GreisGuide to LTACHs

Business and Legal Resources for Long Term Acute Care Hospitals

APRIL 2009 EDITION

Upcoming Events (click on the link to register or for more information)

- April 30, 2009: NALTH Annual Conference (I hope to see you there!!!)
- May 13, 2009: 7th Annual Dialysis & Nephrology Symposium
- May 19, 2009: New Surroundings in Health Care: FMLA, Illinois CON, Financial Challenges and Beyond (including a panel entitled, "The Changing Face of Post-Acute Care"). Panelists include:
  - Tom Clarke, President & CEO, Kissito Post-Acute Care
  - Ellen Smith, President & CEO, Dubuis Health System
  - Brian Wells, Corporate Director, Specialty Hospitals of America
  - William Cash, Founder and CEO, Principle Pharmacy Group (invited)
  - John Baird, CEO, Holy Family Medical Center (invited)
  - Jason Greis, McGuireWoods LLP, Moderator

Benefits and Drawbacks of Acute-Care and Post-Acute Care Payment Bundling

The current Congressional fervor to overhaul the U.S. health care system has some policy makers discussing how to change the way post-acute providers, including LTACHs, home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and outpatient-based hospital rehabilitation facilities are compensated for treating Medicare beneficiaries. One solution proposed by President Barack Obama, the Congressional Budget Office, and certain congressional leaders is to bundle payments for acute care and post-acute care services provided within the first thirty days after being discharged from an acute care facility. This bundling model has been proposed many times since the early 1980s as a measure to control escalating post-acute care costs, decrease the number of preventable acute-care hospital readmissions, and increase Medicare cost savings but has never received broad support—until now.

There appears to be growing Administration and congressional backing for the bundled payment model generally. Critics of the current unbundled system argue that paying post-acute providers a separate payment for medical services creates an inappropriate financial incentive for providing medically unnecessary treatments and extending patients' lengths of stay in certain post-acute care settings. Critics also express concern that the current system provides neither "carrots" nor "sticks" to encourage acute-care providers to prevent some types of otherwise preventable patient readmissions. A recent article in the New England Journal of Medicine analyzed Medicare claims using the MEDPAR file from October 2003 through December 2005 and found that of 11,855,702 patients, 19.6% of patients were rehospitalized within thirty days, 34.0% were rehospitalized within ninety days and 56.1% were rehospitalized within one year.

Proponents of bundling believe that the model offers providers an incentive to reduce costs of services and to increase the efficiency with which they provide medical care. For example, policymakers are considering bundling hospital and physician payments to provide one, fixed payment for some procedures that currently involve separate billable services, such as implanting an artificial hip or providing a course of cancer treatment. The Centers for Medicare and Medicaid Services (CMS) recently began a pilot program in January 2009 in certain Colorado, New Mexico, Oklahoma, and Texas acute-care hospitals where bundled payments are directed to the hospital and then split between the hospital and physicians based on a negotiated contract. For the pilot project, CMS negotiated the rates for the bundled payments for procedures, including hip and knee implants and heart bypass surgery. Depending on the outcome of this pilot, Congress may be prompted to approve a full-scale shift to bundled payments for hospital and physician services. Senate Finance Committee Chair Max Baucus, a vocal proponent of bundled payment

systems, said in his health care reform proposal that bundled payments have the potential to increase efficiency and encourage physicians to better coordinate patient care.

Bundling payments for acute and post-acute care services also appears to be squarely within legislators' crosshairs. In 2008 the Congressional Budget Office (CBO) released a Report to the House and Senate Committees on the Budget providing an expansive list of options for reducing Federal health care spending. In its report, the CBO proposed bundling acute-care and post-acute care services into one payment as a way to "reduce federal outlays by an estimated $0.7 billion over the 2010-2014 period and by almost $19 billion over the 2010-2019 period." Under the system, acute-care hospitals would receive a bundled payment and contract with post-acute care providers for services. Bundling would require acute-care hospitals to be responsible for all levels of care provided outside the hospital setting, thus requiring them to act like insurers in some respects. Hospitals would be required to determine how much post-acute care a patient needs and the best ways to provide that care. They would also be required to make decisions about a patient's continuing care needs, as well as the appropriateness and quality of care.

