansion project as a result of financial concerns. Could this be a sign of things to come in 2009 for LTACHs?

Some larger, better positioned and capitalized LTACH providers, however, may view current market conditions as an opportunity to acquire strained and under-performing facilities that have not adopted an integrated service delivery model in which LTACH, skilled nursing, and other post-acute care services are packaged together.

The Commonwealth Foundation Launches Hospital Comparison Website. The Commonwealth Foundation (Foundation), a private health care foundation supporting independent research on health policy reform, launched www.whynotthebest.org providing hospital performance data on two dozen measures of recommended care. The website allows health care providers and consumers to conduct side-by-side comparisons of over 4,500 hospitals, including many LTACHs, with similar characteristics, such as region, ownership, size, and type.

The website tracks the same measures of hospital quality as those publicly reported on the Centers for Medicare and Medicaid Services' (CMS) website, *Hospital Compare*. The Foundation's website, however, is reportedly easier to navigate and provides more robust data. The website tracks data on quality indicators collected since 2006, so users can see how much hospitals have improved over time, whereas CMS only provides information from the most recent quarter.

The Foundation website tracks 24 Hospital Quality Alliance measures that report how often hospitals deliver recommended care processes for the following four conditions: heart attack, heart failure, pneumonia, and surgical care improvement. For each performance measure, the website identifies the top 1%, 10%, 25%, 50%, and the bottom 25% of hospitals.

In addition, the website includes 10 measures from the Hospital Consumer Assessment of Health care Providers and Systems, which reports hospital patients' satisfaction with their care. A unique feature of the Foundation website is that hospitals also receive a composite score for performance across the four conditions as well as an overall composite score.

CMS Awards Contracts to Evaluate the Medical Necessity of LTACH Patient Admissions. The Centers for Medicare and Medicaid Services (CMS) announced December 19, 2008 that it had awarded two contracts to study the medical necessity of patients admitted to LTACHs. CMS has historically expressed concern about the growing number of LTACHs, and continues to be concerned about the potential over-utilization of LTACHs in light of their substantially higher Medicare reimbursement rates.

The first contract was awarded to AdvanceMed to perform LTACH sampling and validation. Another contract was awarded to Wisconsin Physician Services to review LTACH Medicare claims for discharges to determine whether LTACHs are admitting only medically appropriate patients. The information collected will allow CMS to develop a national error rate for medically unnecessary patient admissions to LTACHs, and may be shared with recovery audit contractors, Fiscal Intermediaries (FI), Medicare Administrative Contractors (MAC), and Quality Improvement Organizations (QIO) for the purpose of recovering Medicare overpayments. CMS expects these medical reviews to begin January 2009.

These claims reviews will be performed in addition to the claims reviews that FIs and MACs began performing in August 2008 as part of CMS's efforts to shift the majority of utilization reviews from QIOs to FIs and MACs—who are authorized to review claims submitted from January 1, 2008 forward. QIOs will retain their responsibility for performing expedited determinations, HINN reviews, quality reviews, and provider-requested higher-weighted DRG reviews. Additional guidance regarding FI and MAC claims audits can be found in the CMS Internet Only Manuals and in the Program Integrity Manual (100-8) in Chapters 1, 2, 3, and 6. All relevant documents can also be found on the Legal Resources page of the weblog.

Medicare Recovery Audit Contractor Update. One of my colleagues, Brent Rawlings, recently wrote a White Paper discussing the temporarily delayed expansion of the Recovery Audit Contractor (RAC) program. It is important to note that although RACs may initially focus their audit efforts on Medicare reimbursable services provided by acute care hospitals, LTACH Medicare claims are also subject to review by RACs.

RACs are auditors contracted by CMS responsible for reviewing claims and medical records to identify overpayments and underpayments for Medicare claims. Claims reviewed by RACs may include Part A, Part B, physician, acute care hospital, LTACH, skilled nursing facility, inpatient rehabilitation, hospice, home health, clinical laboratory, and durable medical equipment, prosthetics, orthotics, and supplies claims. RACs are paid on a contingency basis, retaining a percentage of the amount recovered for overpayments and underpayments identified.

RACs started as a CMS Demonstration Project in the states of California, Florida, and New York, but as a result of Section 302 of the Tax Relief and Health Care Act of 2006, RACs will become permanent and operations are to expand to all states by no later than January 1, 2010. The current expansion strategy could result in RACs operating in all 50 states and the District of Columbia as early as August 1, 2009.

