

JANUARY-FEBRUARY 2010 EDITION

A Status Update on Efforts to Extend MMSEA’s LTACH Provisions

Over the past year, the LTACH industry has worked tirelessly to ensure extension of the LTACH provisions contained in the Medicare, Medicaid and SCHIP Extension Act of 2007 (Public Law No 110-173) (“MMSEA”). Most importantly for LTACHs, Section 114 of MMSEA (i) provides a three-year regulatory reprieve from certain harmful Medicare payment policies, including providing relief from the “25% Rule,” the very short stay outlier policy and a one-time prospective adjustment to the LTACH standard amount, (ii) established new LTACH facility criteria, and (ii) provides a three-year moratorium on the establishment and classification of new LTACHs, LTACH satellite facilities, and LTACH beds in existing LTACHs or LTACH satellite facilities.

The industry’s latest efforts to introduce legislation to extend MMSEA’s LTACH provisions can be found in two bills—namely [H.R. 4213 § 221](#), and [H.R. 3590 § 3106](#). H.R. 4213 is the *Tax Extenders Act of 2009*, which is a bill introduced by Senate Majority Leader Harry Reid (D-Nev.) and Senate Finance Committee Chairman Max Baucus (D-Mont.) on March 1, 2010 as a substitute amendment to a tax extenders bill passed by the House in December 2009. H.R. 3590 is *The Patient Protection and Affordable Care Act*, which is the Senate’s health care reform bill that passed on December 24, 2009 by a party-line vote of 60-39. A comparison of the LTACH-related provisions in these two bills follows:

	H.R. 4213	H.R. 3590
Extension of MMSEA’s LTACH Provisions	One year	Two years*
Other Relevant Provisions	None	(i) LTACH quality reporting (§ 3004); (ii) Expansion of healthcare-acquired conditions policy (§ 3008); (iii) A national pilot program on post-acute payment bundling (§ 3023); and (iv) A pilot program on value-based purchasing of LTACH services (§ 10326).
Bill Status	Passed by the House Dec. 8, 2009. The Senate is presently considering amendments to the Bill. A cloture vote is expected in the next day or two, with a vote on the Bill occurring soon after.	Passed by the Senate Dec. 24, 2009. President Obama appears to be in favor of using the filibuster-proof reconciliation process to move the Bill through Congress.

*Although the text of Section 3106 of *The Patient Protection and Affordable Care Act* available on the Library of Congress website only reflects a one-year extension of MMSEA's LTACH provisions, an amendment proposed by Senator Reid on the eve of the Bill's passage appears to have extended MMSEA's protections for two years.

Although the fate of these bills remains unclear due, in part, to the growing uncertainty that Democrats will be able to muster the needed 217 votes in the House to pass H.R. 3590 (recall that the House passed its version of a healthcare bill (H.R. 3962) in November 2009 by a vote of 220-215), it is clear that the LTACH industry will continue seeking opportunities and legislative vehicles to extend the life of MMSEA's LTACH protections. In the meantime, LTACHs should pay attention to legislative developments related to these two bills, contact their respective trade associations to determine how they can help, and consider contacting congressional representatives to encourage them to vote in favor of passage of these two bills.

Novel Issues in Developing an Antimicrobial Stewardship Program in LTACHs

By Marvin Finnefrock Pharm. D., Divisional Vice President for Clinical Pharmacy Services, Comprehensive Pharmacy Services.

Antimicrobial stewardship is very important globally as pathogens continue to become more resistant to existing antibiotic therapy while, simultaneously, new antibiotic development has become increasingly scarce. Establishing an Antimicrobial Stewardship Program in the LTACH arena is essential. Patients who are admitted to these hospitals often have serious and partially treated infections. Without the constant monitoring of antibiotic use, collateral damage in the form of increased resistance and lack of effectiveness to popular antibiotics may occur.