The Administration appears poised to compel delivery system modifications through aggressive bundled payment policy changes. President Obama's 2010 proposed budget further supports the CBO's proposal. The proposed budget suggests that using bundled payments, together with a "combination of incentives and penalties," should decrease hospital readmission rates for Medicare beneficiaries.

Opponents, however, argue that it would be difficult to craft such a bundled payment system for the following reasons, among others:

1. A person's post-acute care needs may be completely different from the reason for a hospital admission. In short, it may be difficult for an acute-care hospital to appropriately and accurately determine post-acute care payments based on a hospital diagnosis;
2. Providing a fixed payment based on diagnosis creates an inherent financial incentive for acute-care hospitals to underserve the most severely impaired patients;
3. Acute-care hospitals would be required to manage costs for all post-acute care services. As a result, hospitals would take on the role of dominant provider and health insurer in a given area. Post-acute care providers, especially smaller providers, may not have the organizational muscle to negotiate favorable reimbursement rates with their local acute-care hospitals;
4. Relying on acute-care hospitals as the focal point for post-acute health care is contrary to the trend toward community and home-based care, which often reduces length of stay;
5. Bundling may propel acquisitions of post-acute facilities by acute-care hospitals as they attempt to better manage their spending throughout the post-acute care spectrum. It may be increasingly common to see ICU, telemetry, medical/surgical, inpatient rehabilitation, LTACH, SNF, and hospice care services provided under a single umbrella organization or located in a single facility; and
6. Acute care hospitals would likely have to establish hefty reserves to insure against the possibility that post-acute care payments might exceed their financial means.

In a year in which legislators appear to have the political appetite to enact substantial healthcare reform, this bundling proposal deserves attention. Carefully crafted legislation that takes into consideration the reimbursement needs of post-acute care providers could produce an entirely new, workable model. It will be important, however, for all parties to be represented at the negotiation table since the potential pitfalls associated with the bundled delivery system may have unintended, adverse financial consequences for some post-acute care providers and for the delivery of quality patient care.

LTCHs, RACs and Medical Necessity Update

By Carol Burkhart, RN, MS, CNP, CPHRM; William Hammock, RN, BSN, CMC, ACM; and

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Stacey Donegan, CPC. Marsh, The Global Healthcare Consulting Practice

Recovery Audit Contractor (RAC) risks faced by LTCHs and other non-hospital sector health care providers present some additional industry-specific challenges as was recently discussed at the 2009 National Medicare RAC Summit in Washington, D.C. At the Summit, Panelist Debbie Russell of Regency Hospital Company discussed the importance of documentation of medical necessity for admission as well as the need to document daily physician assessment and intervention in LTCHs to support RAC appeals. Ms. Russell stressed the importance of documenting community-specific considerations such as the lack of available Skilled Nursing Facilities (SNFs) level of services, and also discussed known LTCH problem-prone issues identified by the RAC Demonstration Project such as lack of sufficient documentation to support medical necessity and incorrectly coded claims.

