

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**VULNERABILITIES IN
MEDICARE'S
INTERRUPTED-STAY POLICY
FOR LONG-TERM CARE
HOSPITALS**



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EXECUTIVE SUMMARY: VULNERABILITIES IN MEDICARE'S INTERRUPTED-STAY POLICY FOR LONG-TERM CARE HOSPITALS, OEI-04-12-00490

WHY WE DID THIS STUDY

In 2010 and 2011, Medicare paid \$10.3 billion to 449 long-term care hospitals (LTCHs) for services billed on behalf of approximately 254,000 beneficiaries. LTCHs are the most expensive post-acute care setting because they are intended to treat patients with complex medical conditions. Beneficiaries may leave an LTCH and return at a later date. The Medicare LTCH interrupted-stay policy is intended to save money by treating time spent at an LTCH before and after an interruption as a single stay, rather than considering the second portion of the LTCH stay to be a readmission and thus paying for two separate stays. However, LTCHs receive payment for a second stay if a beneficiary returns to the LTCH after a certain number of days (known as the fixed-day period) or receives services from multiple facilities before returning.

HOW WE DID THIS STUDY

We analyzed data from claims from 2010 and 2011 from LTCHs and from “intervening facilities”—i.e., facilities that treat patients during interruptions in their LTCH stays—to identify inappropriate payments for interrupted stays in LTCHs. Additionally, we identified LTCHs with a high number of readmissions immediately after the fixed-day period and after multiple short intervening-facility stays. We also identified co-located LTCHs—i.e., LTCHs located in the same building or on the same campus as another provider—that billed in 2010 and 2011 and determined whether they reported their co-located status and whether they exceeded the 5-percent readmission threshold. (If the number of discharges and readmissions between an LTCH and a co-located provider exceeds 5 percent of the LTCH’s total Medicare discharges to that provider during a cost-reporting period, *all* readmissions from the co-located provider are to be paid for as interrupted stays, regardless of the number of days spent away from the LTCH.)

WHAT WE FOUND

We identified several vulnerabilities in the LTCH interrupted-stay policy, including inappropriate payments, financial incentives to delay readmissions, and potential overpayments to co-located LTCHs. Specifically, in 2010 and 2011, Medicare inappropriately paid \$4.3 million to LTCHs and intervening facilities for interrupted stays. Additionally, 59 LTCHs had a high number of readmissions immediately after the fixed-day period and 24 LTCHs had a high number of readmissions following multiple short stays at intervening facilities. Medicare paid \$12 million and \$3.1 million, respectively, for these readmissions. While these readmissions may be appropriate, this raises concerns about whether financial incentives, rather than beneficiaries’ medical conditions, may have influenced some LTCHs’ readmission decisions. Further, the Centers for Medicare & Medicaid Services (CMS) did not know the co-located status of most LTCHs, preventing it from applying a payment adjustment to the 35 percent of co-located LTCHs that exceeded the 5-percent readmission threshold.

WHAT WE RECOMMEND

We recommend that CMS (1) review existing safeguards to determine whether additional action is needed to prevent future inappropriate payments for interrupted stays, (2) conduct additional analysis to determine the extent to which financial incentives influence LTCHs’ readmission decisions, (3) develop a system to enforce the 5-percent readmission threshold, (4) take appropriate action regarding LTCHs exhibiting certain readmission patterns, and (5) take appropriate action regarding inappropriate payments and overpayments we identified. CMS concurred—contingent on receiving more information from OIG—with two of our recommendations and nonconcurred with three recommendations.

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OBJECTIVES

1. To describe billing of interrupted stays and readmissions in long-term care hospitals (LTCHs).
2. To determine the extent to which Medicare made inappropriate payments for interrupted stays in LTCHs.
3. To determine the extent to which additional Medicare payments were made because LTCHs readmitted beneficiaries immediately after the fixed-day period or after multiple short stays at intervening facilities.
4. To determine the extent to which co-located LTCHs reported their co-located status and exceeded the 5-percent readmission threshold.

BACKGROUND

Patients that require continued medical care after a hospitalization receive post-acute care. Post-acute care can be provided in skilled nursing facilities (SNFs), inpatient rehabilitation facilities, the home, or LTCHs. LTCHs are intended to treat patients with complex medical conditions that require prolonged post-acute hospital-level care. Therefore, LTCHs are the most expensive post-acute care setting and are paid at rates higher than those paid to acute-care hospitals (i.e., hospitals).¹ To qualify for and receive Medicare payments as an LTCH, a facility must meet Medicare conditions of participation for hospitals and have an average length of stay greater than 25 days for its Medicare beneficiaries.² In 2010 and 2011, Medicare paid \$10.3 billion to 449 LTCHs for services billed on behalf of approximately 254,000 beneficiaries.³

LTCHs are located in almost all States, but are not distributed evenly throughout the country. Over 50 percent of LTCHs are located in seven States. Texas and Louisiana have the most LTCHs, with 18 percent and 9 percent of the national amount, respectively. (See Appendix A for the number of LTCHs by State in 2010 and 2011.) Further, two major

¹ The Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Variation and Innovation in Medicare*, June 2003, pp. 71, 84. Accessed at http://www.medpac.gov/publications/congressional_reports/June03_Ch5.pdf on August 27, 2013. See also MedPAC, *Assessing Payment Adequacy and Updating Payments: Hospital Inpatient and Outpatient Services*, December 12, 2013. Accessed at http://www.medpac.gov/transcripts/hospital_dec_2013_public_presentation.pdf on December 20, 2013.

² Social Security Act, § 1861(ccc), 42 U.S.C. 1395x(ccc). 42 CFR pt. 482 defines the conditions of participation for hospitals. 42 CFR pt. 489 specifies the terms of provider agreement for hospitals. 42 CFR § 412.23(e)(2) defines LTCHs as having an average length of stay greater than 25 days for Medicare beneficiaries.

³ OIG analysis of 2010 and 2011 Part A Standard Analytical Files, 2013.

LTCH companies (i.e., chains) own more than half of all LTCHs. Many of the remaining LTCHs belong to smaller chains.⁴

From 2004 to 2007, Medicare spending on LTCH services increased by 22 percent, from \$3.7 billion to \$4.5 billion.⁵ The number of LTCHs also increased by 22 percent during this time.⁶ In December 2007, Congress established a moratorium on new LTCHs and on new beds in existing LTCHs, questioning whether this dramatic growth was due to an increase in clinical need or a means to gain Medicare profits.⁷ The LTCH moratorium expired in December 2012, but LTCH chains appear to be opening new facilities or increasing the number of beds in existing LTCHs at low rates, rather than at the high rates seen before.^{8,9}

Medicare Prospective Payment System for LTCHs

In October 2002, the Centers for Medicare & Medicaid Services (CMS) established a prospective payment system for LTCHs.¹⁰ This prospective payment system uses the inpatient Medicare severity diagnosis related group (MS-DRG) classification system that hospitals use, with

⁴ MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2012, pp. 258, 267. Accessed at http://www.medpac.gov/chapters/Mar12_Ch10.pdf on November 13, 2013.

⁵ *Ibid.*, p. 267.

⁶ *Ibid.*, p. 266.

⁷ The Medicare, Medicaid, and SCHIP Extension Act of 2007, P.L. No. 110-173, § 114(d). The Patient Protection and Affordable Care Act (ACA), P.L. No. 111-148, §§ 3106(b) and 10312(b), extended the moratorium through 2012. See also Pete Stark, *Introduction of the LTCH Moratorium Act*, *Congressional Record*, Volume 150, Number 16 (February 10, 2004). Accessed at <http://www.gpo.gov/fdsys/pkg/CREC-2004-02-10/html/CREC-2004-02-10-pt1-PgE135-3.htm> on December 3, 2013.

⁸ ACA, §§ 3106(b) and 10312(b).

⁹ MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2014, p. 275. Accessed at http://www.medpac.gov/documents/Mar14_entirereport.pdf on April 3, 2014.

¹⁰ A prospective payment system is a method of reimbursement in which Medicare pays providers on the basis of a predetermined, fixed amount. The payment amount for a particular service is derived from the classification system for that service (e.g., diagnosis related group). CMS, *Prospective Payment Systems—General Information*. Accessed at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html?redirect=/prospmedicarefeesvcpmtgen/> on October 10, 2013.

relative weights to account for resource utilization specific to LTCHs (i.e., MS-LTC-DRG).^{11, 12}

Each beneficiary's stay is grouped into an MS-LTC-DRG based on diagnoses (including secondary diagnoses), procedures performed, age, gender, and discharge status.¹³ This grouping reflects the typical resources used for treating an LTCH beneficiary. Each MS-LTC-DRG has a predetermined average length of stay, which CMS updates annually according to LTCH discharge data. LTCHs are paid according to each beneficiary's MS-LTC-DRG and do not receive per diem payments.^{14, 15} Therefore, excluding adjustments, the LTCH receives the same payment for all stays with a certain MS-LTC-DRG, regardless of the length of stay.¹⁶

Interruptions and Readmissions in LTCHs

Beneficiaries may leave an LTCH during their stay and return to the LTCH at a later date. A return to the same LTCH will result in either an interrupted stay or a readmission, depending on how long the beneficiary was away from the LTCH and where he/she received additional services, if any. The LTCH interrupted-stay policy aims to save Medicare money by treating certain LTCH stays before and after an absence (an

¹¹ The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, P.L. No. 106-113 § 123, as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. No. 106-554 § 307. See also: CMS, *Elements of LTCH PPS*. Accessed at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/elements_ltch.html on December 20, 2013.