CMS has established limits on the number of medical records that can be requested by RACs per 45-day period. For example, RACs may not request from hospitals medical records for more than 10% of average monthly Medicare claims, up to a maximum of 200. This limitation is intended to reduce some of the hardship that has been placed upon providers in responding to medical record requests in the Demonstration Project. Information on medical record request limits is available on the CMS website.

Two unsuccessful bidders to become the RAC for one of four CMS-designated regions, Viant and PRG-Schultz, have filed protests with the Government Accountability Office (GAO) pursuant to the Competition and Contracting Act of 1984. As a result of these protests, CMS is required to impose an automatic stay in the contract work of the RACs. This means that the RAC program is permanently on hold and RACs cannot conduct any activity under the RAC program. A decision by the GAO is expected in early February 2009, at which point it is anticipated that the selection process should be finalized and CMS's expansion strategy will continue. CMS officials have stated that due to the delay, the RAC implementation schedule will likely be compressed, but not delayed. The bidders for the RAC program selected by CMS are as follows: Diversified Collection Services, Inc., Livermore, California – Region A; CGI Technologies and Solutions, Inc. of Fairfax, Virginia – Region B; Connolly Consulting Associates, Inc., Wilton, Connecticut – Region C; and HealthDataInsights, Inc., Las Vegas, Nevada – Region D.

CMS's current expansion strategy for the permanent RAC program has RACs operating in 23 states by March 1, 2009 and the remaining 27 states and the District of Columbia beginning August 1, 2009 or later. By October 1, 2008, the following states were expected to have operating RACs: Arizona, Colorado, Florida, Indiana, Maine, Massachusetts, Michigan, Minnesota, Montana, New Hampshire, New York, New Mexico, North Dakota, Rhode Island, South Carolina, South Dakota, Utah, Vermont, and Wyoming. As discussed previously, implementation of RACs in these states is expected to continue once the bid protest is resolved. By March 1, 2009, the following states are expected to have operating RACs: California, Nevada, Oklahoma, and Texas. Beginning August 1, 2009 or later, the remaining states and the District of Columbia are expected to have operating RACs.

If you have any questions regarding RACs, the plans for expansion, how to prepare for a RAC audit (as a number of companies are currently providing RAC preparation audits), or the impact on your organization, please contact Brent Rawlings at (804) 775-1126 or me. Please also visit the weblog if you would like a copy of Brent's White Paper: Medicare Recovery Audit Contractors (RACs): What Providers Need to Know and How to Prepare.

Facility News.

- Heartland Health to Open LTACH. Heartland Health plans to open a 41-bed HwH in St. Joseph, Missouri in early 2009.

Poll Results. Thirty-three people responded to the following poll question: *"What do you think will happen after the three-year moratorium on the establishment of new LTACHs expires?"*

- 45% of respondents said that adjustments to the LTCH-PPS base rate and new patient admission and facility certification criteria will make further growth difficult or impractical;
- 36% of respondents said that LTACH growth will be curbed by adjustments to the LTCH-PPS base rate and new patient admission and facility certification criteria;
- 3% of respondents said that new Federal regulations will grandfather existing LTACHs, but prohibit the development of new LTACHs; and
- 3% of respondents said that the Moratorium will be extended.

The poll has closed and a new poll question will be posted in mid-January.

Upcoming Events. A list of upcoming events is available at www.GreisGuidetoLTACHs.com.

In the Next Issue. The February 2009 issue will feature articles: (i) discussing the benefits and drawbacks of physician integration models; (ii) addressing key considerations when entering into medical director agreements; and (iii) an interview with Jerry Amato, CEO of the Specialty Hospitals of Washington-Hadley.

Developing, Buying and Selling Facilities. We are regularly approached by companies and individuals interested in developing, buying and selling LTACHs and other post-acute care provider facilities, acute care hospitals, dialysis centers, ambulatory surgery centers, billing companies, management companies, and various other healthcare-related businesses. Please contact me if you have an interest in any of these opportunities.

Since launching the ***GreisGuide to LTACHs*** Newsletter and www.GreisGuidetoLTACHs.com over 100 people have signed up to receive the Newsletter electronically and the weblog has received thousands of visits. I am pleased that so many people are finding the information provided to be timely and useful. As always, please contact me if you have questions about the Newsletter or a weblog topic, if you would like to be removed from my distribution list, if you are interested in advertising on the weblog, or if you know of someone who would like to receive the Newsletter. More frequent content updates are posted regularly on the weblog, together with links to valuable business and legal resources, recently published articles, presentations, white papers and details on upcoming industry events.

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