



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

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TO: Marilyn Tavenner
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/S/

FROM: Stuart Wright
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SUBJECT: Early Alert Memorandum Report: *Co-Located Long-Term Care Hospitals Remain Unidentified, Resulting in Potential Overpayments*,
OEI-04-12-00491

This early alert memorandum report provides information related to our ongoing study *Medicare Payments for Interrupted Stays in Long-Term Care Hospitals* (OEI-04-12-00490) and alerts the Centers for Medicare & Medicaid Services (CMS) of vulnerabilities resulting from inaccurate information on the co-located status of long-term care hospitals (LTCHs).¹

SUMMARY

Not all co-located LTCHs (i.e., LTCHs located in the same building or on the same campus as another hospital-level provider or skilled nursing facility) have notified their respective Medicare Administrative Contractors or fiscal intermediaries (i.e., claims processing contractors) of their co-located status. This lack of information on co-located status can cause Medicare to overpay for services provided in these facilities.

Co-located LTCHs must notify their claims processing contractors about the providers with which they are co-located and whether there are any changes in co-located status.² However, preliminary analysis for our ongoing study indicates that many co-located LTCHs are not notifying their claims processing contractors. Specifically, nearly half of the 211 LTCHs whose co-located status we have determined have not reported this information to claims processing contractors. As a result, CMS does not have accurate

¹ Department of Health and Human Services (HHS), Office of Inspector General (OIG), *Work Plan, Fiscal Year 2013*. Available online at <https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf>. Our study will determine the extent to which Medicare made improper payments for interrupted stays in LTCHs and the extent to which LTCHs readmitted patients directly after the fixed-day period, resulting in new admissions rather than interrupted stays.

² 42 CFR § 412.532(i). See also CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 3 § 150.9.1.4.

information on the co-located status of LTCHs, which prevents it from applying two payment policies that would lower Medicare payments if co-located LTCHs exceeded certain readmission thresholds. Failure to appropriately apply these payment policies could result in Medicare overpaying for services provided to beneficiaries in LTCHs.

We are providing this memorandum at this time so that CMS may begin addressing the issue of inaccurate co-location information to avoid overpayments to co-located LTCHs. After completing our ongoing study entitled *Medicare Payments for Interrupted Stays in Long-Term Care Hospitals* (OEI-04-12-00490), we will provide CMS with additional information on this subject and will make recommendations regarding the issues raised in this memorandum.

BACKGROUND

LTCHs generally treat patients who have been discharged from acute care hospitals but have complex medical conditions that require prolonged hospital-level care. LTCH services include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. To qualify as an LTCH for Medicare payment, a facility must meet Medicare conditions of participation for acute care hospitals and have an average length of stay greater than 25 days for its Medicare beneficiaries.³ In 2011, Medicare paid \$5.3 billion for services furnished by 445 LTCHs.⁴

Reporting Requirements of Co-located LTCHs

An LTCH can be freestanding or co-located with another hospital-level provider (e.g., an acute care hospital) or a skilled nursing facility. 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.⁵ An LTCH that is co-located specifically with an acute care hospital is called a hospital-within-a-hospital.⁶ An LTCH may also have a satellite facility, which operates as part of the LTCH but in a separate location.⁷ A satellite facility can also be co-located with a hospital-level provider or a skilled nursing facility.

A co-located LTCH must notify its claims processing contractor about the provider(s) with which it is co-located within 60 days of its first cost-reporting period.⁸ Additionally, an LTCH must report a change in co-located status within 60 days of the change. The

³ 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.

⁴ OIG analysis of 2011 National Claims History Part A Standard Analytic File.

⁵ “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. 42 CFR § 413.65(a)(2).

⁶ 42 CFR § 412.22(e).

⁷ 42 CFR § 412.22(h).

⁸ 42 CFR § 412.532(i). See also: CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 3 § 150.9.1.4.

claims processing contractor notifies the appropriate CMS regional office of an LTCH's co-located status.