Despite the fact that the RAC Demonstration Project sample size for LTCHs was not robust as compared with general acute care hospitals, LTCHs should understand that CMS is currently actively seeking to determine national LTCH error rates through RAC activity. In December 2008, CMS announced contract awards to AdvanceMed and Wisconsin Physician Services (WPS) to perform medical necessity reviews of long-term-care hospital admissions for the purposes of determining a national error rate for LTCHs. WPS will use existing inpatient hospital review criteria in order to determine the medical necessity of LTCHs admissions. These criteria sets include any combination of InterQual, MassPro, and/or NALTH criteria. However, during the 2009 Summit, George Mills, Director of the CMS Provider Compliance Group, Office of Financial Management, also stated that *the permanent RACS are not bound by CMS to use* any specific, proprietary criteria. Mr. Mills confirmed that although the permanent RACS can chose any criteria for use to determine medical necessity, the criteria must be the same criteria which the fiscal intermediaries, carriers, and Medicare administrative contractors are required to apply (CMS Manuals, National and Local Coverage Determinations (NCD, LCD) and CMS Advisories). Therefore, it will be critical for an LTCH to ensure that technical documentation deficiencies of medical necessity are reviewed and corrected in accordance with *CMS* criteria and determinations. Mills also noted that RACS must submit any *new issues* they identify to CMS for approval before any new issues are allowed inclusion in the permanent RAC program.

LTCHs should ensure that providers are educated on specific high risk areas of medical necessity documentation in a *timely* manner. Unfortunately, physician education regarding RAC risks and medical necessity documentation is often overlooked by providers until the third or higher levels of appeals (providers are unable to add documentation and evidentiary support in defense of treatment or coding beyond the second level of appeal). Some LTCHs have also reported that WPS has used technical documentation deficiencies to deny LTCHs reimbursement and seek recoupment, *even where medical appropriateness of admission is otherwise evident*. Although CMS published its long awaited provider outreach schedule this month, LTCHs may want to consider engaging other education resources for physicians due to the somewhat limited outreach education opportunities as currently scheduled.

Documentation improvement initiatives must include more than education and the application of standard billing and coding audits. LTCH RAC readiness should include a careful evaluation of pre-admission screening and gate keeping processes to ensure aggressive identification of potentially inappropriate admissions. For example, during the pre-admission process case managers should actively work with providers to help them understand the inadvisability of admissions for three-day stays to qualify patients for SNF placement. LTCHs should also be prepared to appeal denials based on SNF inability to provide appropriate level of services in the community, and documentation must *support* the appeal. Additionally, if the ALOS falls below the 25-day requirement, the commentators expressed concern that RACS could potentially deny partial admissions for LTCHs.

In summary, LTCH RAC readiness should include:

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1. A mock RAC audit to identify vulnerabilities (general RAC readiness, voluntary repayment to prevent RAC review, revenue recovery review to detect undercharges and underpayments, appeals process);
2. Correction of frequently seen and systemic billing and coding errors;
3. Provision of timely, intensive initial and ongoing education regarding documentation of medical necessity for admission and continued stay; and
4. Concurrent, proactive, case management and documentation improvement program review.

Georgia Division of Health Planning Releases Bed Needs Analysis Showing Possible LTACH Bed Shortage by 2014

On April 1, 2009 the Georgia Division of Health Planning, Data Resources and Analysis Section released a Bed Needs Analysis showing that by 2014 Georgia residents in the southeast and southwest regions of the State could face LTACH bed shortages, unless new LTACHs are built or existing LTACHs are expanded. Development and expansion of LTACHs, however, has been drastically curbed by the Medicare, Medicaid and SCHIP Extension Act of 2007's three-year moratorium on the classification of new LTACHs and LTACH satellite facilities and new Medicare-certified beds at existing LTACHs. The findings were commissioned by the Georgia Health Strategies Council (Council) as part of its ongoing effort to develop and maintain the State's strategic health plan.

In 2005, the Council's Long Term Care Standing Committee (Standing Committee) found that the 1994 State Health Plan and Rules governing the need for new or expanded inpatient physical rehabilitation services in the State were outdated. In particular, the Standing Committee recommended creating a technical advisory committee (TAC) to review both the State Health Plan and Rules to ensure that they adequately address the needs of patients and other healthcare stakeholders.