¹² Two LTCHs in Maryland are paid in accordance with demonstration projects under the Maryland hospital waiver and are thus not subject to payments under the prospective payment system. Novitas Solutions, *Provider Audit & Reimbursement Part A: Maryland Waiver*. Accessed at <https://www.novitas-solutions.com/parta/arcenter/reimb-ref/md-waiver.html> on August 27, 2013. (Note: Link no longer works.) These LTCHs are not included in our analysis.

¹³ CMS, Medicare Learning Network Fact Sheet, *Long Term Care Hospital Prospective Payment System: Interrupted Stay*, December 2012, p. 2. Accessed at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ltch-intstay.pdf> on August 22, 2013.

¹⁴ 42 CFR § 412.521.

¹⁵ A beneficiary's MS-LTC-DRG may change during an LTCH stay. In such a case, LTCHs are paid according to the beneficiary's MS-LTC-DRG on the discharge date.

¹⁶ Adjustments include facility-level and case-level adjustments. Facility-level adjustments include adjustments for differences in area wages and cost of living for LTCHs in Hawaii and Alaska. CMS, *Elements of LTCH PPS*. Accessed at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/elements_ltch.html on August 26, 2013. Case-level adjustments include short-stay outlier payments, which are reduced payments for certain shorter LTCH stays; and high-cost outlier payments, which are increased payments for LTCH stays that meet a cost threshold. CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 3 §§ 150.9.1.1 and 150.9.1.5.

interruption) as a single episode of care, rather than paying LTCHs for two separate stays.

Interruptions. An interruption occurs when a beneficiary leaves an LTCH and returns to the same LTCH for further medical treatment within a specific number of days.¹⁷ During the interruption, the beneficiary may receive services at an intervening facility that are not available at the LTCH. An intervening facility may be a hospital, an inpatient rehabilitation facility, or a SNF or “swing bed.”¹⁸ The interruption begins on the first day that the beneficiary is away from the LTCH and continues until the beneficiary returns to the same LTCH.¹⁹ A beneficiary may have multiple interruptions during one LTCH stay. The term “interrupted stay” refers to an LTCH stay with one or more interruptions.

There are two types of interruptions in LTCH stays, defined by the length of the interruption: 3-day-or-less interruptions and greater-than-3-day interruptions. Excluding any adjustments, the total Medicare payment to the LTCH is the same for a stay with a 3-day-or-less interruption and a stay with a greater-than-3-day interruption. However, the method of paying intervening facilities differs.

During a 3-day-or-less interruption, beneficiaries may receive services from one or more intervening facilities or return home without receiving additional services before returning directly to the LTCH. CMS considers this interruption to be part of a single LTCH stay. CMS makes one payment to the LTCH based on the beneficiary’s MS-LTC-DRG at discharge.²⁰ The LTCH must pay the intervening facility, or facilities, under arrangements for any services provided during the interruption.²¹ CMS has system “edits” (i.e., automated system processes) to prevent payments to intervening facilities for services provided during a

¹⁷ 42 CFR § 412.531. See also CMS, Medicare Learning Network Fact Sheet, *Long Term Care Hospital Prospective Payment System: Interrupted Stay*, December 2012, p. 1. Accessed at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/lrch-intstay.pdf> on August 22, 2013.

¹⁸ A “swing bed” is a hospital bed for which reimbursement is made for skilled nursing services. Hospitals that have received approval from CMS use “swing beds” to provide hospital- or SNF-level care, as needed. Social Security Act, § 1883, 42 U.S.C. § 1395tt.

¹⁹ CMS, Medicare Learning Network Fact Sheet, *Long Term Care Hospital Prospective Payment System: Interrupted Stay*, December 2012, p. 5. Accessed at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/lrch-intstay.pdf> on August 22, 2013.

²⁰ 42 CFR § 412.531(b)(1)(ii)(A).

²¹ “Under arrangements” means that the LTCH bills and is paid by Medicare for a beneficiary’s stay, and the LTCH is then responsible for paying the intervening facility or facilities. Medicare does not make a separate payment to intervening facilities for services provided during a 3-day-or-less interruption. See Social Security Act, § 1861(w), 42 U.S.C. § 1395x (w).

3-day-or-less interruption.²² See Appendix B for an example of payments for a stay with a 3-day-or-less interruption.

During a greater-than-3-day interruption, beneficiaries receive services from one intervening facility and do not return home before returning directly to the LTCH. CMS makes a separate payment to the intervening facility for services provided during a greater-than-3-day interruption.²³ If a beneficiary's return to the same LTCH occurs between 4 days and a certain maximum number of days (i.e., the fixed-day period), CMS considers it a continuation of the original LTCH stay and will pay the LTCH for one stay upon the beneficiary's discharge. The fixed-day period varies by the type of intervening facility from which the beneficiary receives services:

- 4–9 days for hospitals,
- 4–27 days for inpatient rehabilitation facilities, and
- 4–45 days for SNFs or swing beds.²⁴

For these stays, Medicare makes one payment to the LTCH based on the beneficiary's MS-LTC-DRG at discharge and a separate payment to the intervening facility. CMS has system edits to prevent payments to LTCHs for a new stay if a beneficiary returns to the LTCH within the fixed-day period.²⁵

Readmissions. If a beneficiary returns to the same LTCH after the fixed-day period, CMS considers it a readmission rather than an

²² CMS Manual System, *Pub. 100-04 Medicare Claims Processing, Transmittal 1001*, July 21, 2006. Accessed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1001CP.pdf> on August 22, 2013. Edits validate claims data by detecting errors or potential errors and verifying that certain data are consistent and appropriate. CMS, *Medicare Administrative Contractor Workload Implementation Handbook (Legacy-to-MAC)*, pp. 4–8. February 2012. Accessed at <http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/Handbooks/Legacy2MACImp.pdf> on October 10, 2013.

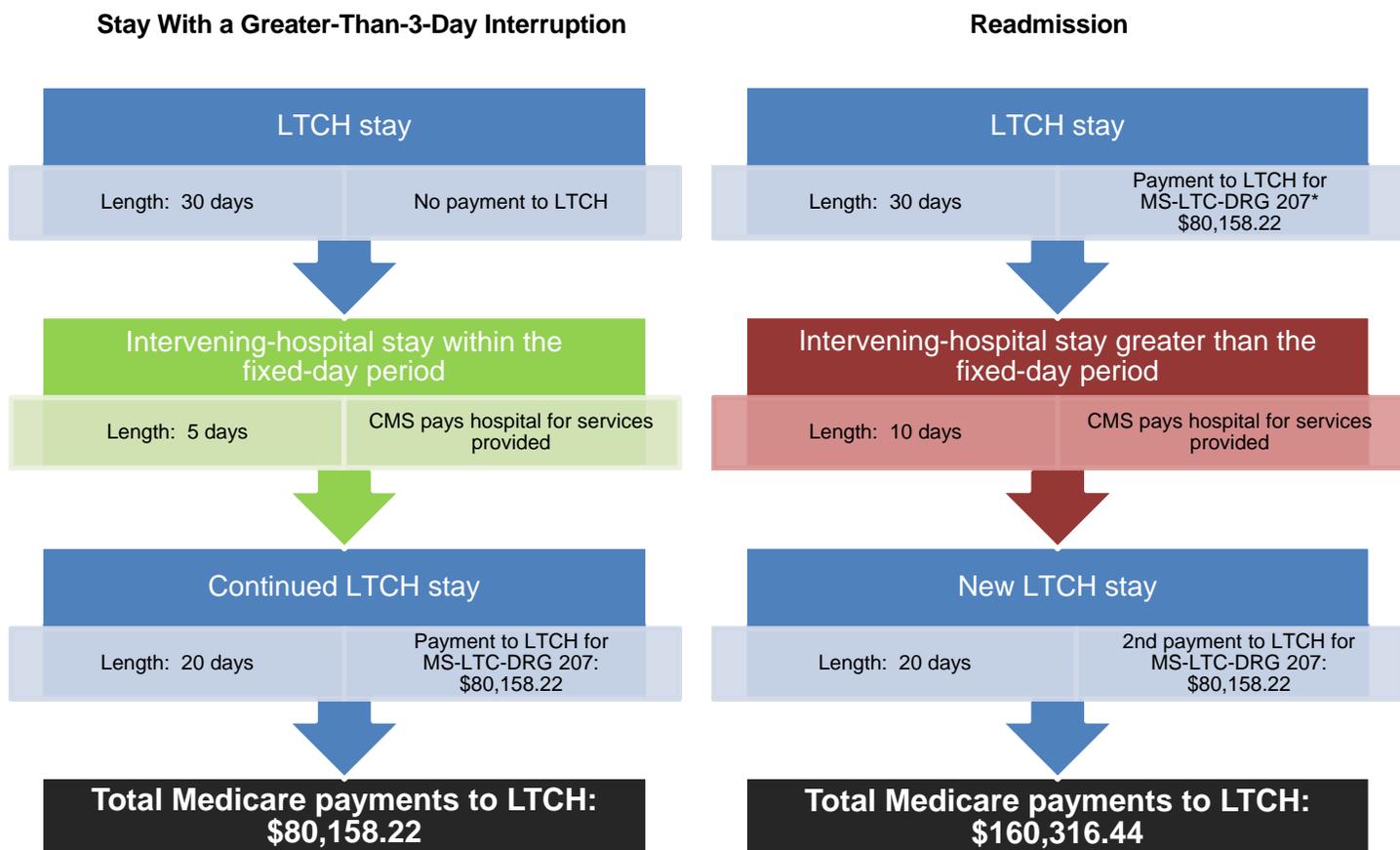
²³ CMS, Medicare Learning Network Fact Sheet, *Long Term Care Hospital Prospective Payment System: Interrupted Stay*, December 2012, p. 4. Accessed at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/lrch-intstay.pdf> on August 22, 2013.