Medicare Payment Policies for Co-located Providers

Co-location of LTCHs creates incentives for co-located providers to make decisions about admitting and discharging patients on the basis of maximizing Medicare payments, rather than providing effective and efficient care.⁹ As a result, CMS developed two payment policies that apply to co-located LTCHs.

The first payment policy, known as the 25-percent threshold rule, was established in fiscal year 2005 and applies only to LTCH hospitals-within-hospitals and satellites.¹⁰ The 25-percent threshold rule limits the proportion of patients that an LTCH admits from its host hospital during the LTCH's cost-reporting period.¹¹ Medicare payments for stays that occur after an LTCH exceeds this threshold are subject to adjustments that reduce the amounts the LTCH receives. For such stays, Medicare will pay the LTCH the lesser of (1) the LTCH prospective payment system (PPS) amount, or (2) an amount equivalent to the Inpatient PPS rate for patients admitted from the host hospital.^{12, 13} That is, an LTCH's payments for certain stays that occur after exceeding the admission threshold should be reduced to a lower Medicare payment rate.

Additionally, a separate payment policy applies specifically to interrupted stays that occur between co-located providers. An interrupted stay is when a patient is discharged from an LTCH for treatment and services that are not available at the LTCH and returns after a specific number of days to the same LTCH for further medical treatment. If the patient returns to the same LTCH after a certain defined fixed-day period, CMS considers it a new admission rather than an interrupted stay. As a result, the LTCH will receive two Medicare payments—one payment for the first stay and a separate payment for the subsequent stay. Had the patient been readmitted during the fixed-day period, the LTCH would have received only one Medicare payment. If the number of discharges and readmissions between a co-located LTCH and the provider with which it is co-located

⁹ Testimony of Herb Kuhn, former Director of the Center for Medicare Management at CMS, before the House Committee on Ways and Means, Subcommittee on Health, U.S. House of Representatives, 110th Cong., March 15, 2006. Accessed at <http://www.hhs.gov/asl/testify/t060315a.html> on January 4, 2013.

¹⁰ 42 CFR § 412.534. In July 2007, the 25-percent threshold rule was to be expanded to almost all LTCHs (i.e., freestanding LTCHs and those co-located with providers other than acute care hospitals) and phased in over 3 years; however, legislation and CMS have delayed the expansion of this policy until fiscal year 2013. Additionally, less stringent thresholds apply to hospital-within-hospitals and satellites in rural areas or in urban areas where an LTCH is the sole LTCH or where there is a dominant acute care hospital—i.e., a hospital with one-fourth or more of the acute care cases for the metropolitan statistical area.

¹¹ Ibid. See also: CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 3 § 150.9.1.4.

¹² Medicare payments under the LTCH PPS are based on the same diagnosis-related group system (i.e., rates are set prospectively based on the patient's diagnosis and the severity of the patient's medical condition) as the Inpatient PPS, but payment weights associated with the LTCH patient classifications are calculated based on generally higher treatment costs at LTCHs.

¹³ Patients from the host hospital who are considered to be outliers under the Inpatient PPS before their transfer to the hospital-within-a-hospital do not count toward the threshold and continue to be paid for at the LTCH PPS rate even if the threshold has been reached.

exceeds 5 percent of the LTCH's total discharges during a cost reporting period, all such discharges and readmissions are to be paid as one discharge, regardless of the time spent at the intervening facility.¹⁴

Related Work

In 2004, OIG found that 19 of 87 LTCH hospitals-within-hospitals exceeded the annual 5-percent threshold for readmissions from their host hospitals at least once during the fiscal years ending in September 2000 through December 2002.¹⁵ For that study, OIG developed its own list of LTCHs that were co-located with acute care hospitals because CMS data systems did not identify hospitals-within-hospitals. Additionally, OIG found that CMS lacked a system to detect readmissions over the 5-percent threshold. LTCH hospitals-within-hospitals currently operate under a modified readmission threshold, which CMS has not established a program to enforce.