The TAC consisted of nineteen members affiliated with acute care hospitals with rehabilitation units, freestanding rehabilitation hospitals, state-operated rehabilitation hospitals, third-party payors, state agencies, and representatives serving unique patient populations. The TAC met during 2005 and 2006, and observed that rehabilitation services and LTACH services often overlap. A subcommittee was subsequently formed to develop Certificate of Need (CON) rules and standards specific to LTACHs with which organizations applying for a CON to establish a new LTACH or to expand an existing LTACH would be required to comply. The subcommittee's recommendations for CON rules applicable to LTACHs were approved by the Council and the Board of Community Health and became effective in December 2006 (see GA COMP. R. & REGS. 111-2-2-.36) (collectively, the Rules).

Subject to certain limited exceptions, the Rules generally require CON applicants interested in establishing a new LTACH or expanding an existing LTACH to:

1. Demonstrate need for LTACH beds in an established planning region of the State (Georgia has been divided into four planning regions) based upon the formula set forth in the Rules;
2. Prove that the establishment or expansion of an LTACH will not have an adverse impact on an existing LTACH in its planning region;
3. Have the following minimum bed requirements: (i) a new freestanding LTACH is required to have at least forty beds; (ii) a new Hospital-within-Hospital LTACH must have at least twenty beds; and (iii) the minimum number of beds for the expansion of an existing LTACH, including satellite locations, is ten beds or ten percent of the total current licensed bed total of the current LTACH, whichever is less;
4. An applicant is also required to demonstrate the intent to meet The Joint Commission (TJC) standards within twenty-four months of accepting its first patient. An applicant to expand an LTACH is required to be TJC-certified as of the date of its application;
5. Demonstrate intent to meet the licensure rules of the Georgia Department of Human Resources. An

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applicant for an expanded LTACH must demonstrate a lack of uncorrected deficiencies;
6. Have written policies and procedures for utilization review, taking into consideration factors such as medical necessity, appropriateness and efficiency of services, quality of patient care, and rates of utilization;
7. Document the existence of referral arrangements, including transfer agreements, with an acute-care hospital(s) within the planning region to provide emergency medical treatment; and
8. Foster an environment that assures access to services to individuals unable to pay and regardless of payment source.

Organizations considering applying for an LTACH CON in Georgia at the expiration of the Federal moratorium (assuming it is not extended) should note (i) that the Rules place a significant burden on applicants to prove that the establishment or expansion of an LTACH will not have an adverse impact on an existing LTACH in its planning region; and (ii) that the Beds Need Analysis found that the metropolitan Atlanta area had a forty-four LTACH bed surplusage. In fact, as of March 2007, eight of the State's fourteen LTACHs were located in the metropolitan Atlanta area. It will therefore be difficult to obtain a CON in more densely populated Fulton, DeKalb, Gwinnett, and Cobb counties.

Poll Question and Results:
What are the top 5 key operational statistics that you review on a daily basis? (26 total respondents)

- Case mix index and DRG codes **(92%)**
- Length of stay data **(77%)**
- Admissions data **(65%)**
- Other information **(54%)**
- Revenue per discharge **(46%)**
- Labor management reporting **(35%)**
- Key area expense data (e.g., pharmacy) **(35%)**
- Patient outcome data **(31%)**
- Quality reports from local, state, and Federal agencies **(15%)**
- Patient satisfaction information and scores **(12%)**

Other Recently Posted Articles
- Medicare Announces Sites for Pilot Program to Improve Quality As Patients Move Across Care Settings
- Medicare Recovery Audit Contractor (RAC) Update - Spring 2009
- LTACHs Should be on the Lookout for Recalled Peanut Products
- CMS Special Open Door Forum: Part A Providers, RAC Teleconference

Developing, Buying and Selling Facilities.
I am regularly approached by parties interested in developing, buying, and selling LTACHs and other post-acute care providers, 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.

Looking for Guest Columnists
Do you have an LTACH-related story or news that you want to share with peers? Please contact me if you are interested in reaching a large audience of key executives and professionals in the LTACH industry.

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 regarding upcoming industry events.

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