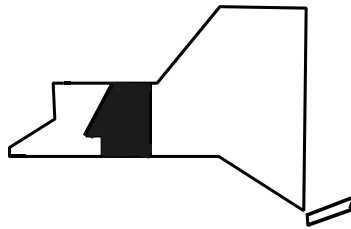


Non-Acute Patients in Acute Care Beds

**Rochester Hospitals
and
Nursing Homes
2004**



**Finger Lakes Health Systems Agency
1150 University Avenue
Rochester, New York 14607
April 2005**

Copyright, April 2005
by Finger Lakes Health Systems Agency
Rochester, NY 14607

The text of this publication, or any part thereof, may not be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording, storage in an information retrieval system, or otherwise, without the prior written permission of the Agency.

ACKNOWLEDGEMENT

The Finger Lakes Health Systems Agency and the Community Access Management Committee are grateful to the following hospitals and nursing homes that generously provided staff support for this study.

Nursing Homes

Arbor Hill Care Center
Hill Haven
Jewish Home of Rochester
Kirkhaven
Monroe Community Hospital SNF
Park Ridge Living Center
St. John's Home
The Highlands Living Center
The Friendly Home
The Hurlbut
The Highlands at Brighton
Woodside Manor

Hospitals

Highland Hospital
Park Ridge Hospital
Rochester General Hospital
Strong Memorial Hospital

Table of Contents

EXECUTIVE SUMMARY	i-iv
PROBLEM STATEMENT	1-3
STUDY FINDINGS	3-8
● Demographics of ALC Population	
● Reason for Initial Hospitalization	
● Hospital-Identified Barriers to Nursing Home Admissions	
● Nursing Home Reviews of ALC Patients	
● Nursing Home Capabilities	
● The Role of “System” Nursing Homes	
● Comparative Costs/Charges	
SOLUTIONS	9-13
● Symptomatic	
● Systemic	
CONCLUSION	14
APPENDICES	
● Methodology	
● Correlation of Hospital and Nursing Home Analysis of Barriers to Placement	
● Long Term Hospitals	
● Community Access Management Committee Roster	

Study of Non-Acute Patients in Acute Care Beds Rochester Hospitals and Nursing Homes, 2004

Executive Summary

On Wednesday, October 6, 2004, in a “snapshot” study by Rochester hospitals and nursing homes, there were 80 patients no longer in need of acute care (Alternate Level of Care {ALC} and other non-acute patients) occupying acute care beds in Rochester hospitals – 27 at Strong, 25 at Rochester General, and 14 each at Highland and Park Ridge. They had spent a total of over 4,000 patient days on ALC status.

Also on October 6, 2004, there were 80 “boarders”, patients who had been admitted to the hospital but for whom there was no bed available. Further, one of the hospital Emergency Rooms had declared “Code Red” and another was close to Code Red – meaning they were full and could not accept any more patients transported by ambulance.

THE PROBLEM

These patients to date had cost the hospitals approximately an additional \$3.2 million above reimbursement to care for as non-acute patients (\$3.8 million in cost, \$0.6 million in reimbursement). In 2004, ALC patients alone accounted for over 23,000 hospital patient days in Monroe County, resulting in an uncompensated cost of as much as \$15 million.

ALC and other non-acute patients are a substantial financial burden on hospitals and many nursing homes. More important than the cost to the health care system, however, is the fact that in a community wide hospital system with no excess hospital beds, patients are not getting the best possible care:

- ALC patients should more appropriately be in nursing homes that have the programs to address their non-acute health care needs;
- Boarder patients (patients who have been admitted to the hospital but who wait in emergency rooms, hospital hallways or in doubled up rooms until there is a bed/room) are best cared for on a defined inpatient unit;
- Emergency room patients have unnecessarily long, and often uncomfortable waits because emergency department beds are occupied by boarders;
- Patients brought to the hospital by ambulance are sometimes diverted to another hospital if the preferred hospital is in ‘Code Red’ due to the back log of patients.

Why don’t the hospitals simply discharge ALC and other non-acute patients to nursing homes or send them home?

- Non-acute patients, because of the type of health conditions they have (infectious disease, high pharmacy costs and behavioral problems), are difficult to place because they require special services and cannot be cared for at home.

- Non-acute patients are ‘expensive’ patients with higher than normal costs for such things as pharmacy, special services or the need for a private room because of their health condition(s). As a result, many nursing homes are unable to take these patients because the nursing home would not be adequately reimbursed and would lose more money than they could absorb.

What are solutions to the “ALC overcrowding” problem?

SYMPTOMATIC TREATMENT

1. Increase Emergency Department Capacity

To an extent, this is already happening in Monroe County, where all of the hospitals have undertaken or are in the process of undertaking expansions of their EDs and development of additional “observation” or “holding” beds. However, this solution does not improve the situation and care for the patient who is ‘boarded’ in the ED awaiting transfer to the next available inpatient bed.

2. Build more hospital beds

This solution, while alleviating at least on a short term basis the acute care capacity strain, is the most expensive solution and will likely lead to higher insurance premiums for everyone in the community. A minimal type expansion would cost as much as \$50 million in capital costs. As a solution, it still does nothing to address the issue of appropriate placement for ALC and other non-acute patients.

3. Build more nursing home beds

Nursing homes in Monroe County are currently functioning at about 95% capacity and theoretically should have been able to accept the non-acute patients on October 6. Analysis of the ALC problem clearly demonstrates that lack of bed availability is not the problem. Rather, the type of beds and reimbursement levels for nursing home care are at the root of the ALC problem.

SYSTEMIC SOLUTIONS

1. Reduce the incidence of nosocomial infections

The largest block of patients awaiting placement had infectious diseases. Hospitals need to reduce the number of patients acquiring infections in the facility.

2. Improve Linkages Between Hospitals and Nursing Homes

- **Reduce the barriers to admitting infectious disease patients to nursing homes**
This would include training programs for NH staff on the care of infected patients.

- **Reduce the barriers to admitting behavioral patients to nursing homes**
In addition to adding more specialty beds for behavioral patients, providers agree that training in the care of patients with behavioral problems and behavioral consultation arrangements would facilitate placement.
- **Permit the provision of hospital supplementation of NH capabilities**
The PATHWAYS demonstration program between Strong and Arbor Hill NH shows the potential power of this linkage.

3. **Enhance Post-Acute Clinical Capacities in Nursing Homes**

- **Develop more specialty nursing home beds**
Many of the ALC/non-acute patients awaiting placement required a specialty nursing home bed which was unavailable. Types of beds needed include:
 - **Ventilator beds**
 - **Behavioral beds** (Psycho-Geriatric designation)
 - **Private rooms**
- **Develop a long-term-care hospital or sub-acute units**
In communities outside of New York State patients with similar clinical profiles to the ALC patients in this study are cared for in specialty post-acute facilities or units.

4. **Correct the Reimbursement Inadequacies and Administrative Barriers of the Medicaid Program**

- **Provide Medicaid enhancements for the following special needs:**
 - **High pharmacy costs**
 - **Medically necessary private rooms, e.g., for infectious patients**
 - **Obese patients and other patients with special equipment needs**
 - **Nursing-related dialysis costs**
- **Resolve systemic problems of Medicaid as payer:**
 - **Establish disproportionate share payments for nursing homes with high volumes of Medicaid patients**
 - **Streamline and facilitate the application and recertification process**

CONCLUSION

Failure to address the causes of patients being ‘stuck’ in the hospital –

- Medically complicating nosocomial infections
- Inadequate nursing home reimbursement for medically complicated patients and
- Lack of sub-acute level of care
- Insufficient capacity of specialty nursing home beds

– place the entire health care system at risk both from a capacity and a financial standpoint.

At the same time patients are not receiving the best care possible. Non-acute patients are in hospital beds. Hospital patients are in doubled-up rooms or staying as boarders in emergency departments. ED patients experience long waits because ED beds are clogged with patients needing an inpatient bed.