²⁴ If a beneficiary returns to an LTCH after spending 3 or more days at home, CMS considers this to be a readmission rather than an interrupted stay. CMS, Medicare Learning Network Fact Sheet, *Long Term Care Hospital Prospective Payment System: Interrupted Stay*, December 2012, p. 4. Accessed at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/lrch-intstay.pdf> on August 22, 2013.

²⁵ CMS Manual System, *Pub. 100-04 Medicare Claims Processing, Transmittal 1001*, July 21, 2006. Accessed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1001CP.pdf> on August 22, 2013.

interruption and will pay the LTCH for two separate stays.²⁶ CMS also makes a separate payment to the intervening facility. See Figure 1 for an example of payments for a stay with a greater-than-3-day interruption versus payments for a readmission for a common MS-LTC-DRG.²⁷

Figure 1: Comparison of Total Payments to an LTCH for a Stay With a Greater-Than-3-Day Interruption and Payments for a Readmission for MS-LTC-DRG 207



*Payments reflect fiscal year (FY) 2011 LTCH Prospective Payment System rates and do not include any potential case-level or facility-level adjustments.
 Source: Office of Inspector General (OIG) analysis of interrupted-stay policy and 2011 LTCH Prospective Payment System Reimbursement Rates, 2013.

Additionally, if a beneficiary returns to the LTCH within the fixed-day period but has received services from more than one intervening facility,

²⁶ In this report, unless otherwise stated, the term “readmission” refers specifically to direct readmissions or those involving one LTCH and one intervening facility with no days between discharge and readmission.

²⁷ MS-LTC-DRG 207 is for respiratory system diagnosis with ventilator support for 96+ hours. This was the most common MS-LTC-DRG in 2010 and 2011, accounting for 11 percent of all LTCH stays during this period.

CMS considers the return to be a readmission, regardless of the total length of stay at the intervening facilities.²⁸

Policies for Co-Located LTCHs

An LTCH can be freestanding or co-located with another provider (e.g., a hospital or SNF). A co-located LTCH is located in the same building as another provider or in a separate building on the same campus as another provider.²⁹ An LTCH may also have a satellite facility, which operates as part of the LTCH but in a separate location.³⁰ A satellite facility can also be co-located with another provider.

Interrupted Stays for Co-Located LTCHs. In 2002, CMS established a payment adjustment that applies if the number of discharges and readmissions between an LTCH and a co-located provider exceeds 5 percent of the LTCH's total Medicare discharges to that provider during a cost-reporting period. If an LTCH exceeds this threshold, all readmissions from the co-located provider are to be paid for as interrupted stays, regardless of the number of days spent away from the LTCH.³¹ For example, if an LTCH discharged 40 patients to a co-located hospital and readmitted 10 of those patients during the same cost-reporting period, the LTCH exceeded the 5-percent threshold because it readmitted 25 percent of the patients discharged to a co-located hospital. Therefore, all 10 of the stays will be treated as interrupted stays rather than readmissions, and the LTCH will be subject to a payment adjustment and receive only 1 payment for each of the 10 stays instead of 2 payments. CMS calculates the 5-percent readmission threshold separately for (1) all discharges and readmissions between co-located LTCHs and hospitals; and (2) all discharges and readmissions between co-located LTCHs and inpatient rehabilitation facilities, SNFs or swing beds, and/or psychiatric facilities.³²

²⁸ CMS, Medicare Learning Network Fact Sheet, *Long Term Care Hospital Prospective Payment System: Interrupted Stay*, December 2012, p. 4. Accessed at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ltch-intstay.pdf> on August 22, 2013.

²⁹ 42 CFR § 413.65. "Campus" means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas that the CMS regional office determines (on an individual-case basis) to be part of the provider's campus.

³⁰ 42 CFR § 412.22(h).

³¹ 67 Fed. Reg. 55954, 56053–56054 (August 30, 2002), codified at 42 CFR § 412.532. A similar payment adjustment was established in 1999 specifically for LTCHs that were located within a hospital. 67 Fed. Reg. 56005–56007.

³² 42 CFR § 412.532(c)–(d). There is no interrupted-stay policy or fixed-day period for psychiatric facilities. However, CMS includes these facilities in the 5-percent readmission threshold for co-located LTCHs.

Reporting Requirements for Co-Located LTCHs. A co-located LTCH must notify its Medicare Administrative Contractor (MAC) about the provider(s) with which it is co-located within 60 days of its first cost-reporting period.^{33, 34} Additionally, an LTCH must report a change in co-located status within 60 days of the change. The MAC should notify the appropriate CMS regional office of an LTCH's co-located status.³⁵

Related OIG Work

In 2004, OIG found that 19 of 87 “hospitals-within-hospitals”—i.e., LTCHs that are co-located specifically with acute-care hospitals—exceeded the 5-percent threshold for readmissions from their host hospitals at least once during their fiscal years ending in September 2000 through December 2002.³⁶ Additionally, OIG found that CMS lacked a system to detect readmissions over the 5-percent threshold. In its response to this 2004 report, CMS stated that it was formulating an effective program to enable claims processing contractors to enforce this threshold. Further, in 2008, OIG found that discharge patterns for short-stay outliers—i.e., stays that end before they reach five-sixths of the average length of stay for the patient's MS-LTC-DRG—in LTCHs raised questions as to whether financial incentives, rather than beneficiaries' condition, triggered discharges.³⁷

In 2009, OIG found that 448 of 986 inpatient rehabilitation facilities did not bill correctly for interrupted stays during 2004 and 2005; as a result, Medicare made overpayments of \$4.2 million.³⁸ These inpatient rehabilitation facilities incorrectly billed for interrupted stays as two or more stays instead of single stays.

Finally, in March 2013, OIG issued an early alert memorandum to CMS to report the preliminary finding that co-located LTCHs remained

³³ 42 CFR § 412.532(i). See also: CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 3, § 150.9.1.4. CMS uses contractors known as MACs and Fiscal Intermediaries to process Part A claims. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173 § 911, required CMS to replace Fiscal Intermediaries with MACs. CMS was completing this transition at the time of our review. In this report, we refer to both types of contractors as MACs.

³⁴ A cost-reporting period is an annual period selected by providers for Medicare cost-reporting purposes. Cost-reporting periods vary among providers. CMS, *Medicare Provider Reimbursement Manual, Part 2*, ch. 1, § 102.

³⁵ CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 3, § 150.9.1.4.

³⁶ OIG, *Long-term Care Hospitals-within-Hospitals*, OEI-01-02-00630, July 2004.

³⁷ OIG, *Long Term Care Hospital Short-Stay Outliers*, OEI-01-07-00290, March 2008.

³⁸ OIG, *Review of Interrupted Stays at Inpatient Rehabilitation Facilities for Calendar Years 2004 and 2005*, A-01-08-00502, April 2009.

unidentified and that potential overpayments could result.³⁹ Since this early alert memorandum was issued, CMS has begun to review the co-located status of the LTCHs identified in this report. Additionally, CMS cited the report in its 2014 LTCH Prospective Payment System Final Rule, published in August 2013, and urged co-located LTCHs that had not fulfilled the reporting requirement to do so immediately.⁴⁰

METHODOLOGY

We analyzed the population of 310,860 claims submitted by LTCHs from CMS' National Claims History Part A Standard Analytical Files for 2010 and 2011. We also analyzed intervening facility claims from 2010 and 2011, which included claims submitted by hospitals, inpatient rehabilitation facilities, SNFs or swing beds, and psychiatric facilities for beneficiaries who had LTCH stays in 2010 and/or 2011.

We were generally unable to identify 3-day-or-less interruptions using Medicare claims data because these types of interruptions are not identified on claims, and intervening facilities should not submit claims for services provided during these interruptions.⁴¹ Therefore, unless otherwise specified, the term "interruption" hereinafter refers to a greater-than-3-day interruption.

Identifying Interruptions

We analyzed claims submitted by LTCHs and intervening facilities from 2010 and 2011 to identify interruptions. We first identified LTCH claims indicating that a leave of absence occurred during the stay.⁴² We analyzed claims from intervening facilities to identify those that had the same service dates as the leave of absence from the LTCH stay. If an LTCH claim had a corresponding intervening-facility claim with service dates that matched the leave of absence, we considered it to be an interruption.

We determined the number of LTCH stays with interruptions in 2010 and 2011 and their length. We also determined the number of LTCHs, the types of intervening facilities, and the MS-LTC-DRGs associated with interruptions.

³⁹ OIG, *Early Alert Memorandum Report: Co-Located Long-Term Care Hospitals Remain Unidentified, Resulting in Potential Overpayments*, OEI-04-12-00491, March 2013.

⁴⁰ 78 Fed. Reg. 50496, 50771–50772 (August 19, 2013).

⁴¹ In some cases, intervening facilities inappropriately submitted claims for 3-day-or-less interruptions, enabling us to identify some 3-day-or-less interruptions. OIG analysis of 2010 and 2011 Part A Standard Analytical Files, 2013.

⁴² Span code 74 on a Part A claim indicates a leave of absence.

Identifying Inappropriate Payments for Interrupted Stays

We analyzed claims submitted by LTCHs and intervening facilities to identify two types of inappropriate payments:

- (1) to LTCHs for readmissions after stays at intervening facilities within the fixed-day period (i.e., stays that should have been paid as interruptions rather than readmissions) and
- (2) to intervening facilities for services provided during 3-day-or-less interruptions (i.e., services that should have been paid for by the LTCH under arrangements rather than paid by CMS to the intervening facility).