Dr. Robert Stanton is a pharmacist who is employed by Comprehensive Pharmacy Services ("CPS"), and covers many of the LTACH facilities within CPS'

client base. Dr. Stanton also sits on CPS' Antibiotic Stewardship Committee and provides the following insight into successful development of an Antimicrobial Stewardship Program within the LTACH environment.

1. Microbiology Services. Microbiology services are usually performed by an outside laboratory. Identifying the individual who is capable, *and willing*, to participate on an LTACH antimicrobial team may be challenging. Almost always a personal visit to the microbiology department is required to establish these relationships. Key objectives are to determine an individual to serve on the LTACH antimicrobial team, to keep the LTACH information separate so that an antibiogram for the LTACH can be developed, and to have Culture and Susceptibilities, including preliminary results, sent to the pharmacy on a daily basis.

2. Team Leader. While ultimately the pharmacist is identified as the key individual performing antimicrobial stewardship tasks, a physician team leader also needs to be identified. If there is an Infectious Disease physician on staff, then that physician may be the leader. If an infectious disease physician is not available, then another physician must be identified; usually it is the physician most involved with infection control activities within the facility. These team meetings should occur at least monthly initially so that everyone understands the pieces that need to be in place for effective antimicrobial stewardship.

3. Setting Goals and Objectives. During the initial stages of program development, it may be necessary to cover the Infectious Disease Society of America ("IDSA") guidelines in order that each member of the team understands objectives to be accomplished and the methods that will be employed to achieve those goals. There should also be measurable parameters. Some examples include keeping track of how many Culture and Susceptibility results were reviewed and how many times the pharmacist had to notify the physician that the patient was on an antibiotic to which the pathogen was resistant. Likewise, documentation should include those instances when a

pharmacist intervenes to change a patient from a broad spectrum antibiotic to a narrower spectrum antibiotic (de-escalation).

4. Infections and treatment that Arise Outside the Facility. One of the most challenging aspects of antimicrobial stewardship in an LTACH is that usually neither the pathogen nor the initial treatments are initiated from the medical staff of the LTACH itself. Obtaining antibiograms from hospitals that commonly admit to your LTACH is a good idea. This information and a thorough review of the chart will help you plan a de-escalation plan for the antibiotics. Likewise, cost-effective antibiotic regimens must be evaluated. For example, if a patient is admitted to the LTACH on a newer, more expensive antibiotic for methicillin-resistant *Staphylococcus aureus* (“MRSA”) but has not been tried on, nor has a contraindication to vancomycin, then this would be a clinically-equivalent antibiotic and less expensive option for the majority of MRSA infections.

In conclusion, the fundamental goals of Antimicrobial Stewardship that have been implemented in short-term acute care hospitals must be adopted by LTACHs. One can easily argue that it is even more important for LTACHs to implement effective Antimicrobial Stewardship programs than short-term acute care hospitals because LTACHs are more likely to see resistant pathogens. Programs to conserve newer antibiotics, trend resistance patterns, and choosing the initial antibiotic for empiric therapy that is most appropriate for their LTACH will result in (i) a decrease in the rate of resistance, (ii) decreased cost of antimicrobial therapy, and most importantly, (iii) improvement in the lives and outcomes of patients.

[Comprehensive Pharmacy Services](#) is the nation’s leading pharmacy services provider serving acute care hospitals, LTACHs and specialty hospitals. For more information about developing an Antimicrobial Stewardship Program or about CPS’ services, please contact:

Walker Upshaw, Chief Development Officer
800.968.6962
walker.upshaw@cpspharm.com

The Joint Commission Approves Interim Staffing Effectiveness Standards for Hospitals and Long Term Care Organizations

The Joint Commission (“TJC”) recently released interim staffing effectiveness standards (“Interim Standards”) applicable to its hospital (including LTACHs) and long term care certification programs that will become effective July 1, 2010. Draft Interim Standards were first proposed by TJC in April 2009 and underwent field engagements in June 2009 and September 2009. The Interim Standards were then approved by TJC’s Standards and Survey Procedures Committee on December 9, 2009. The Interim Standards will replace currently-suspended staffing effectiveness standards PI.04.01.01 (hospitals) and HR.1.30 (long term care facilities) while more extensive research is performed to improve staffing effectiveness requirements. The Interim Standards will first appear in the July 2010 update to the Comprehensive Accreditation Manual and E-dition electronic standards manual.