The solutions need to be both general/state-wide, and specific to Monroe County. Some of the Monroe county solutions can be accomplished under present authority, for instance development of additional private rooms or outstationing Medicaid intake workers. Others, such as recognition of the additional costs of caring for bariatric patients, may best be accomplished under a demonstration program to reduce the state-wide cost of implementation.

The hospitals have developed responses to expand capacity, such as admitting patients to hallways (boarders). Their next response if none of the identified systemic solutions are applied will be to add more acute beds and bigger Emergency Departments. As has been previously stated, these “solutions” are expensive and fail to address the root causes of the problem.

Study of Non-Acute Patients in Acute Care Beds Rochester Hospitals¹ and Nursing Homes², 2004

Problem Statement

Since the realignment of services in 1999 between St. Mary's and Park Ridge Hospitals (net reduction of 127 acute beds) and closure in 2001 of the Genesee Hospital (loss of 388 acute beds), Monroe County hospitals generally are operating at or above capacity, yet many non-acute patients remain in acute hospital beds due to inability to discharge on a timely basis. Many of these patients have Alternative Level of Care (ALC) status³, but there are also patients who meet the criteria and standards of InterQual as being ready for discharge. With hospitals now operating at or above capacity – through the use of doubled-up rooms and inpatients being held in emergency departments because no bed is available (“boarders”) – the presence of ALC and other non-acute patients makes it difficult for them to serve their acute care patients. In addition to any quality of care issues, there are substantial financial implications to caring for patients in hospital beds – the most expensive site of care – when other care sites such as nursing homes could meet the patients clinical needs at a lower cost.

In 2004, ALC patients alone accounted for over 23,000 hospital patient days in Monroe County. These patients are costly to hospitals because reimbursement for them is low, and in high occupancy situations they may block other patients from being admitted to the hospital.

At the same time patients are not receiving the best care possible. ALC and other non-acute patients, who could be cared for in more appropriate and home-like settings where access to family and friends is greater, are in hospital beds. Hospital patients are in doubled-up rooms or staying as boarders in emergency departments. Emergency Department beds become clogged—a situation called Code Red—because patients awaiting an acute care bed have to be retained in the ED. Access to acute and emergency care is jeopardized.

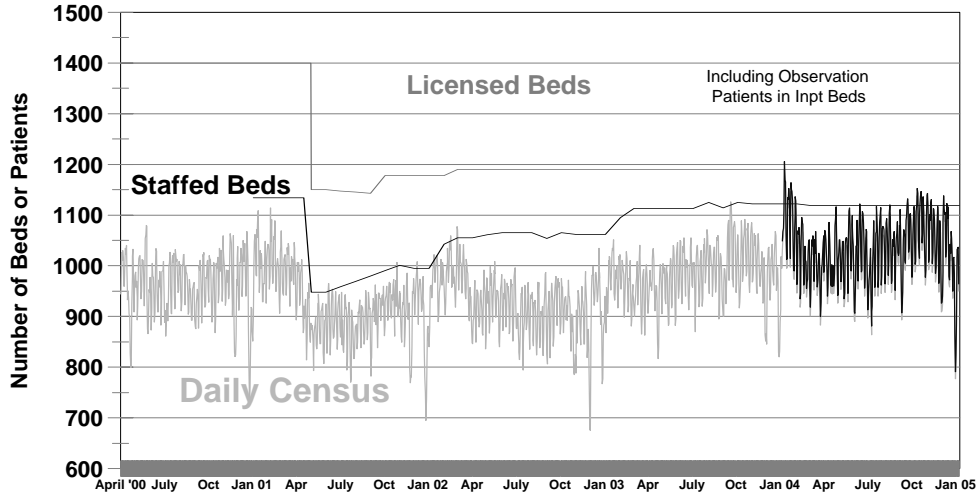
While the number of hospital beds in Monroe is now much closer to “need” than in former times, the hospitals struggle to accommodate seasonal variation in census, or substantial boarder and ALC census.

¹ Highland Hospital, Park Ridge Hospital, Rochester General Hospital, Strong Memorial Hospital

² Arbor Hill Care Center, Hill Haven, Jewish Home of Rochester, Kirkhaven, Monroe Community Hospital SNF, Park Ridge Living Center, St. John's Home, The Highlands Living Center, The Friendly Home, The Hurlbut, The Highland at Brighton, Woodside Manor

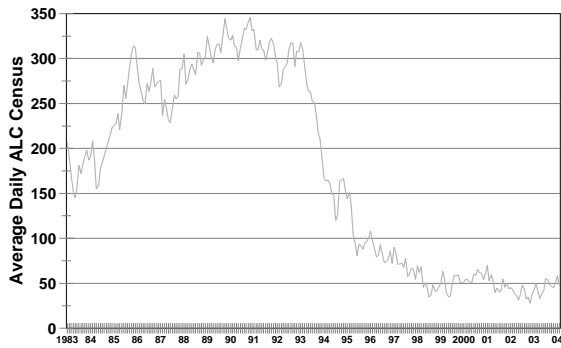
³ Alternative Level of Care (ALC) is formally a designation under the Medicare program, but there are other insurance companies who use similar criteria. ALC patients are patients occupying acute care hospital beds who no longer clinically require acute care services. They are generally awaiting admission to long term care services – usually in a long term care facility, but sometimes at home or at a psychiatric facility. For this project, non-acute patients were defined as “patients ready for hospital discharge, those who are hemodynamically stable, require daily skilled nursing services, and meet the InterQual Discharge Screens for alternate level of care.”

Daily Hospital Census vs. Capacity Rochester Hospitals, Med/Surg Beds

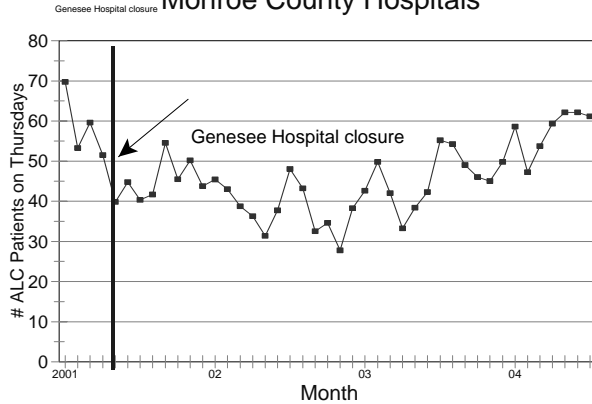


While ALC levels are significantly lower than in past times, they have been rising in the past three years.

**ALC Average Daily Census
Monroe Co. Hospitals, 1983-2003**



**Avg Daily ALC Patients
Monroe County Hospitals**



Average # ALC patients on Thursdays during the month
Source: Telephone survey of hospitals

In 2004, ALC patients alone effectively occupied 63 hospital beds on any given day. While the current number of ALC patients is not as great as it was 15 years ago, it is generally recognized that the individuals are now more difficult to place and have multiple barriers to placement.

On Wednesday, October 6, 2004, there were 80 patients no longer in need of acute care in acute care beds – 27 at Strong, 25 at Rochester General, and 14 each at Highland and Park Ridge. They had spent a total of over 4,000 patient days on ALC status (average ALC length of stay 50 days). These patients had cost the hospitals approximately \$3.8 million to care for as non-acute patients (and their discharges were yet to come), while reimbursement under Medicare and Medicaid had been approximately \$0.6 million; thus, the non-acute patients were not only being cared for at the wrong level of care, but they represented a financial burden to the hospitals.

The effect of having acute beds filled with non-acute patients spills over into the Emergency Department. Admitted patients are often held in the ED until an acute bed opens, effectively blocking the use of that ED bed for an emergency patient. This leads to the condition known as “Code Red”. On October 6, one hospital emergency room was “red” (meaning it could accommodate no more patients), one was “yellow” (meaning it was close to being unable to accommodate more patients), and two were “green.”