First, to identify readmissions, we selected three consecutive claims for beneficiaries: (1) an LTCH claim, (2) a claim from an intervening facility, and (3) a claim from the original LTCH. If the length of the intervening facility stay was within the fixed-day period, we estimated inappropriate payments by summing the reimbursement amounts of the second LTCH claim.⁴³

Second, using the same claims sequences, we identified intervening-facility claims with lengths of stay of 3 days or less.⁴⁴ We also identified intervening-facility claims that overlapped with LTCH stays and had lengths of stay of 3 days or less. We considered both types of payments to intervening facilities to be inappropriate and summed the reimbursement amounts.

Identifying LTCHs With a High Number of Readmissions Immediately After the Fixed-Day Period

Using the service dates on the hospital claim, we determined the length of stay at an intervening hospital for all interruptions and readmissions. We limited this analysis to interruptions and readmissions involving hospitals because there were few interruptions and readmissions involving inpatient rehabilitation facilities, SNFs, or swing beds.⁴⁵ We compared the number of beneficiary returns to each LTCH on the 9th day (i.e., the last day of the fixed-day period for hospitals) and 10th day (i.e., immediately after the

⁴³ The services provided during the second LTCH stay should have been included in the claim for the first LTCH stay. Therefore, the total reimbursement for the second LTCH stay may not equal the total amount of inappropriate payments after adjusting the claim for the first stay to reflect all services.

⁴⁴ These stays should have resulted in a single stay with a 3-day-or-less interruption rather than three separate stays. Therefore, we considered the payment to the intervening facility to be inappropriate, as well as the payment for the second LTCH stay.

⁴⁵ In 2010 and 2011, there were 19 interruptions and 3 readmissions involving inpatient rehabilitation facilities. There were 118 interruptions and 228 readmissions involving SNFs or swing beds. However, there were approximately 9,000 interruptions and approximately 5,000 readmissions involving hospitals.

fixed-day period for hospitals) of a hospital stay and identified LTCHs with a high number of readmissions on the 10th day. These readmissions resulted in additional LTCH payments.

We analyzed LTCHs with a high number of readmissions immediately after the fixed-day period by State and chain. We identified chains using Web sites and information from the National Plan and Provider Enumeration System (e.g., legal business name, authorized official, and business address). For example, LTCHs that are part of the same chain often share a legal business name and/or have the same authorized official and business address.

Identifying LTCHs With a High Number of Readmissions Following Multiple Short Stays in Intervening Facilities

If a beneficiary receives services consecutively from two or more intervening facilities and then returns to the same LTCH after 3 days, the beneficiary's return is considered a readmission and results in an additional LTCH payment, regardless of the combined lengths of stay at the intervening facilities.

To identify short stays in separate intervening facilities, we identified sequences of four claims for beneficiaries with no days in between: (1) an LTCH claim, (2) an intervening facility claim, (3) a claim from a different intervening facility, (4) a claim from the original LTCH. We also analyzed sequences of five claims to identify readmissions occurring after three intervening facility claims. We considered stays at intervening facilities to be short if the combined length of stay was greater than 3 days, but less than or equal to 9 days (i.e., the shortest fixed-day period).⁴⁶ We identified LTCHs with a high number of these readmissions and analyzed them by State and chain. We summed the reimbursement amount for the second LTCH claim in the sequence to estimate the potential savings to Medicare had these stays been paid for as interrupted stays, rather than readmissions.⁴⁷

⁴⁶ If the combined length of stay was 3 days or less, this should be considered a 3-day-or-less interruption, during which beneficiaries may receive services from multiple intervening facilities that should not separately bill Medicare. We did not identify any payments for short stays with a total length of 3 days or less.

⁴⁷ The services provided during the second LTCH stay would be included in the claim for the first LTCH stay. Therefore, the total reimbursement for the second LTCH stay may not equal the total amount of potential savings after adjusting the claim for the first stay to reflect all services.

Determining the Co-Located Status of LTCHs and the Extent to Which Co-Located LTCHs Exceeded the 5-Percent Readmission Threshold

We requested information on LTCHs' co-located status from MACs and then independently determined their co-located status to validate MAC responses. To determine whether LTCHs were co-located, we obtained addresses from the Services Tracking, Analysis, and Reporting System (STARS) database for LTCHs; hospitals; inpatient rehabilitation facilities; SNFs or swing beds; and psychiatric hospitals that billed Medicare in 2010 and/or 2011.⁴⁸ We used LTCHs' Web sites to obtain addresses of their satellite facilities. We then used BatchGeo and Google Maps to determine whether an LTCH's campus was less than 250 yards away from another provider's campus pursuant to 42 CFR § 413.65.^{49, 50}

To determine the number of co-located LTCHs that exceeded the 5-percent readmission threshold, we first calculated the number of discharges an LTCH made to each co-located provider during its cost-reporting period. We then calculated the number of readmissions between an LTCH and each of its co-located providers and determined whether this number was greater than 5 percent of the total discharges to that provider.

Limitations

We were unable to identify the addresses of satellite facilities for all hospitals, independent rehabilitation facilities, and SNFs. Therefore, we may have underestimated the number of co-located LTCHs and/or the number of providers with which they are co-located. Further, our findings are based on an analysis of claims data, rather than medical documentation; we did not determine whether the lengths of stay at intervening facilities were appropriate.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

⁴⁸ Five LTCHs that billed Medicare in 2010 and/or 2011 were not in the STARS database. We obtained the address of these LTCHs using the National Plan & Provider Enumeration System's online National Provider Identifier Registry.

⁴⁹ BatchGeo is a free online mapping tool that generates maps from location data saved in spreadsheets.

⁵⁰ Google Maps is a free online mapping tool that produces street maps and satellite images of requested locations and can measure distance between selected geographic points.

FINDINGS

Nearly all interruptions and readmissions occurred between LTCHs and hospitals

Returning to an LTCH after an intervening-facility stay results in an interrupted stay or a readmission, depending on the length of stay at the intervening facility.

- Of the 449 LTCHs that billed Medicare in 2010 or 2011, 422 had at least 1 interrupted stay. In 2010 and 2011, 8,823 interruptions occurred during 8,350 interrupted stays, representing 3 percent of all LTCH stays. The number of interruptions for each LTCH ranged from 1 to 209.
- In 2010 and 2011, 427 LTCHs had at least 1 readmission. There were 5,659 readmissions in 2010 and 2011, representing 2 percent of all LTCH stays. The number of readmissions for each LTCH ranged from 1 to 95.

For nearly all interruptions and readmissions in 2010 and 2011, the intervening facility was a hospital. Table 1 shows the number of interruptions and readmissions by type of intervening facility for 2010 and 2011.

Table 1: Interruptions and Readmissions by Type of Intervening Facility, 2010–2011

Type of Intervening Facility	Interruptions	Readmissions
Hospital	8,686	5,428
Inpatient Rehabilitation Facility	19	3
SNF or Swing Bed	118	228
Total	8,823	5,659

Source: OIG analysis of 2010 and 2011 Part A Standard Analytical Files, 2013.

Medicare inappropriately paid \$4.3 million to LTCHs and intervening facilities for interrupted stays

From 2010 to 2011, Medicare inappropriately paid \$4.3 million for interrupted stays in LTCHs. The inappropriate payments were

- (1) to LTCHs for readmissions after stays at intervening facilities within the fixed-day period (i.e., stays that should have been paid for as interruptions rather than readmissions) and

(2) to intervening facilities for services provided during 3-day-or-less interruptions (i.e., services that should have been paid for by the LTCH under arrangements rather than paid directly by Medicare to the intervening facilities).

Medicare inappropriately paid \$3.8 million to LTCHs for readmissions after stays at intervening facilities within the fixed-day period

If a beneficiary receiving services at an intervening facility returns to the same LTCH within the fixed-day period, then CMS considers it an interrupted stay rather than a readmission and should pay the LTCH for one stay rather than two stays. However, Medicare inappropriately paid an estimated \$3.8 million to 87 LTCHs in 2010 and 2011 because it paid LTCHs for a second stay, or readmission, after a beneficiary returned from an intervening facility within the fixed-day period.⁵¹ This represents less than one-tenth of a percent of all Medicare payments to LTCHs. Most (96 of 132) of these inappropriately paid readmissions followed intervening SNF stays.

Medicare inappropriately paid approximately \$523,000 to intervening facilities for services provided during interruptions of 3 days or less

Intervening facilities should not submit claims to Medicare for services provided during 3-day-or-less interruptions, as these facilities are paid for the services by the LTCH under arrangements. However, Medicare inappropriately paid \$523,079 to 50 intervening facilities for services provided during 3-day-or-less interruptions in 2010 and 2011. For nearly all (58 of 59) of these 3-day-or-less interruptions for which Medicare inappropriately paid, the intervening facility was a hospital.⁵²

Financial incentives in the interrupted-stay policy may influence the readmission decisions of some LTCHs

Returning to the same LTCH after an intervening-facility stay results in an interrupted stay or a readmission, depending on the length of stay at the intervening facility. Medicare pays LTCHs for a new stay following a readmission to the LTCH after the fixed-day period. Therefore, readmitting beneficiaries immediately after the fixed-day period, rather than during the fixed-day period, results in additional Medicare payments to the LTCHs.

⁵¹ This figure is an estimate because CMS must adjust the claim for the first stay to reflect services provided during both LTCH stays.

