LONG-TERM CARE HOSPITAL (LTCH) IMPROVEMENT ACT

SECTION 1: SHORT TITLE AND TABLE OF CONTENTS
Long-Term Care Hospital Improvement Act of 2011

SECTION 2: SPECIFICATION OF CRITERIA FOR PATIENT PREADMISSION, ADMISSION, AND CONTINUING STAY ASSESSMENTS

1. <u>Pre-Admission Screening</u>
   Screening conducted by a clinical health care professional – physician, registered professional nurse, licensed practical or vocational nurse, physician assistant, respiratory therapist, or others defined by Secretary – during 36-hour period preceding admission. If the screening takes place prior to the 36-hour period, it must be updated by telephone or otherwise.

   The screening is a process which determines whether a LTCH admission is medically reasonable and necessary, must include: 1) medical status of patient, 2) planned level of improvement, 3), expected length of stay, 4) evaluation of risk for clinical complications, 5) primary and secondary diagnosis, 6) identification of the primary treatment needed by the patient, 7) evaluation of whether there is appropriate treatment at a lower level of care, 8) anticipated post-discharge settings and treatments, and 9) any other clinical rationale for admission.

   A physician must review and concur with the pre-admission screening, and approve in advance, the admission.

2. <u>Admission</u>
   A face-to-face physician evaluation and attestation must occur within 24 hours of admission. A patient meets LTCH admission criteria if they: 1) have 2 or more active secondary diagnoses, 2) are reasonably expected to require inpatient hospital level of care, benefit from LTCH care, and require an extended stay in a hospital that is typical of LTCHs, and 4) are not admitted for the primary purpose of intensive therapy (i.e., therapy typically provided at an inpatient rehabilitation facility.) The physician must note these and any additional clinical rationale in the patient's medical records.

3. <u>Continuing Stay Assessments</u>
   A face-to-face physician reevaluation must occur within 7 days of the date of admission, and weekly thereafter until discharge to determine whether a continued stay at the LTCH is medically reasonable and necessary. The evaluation must be based on something other than the admission criteria, and must be documented in the patient's medical record.

4. <u>Discharge</u>
   If a physician determines that the patient no longer requires hospital inpatient care, the patient is discharged when a safe and appropriate discharge option is available. Until such an option is available, the patient may continue to stay the LTCH, if the patient is

notified of the physician's determination and the LTCH is actively seeking a safe and appropriate discharge option that is available for the patient. The LTCH is paid at the lesser of the inpatient prospective payment amount for acute care hospitals or its cost. The extended stay does count towards the facility's length of stay calculation for purposes of LTCH classification.

SECTION 3: SPECIFICATION OF CORE SERVICES AND PATIENT CARE REQUIREMENTS

1. Required Items and Services
   LTCHs must have complex respiratory services, which include on-site availability of respiratory therapists 24 hours a day, 7 days a week and access to consultation by pulmonologists 24 hours a day, 7 days a week; complex wound services, which include wound care by registered nurses and access to consultations by physicians; care for patients with medically complex conditions; and, on-site availability of advanced cardiac life support 24 hours a day, 7 days a week.

2. Plan of Care
   Within 24 hours of admission, a physician must conduct a face-to-face evaluation and begin to development a plan of care. Not later than 7 days after the evaluation, and weekly thereafter until discharge, a physician-directed interdisciplinary team must establish and update the plan of care.

3. Physician & Nurse Availability
   Physician must be on-site 24 hours a day, 7 days a week, or on call and immediately available by telephone or radio contact and available on site within 30 minutes (60 minutes for rural areas.) If a physician is not on-site 24 hours a day, 7 days a week, the LTCH must provide notice to the patient at the beginning of the stay.

   Registered nurses must be on-site 24 hours a day, 7 days a week.

SECTION 4: ADDITIONAL LONG-TERM CARE HOSPITAL PAYMENT CLASSIFICATION CRITERIA

1. Applicable Percentage of Discharges
   An applicable percentage of discharges must meet one or more of the following criteria: 1) a patient stay of 25 days or greater; 2) an inpatient who was a short-term acute care hospital outlier immediately prior to admission to the LTCH; 3) an inpatient who received ventilator services in the LTCH; 4) the patient has 3 or more of any MS-LTC-DRG complications and comorbidities or major complications and comorbidities.

   The applicable percentage is 50 percent the first year after enactment; 60 percent the following year; 70 percent in the third year (except government-owned and operated hospitals at 65 percent); and 70 percent in the fourth year and thereafter for all hospitals.

2. Failure to Meet Criteria

If the Secretary of HHS determines that a LTCH fails to meet the applicable percentage criteria, she must provide notice, and a cure period.

The cure period begins on the first day of the first month after the date of notice, for not less than 5 months. If a LTCH fails to correct itself during the cure period, payment adjustments apply to the first cost reporting period after the failure.

3. Repeal of the 25 Percent Rule, Short-Stay Outlier Cuts, and Budget Neutrality
   The bill repeals the 25 percent rule for all LTCHs. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) as amended by ARRA and PPACA rolls back the phased-in implementation of the 25 percent rule for hospitals within hospitals (HWHs) and satellites, limiting the proportion of Medicare patients who can be admitted from a HWH's or satellite's host hospital to not more than 50 percent until October 1, 2012 (July 1, 2012 for satellites.) In addition, the Secretary is prohibited from applying the 25 percent rule to freestanding LTCHs before July 1, 2012. The amended 25 percent rule remains in effect until the Secretary issues regulations to substitute the rule with the new LTCH criteria.

   The bill repeals the scheduled payment change for very short-stay outliers. The MMSEA as amended by ARRA and PPACA prohibits the Secretary from further reducing payments for LTCH cases with the shortest lengths of stay ("very short-stay outliers") until December 29, 2012.

   The bill repeals the one-time budget neutrality adjustment requirement. When the LTCH prospective payment system (PPS) was implemented in 2003, CMS set payments at a level calculated to be equal to the estimated aggregate payments that would have been if the PPS had not been implemented. This budget neutrality adjustment was required by statute. CMS cautioned that additional adjustment to the PPS rates for the first year might be necessary, but such adjustments have never been proposed. The MMSEA as amended by ARRA and PPACA prohibits the Secretary from applying any budget neutrality adjustment until December 29, 2012.

SECTION 5: APPLICATION OF CRITERIA FOR CERTAIN HOSPITALS

1. Provides special exemptions for Maryland and the Cancer LTCH from the retrospective criterion described above. Maryland LTCHs operate under a special CMS waiver, and the single Cancer LTCH have always been treated differently. However the bill would apply the new patient and facility criteria to all LTCHs, including the MD LTCHs.

   Note: Per a statutory waiver, LTCHs in Maryland are paid through a state-level rate-setting process, rather than through the LTCH PPS. They are subject to Medicare conditions of participation, but exempt from the LTCH 25% Rule. (Section 1814(b)(3) of the Social Security Act.)