Thus, in a situation of tight bed supply and high occupancy, having non-acute patients in acute beds jeopardizes access to both acute care and emergency services.

Rochester hospitals and nursing homes sought to characterize the non-acute patients by taking a “snapshot” of patients awaiting placement on Wednesday, October 6, 2004. The purpose of this research was to identify barriers to discharge of non-acute patients to nursing homes, to identify mechanisms to facilitate more timely discharges, and to identify the costs associated with ALC and other non-acute patients in order to quantify the cost savings that could be realized if these patients were discharged sooner.

Study Findings

Demographics of the ALC Population

While the ALC/non-acute population is generally considered to be awaiting nursing home placement, its profile is substantially different from that of the Monroe County nursing home population. The table on the next page provides some statistics; summarized, they indicate a number of barriers to NH placement:

- **AGE**—The ALC population is substantially younger. Nursing homes often do not have appropriate services, such as activities programs, to care for younger patients.
- **GENDER**—There are substantially more males in the ALC population than in the average nursing home. This poses problems for placement in nursing homes, in that the homes must have either an open private room or a multi-bed room presently occupied by a male patient.
- **RACE/ETHNICITY**—The ALC population is more racially/ethnically diverse than the average nursing home patient population.
- **PAYOR**—While Medicare is the primary payor for most hospital care, Medicaid is expected to be the primary payor for the nursing home stay. Most providers think that Medicaid does not pay an adequate amount, and nursing homes limit their Medicaid patients and cross-subsidize from private-pay patients in order to survive financially.
- **NURSING HOME REIMBURSEMENT LEVEL (RUGs GROUP)**—For reimbursement purposes, nursing home patients are categorized into groups according to the intensity of their care (Resource Utilization Groups, or RUGs). Nursing homes are reimbursed based on the distribution of patients by group, the case-mix index; the higher the index, the greater the reimbursement. Lower-intensity patients are often deemed undesirable because their score is so low it pulls down the facility case-mix index and thus the nursing home’s reimbursement. Twenty percent of the ALC patients had low intensity RUGs scores.

Comparison of Non-Acute and Nursing Home Patients

<u>Characteristic</u>	<u>Hospital Non-Acute Patients</u>	<u>Nursing Home Patients</u>
Age	Average Age 63 years One-quarter 25 years old or less Less than one-half (45%) 65 years or older	93% 65 years or older
Gender	More than one-half (53%) are Male	75% are Female
Race/Ethnicity	64% White 30% Black 2% Hispanic 4% Asian	92% White 7% Black <1% Hispanic <1% Asian
Payor	For Hospital Stay: 71% Medicare and Medicare HMO One-quarter disabled <age 65 but Medicare For NH Stay: 65% Medicaid 25% Medicare for some part of admission 1 person LTC Insurance 1 person private pay	18% Medicaid or Medicaid/Medicare on admission 80% of total days paid by Medicaid
RUG Category	Case Mix Index 1.25 80% high intensity RUGs/20% low intensity	Average Case Mix Index 1.10

Reason for Initial Hospitalization

The reason for hospitalization of the non-acute patients (Working DRG) was quite varied. Infection-related causes (e.g., skin ulcer, cellulitis, septicemia) comprised the single largest category (25%). 10% were related to patients having ventilators or tracheostomies to assist with breathing. 10% were heart related; 5%, related to other parts of the circulatory system.

Hospital-Identified Barriers to Nursing Home Admissions

Hospital personnel identified up to three “barriers to length of stay management” for each individual on ALC/non-acute status. The barriers most identified (each for 20% or more of the patients) were infectious disease, uncooperative patient/family, Medicaid as payor, Medicaid pending, and behavioral problems. Only 1% of patients had an identified barrier of “custodial level of care,” reflecting the relatively high case-mix index of the ALC population.

<u>Barrier to Placement</u>	<u>% of Patients</u>
Infectious Disease	29%
Medicaid Pending	23%
Medicaid as Payor	24%
Medicaid Pending	23%
Uncooperative Pt/ Family	24%
Behavioral Problems	20%
Ventilator/ Respiratory equip	16%
Wound Care	16%
Pharmaceutical Cost	14%
Dialysis	14%
Young Age	13%
No bed available	10%
History of Drugs/Alc.	9%
Guardianship Requirement	8%
Obesity	5%
Lack of home care	4%
Physical Restraint	1%
History of sexual abuse/ criminal record	1%
Custodial Level of Care	1%
Pending placement in group home	1%
Undocumented immigrant	1%

Nursing-Home Reviews of ALC Patients

Using the patient profiles provided by the hospitals and the Patient Review Instruments, participating nursing homes indicated reasons they could or could not admit patients.

For the nursing homes, care issues predominated as barriers to placement. Infectious disease was by far the most often cited barrier, identified twice as often as any other barrier. It was followed by Other, Behavioral Problems, and Ventilator/Respiratory Equipment. “Other” often included nursing home facilities/services that were not available, such as the need for whirlpool, nasogastric tubes, and PICC lines.

“No bed available” was used both for situations where the specific type of bed was not available (e.g., a male bed or a rehab bed) and for situations when the nursing home was 100% occupied. The type of nursing home bed was also an issue when other barriers were identified. For example, problems with infectious disease often had notes specifying “no private room available,” and one facility noted, while it serves patients with ventilator/respiratory problems, it had no ventilator beds available on October 6.

Nursing homes were much less likely than hospitals to identify Medicaid issues and uncooperative patient/family as issues. The fact they were asked to determine, *without considering reimbursement issues*, whether they could admit the patients, may account for the low rating Medicaid barriers received. Uncooperative patients and families (and guardianship) logically appear to be more problematic for hospitals than for nursing homes during the placement process.

<u>Barrier to Placement</u>	<u>% Patients Reviewed by Nursing Homes</u>
Infectious disease	41%
Other	29%
Behavioral problems	20%
Vent/resp equip	16%
No bed available	16%
Medicaid pending	8%
Medicaid as payor	8%
Hx of drugs/alcohol	8%
Uncooperative pt/fam	8%
Young pt age	8%
Custodial LOC	6%
Obesity	6%
Wound care	6%
Guardianship req	6%
Dialysis	4%
Physical restraint req	4%
Hx sex abuse/crime	2%

There was fairly good concordance between hospital and nursing home analysis of barriers to placement. See Appendix II.

Nursing Home Capabilities

While the Monroe long-term care system has approximately 5,500 nursing home beds, not all beds are available for all patients. Some of the ALC/non-acute patients could not be admitted due to lack of clinical capability. As the table below shows, there are some patients for whom there is a very limited supply of beds available. Beds for ventilator-dependent patients are the most constrained. In the table, derived from a survey of Monroe nursing homes, many facilities indicate that they are not able to admit specific types of patients under any circumstances. Other facilities indicate they could admit, but with limits or conditions on the specific patients they could or would care for. Thus, 53% of nursing homes indicated they were not set up to care for bariatric (obese) patients. Another 10% said they could take overweight patients, but with a limit; often the limit was 300 pound weight. Over 90% of nursing home beds were not available, or were available with conditions, for those patients still in need of IVs. And while many facilities indicated an ability to care for a central (PICC) line, over 90% said they could not care of a patient on TPN (total parenteral nutrition, or intravenous feedings). It should be noted that hospital social workers indicate they experience far greater placement constraints than are portrayed by the chart.

MONROE NURSING HOME CAPABILITY PROFILE

	TOTAL BEDS	5,512	% OF TOTAL
<u>NUMBER UNABLE TO ADMIT PATIENTS WITH</u>			
IVs		3,758	68%
With limits on admissions		1,252	23%
TPN		4,951	90%
With limits on admissions		80	1%
Complex Wounds		2,695	49%
With limits on admissions		683	12%
Behavioral Problems		3,187	58%
With limits on admissions		1,136	21%
Vents		5,392	98%
With limits on admissions		240	4%
Bariatric		2,928	53%
With limits on admissions		570	10%
Dialysis *		1,924	35%
With limits on admissions		956	17%
Rehab		1,246	23%
With limits on admissions		378	7%
Other		2,340	42%
With limits on admissions		1,308	24%

Based on survey of Monroe Nursing Facilities, December 2004

* Assumes availability of external dialysis slot.