⁵² For the remaining inappropriate payment, the intervening facility was an independent rehabilitation facility.

Fifty-nine LTCHs had a high number of readmissions from hospitals immediately after the fixed-day period, allowing them to receive additional payments more often than other LTCHs. This raises concerns about whether financial incentives, rather than beneficiaries' conditions, influenced readmission decisions of some LTCHs. In 2010 and 2011, Medicare paid \$12 million for readmissions immediately after the fixed-day period in these 59 LTCHs.⁵³

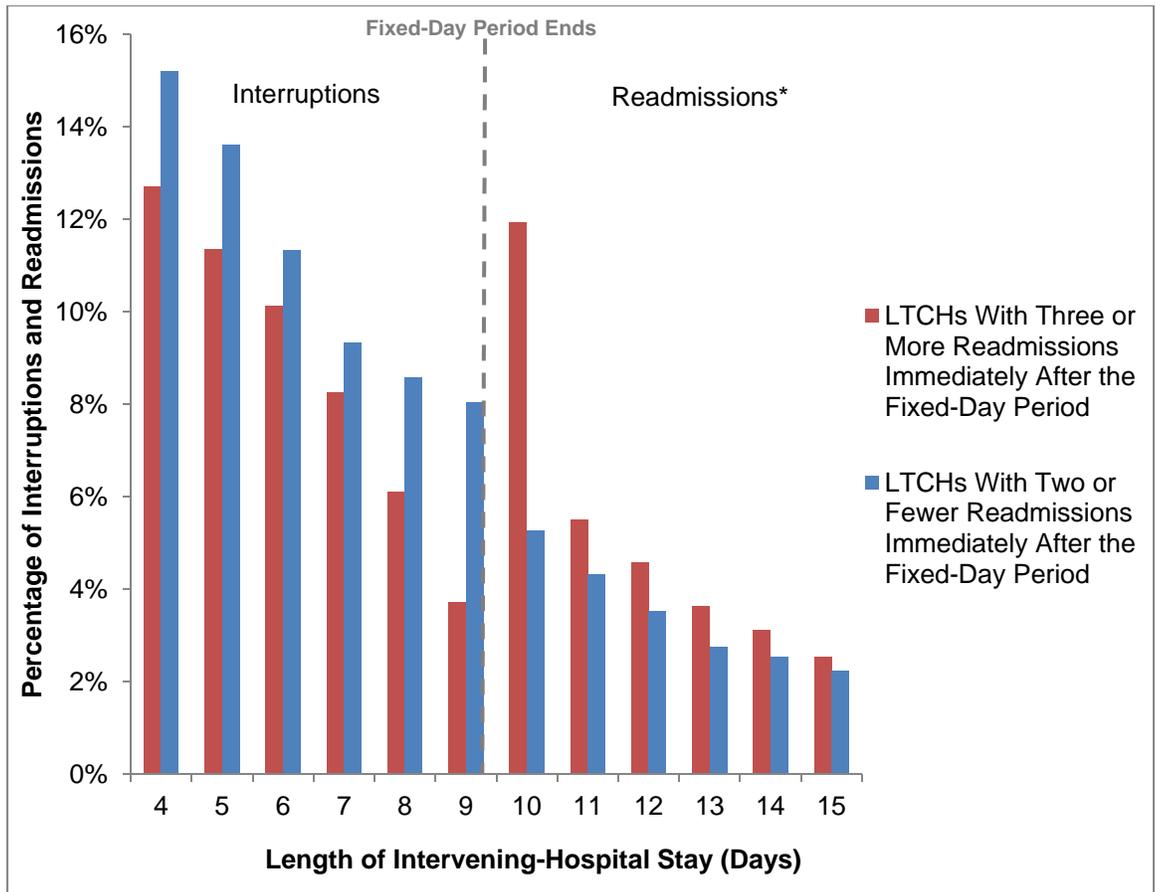
Additionally, CMS considers it a readmission, which results in an additional LTCH payment, if beneficiaries receive services at more than one intervening facility, regardless of whether the combined length of stay at the intervening facilities is within the fixed-day period. In 2010 and 2011, Medicare paid LTCHs \$8.2 million for 259 readmissions that occurred after 2 or more short stays at intervening facilities.

Fifty-nine LTCHs had a high number of readmissions immediately after the fixed-day period; as a result, additional LTCH payments were made

In 2010 and 2011, beneficiaries left LTCHs to receive services from intervening hospitals and returned to the same LTCHs approximately 14,000 times. Of these returns, 5,428 occurred after the fixed-day period for hospitals and resulted in readmissions, and second payments, for 424 LTCHs. Most (264 of 424) LTCHs had the same number or fewer returns after a 10-day hospital stay (i.e., immediately after the fixed-day period) than after a 9-day hospital stay (i.e., the last day of the fixed-day period). Sixty-nine LTCHs had 1 more, and 32 LTCHs had 2 more returns immediately after the fixed-day period than on the last day of the fixed-day period. We considered the remaining 59 LTCHs with at least 3 more returns immediately after the fixed-day period to have a high number of these readmissions. See Figure 3 for a comparison of the percentage of intervening hospital stays ending during and after the fixed-day period for these 59 LTCHs and all other LTCHs with at least 1 readmission.

⁵³ Medicare paid \$31.2 million to the 365 LTCHs with 2 or fewer returns immediately after the fixed-day period, resulting in a total of \$43.2 million for all returns immediately after the fixed-day period.

Figure 3: Percentage of Interruptions and Readmissions by Length of Intervening Hospital Stay, 2010 and 2011



*Additionally, 17 percent (556) and 14 percent (1,529) of returns occurred after intervening hospital stays lasting 16 days or longer for LTCHs with a high number of readmissions immediately after the fixed-day period and all remaining LTCHs, respectively.

Source: OIG analysis of 2010 and 2011 Part A Standard Analytical Files, 2013.

For the 59 LTCHs with a high number of readmissions immediately after the fixed-day period, 12 percent (380 of 3,222) of all returns took place immediately after the fixed-day period compared to only 5 percent (578 of 10,817) for the remaining 365 LTCHs. Medicare paid \$12 million in 2010 and 2011 for readmissions occurring immediately after the fixed-day period in the 59 LTCHs with a high number of these readmissions. Therefore, only 14 percent of LTCHs with at least 1 readmission (59 of 424 LTCHs) accounted for approximately 38 percent of all Medicare payments for readmissions occurring immediately after the fixed-day period. While the payments for these readmissions may be appropriate, they raise concerns about whether financial incentives in the interrupted-stay policy drive readmission decisions, rather than beneficiaries' conditions. Retaining beneficiaries in intervening facilities until immediately after the fixed-day period results in an additional

payment to LTCHs, which could essentially double an LTCH's overall Medicare reimbursement.

Forty-five of the 59 LTCHs were part of a chain, and 23 of these LTCHs were part of the same chain. The 23 LTCHs in this chain accounted for 38 percent of the 380 readmissions immediately after the fixed-day period.⁵⁴ Further, Medicare paid \$4.9 million to these 23 LTCHs for readmissions immediately after the fixed-day period, or 41 percent of the \$12 million paid to LTCHs with a high number of readmissions immediately after the fixed-day period.

Additionally, the number of returns to these 59 LTCHs increased by over 200 percent immediately after the fixed-day period. For 50 of these 59 LTCHs, the number of returns doubled immediately after the fixed-day period. Three LTCHs had more than 10 more returns immediately after the fixed-day period than on the last day of the fixed-day period. These 59 LTCHs were located in 24 States, with the highest concentrations in Texas, California, Ohio, Florida, and Massachusetts. See Appendix C for the number of LTCHs with a high number of readmissions immediately after the fixed-day period, by State.

Twenty-four LTCHs had a high number of readmissions following multiple short stays at intervening facilities; as a result, additional LTCH payments were made

In 2010 and 2011, 259 readmissions occurred after multiple stays at intervening facilities with combined lengths of stay of 9 days or less (i.e., the shortest fixed-day period); as a result additional LTCH payments were made.⁵⁵ For 86 percent of these readmissions, the beneficiary was discharged to a SNF and then to a hospital, or two separate hospitals, before returning to the LTCH. Medicare paid \$8.2 million to 144 LTCHs for these readmissions.

Of the 144 LTCHs with at least 1 of these readmissions, most (120 LTCHs) had 2 or less. However, there were 24 LTCHs with 3 or more of these readmissions in 2010 and 2011. We considered these LTCHs to have a high number of readmissions following multiple short stays at intervening facilities. Medicare paid these 24 LTCHs \$3.1 million for readmissions following multiple short stays at intervening facilities. While the payments for these readmissions may be appropriate, they raise questions about whether financial incentives in the interrupted-stay policy

⁵⁴ This chain represented 29 percent of all LTCH readmissions from hospitals from 2010 to 2011.

⁵⁵ Of these 259 readmissions, 257 occurred after 2 short stays at intervening facilities and 2 occurred after 3 short stays at intervening facilities.

drive discharge and readmission decisions for intervening facilities and LTCHs, rather than beneficiaries' medical conditions. Eight of these 24 LTCHs also had a high number of readmissions immediately after the fixed-day period and 12 were part of the same chain. These LTCHs were located in nine States; the highest concentrations were in California, Ohio, and Texas.⁵⁶

Approximately one-third of co-located LTCHs exceeded the 5-percent readmission threshold, but CMS lacks the information to apply a payment adjustment

Of the 449 LTCHs that billed Medicare in 2010 and 2011, we identified 329 that were co-located with at least 1 other provider.⁵⁷ The number of providers with which LTCHs were co-located ranged from one to nine. Of the 329 co-located LTCHs, 88 (27 percent) reported their co-located status to MACs. Further, 35 percent of co-located LTCHs exceeded the 5-percent readmission threshold. Without complete information on LTCHs' co-located status, CMS cannot enforce the 5-percent readmission threshold and apply payment adjustments to these LTCHs.