Originally introduced by TJC in July 2002, “staffing effectiveness” is generally defined as the appropriate level of staffing to provide the best possible patient outcome in a particular care setting. When the standard was first introduced, accredited organizations were required to track certain indicators for purposes of detecting staffing problems and determining if any correlations existed between staffing levels and patient outcomes.

In early 2009, however, the public was invited to comment on whether it believed TJC’s staffing effectiveness standard met the organization’s objectives of value and achievability to accredited organizations. Feedback indicated that the standard did not significantly impact patient quality of care or safety and also showed that the standard consumed a significant amount of resources and was among the most commonly cited standards during TJC surveys. As a result, TJC decided to suspend its staffing effectiveness standards until it had examined reported issues with the standards.

The suspension, however, was short-lived and TJC approved the following Interim Standards for accredited hospital and long term care organizations until such time as it completes its review of current staffing effectiveness standards:

- At least once a year, an organization must provide its Board of Directors with written reports on: (i) all system or process failures; (ii) the number and types of sentinel events; (iii) whether the patient/resident and their families were informed of the event; (iv) all proactive and responsive actions taken to improve staffing safety; and (v) all results of analyses related to the adequacy of staffing. [LD.04.04.05 EP 13].
- When an organization identifies undesirable patterns, trends, or variation in its performance related to the safety or quality of care, it includes the adequacy of staffing in its analysis of possible causes. [PI.02.01.01 EP 12].
- When analysis reveals a problem with the adequacy of staffing, an organization’s leaders responsible for patient/resident safety are informed of the results of this analysis and action is taken to resolve the identified problems. [PI.02.01.01 EP 13].
- At least once a year, an organization’s leaders responsible for the patient/resident safety program review a written report of the results of any analysis related to the adequacy of staffing and any actions taken to resolve identified problems. [PI.02.01.01 EP 14].

The Interim Standards broadly tie the adequacy of an organization’s staffing to patient outcomes and place accountability for compliance upon its Board of Directors and other leadership. Please feel free to contact me if you have questions about methods for achieving compliance with the Interim Standards.

MedPAC Releases 2010 Final Report Recommending No Payment Update for LTACHs for RY 2011

On March 1, 2010, the Medicare Payment Advisory Commission (“MedPAC” or the “Commission”) released its [2010 Report to the Congress: Medicare Payment Policy](#) (the “Final Report”). The purpose of the Final Report is to recommend annual Medicare payment updates for the following nine Medicare fee-for-service (“FFS”) payment systems: short-term acute care hospitals, physicians, ambulatory surgery centers, outpatient dialysis services, hospices, skilled nursing facilities, home health services, inpatient rehabilitation facility services and LTACHs.

Payment updates change the base rate paid by Medicare for each unit of service provided by a FFS provider—for example, a hospital admission, a physician visit or procedure, or an episode of care. Recommended payment updates are based on an assessment of payment adequacy taking into account beneficiaries’ access to care, supply of providers, quality of care, providers’ access to capital and Medicare margins.

It is important to note that although lawmakers are not required to take the Commission’s advice, MedPAC’s recommendations often influence congressional debate. For this reason the Final Report provides important guidance to lawmakers grappling with stalled efforts to reform the nation’s healthcare system and to enact legislation to fix a 21% Medicare physician payment cut that became effective March 1, 2010. This article highlights some of MedPAC’s recommendations for LTACHs and other providers:

1. Short-Term Acute Care Hospitals.

- Recommended payment rate increases for inpatient and outpatient prospective payment systems for fiscal year 2011 by the projected rate of increase in the hospital market basket index (presently estimated to be 2.4% for fiscal year 2011), together with implementation of a quality incentive payment program.