The Role of “System” Nursing Homes

All nursing facilities play a role in the long term care system, but those nursing homes which are owned or affiliated with the hospitals – Hill Haven for ViaHealth; the Highlands at Brighton and the Highlands Living Center for StrongHealth; Park Ridge, Park Hope, and E.T. Wilson Nursing Homes for Unity – play a special role of “pressure valve” for the hospitals. These facilities, which have a high level of clinical capability, often are requested to admit hard-to-place ALC patients. Given current reimbursement policies, these admissions may cost the nursing homes more than the reimbursement. However, the hospital systems calculate that the financial loss at the nursing home may be less than the loss at the hospital. Thus, hospital beds are freed for acute patients and difficult patients are placed at a more appropriate level of care, but at a financial cost. Also, the complexity of these patients tends to “fill” the system nursing homes, reducing their ability over time to take more patients and fulfill the pressure valve role.

Comparative Costs/charges

Expenses for patients were more than twice as high in the hospital as in the nursing home. If October 6 is a representative day, it would cost over \$15 million less per year to care for these patients in a nursing home than in a hospital.

<i>People with Financial Information from Both Hospital & NH</i>	Average Cost on 10/6/04		Aggregate Cost for 10/6/04		
	In the Hospital	In the Nursing Home	In the Hospital	In the Nursing Home	
All patients	\$956	\$402	\$76,519	\$32,197	n=80
Patients "accepted" by at least one nursing home	\$955	\$424	\$17,185	\$ 7,624	n=18

The average hospital charge⁴ for patients not able to be accepted clinically by any reviewing nursing home was \$1,604, 68% higher than those patients able to be accepted. This average, however, was driven by five patients with substantial dialysis and/or test (e.g., CT scan) charges/costs. The average hospital charges for the other 15 patients in this group was \$911.

⁴ Note Regarding Costs: Hospitals and nursing homes appear to have provided information which reflects “average costs” for the patients, rather than intensively-analyzed individual costs. Thus, for instance, a patient with ventilator needs was costed out at the average of patients on the ventilator service or nursing unit. This number would not necessarily reflect the specific cost of caring for that individual patient.

SOLUTIONS

What are possible solutions to this “ALC overcrowding” problem? Based on review of non-acute patients’ needs and barriers to acute discharge, a number of possible solutions were analyzed. Some of the “solutions” would address the symptoms, but not the causes, of non-acute patients occupying acute beds.

Symptomatic Solutions

- **Build more Emergency Department capacity.** To an extent, this is already happening in Monroe County, where all of the hospitals have undertaken or are in the process of undertaking expansions of their EDs and development of additional “observation” or “holding” beds. This is not the best solution from a patient care perspective – inpatients should be in inpatient beds, not holding beds. While only partially related to the ALC problems, the completed or anticipated ED expansions are expected to cost in the range of \$58 million in capital cost.
- **Build more hospital beds.** It is inappropriate to meet the needs of long term care patients by creating more hospital beds. However, one local hospital has already converted nursing units back to inpatient care use, at a capital cost of approximately \$6 million. All local hospitals have at times been at or above 100% occupancy of operational med/surg beds, and there is great pressure to provide relief from excessively high occupancy levels.

Based on local experience, the cost of renovating existing space for inpatient use is about \$150,000 per bed, but there are limited opportunities for such renovations. The cost of new construction for additional beds (assuming that infrastructure such as lab and dietary do not require expansion) appears to be in the range of \$400,000 to \$500,000 per bed. If one posited the need for 100 beds to care for the present ALC population reducing occupancy levels toward the 90% range, capital costs of \$13.5 million (if renovation space is available) to \$50,000 million (if new construction) would be required.

- **Build more nursing home beds.** This solution is unlikely. The current State need methodology indicates Monroe County has 450 more nursing home beds than it needs. Nursing home bed occupancy is at 95%; the state’s target occupancy is 97%-98%. More appropriate solutions would facilitate timely placement of ALC patients into existing empty nursing home beds.

SYSTEMIC SOLUTIONS

1. Reduce the incidence of nosocomial infections

Hospitals could make one of the single greatest contributions to alleviating the ALC problem by reducing the incidence of nosocomial infections. The single largest barrier identified by nursing homes in this study was infection. While some infections are acquired in the community, and some exist from previous encounters with the medical community, many

infections are nosocomial, that is hospital-acquired. Local facilities need to seek out best-practices and put in place techniques for avoiding nosocomial infections.

Some of that is already happening: Strong Memorial Hospital, for instance, has adopted a protocol to avoid ventilator-associated pneumonias, and has had no such cases in the past year. All three Monroe hospital systems are adopting other protocols sponsored by the Healthcare Association of New York State and the national Institute for Healthcare Improvement.

2. **Improve Linkages Between Hospitals and Nursing Homes**

- **Reduce the Barrier to Admitting Infectious Disease Patients to Nursing Homes**

While patients with infectious disease represent a substantial patient care challenge to nursing homes, area homes generally are capable of caring for such patients. There often is a “fear factor” which inhibits nursing homes’ acceptance of infectious disease patients. A training program for nursing home staff on how to care for infectious disease patients could reduce that factor, leading to facilitated placement. Such a training program could be produced by, for instance, the local infectious disease professional group, the Association of Practitioners in Infectious Diseases.

- **Reduce the Barriers to Admitting Behavioral Patients to Nursing Homes**

While certain patients with behavioral health problems require the high-intensity care of a psycho-geriatric unit, many have lesser problems and can be and often are cared for in the general nursing home unit. However, many nursing homes are reluctant to admit behavioral patients because, while the RUGs reimbursement system has separate rates for behavioral patients, those rates do not adequately recognize the extra nursing costs associated with care of behavioral patients. There is also a reluctance because some nursing home staff are unsure how to care for such patients.

A program of training and support through consultative agreements could be developed to facilitate care of behavioral patients in nursing homes.

- **Permit the provision of Hospital Supplementation of Nursing Home capabilities**

Strong presently has a demonstration program called PATHWAYS which allows it to provide special augmentation to nursing homes, such as placement of a behavioral health specialist; such augmentation is not usually allowed under Medicare and Medicaid regulations. If the PATHWAYS demonstration is successful, it could be extended to other facilities and for other augmentive services.

3. Enhance Post-Acute Clinical Capacities in Nursing Homes

- **Develop more specialty nursing home beds**

- **Ventilator beds.** While the existing nursing home with ventilator beds said it could clinically care for all but one of the non-acute ventilator patients (one with both ventilator and dialysis needs), there were no ventilator beds available at the facility. The NYS Department of Health recently approved development of 10 new Nursing Home-based ventilator beds at Unity's Genesee St. campus. Reimbursement arrangements are being sought which would allow the re-opening of 5 approved ventilator beds at Monroe Community Hospital; these are primarily for pediatric patients. The 80 non-acute patients on October 6 included 13 ventilator-dependent patients.
- **Behavioral beds** (Psycho-Geriatric designation). Approximately 20 percent of the non-acute patients exhibited behavioral problems which posed placement barriers. While most nursing homes can and do care for patients with mental disorders, nearly 80% of nursing homes indicate they are unable to admit, or admit in limited situations, patients with behavioral problems. Monroe County has 151 state-designated Psycho-Geriatric beds, which are generally 100% occupied, and by Department of Health calculation, has an unmet need for 10 more such beds.
- **Private rooms** Many of the responding nursing homes indicated they could clinically care for patients with antibiotic-resistant infections, but did not have a private room, or a bed in a room of an individual with a like infection, in which to place them. Infectious disease was cited by hospitals as a barrier to placement for 30% of patients, and cited by nursing homes for 40% of patients.