Co-located LTCHs had a total of 537 readmissions that should have been treated as interruptions

CMS is supposed to apply a payment adjustment to decrease reimbursements for co-located LTCHs that exceed the 5-percent readmission threshold. Thirty-five percent (116 of 329) of co-located LTCHs exceeded the 5-percent threshold for readmissions from co-located hospitals during a cost reporting period in 2010 and 2011.⁵⁸ These 116 LTCHs had a total of 537 readmissions from co-located providers that should have been treated as interruptions; only 1 payment should have been made to the LTCH rather than 2. Approximately 31 percent (36 of 116) of the LTCHs that exceeded this threshold had reported their co-located status

⁵⁶ Florida, Illinois, Louisiana, Massachusetts, New Jersey, and Nevada contained two or fewer LTCHs with a high number of readmissions following multiple short stays at intervening facilities.

⁵⁷ In March 2013, OIG issued an early alert memorandum to CMS to report the preliminary finding that co-located LTCHs remained unidentified and that overpayments could result. For the early alert memorandum, OIG determined the co-located status of 211 LTCHs. This finding updates the information in the early alert based on an analysis of all 449 LTCHs. See OIG, *Early Alert Memorandum Report: Co-Located Long Term Care Hospitals Remain Unidentified Resulting in Potential Overpayments*, OEI-04-12-00491, March 2013.

⁵⁸ An additional 55 co-located LTCHs exceeded the 5-percent threshold by readmitting only 1 beneficiary discharged to a hospital. We did not include these LTCHs in this total because there were so few readmissions from the hospital with which the LTCH was co-located.

to a MAC. Eighteen LTCHs readmitted at least 40 percent, or 8 times the threshold, of the beneficiaries discharged to a co-located hospital. Four of these eighteen LTCHs were located in Texas. Further, three LTCHs exceeded the threshold with three different co-located hospitals, and five LTCHs exceeded the threshold with two different co-located hospitals. No co-located LTCHs exceeded the threshold for readmissions from co-located SNFs, inpatient rehabilitation facilities, swing beds, and psychiatric hospitals.

Eighty-two percent of the co-located LTCHs that exceeded the 5-percent threshold were part of a chain.⁵⁹ One chain represented 33 percent (38 of 116) of the co-located LTCHs that exceeded the 5-percent threshold and 30 percent of the 537 readmissions that should have been treated as interruptions.⁶⁰

Additionally, although the threshold does not apply to freestanding LTCHs, 195 freestanding LTCHs readmitted more than 5 percent of beneficiaries discharged to a single hospital.⁶¹ Eighty-one percent of these LTCHs were part of a chain. Fifty-six freestanding LTCHs readmitted at least 50 percent, or 10 times the threshold, of the beneficiaries discharged to a single hospital. Two freestanding LTCHs exceeded the 5-percent threshold with a SNF.

CMS lacked information to identify co-located LTCHs that exceeded the 5-percent readmission threshold; as a result, overpayments were made

LTCHs are required to notify MACs of their co-located status. MACs are then required to report this information to CMS regional offices. However, in 7 of the 14 claims-processing jurisdictions, no co-located LTCHs notified their MAC of their co-located status. We identified 96 co-located LTCHs in these 7 jurisdictions. Additionally, two of these seven MACs stated that they do not monitor the co-located status of LTCHs in their jurisdictions. See Appendix D for the number and percentage of co-located LTCHs in each MAC jurisdiction in 2010 and 2011.

For 11 of the 14 jurisdictions, less than half of the co-located LTCHs that we identified reported their co-located status. Additionally, some LTCHs that reported their co-located status did not follow reporting requirements.

⁵⁹ Seventy-four percent of all co-located LTCHs were part of a chain.

⁶⁰ This chain represented 15 percent of all LTCH discharges during a cost-reporting period from 2010 to 2011.

⁶¹ An additional 235 freestanding LTCHs readmitted more than 5 percent of beneficiaries discharged to a single hospital by readmitting only 1 beneficiary discharged to that hospital. We did not include these LTCHs in this total because there were so few readmissions from the hospital.

Specifically, 1 hospital chain provided the co-located status of 79 LTCHs to 1 MAC, although none of these LTCHs were in that MAC's jurisdiction.

We were unable to determine whether the appropriate payment adjustments have been or will be made for the LTCHs that exceeded the 5-percent readmission threshold in 2010 and 2011. According to CMS, the adjustments would be made during the cost-report settlement process, which had not been completed at the time of this review. However, CMS did not know the co-located status of most LTCHs. Further, CMS has not instructed MACs or CMS regional offices to identify co-located LTCHs that exceed the 5-percent readmission threshold and has not created system edits to identify these LTCHs since the threshold was established in 2002.

CONCLUSION AND RECOMMENDATIONS

Medicare paid \$10.3 billion to 449 LTCHs for services billed on behalf of approximately 254,000 beneficiaries in 2010 and 2011. The number of LTCHs increased dramatically prior to a 2007 moratorium on their growth. This moratorium ended in 2012. The LTCH interrupted-stay policy is intended to save Medicare money by treating the LTCH stays before and after an interruption as a single stay, rather than paying LTCHs for two separate stays. However, our evaluation identifies several vulnerabilities in the LTCH interrupted-stay policy, including inappropriate payments, financial incentives to delay readmissions, and potential overpayments to co-located LTCHs.

Medicare inappropriately paid \$4.3 million to LTCHs and intervening facilities for interrupted stays. Additionally, financial incentives created by the interrupted stay payment policy may influence the readmission decisions of some LTCHs. For example, LTCHs can increase their reimbursement if beneficiaries stay at an intervening facility longer than the fixed-day period because this results in a readmission and an additional payment for the new LTCH stay. Specifically, 59 LTCHs had a high number of readmissions immediately after the fixed-day period. Medicare paid \$12 million for these readmissions. LTCHs also receive an additional payment for a new stay if beneficiaries receive services from multiple intervening facilities before returning to the LTCH. Twenty-four LTCHs had a high number of readmissions following multiple short stays at intervening facilities. Medicare paid \$3.1 million for these readmissions. A high number of either of these types of readmissions raises questions as to whether financial incentives—rather than beneficiaries’ medical conditions—influenced readmission decisions.

Finally, CMS does not have the information needed to apply payment adjustments to the one-third of co-located LTCHs that exceeded the 5-percent readmission threshold; as a result, overpayments were made. CMS has not developed a process to identify co-located LTCHs that exceed the 5-percent readmission threshold since this threshold was established in 2002.

We recommend that CMS:

Review existing safeguards to determine whether additional action is needed to prevent future inappropriate payments for interrupted stays

CMS should determine why its existing safeguards did not prevent all inappropriate payments to LTCHs and intervening facilities for interrupted stays. CMS inappropriately paid a total of \$4.3 million to (1) LTCHs for

readmissions after stays at intervening facilities within the fixed-day period and (2) intervening facilities for services provided during interruptions of 3 days or less. CMS should address any issues it identifies to prevent future inappropriate Medicare payments for interrupted stays.

Conduct additional analysis to determine the extent to which financial incentives influence LTCH readmission decisions

CMS should conduct additional analysis of LTCH readmissions to determine the extent to which financial incentives, rather than beneficiaries' conditions, influence LTCH readmission decisions. If it determines that this is an issue, CMS should consider ways to decrease the financial incentives created by the interrupted-stay policy. For example, CMS could consider imposing a readmission threshold on all LTCHs. If an LTCH exceeds the threshold, CMS could treat the readmissions as interruptions, which would decrease the financial incentive for readmissions. CMS could also consider expanding the interrupted-stay policy to include multiple short stays at different intervening facilities.

Develop a system to enforce the 5-percent readmission threshold

OIG continues to recommend that CMS develop a system to enforce the 5-percent readmission threshold. MACs should consistently collect and store information on the co-located status of LTCHs and immediately share it with CMS regional offices. CMS or MACs could survey LTCHs on a recurring basis to identify co-located LTCHs and changes in co-located status. CMS should also continue to educate LTCHs on the requirement to notify MACs of their co-located status. This education could help ensure that LTCHs report this information to the appropriate MAC. CMS should then use this information to determine which LTCHs exceeded the 5-percent readmission threshold and recover overpayments to these LTCHs.

Take appropriate action regarding LTCHs with a high number of readmissions immediately after the fixed-day period and LTCHs with a high number of readmissions following multiple short stays at intervening facilities

In a separate memorandum, we will refer to CMS for appropriate action (1) the LTCHs with a high number of readmissions immediately after the fixed-day period, (2) the LTCHs with a high number of readmissions following multiple short stays at intervening facilities, and (3) the intervening facilities associated with these readmissions. Appropriate action may include determining whether all days at the intervening facilities and

readmissions to these LTCHs were appropriate, by conducting medical record reviews and/or site visits and/or implementing prepayment reviews. If fraudulent or abusive activity is discovered, CMS should refer the LTCHs and/or intervening facilities to law enforcement for investigation. Further, CMS should monitor LTCHs with a high number of these readmissions and ensure that they do not use these methods to inappropriately receive additional payments.