- Recommended reducing payment rates in the inpatient prospective payment system by the same percentage (not to exceed 2%) during fiscal years 2011, 2012 and 2013 to recapture overpayments to hospitals resulting from the conversion to Medicare Severity-Diagnosis Related Groups.
2. Physicians.
- Recommended updating payment for physician services in 2011 by 1%.
 - Again recommended establishing a budget-neutral payment adjustment for primary care services billed under the Medicare physician fee schedule and furnished by primary-care-focused practitioners (previously recommended in June 2008 and March 2009).
3. Ambulatory Surgery Centers (“ASC”).
- Recommended increasing payments for ASC services in calendar year 2011 by 0.6%.
 - Recommended requiring ASCs to submit annual cost and quality data.
4. Outpatient Dialysis Services.
- Recommended updating the composite rate by the projected rate of increase in the ESRD market basket index, less the adjustment for productivity growth for calendar year 2011 (an estimated net update of approximately 0.7%).
 - Expressed support for Congress’ passage of the Medicare Improvements for Patients and Providers Act of 2008, and implementing rules proposed by the Centers for Medicare & Medicaid Services in September 2009, which together would implement (i) a new dialysis prospective payment system to broaden the dialysis payment bundle beginning in calendar year 2011, and (ii) the development of a quality incentive program beginning in 2012.
5. Hospices.
- Recommended updating payment rates for hospice services for fiscal year 2011 by the projected rate of increase in the hospital market basket index (presently estimated to be 2.4%), less the Commission’s adjustment for productivity growth (an estimated net update of approximately 1.1%).
 - Reiterated recommendations from March 2009 advising implementation of the following payment system changes by fiscal year 2013: (i) making relatively higher payments per day at the beginning of an episode of care, and relatively lower payments per day as the length of an episode increases; (ii) including a relatively higher payment for costs associated with patient death at the end of the episode; and (iii) requiring that a physician or advanced practice nurse visit a patient to determine continued eligibility prior to the 180th-day recertification and each subsequent recertification and attest that such visits took place.
 - Recommended investigating the prevalence of improper financial relationships between hospices and long-term care facilities such as SNFs, IRFs and LTACHs that may represent a conflict of interest and influence hospice admissions.
6. Skilled Nursing Facilities (“SNF”).
- The Commission found that Medicare margins were over 16% in 2008 and recommended eliminating the update to payment rates for SNF services for fiscal year 2011.
 - Recommended revising the SNF prospective payment system by adding a non-therapy ancillary component based on patient needs and replacing the therapy component with one based on predicted patient care needs, and adopting an outlier policy.
 - Recommended establishing a budget-neutral quality incentive payment policy for SNFs based on risk-adjusted rates of potentially-avoidable rehospitalizations.
 - Recommended requiring SNFs to conduct patient assessments upon admission and discharge.

7. Home Health Services.

- Recommended eliminating the market basket update for 2011 and rebasing rates for home healthcare services to reflect the average cost of providing care.
- Recommended identifying categories of patients who are likely to receive the greatest clinical benefit from home health and develop quality outcomes measures for each category of patient.
- Recommended reviewing home health agencies that exhibit unusual patterns of payment claims, and implementing safeguards, such as a moratorium on new providers, preauthorization, or suspension of prompt payment requirements, in potentially high risk areas.

8. Inpatient Rehabilitation Facilities (“IRF”). Recommended no payment rate update for IRF services for fiscal year 2011.