Present Medicaid reimbursement policies act as a barrier to conversion of existing rooms to private room configuration. While some local nursing homes have already increased their proportion of private rooms, either by renovation or by new construction, generally facilities are unwilling to convert multi-bed rooms to privates with the loss of total beds. Construction of new nursing home beds appears to cost \$125,00-\$150,000 per bed, so that solution is not without cost. Cost for renovation is presumed less than new construction, but is difficult to quantify. However, substantial increases in flexibility of use come with development of more private rooms.

- **Develop a long-term-care hospital or sub-acute units**

To date, there is not a level of care in New York called sub-acute. However, Medicare's Long-Term Care Hospital (LTCH) program provides an option with adequate reimbursement to support care for high cost/high complexity ALC and other non-acute patients.

Monroe Community Hospital is a community facility which has the potential of becoming an LTCH if regulatory and reimbursement issues are resolved. Even if just 15 to 20 beds of MCH's 565-bed capacity were converted to LTCH, there would be significant impact on the ALC/non-acute patient problem.

4. Correct the Reimbursement Inadequacies and Administrative Inefficiencies of the Medicaid Program

● **Resolve specific reimbursement barriers:**

- Pharmacy costs. A number of ALC and other non-acute patients cannot be placed because they have medication costs which are beyond what nursing homes can afford in their routine per diem reimbursement rate. The nursing homes indicate they receive only a few dollars per patient day to cover all medications. Some ALC patients have need for medications costing \$1,000 per month or more; nursing homes cannot absorb such costs, even under the principle that it will "average out" because of patients with lower medication costs.

The recently-adopted 2006 state budget calls for a total carve out of pharmacy costs from nursing home reimbursement. Regulations for the pharmacy carve-out should be expeditiously promulgated. The new Medicare Part D drug payment program may also have a substantial impact on how pharmaceutical costs are paid in nursing homes.

- Medically necessary private rooms, e.g., for infectious patients. The Medicaid reimbursement formulas for nursing homes do not recognize the extra costs of private rooms, even when medically necessary.
- Caring for obese patients and other patients with special equipment needs. The present nursing home reimbursement system does not recognize the extraordinary costs of caring for bariatric patients. These cost can include the expenses of special equipment such as heavy-duty beds and patient lifts, and alternating-pressure mattresses (generally rented at a cost of \$100s per day). It also does not recognize the increased nursing care costs, such as need for multiple staff to perform a patient lift usually performed by a single staff person. Nearly two-thirds of Monroe nursing homes indicated they could not care for bariatric patients.
- Nursing-related dialysis costs. While about one-half of Monroe facilities noted they could care for a patient needing dialysis services, and the cost of such services would be outside of the nursing home per diem, many also noted that the RUGS system does not adequately recognize the high level of nursing care required of such patients.

- **Resolve systemic problems of Medicaid as payer:**

The hospitals identified “Medicaid as payer” as a problem with one-quarter of the non-acute patients. The hospitals also identified Medicaid-pending as a placement problem for nearly another one-quarter of non-acute patients.

- Recognize the difficulties of facilities in meeting their budgets if they take large percentages of Medicaid patients, by providing special payments, similar to those provided to hospitals who care for a larger share of Medicaid payments (e.g., disproportionate share payments).
- Streamline the Medicaid application and recertification process to reduce the amount of time staff need to spend on this effort and to reduce the financial risk to facilities that take Medicaid-pending patients. Anecdotally, it can take up to four months to certify a patient for Medicaid eligibility for nursing home expenses. This puts the facility at risk in two ways: 1) When the patient is certified, the nursing home can bill Medicaid retroactively only for three months’ expenses, resulting in a period of unreimbursed expense; and 2) If the patient is deemed in-eligible, the facility is often without any recourse for reimbursement for the time the patient has been receiving services.
- Add mechanisms, such as 1) designating eligibility determination workers specific to nursing home determinations; 2) allowing presumptive eligibility based on a preliminary eligibility review; and 3) shorten the eligibility determination timeline and reduce the financial risk to nursing homes, facilitating nursing home placement.

On a demonstration basis, Monroe Department of Health and Human Services has out-stationed an eligibility worker at Strong to process Medicaid applications; this worker is underwritten by the hospital. The demonstration appears to have positive effects on length of time to complete the Medicaid eligibility process, and should be extended to the other hospitals.

CONCLUSION

In 2004, ALC patients accounted for over 23,000 hospital patient days in Monroe County. These patients are costly to hospitals because reimbursement for them is low, and in high occupancy situations they may block other patients from being admitted to the hospital.

From a State Medicaid financial perspective, caring for non-acute patients in acute beds does not impose much of a financial penalty. One local hospital, for instance, is paid just over \$150 per day for an ALC patient. The same patient would cost the Medicaid program about \$125 per day in a nursing home. However, in the current high hospital occupancy situation in Monroe County, the state, and society as a whole, is in jeopardy of incurring substantial costs to build and operate more hospital beds, at a capital cost of perhaps \$50 million, while area nursing homes have ample empty space.

At the same time patients are not receiving the best care possible. Non-acute patients, who could be cared for in more appropriate and home-like settings where access to family and friends is greater, are in hospital beds. Hospital patients are in doubled-up rooms or staying as boarders in emergency departments. ED patients are held awaiting an inpatient bed.

Some of the situations documented in this study, such as patients not able to get into nursing homes due to high medication costs, are applicable throughout the region and state. Other situations, such as the level of boarders, may be specific to Monroe County and its tight hospital bed supply. Thus, solutions need to be both general/state-wide, and specific to Monroe County. Some of the local solutions can be accomplished under present authority, for instance development of additional private rooms and psycho-geriatric specialty beds. Others, such as recognition of the additional costs of caring for bariatric patients, may best be accomplished under a demonstration program to reduce the state-wide cost of implementation.

The hospitals have developed responses to expand capacity, such as admitting patients to hallways (boarders). Their next response if none of the identified systemic solutions are applied will be to add more acute beds and bigger Emergency Departments. As has been previously stated, these “solutions” are expensive and fail to address the root causes of the problem.

On October 6, 2004, area hospitals and nursing homes took a “snapshot” of ALC and other non-acute patients in the hospitals on that day. Hospitals provided demographic, clinical and cost information on their non-acute patients. That information was then reviewed by a sample of eleven nursing homes to evaluate 1) if they had beds available to admit one or more of the non-acute patients; 2) if they had the mix of clinical skills needed to admit the patients; and 3) how much it would have cost to care for the patient, without regard to the present reimbursement which would be attached to the patient. Both hospitals and nursing homes determined the most important obstacles to hospital discharge and nursing home placement.

For each ALC/non-acute patient, the hospital provided a patient profile consisting of a social work assessment of the barriers to patient discharge, a copy of the Patient Review Instrument (PRI), and a listing of hospital costs (routine services, special services, pharmacy, ancillary testing) for that patient for October 6. Each profile was then sent to two participating nursing homes which were asked to evaluate admission of the patient *without regard to reimbursement issues*.

Eleven nursing homes agreed to participate in a review of the non-acute patients to determine whether, on October 6, given their open beds, staffing, and clinical capabilities, they could have admitted the patients. They were asked to make the “admission” determination *without consideration of reimbursement issues*.

On October 6, 2004, the 11 nursing homes participating in the review of the ALC patients had 89+ empty beds (out of a total of 2,861, a 96.9% occupancy rate; based on polling data, the rest of the local NH system has about a 96% occupancy rate, while the NYS Department of Health target occupancy for nursing homes is 98%).

Profiles of 51 patients were sent out,^{5, 6} each to two nursing homes. Of these 51 patients, 32 were unable to be admitted by any of the participating nursing homes; 19 were accepted by one home (and refused by any other homes reviewing them).⁷

Complete hospital “charge-master” data were available for 51 of the ALC patients. Nursing homes provided information on their costs for 27 of the patients reviewed.⁸ There were 27 patients with financial information from both hospitals and nursing home; 18 of these patients were “accepted” by at least one nursing home.