Take appropriate action on inappropriate payments for interruptions and overpayments to co-located LTCHs that exceeded the 5-percent readmission threshold

In the aforementioned memorandum, we will also refer to CMS the claims associated with inappropriate payments to LTCHs and intervening facilities. CMS should review and recover these inappropriate payments, as appropriate. We will also refer to CMS the co-located LTCHs that exceeded the 5-percent readmission threshold and the claims associated with readmissions that should have been treated as interrupted stays. CMS should identify and recover overpayments to these LTCHs, as appropriate.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, CMS concurred—contingent on receiving more information from OIG—with two of our recommendations and nonconcurred with three recommendations. Noting that recently enacted legislation established a new LTCH Prospective Payment System payment structure beginning in FY 2016, CMS stated that it is examining whether the 5-percent readmission threshold will continue to be necessary under this new system.

In several places in its comments, CMS stated that it needs to review OIG data before concurring, or fully concurring, with our recommendations. OIG's Office of Evaluation and Inspections does not provide detailed evaluation data and analyses to agencies prior to the finalization of a report, and we do not believe that the decision to concur or noncur with our recommendations requires a full review of these data and analyses. After the release of the final report, OIG will provide CMS with all appropriate data and analyses to support CMS's efforts to address the vulnerabilities identified by our evaluation.

With regard to our first recommendation, CMS concurred contingent on OIG's providing information that indicates that existing program safeguards are not preventing inappropriate payments. CMS stated that it would need to review OIG's data to determine whether it agrees that inappropriate payments were made. Our analyses indicate that inappropriate payments did occur. After issuing the final report, we will provide the appropriate information in a separate memorandum. We encourage CMS to review this information and the agency's existing safeguards to determine whether additional action is needed to prevent future inappropriate payments for interrupted stays.

With regard to our second recommendation, CMS stated that it nonconcurred at this time. CMS agreed that LTCH prospective payment system policies should not provide incentives for LTCH readmission decisions to be based on financial benefit. However, CMS stated that it cannot agree that additional analyses are warranted until OIG provides it with information to enable additional financial review. CMS stated that it would need to investigate ownership and/or control relationships between referring hospitals and the LTCHs in question and evaluate whether there is a pattern of behavior over several years. CMS also stated that it would need further information from OIG suggesting that Medicare payment policy is influencing LTCH readmission decisions. We will provide CMS with ownership information for LTCHs as well as data and analyses

concerning readmissions between LTCHs and hospitals for the 2 years included in this evaluation. We will not conduct or provide any additional analyses at this time. We continue to recommend that CMS conduct additional analyses to determine the extent to which financial incentives influence readmission decisions.

With regard to our third recommendation, CMS nonconcurred and stated that it is examining whether the 5-percent readmission threshold will continue to be necessary under the new LTCH payment system, which will begin in FY 2016. OIG reiterates that CMS should enforce the current policy until the new prospective payment policy is in effect. Not doing so would prevent CMS from collecting any overpayments associated with the current policy during the period—more than a year—before the new policy takes effect, in addition to any overpayments that it has failed to collect since the current policy was implemented in 2003. Further, OIG believes that CMS currently does not have the information necessary (e.g., number of co-located LTCHs, identity of co-located LTCHs and host facilities, number of discharges to host facilities) to determine whether the 5-percent threshold should remain in effect under the new payment system. We will refer to CMS the information that we collected regarding co-located LTCHs and host facilities, and we encourage the agency to use this information when making this determination.

With regard to our fourth recommendation, CMS stated that it nonconcurred at this time. CMS said that it cannot determine what, if any, appropriate actions are necessary with regard to LTCHs with a high number of readmissions immediately after the fixed-day day period or following multiple short intervening-facility stays because neither necessarily indicate improper practice or inappropriate payment. Our report states that payment for these readmissions may be appropriate; however, having a high number of either type of readmission raises questions as to whether financial incentives—rather than beneficiaries' medical conditions—drove readmission decisions. We will refer to CMS the LTCHs, intervening facilities, and claims associated with these readmissions to determine the most appropriate action for the LTCHs that we identified.

With regard to our fifth recommendation, CMS concurred on the condition that it can validate OIG's assertion that hospitals were overpaid because CMS did not apply the 5-percent readmission threshold. CMS requests that OIG provide specific information for each of the identified claims, including the overpayment amount. We will provide specific claims information, but we are unable to provide an overpayment amount for these claims. The 5-percent readmission threshold policy requires that

certain claims be adjusted after an LTCH exceeds the threshold to reflect an interrupted stay rather than a separate readmission. This adjustment could trigger other payment adjustments (e.g., a high-cost outlier payment or the reversal of a short-stay outlier payment), and OIG cannot calculate the exact overpayment amounts in these cases. Further, CMS was unable to provide its methodology for calculating these overpayments, suggesting that it has not made these calculations since the current prospective payment policy was implemented in 2003 and thus has missed the opportunity to collect 7 years of potential overpayments. We encourage CMS to use the information that we refer to it to calculate and collect overpayments made to LTCHs that exceeded the 5-percent readmission threshold.

We support CMS's efforts to address these issues and encourage it to continue making progress in these areas. For the full text of CMS's comments, see Appendix E.

APPENDIX A

Number of LTCHs by State, 2010 and 2011

State	Number of LTCHs*	Percentage of LTCHs
Texas	82	18%
Louisiana	39	9%
Ohio	25	6%
Pennsylvania	23	5%
California	20	4%
Florida	20	4%
Michigan	19	4%
Georgia	15	3%
Massachusetts	15	3%
Indiana	14	3%
Oklahoma	14	3%
Missouri	12	3%
Mississippi	10	2%
North Carolina	9	2%
Tennessee	9	2%
Alabama	8	2%
Arkansas	8	2%
Arizona	8	2%
Colorado	8	2%
Illinois	8	2%
New Jersey	8	2%
Kentucky	6	1%
Nevada	6	1%
South Carolina	6	1%
Virginia	6	1%
Kansas	5	1%
Wisconsin	5	1%
Maryland	4	1%
New York	4	1%
Connecticut	3	1%
Idaho	3	1%
New Mexico	3	1%
Utah	3	1%
Washington, D.C.	2	<1%

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Appendix A (Continued)

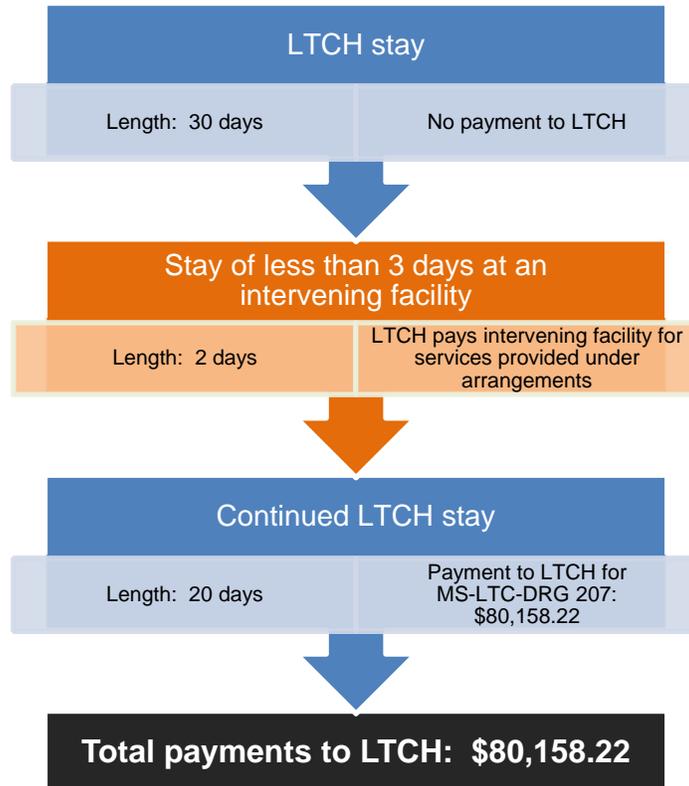
State	Number of LTCHs	Percentage of LTCHs
Iowa	2	<1%
Minnesota	2	<1%
North Dakota	2	<1%
Nebraska	2	<1%
Washington	2	<1%
West Virginia	2	<1%
Alaska	1	<1%
Delaware	1	<1%
Hawaii	1	<1%
Montana	1	<1%
Oregon	1	<1%
Rhode Island	1	<1%
South Dakota	1	<1%
Total	449	100%

*This column indicates the number of LTCHs that billed Medicare in both 2010 and 2011.

Source: OIG analysis of 2010 and 2011 Part A Inpatient Standard Analytical Files, 2013.

APPENDIX B

Example of Total Payments to an LTCH for a Stay With a 3-Day-or-Less Interruption for MS-LTC-DRG 207



*Payments reflect FY 2011 LTCH Prospective Payment System rates and do not include any potential case-level or facility-level adjustments.
Source: OIG analysis of interrupted-stay policy and 2011 LTCH Prospective Payment System Reimbursement Rates, 2013.

APPENDIX C

Number of LTCHs With a High Number of Readmissions Immediately After the Fixed-Day Period by State, 2010 and 2011

State	Number of LTCHs with a High Number of Readmissions Immediately After the Fixed-Day Period
Texas	10
California	6
Ohio	6
Florida	4
Massachusetts	4
Illinois	3
Louisiana	3
Oklahoma	3
Michigan	2
North Carolina	2
Tennessee	2
Virginia	2
Alabama	1
Colorado	1
Kentucky	1
Mississippi	1
Montana	1
Nebraska	1
Nevada	1
New Jersey	1
New Mexico	1
New York	1
Utah	1
Wisconsin	1
Total	59

Source: OIG analysis of 2010 and 2011 Part A Inpatient Standard Analytical Files, 2013.