9. LTACHs. Recommended no payment rate update for LTACH services for rate year 2011.

The payment recommendation for LTACHs contained in the Final Report is consistent with MedPAC’s draft recommendations released December 11, 2009 (see [meeting transcript](#)). The Final Report explained that MedPAC’s payment adequacy indicators suggest that a payment rate update is not presently needed. Specifically, MedPAC found that:

- the capacity and supply of LTACHs generally remained stable from 2007 to 2008 (the overall number of LTACHs filing cost reports declined by about 1% during that period, while the number of LTACH cases rose by 3.6% during the same period);
- quality of care appeared to remain stable, based upon trends in in-facility mortality, mortality within 30 days of discharge, and hospital readmission rates. The Commission, however, emphasized the need to develop meaningful quality measures;

- relatively little equity was raised in 2009 by chains, other than by Select and RehabCare, but that access to capital was not critical due, in part, to the moratorium on new LTACHs; and
- Medicare margins for LTACHs was 3.4% in 2008 and is expected to increase to 5.8% by 2010.

The Commission emphasized throughout the Final Report that payment rate updates alone are incapable of solving the underlying problem that providers are paid more when they deliver more services without regard to the quality or value of those additional services. The Commission therefore encouraged Congress to consider its payment update recommendations in the larger context of its growing number of recommendations to move beyond FFS to more comprehensive payment systems (e.g., medical homes, readmissions penalties and pilot testing of bundled payment models) that would cross silos of care and pay for higher quality.

In the Next Edition

The newsletter will have a fresh new look and design.

Other Recent GreisGuide Posts

- [Jim Prister to Chair AHA’s Section for Long-Term Care and Rehabilitation](#)
- [Many HIPAA Changes under the HITECH Act Now Effective](#)

Career Opportunities

- (Houston, Texas) A publicly-traded LTACH and Post-Acute Care company is looking for a Senior Vice President of Finance for its Hospital Division. Requirements include:
 - 10-15 years of hospital financial management experience in an executive management roll;
 - Sarbanes-Oxley experience required;
 - Multi-site facility experience and an understanding of hospital operations;
 - Public company experience and/or for-profit experience;
 - Executive presence; and

- MBA or Master's Degree in Hospital Administration, or equivalent.

Please contact ndemoss@dhrinternational.com

- (Orange County, CA) A publicly-traded LTACH and Post-Acute Care company is looking for a Director of Quality Management for its regional flagship LTACH. Requirements include:
 - Minimum of 3 years of performance improvement and/or risk management experience in a hospital setting;
 - Must be an R.N., M.S.N preferred;
 - Previous experience with regulatory surveys highly desirable since this person will be responsible for overseeing all regulatory body surveys; and
 - CPHQ certification desirable.

Please contact ndemoss@dhrinternational.com

Upcoming Events

- March 24-26: [AHLA Institute on Medicare and Medicaid Payment Issues](#)
- Mar. 26: [ALTHA Capital Markets Meeting](#)
- Apr. 28-30: [NALTH 2010 Annual Meeting](#) (the agenda for this meeting looks excellent. The various speakers should provide timely and useful substantive information)
- May 12: [McGuireWoods 8th Annual Business & Legal Issues in Dialysis & Nephrology Symposium](#)
- September 26-28: [AHLA Fraud and Compliance Forum](#)
- September 28: [ALTHA 2010 Legal Issues Meeting](#)
- October 21-22: [NALTH Education Conference](#)
- January 12-14, 2011: [ALTHA 2011 National Clinical Conference: Back to Basics-Building Blocks of LTACHs](#)

Developing, Buying and Selling

Please contact me if you are interested in developing, buying, and/or selling LTACHs, IRFs, SNFs, HHAs, hospices, acute care hospitals, dialysis centers, ambulatory surgery centers, billing companies, management companies, and various other healthcare-related businesses.

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 an audience of key executives in almost every LTACH across the country.

Questions and Comments

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 events.

[Jason S. Greis, Esq.](#)
[McGuireWoods LLP](#)
77 W. Wacker Drive, Suite 4100
Chicago, Illinois 60601
P: 312.849.8217
jgreis@mcguirewoods.com
www.GreisGuidetoLTACHs.com