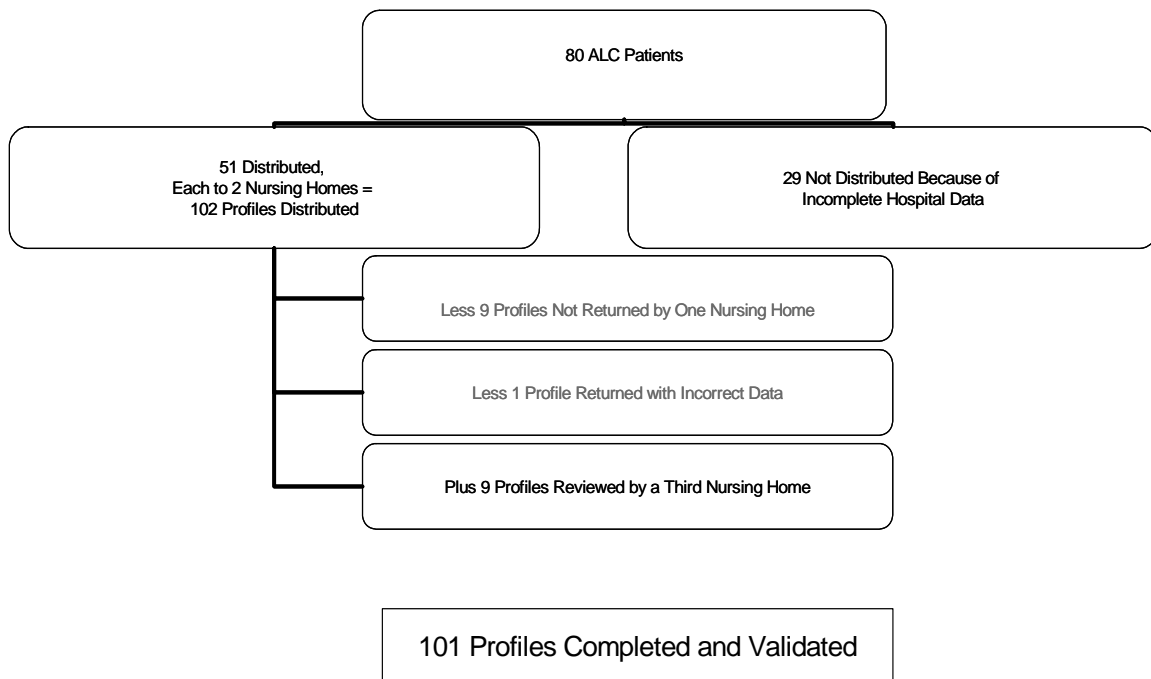
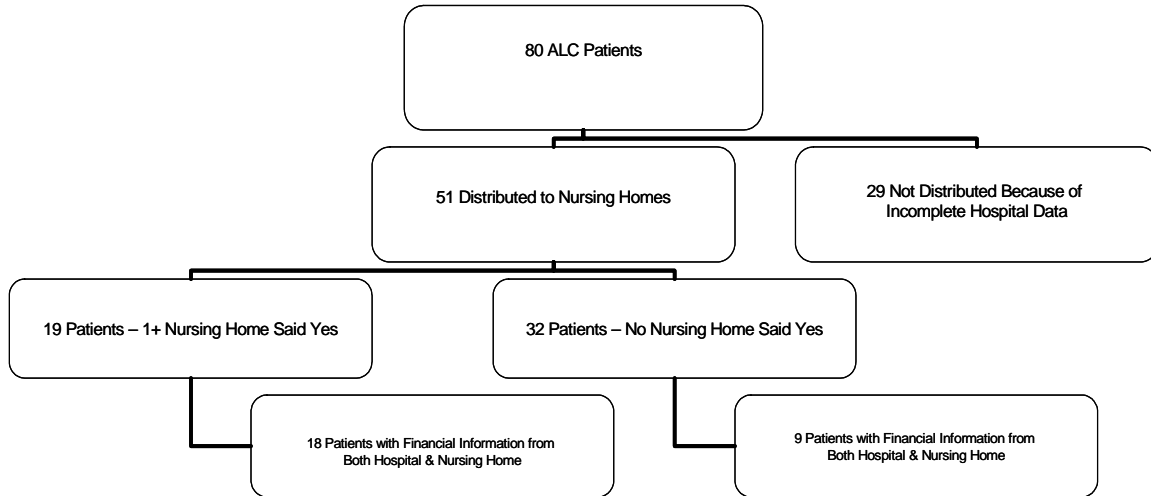
⁵The 29 patients for whom profiles were not sent had incomplete hospital information.

⁶Reviewed patients were similar to non-reviewed patients, except the reviewed patients had been on ALC status longer and were more likely to be female than the non-reviewed patients. It is difficult to determine if those differences would have had any effect on the ability of hospitals to place the patients. If the reviewed patients had been on ALC status longer than the total population, it may indicate they are inherently harder to place than the non-reviewed patients. On the other hand, the reviewed patients were more likely than the total population to be female, and, to the extent male beds are at a premium, may have been easier to place.

⁷One nursing home did not respond; one “system” had two of its nursing homes review each assigned patient profile. Therefore, patients were reviewed by from one to three nursing homes.

⁸Three nursing homes provided financial information on patients they would have been able to accept clinically had they had an appropriate empty bed.

The chart below indicates the number of patients analyzed at each step of the process.



Correlation of Hospital and Nursing Home Analysis of Barriers to Placement

Despite the fact that infectious disease is so often identified as a barrier to placement, both by hospitals and nursing homes, patients with infectious disease identified as a barrier by hospitals were as likely to be accepted by a nursing home as to be refused by a nursing home. Half of patients with a hospital-identified barrier of infectious disease were accepted by a nursing home, and half were rejected by all reviewing nursing homes.

Ventilator/respiratory equipment and behavioral problems identified by the hospital were much more likely to identify those patients accepted and those patients refused by nursing homes.⁹ Almost nine out of ten patients with ventilator/respiratory equipment and eight out of ten patients with behavioral problems were not accepted by a nursing home.

Hospital identified barriers to LOS management	All patients reviewed by NHs	Pts with at least one NH "yes"		Pts with NO NH "yes"	
		#	% of pts with this barrier	#	% of pts with this barrier
Medicaid pending	10	5	50%	5	50%
Medicaid as payor	6	2	33%	4	67%
Behavioral problems	9	2	22%	7	78%
History of drugs/alc.	5	1	20%	4	80%
Infectious disease	16	8	50%	8	50%
Pharmaceutical cost	9	3	33%	6	67%
Ventilator/respiratory equip	8	1	13%	7	88%
Uncooperative pt/family	14	6	43%	8	57%
Young age	9	4	44%	5	56%
Guardianship requirement	6	3	50%	3	50%
Dialysis	7	3	43%	4	57%
Wound care	8	3	38%	5	63%
Hx of sexual abuse/crime	1	0	0%	1	100%
Obesity	2	1	50%	1	50%
Other	4	0	0%	4	100%
Other	1	0	0%	1	100%

⁹History of drug/alcohol use also shows such differences, but the number of patients with such an identified problem is quite small.

Long-Term Hospitals

Medicare's Long-Term Care Hospital (LTCH) program provides substantial reimbursement (base reimbursement of \$35,000, rising as high as \$115,000 for certain DRGs), but requires a average post-acute length of stay of at least 25 days. As noted in the summary below of a report on LTCHs, MedPAC is very suspicious of LTCHs, seeing substantial potential for reimbursement abuse. MedPAC recommends to Congress and CMS that the program be sharply defined so that only patients who would truly benefit from that level of care would be admitted. It definitely will not remain a program for SNF-level care to be reimbursed at higher levels, as some proprietary companies have used it.