APPENDIX D

Number and Percentage of Co-Located LTCHs by MAC Jurisdiction, 2010 and 2011

MAC	Number LTCHs That Reported Being Co-Located	Number of Co-Located LTCHs	Number of LTCHs	Percentage of Co-Located LTCHs That Reported Being Co-Located	Percentage of LTCHs That Are Co-Located
A	65*	105	121	62%	87%
B	10	18	20	56%	90%
C	1	2	8	50%	25%
D	3	10	11	30%	91%
E	5	17	19	29%	89%
F	2	9	14	22%	64%
G	2	72	109	3%	65%
H	0	3	7	0%	43%
I	0	4	6	0%	67%
J	0	4	7	0%	57%
K	0	4	11	0%	36%
L	0	6	12	0%	50%
M	0	8	14	0%	57%
N	0	67	90	0%	74%
Total	88**	329	449	27%	73%

*The 65 LTCHs that reported their co-located status in this jurisdiction did so to a different MAC.

**MACs reported that 99 LTCHs had notified them of being co-located. Of these 99, 88 LTCHs were co-located and submitted claims to Medicare in 2010 and/or 2011.

Source: OIG analysis of MAC responses, co-location information, and 2010 and 2011 Part A Inpatient Standard Analytical Files, 2013.

APPENDIX E

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: MAR 28 2014

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Administrator

ISI

SUBJECT: Office of Inspector General (OIG) Draft Report: Vulnerabilities in Medicare's Interrupted Stay Policy (OEI-04-12-00490)

The Centers for Medicare & Medicaid Services (CMS) thanks OIG for the opportunity to review and comment on the above subject draft report. OIG's objectives for this study were to--(1) describe billing of interrupted stays and readmissions in long-term care hospitals (LTCHs); (2) determine the extent to which Medicare made inappropriate payments for interrupted stays in LTCHs; (3) determine the extent to which LTCHs readmitted beneficiaries immediately after the fixed-day period or after multiple short intervening facility stays, resulting in an additional LTCH payment; and (4) determine the extent to which co-located LTCHs reported their co-located status and exceeded the 5-percent readmission threshold.

The OIG analyzed data from Long Term Care Hospitals (LTCHs) and intervening facility claims in 2010 and 2011 to identify inappropriate payments for interrupted stays in LTCHs. Additionally, OIG identified LTCHs with a high number of readmissions immediately after the fixed-day period and after multiple short intervening facility stays. OIG also identified co-located LTCHs billing in 2010 and 2011 and determined whether they reported their status and whether they exceeded the 5-percent readmission threshold. OIG concluded that CMS has vulnerabilities in the LTCH interrupted stay policy, including inappropriate payments, financial incentives to delay readmissions, and potential overpayments to co-located LTCHs. OIG concluded that in 2010 and 2011, Medicare inappropriately paid \$4.3 million to LTCHs and intervening facilities for interrupted stays. Additionally, 59 LTCHs had a high number of readmissions immediately after the fixed-day period and 24 LTCHs had a high number of readmissions following multiple short intervening facility stays. Medicare paid \$12 million and \$3.1 million, respectively, for these readmissions. While OIG indicates that these readmissions may be appropriate, they raised concerns about whether financial incentives, rather than beneficiaries' medical conditions, may have influenced readmission decisions of some LTCHs. They also found that CMS did not know the co-located status of most LTCHs, preventing it from applying a payment adjustment to the 35 percent of co-located LTCHs that exceeded the 5-percent readmissions threshold.

We note that recently enacted legislation establishes a new LTCH Prospective Payment System (PPS) payment structure beginning in fiscal year (FY) 2016 that specifies clinical criteria for

standard payments under the LTCH PPS and “site-neutral” payments for patients not meeting the criteria (the lesser of an “Inpatient PPS comparable” amount or 100 percent of the estimated cost of the case). CMS is currently examining whether the 5 percent readmission threshold will continue to be necessary under the new LTCH payment system.

The OIG recommendations and CMS responses to those recommendations are discussed below.

OIG Recommendation

The OIG recommends that CMS review existing safeguards to determine whether additional action is needed to prevent future inappropriate payments for interrupted stays.

CMS Response

The CMS concurs with this recommendation contingent upon OIG providing us with information that indicates that existing program safeguards are not preventing inappropriate payments. While we agree that inappropriate payments for interrupted stays should be prevented, we note that OIG has not provided us with the data used in its analysis. We would need to review the data that OIG used to determine whether we agree that inappropriate payments were made during 2010 and 2011 under the interrupted stay policy. Therefore, at this time, CMS cannot agree/disagree that overpayments occurred or that system edits need to be added/revised without evaluating the claims data to confirm that the interrupted stay policy was in fact not applied correctly in determining payments for such cases.

OIG Recommendation

The OIG recommends that CMS conduct additional analysis to determine the extent to which financial incentives influence LTCH readmission decisions.

CMS Response

The CMS non-concurs with this recommendation at this time. While we agree that LTCH PPS policies should not provide incentives for LTCH readmission decisions that are based on the hospital’s financial benefit rather than the patients’ clinical needs, CMS cannot agree/disagree that such analyses are warranted until OIG provides us with identifying information to enable additional financial review. The establishment of the interrupted stay policy, which has been in existence since the start of the LTCH PPS FY 2003 is predicated on the following three essential facts: (1) That LTCHs do not provide a full range of acute care services; (2) That during the long stays typical of LTCH patients, with multiple comorbidities, it is not uncommon that a patient requires an acute intervention that can best be furnished at a short-term acute care hospital; and (3) That following the acute intervention, the patient may still require the hospital-level of care provided by the LTCH.

In order to analyze what is suggested as potentially inappropriate patient shifting for financial gain, we would need to investigate ownership and/or control relationships between referring IPPS hospitals and the LTCHs in question as well as to evaluate whether there is a pattern of

behavior (i.e., that the same behavior has occurred over several years with the same hospitals). We would need further information from OIG suggesting that Medicare payment policy is influencing LTCH readmission decisions to determine whether such an analysis is warranted.

OIG Recommendation

The OIG recommends that CMS develop a system to enforce the 5-percent readmission threshold.

CMS Response

The CMS non-concurs with this recommendation. When LTCHs were paid under the prior reasonable cost payment system, CMS implemented the 5-percent readmissions threshold policy. This policy was established in recognition of the proliferation of co-located inpatient providers and the potential for patient-shifting that could result in Medicare payments for each provider for what could have been understood to be a single episode of treatment. This payment adjustment was carried over to the LTCH PPS when it was originally implemented for FY 2003. As noted earlier, CMS is currently examining whether the 5 percent readmission threshold will continue to be necessary under the new LTCH payment system. In the interim, the interrupted stay policy applies on a claim specific basis and will control for any potential vulnerabilities that may result from inappropriate readmissions.

OIG Recommendation

The OIG recommends that CMS take appropriate action regarding LTCHs with a high number of readmissions immediately after the fixed-day period and LTCHs with a high number of readmissions following multiple short intervening facility stays.

CMS Response

The CMS non-concurs on this recommendation at this time. CMS cannot determine what, if any, appropriate actions are necessary with regard to LTCHs with “a high number of readmissions” because having “a high number of readmissions” immediately after the fixed-day period or following multiple short intervening facility stays does not necessarily indicate improper practice patterns or that inappropriate payments were made. As noted previously, CMS would need to review (including possibly a medical review) the claims to determine if any appropriate action regarding such situations is warranted.

OIG Recommendation

The OIG recommends that CMS take appropriate action on inappropriate payments for interruptions and overpayments to co-located LTCHs that exceeded the 5-percent readmission threshold.

CMS Response

The CMS concurs on the condition that we can validate that OIG's assertion that hospitals were overpaid inconsistent with Medicare's 5 percent readmission threshold. At the exit conference CMS requested that OIG provide us with information regarding the \$4.3 million in inappropriate payments to LTCHs and intervening facilities for interrupted stays. Without that information, we do not know the hospitals from which we would collect the overpayments much less whether overpayments were made. If OIG were to provide us with information on the hospitals that they believe were overpaid and the basis upon which OIG determined that overpayments were made that CMS can validate, CMS will attempt to collect overpayments that exceed CMS' recovery threshold and can be collected consistent with agency's policies and procedures. Since the OIG reviewed claims for dates of service during calendar years (CY) 2010 and 2011 some of the CY 2010 claims are no longer collectable as these claims have or will shortly exceed the 4-year claim reopening period as mandated by 42 CFR 405.980(b)(2). The OIG should furnish CMS with the list of claims that should have been paid as an interruption rather than a readmission and claims that should have been paid for by the LTCH before we can proceed further. The claims data should include, at a minimum, the provider number, the overpayment amount, Medicare contractor number, claim paid date, HICN, and claim/document control number. Upon the receipt of the overpayment data from OIG, CMS will attempt to collect overpayments consistent with the agency's policies.

Similarly, CMS concurs with the part of this recommendation related to identifying and collecting overpayments to co-located LTCHs that exceeded the 5-percent readmission threshold on the condition that OIG provides us with the hospitals that they allege were overpaid and the information demonstrating an overpayment that can be validated by CMS.

The CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

ACKNOWLEDGMENTS

This report was prepared under the direction of Dwayne Grant, Regional Inspector General for Evaluation and Inspections in the Atlanta regional office, and Jaime Durley, Deputy Regional Inspector General.

Sarah Langford served as the lead analyst. Other Office of Evaluation and Inspections staff from the Atlanta regional office who conducted the study include Rachel Besette. Central office staff who provided support include Althea Hosein, Scott Manley, and Christine Moritz.

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