METHODOLOGY

As part of our ongoing study entitled *Medicare Payments for Interrupted Stays in Long-Term Care Hospitals* (OEI-04-12-00490), we requested that all CMS claims processing contractors provide data on the co-located status of LTCHs in their respective provider service areas for calendar years 2010 and 2011.¹⁶ We received responses from all contractors, a 100-percent response rate. We reviewed claims processing contractors' responses to determine how many LTCHs had notified them of their co-located status.

We are also mapping LTCHs' geographic locations in relation to those of other providers to independently identify co-located LTCHs. We analyzed claims data from CMS's National Claims History Part A Standard Analytic File to identify LTCHs that received Medicare payment in 2011. We have completed this process for 47 percent (211 of 445) of LTCHs. We compared our results to contractor responses to identify co-located LTCHs that have not notified their claims processing contractors of their status.

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.

RESULTS

At Least 97 Co-located LTCHs Have Not Notified Their Claims Processing Contractors of Their Status

Eight of fourteen CMS claims processing contractors provided information on 98 co-located LTCHs and the providers with which they are co-located. One large

¹⁴ 42 CFR § 412.532.

¹⁵ OIG, *Long-Term Care Hospitals-within-Hospitals*, OEI-01-02-00630, July 2004. Prior to October 1, 2002, CMS paid LTCHs on a cost basis and imposed a payment limitation when an LTCH hospital-within-a-hospital readmitted more than 5 percent of its discharges to its host hospital within the LTCH's fiscal year. This policy is no longer in effect and is different than the current 5-percent threshold for interrupted stays in LTCHs. Compare 42 CFR § 413.40 (2000) with 42 CFR § 412.532(c) (2009).

¹⁶ At the time of our data request, certain claims processing contractors changed and/or were consolidated; however, our data are comprehensive and include all provider service areas.

hospital chain provided the co-located status of the majority (78 of 98) of LTCHs to 1 claims processing contractor. Additionally, five of these eight contractors did not report that any LTCHs in their provider service areas were co-located with providers other than hospitals (e.g., skilled nursing facilities or inpatient rehabilitation facilities).

Six contractors reported that no LTCHs in their provider service areas had notified them of being co-located. Additionally, two of these six contractors stated that they do not track LTCHs that are co-located. Although contractors are not required to actively track LTCHs' co-located status, LTCHs are required to notify contractors of their co-located status and contractors are required to report this information to CMS regional offices.

Of the 211 LTCHs for which we have determined the co-located status, our preliminary data analysis shows that 141 (or 67 percent) are co-located.¹⁷ Only 44 of these 141 LTCHs had notified their claims processing contractor of their co-located status. Consequently, at least 97 co-located LTCHs (46 percent of the 211 LTCHs) had not, according to contractor responses, notified their respective claims processing contractors of their co-located status. This inaccurate data on LTCHs' co-located status could result in overpayments if these LTCHs exceeded the readmission threshold for either payment policy.

CONCLUSION

Not all co-located LTCHs have notified their respective claims processing contractors of their co-located status. Specifically, nearly half of the 211 LTCHs whose co-located status we have determined have not reported this information to contractors. This prevents CMS from applying two payment policies specific to co-located providers and thus could result in Medicare overpaying for LTCH services. Claims processing contractors had information on 98 co-located LTCHs. Our preliminary analysis identifies an additional 97 co-located LTCHs that have not notified their contractors of their status.

We are providing this information at this time so CMS may begin addressing the inaccuracy of co-location information to avoid overpayments to co-located LTCHs. CMS could have claims processing contractors provide educational materials to LTCHs regarding this notification requirement. CMS or its contractors could also survey LTCHs on a recurring basis to identify co-located LTCHs and changes in co-located status. We will provide information to CMS on the 211 LTCHs whose co-located status we have determined thus far. Upon completion of our ongoing study entitled *Medicare Payments for Interrupted Stays in Long-Term Care Hospitals* (OEI-04-12-00490), we will provide additional information on this subject and make recommendations to CMS regarding the issues raised in this memorandum report.

This report is being issued directly in final form. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-04-12-00491 in all correspondence.

¹⁷ We have not yet identified the provider service areas in which these LTCHs are located.