If all of the ALC patients on October 6 were treated in an LTCH, the expected average length of stay would be 26.7 days, with average reimbursement per case of \$35,630. However, those patients would only use 6 beds per day. If one selected only patients whose post-acute length of stay was expected to be 25 days or more, the ALOS would rise to nearly 35 days, the average reimbursement per case would be over \$50,000, but fewer than half of the "snapshot" patients would be selected, using 3 beds consistently over a year. There are more ALC patients during the year than just those observed on October 6 (perhaps 350/year), but it appears that an LTCH in Monroe County, with appropriate patient selection, would not be very large in bed-size (perhaps 15-20 beds).

MedPAC Report and Recommendations Concerning Long Term Care Hospitals

In June, 2004, the Medicare Payment Advisory Commission (MedPAC) submitted a *Report to Congress: New Approaches in Medicare*. Chapter 5 of the report deals exclusively with Long Term Care Hospitals, or LTCHs. While the report is only a set of recommendations at this time, it provides an indication of future changes in the LTCH program.

Findings:

- ◆ LTCH care is costly. The per case base rate is \$37,000 and payments can be as high as \$115,000 per case for the most complex patients.
- ◆ L-TCHs cost Medicare much more per episode than do alternative post-acute settings. For certain select patients, however, costs in LTCHs are equivalent to costs in alternative settings.

Payments usually are higher for long-term care hospitals than for other post-acute settings, fiscal year 2004

Principal Diagnosis	Per case payment for post-acute setting		
	Long-term care hospital	Inpatient rehabilitation facility*	Skilled nursing facility**
Tracheostomy w/ ventilator 96+ hours	\$115,463	\$ 26,051	\$ 10,051
Respiratory system with ventilator	74689	26051	7897
Major joint and limb replacement, low extremity	67104	17135	6165
Skin graft and wound debridement	48595	N/A	8111
Amputation	44983	33245	9590
Hip fracture	44633	18487	10618
Stroke	31496	34196	8905
Skin Ulcers	34704	N/A	8111
Septicemia	34340	N/A	8974
Osteomyelitis	29563	N/A	10416

Notes: N/A (not applicable)

*For inpatient rehabilitation facilities, payments are for the case-mix group with the lowest functional status and the most comorbidities. This seemed to be the most conservative comparison to LTCHs.

** For skilled nursing facilities (SNFs), payments are estimated based on the actual average length of stay by diagnosis (for the first SNF admission after hospital discharge) times the per diem rate for the case-mix group to which patients with that diagnosis are most likely to be assigned.

Source: Federal Registers; MedPAC analysis of 2001 claims from CMS

- ◆ With PPS in both hospitals and LTCHs, there is an incentive for hospitals to quickly transfer patients to LTCHs if they are likely to become high-cost outliers to avoid losses on these patients. LTCHs have an incentive to admit patients within a diagnosis who are likely to require the fewest resources.
- ◆ As the number of LTCHs increases nationally, facilities may find it increasingly difficult to find patients who truly require LTCH-level care; this would lead to an increase in lower severity patients being cared for in LTCHs and higher Medicare spending.
- ◆ Many recently-developed LTCHs are “hospitals within hospitals”. These appear to be especially vulnerable to manipulation and reimbursement abuse.
- ◆ The role of LTCHs is unclear, especially as some areas of the country have them but many markets do not. In markets without LTCHs, similar patients are cared for in hospitals step-down units, high-level-capability SNFs, or inpatient rehab facilities.
- ◆ LTCHs provide services to a small number of clinically complex patients

- respiratory
 - ventilator, including tracheostomy and ventilator weaning
 - infectious disease
 - wound care
 - rehabilitation
 - cardiovascular/peripheral vascular
- ◆ LTCH supporters maintain that other post-acute settings cannot substitute for long-term care hospitals and that LTCHs are different from other settings, especially SNFs.
- Have active daily physician involvement with patients
 - Have licensed nurse staffing of 6 to 10 hours per day per patient
 - Frequently employ specialist registered nurses
 - Employ physical, occupational, speech, and respiratory therapists
 - Have respiratory therapists available 24 hours per day
 - Have multi-disciplinary teams.

Recommendations:

- ◆ To assure that LTCHs serve patients for which the extra cost is justified, CMS should establish criteria which focus especially on patient needs, but in the interim also on facility characteristics. Facility criteria should include a patient review and evaluation process, a common patient assessment tool, and the availability of physicians and multi-disciplinary teams as well as the present criterion of average length of stay of more than 25 days. Patient criteria should include national admission and discharge criteria, such as InterQual Long-Term Acute Care Criteria, minimum staffing per patient day, high level patient severity within the case mix.

Admission criteria might include clinical characteristics such as specific heart, blood pressure or respiratory insufficiency rates; open wounds; third degree or necrotic wounds, specific conditions which require frequent blood product replacement, or active infection requiring prolonged treatment. Admission criteria might also include the need for specific treatments, such as continuous or frequent IV fluid or medication administration, telemetry or pulmonary monitoring, pulse oximetry, TPN or enteral feeding, continuous GI suction, complex wound care, chest tubes, or ventilator support.

- ◆ There are also shortcomings in the other payment systems which may inappropriately encourage the use of LTCHs. Refinements to the payment policies for SNFs and acute hospitals could ensure that payments more accurately reflect patients' resource needs, thereby encouraging providers to make placement decisions based on the clinical characteristics of the patient rather than financial considerations. Refinements to the SNF PPS could make SNFs financially neutral to treating medically complex patients (e.g., wound care, AIDS, ventilator-dependent patients) who could be appropriately treated in that lower-cost setting.

Summary of May 7, 2004 Regulations Medicare Program Prospective Payment System for Long-Term Care Hospitals

Legislative and Regulatory Authority

- To qualify for payment under the LTCH PPS, a hospital must have a provider agreement with Medicare and must have an average Medicare inpatient length of stay greater than 25 days (412.22e).
- LTCH qualification is based on the hospital's discharge data from its most recent cost reporting period and is effective at the start of the hospital's next cost reporting period (412.22e)
- LTCHs that exist as hospitals-within-hospitals or satellite facilities of LTCHs must also meet the criteria set forth in 412.22(e) or 412.22(h) for the LTCH to be excluded from the acute care hospital inpatient prospective amount.
- 412.22(h) defines a satellite as "a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital." Satellite arrangements exist when an IPPS excluded hospital or a hospital-within-a-hospital under 412.22 (e) that establishes an additional location by sharing space in a building also used by another hospital, or in one more entire buildings located on the same campus as buildings used by another hospital. It is necessary to ensure that the facility is, in fact, organized and operated as part of the IPPS-excluded hospital and is not simply a unit of the acute hospital with which it is co-located. The physical proximity inherent in such arrangements also has considerable potential for Medicare program payment abuse in that it may facilitate patient shifting for reasons related to payment rather than clinical benefits.
- Annual updated rates are now effective from July 1 to June 30 instead of from October 1 through September 30. This time period is referred to as a "long-term care hospital rate year."

Limitation on Charges to Beneficiaries

- LTCH may not bill a Medicare beneficiary for more than the deductible and coinsurance amounts.
- payments, the outlier threshold, the short-stay outlier policy for certain LTCHs, the transition period, and the budget neutrality factor.

LTC-DRG Classifications and Relative Weights

- LTCHs that have qualified to be paid under the LTCH PPS by having a provider agreement with Medicare and also having an average inpatient length of stay greater than 25 days use LTC-DRGs for billing purposes. The LTC-DRGs are derived from the inpatient DRG system. Generally under the LTCH PPS, Medicare payment is made at a predetermined specific rate for each discharge; that payment varies by the LTC-DRG to which a beneficiary's stay is assigned. Cases are classified into LTC-DRGs for payment based on the following six data elements:

- Principal diagnosis;
- Up to eight additional diagnoses;
- Up to six procedures performed;
- Age;
- Sex;
- Discharge status of the patient.

- In comparison, Medicare reimbursement to nursing homes under the prospective payment system is derived from RUG (Resource Utilization Groups) coding. RUGs flow from the Minimum Data Set (MDS). A resident is initially assigned to one of the seven major categories of RUGS based on their clinical characteristics and functional abilities. Upon completion of the MDS, Medicare residents are further classified into 1 of 44 minor RUGS categories.

- Each LTCH will receive a payment that represents an appropriate amount for the efficient delivery of care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. Therefore, adjustments are made to the standard Federal PPS rate by the LTC-DRG relative weights in determining payments to LTCHs for each case.

- By nature, LTCHs often specialize in certain areas, such as ventilator dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated to a large extent in hospitals that have, from a perspective of charges, relatively high (or low) charges. Such distribution of cases with relatively high (or low) charges in specific LTC-DRGs has the potential to inappropriately distort the measure of average charges. Thus, hospital-specific relative value method is used to calculate relative weights.

Changes to LTCH PPS Rates and Changes in Policy for 2005 LTCH PPS Rate Year

- New LTCHs (as defined at 412.23(e)(4)) are paid based on 100 percent of the Federal rate, with no phase-in transition payments.

- The standard Federal rate for the 2005 LTCH PPS rate year will increase 3.1 percent compared to the 2004 LTCH PPS rate year standard Federal rate.

- Adjustment is made for additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges.

- Providing additional payments for outliers strongly improves the accuracy of the LTCH PPS in determining resource costs at the patient and hospital level.

- As of August 8, 2003, a minimum cost-to-charge ratio threshold (floor) is no longer applicable. However, if a LTCH's cost-to-charge ratio is above the ceiling, the applicable statewide average cost-to-charge ratio is assigned to the LTCH.

- **Short outlier cases:**

- A short-stay outlier case may occur when a beneficiary receives less than the full course of treatment at the LTCH before being discharged. These patients may be discharged to another site of care or they may be discharged and not readmitted because they no longer require treatment. Furthermore, patients may expire early in their LTCH stay.
- If the costs exceeded the outlier threshold (that is, the short-stay outlier payment plus the fixed-loss amount), the discharge would be eligible for payment as a high-cost outlier. Thus, for a short-stay outlier case in 2005 LTCH PPS rate year, the high-cost outlier payment will be 80% of the difference between the estimated cost of the case and the outlier threshold (the sum of the fixed-loss amount of \$17,864 and the amount paid under the short-stay outlier policy).
- Adjustments are made per discharge payment to the least of 120% of the LTC-DRG specific per diem amount multiplied by the length of stay of that discharge, or the full LTC-DRG payment, for all cases with a length of stay up to and including five-sixths of the geometric average length of stay of the LTC-DRG.
- “Interruption of a stay” is a stay at a LTCH during which a Medicare inpatient is transferred upon discharge to an acute care hospital, an IRF, or a SNF for treatment or services that are not available in the LTCH and returns to the same LTCH within applicable fixed-day periods. Transfers to swing beds are included under this policy.
- An interrupted stay is treated as one discharge from the LTCH. The day-count of the applicable fixed-day period of an interrupted stay begins on the day of discharge from the LTCH (which is also the day of admission to the other site of care). For a discharge to an acute care hospital, the applicable fixed-day period is 9 days, for an IRF, 27 days, and for a SNF, 45 days. The counting of days begins on the day of discharge from the LTCH and ends on the 9th, 27th, or 45th day for an acute care hospital, an IRF, or a SNF, respectively, after the discharge.
- If a patient is readmitted to the LTCH within the fixed-day threshold, return to the LTCH is considered a part of the first admission and only a single LTCH PPS payment will be made.
- Existing regulations require a LTCH to furnish all necessary covered services for a Medicare beneficiary who is an inpatient of the hospital either directly or under arrangements.
- When services are rendered under arrangements, Medicare payments made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for those services.
- If services that should have been furnished directly or under arrangements by the LTCH are instead unbundled and billed separately, Medicare would pay the other provider for the service that should have been paid “under arrangements” by the LTCH.
- A discharge for outpatient services and a subsequent readmission to the LTCH is not currently covered under the interrupted stay policy. If such a scenario occurs, after making a LTCH PPS payment for the first discharge, there would be a second Medicare payment to the LTCH when the patient is finally discharged.

- In the January 30, 2004 proposed rule will address this type of concern by revising current definition of an interrupted stay. Revision to include adding situations in which a patient is discharged from the LTCH and readmitted to the same LTCH within 3 days of the discharge. If a patient is discharged from a LTCH for any reason to an acute care hospital, IRF, SNF, or home, and is then readmitted within 3 days, in general, the patient's original admitting diagnoses would not change significantly during those 3 days. Therefore a readmission would not constitute a new episode of care.
- If following discharge from a LTCH, and treatment or services as an inpatient at acute care hospital, IRF, or SNF for greater than 3 days, but less than the interrupted stay threshold for the provider type (9, 27, or 45 days respectively), when the patient is readmitted to the LTCH, only one payment would be made to the LTCH, but the intervening provider may also submit a Medicare claim for that patient. Moreover, if the patient's stay at the intervening provider exceeds the threshold, a readmission to the LTCH will be counted as a new stay for each provider.
- Medicare will pay one LTC-DRG payment to the LTCH and the LTCH would be responsible for paying the acute care hospital for the costs of the tests which should have been provided under arrangements by the LTCH.
- Exception to the general 3-day or less rule for the 2005 LTCH PPS rate year to the payment policy in the event that during an up to 3-day interruption a LTCH patient receives treatment in an acute care hospital that results in the case being grouped to the surgical DRG. For this limited instance, the acute hospital is able to bill separately for the discharge that is grouped to a surgical DRG.

Satellite Facility or a Remote Location to Qualify as a LTCH

- Satellite facility is defined as “a part of a hospital that provides inpatient services in a building also used by another hospital or in one or more entire buildings located on the same campus as buildings used by another hospital.”
- Satellite arrangements exist when an IPPS excluded hospital is either a freestanding hospital or a hospital-within-a-hospital under 412.22(e) that establishes an additional location by sharing space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital.
- A satellite facility is not considered a separate hospital under Medicare. If a LTCH with a satellite facility is interested in “spinning off” the satellite facility and establishing the previous satellite facility as an independent LTCH, the satellite must first be separately licensed by the State.

COMMUNITY ACCESS MANAGEMENT COMMITTEE

Nancy Adams
Executive Director
Monroe County Medical Society

Cindy Becker
Vice President
Patient Care Services
Highland Hospital of Rochester

Martin Carlin
President
Unity Health System
Park Ridge Hospital

Mark Cronin
Vice President, Provider Relations
Rochester Individual Practice Association

Timothy Czapranski
Director
Monroe County EMS Office

Kenneth L. Dean
Special Assistant to the Mayor
City Hall

Bonnie DeVinney
Executive Director
Finger Lakes Health Systems Agency

James DeVoe
Administrator
Kirkhaven Nursing Home

Andrew S. Doniger, MD
Director
Monroe County Department of
Public Health

Sherry Emrich, RN
Consultant Nurse
NYS Department of Health

Richard Gangemi, MD
Senior VP for Academic & Medical
Affairs for ViaHealth
Rochester General Hospital

James Garnham
Rochester Health Commission

William Hoogland
Program Director
NYS Department of Health/
Western Regional Office

Robert W. Hurlbut
Rohm Services

Jodi A. Lubba
Director, Care Managed Services
Greater Rochester Independent
Practice Association

Christopher O'Donnell
Vice President of Network Management
Excellus, BlueCross BlueShield
of the Rochester Region

Kathleen Parrinello
Chief Operating Officer
Strong Health

Kathleen C. Plum, Ph.D., RN
Director
Monroe County Office of Mental Health

Stephanie Salmon
Preferred Care
Contract Representative

Edward Sassaman, MD
Corporate Medical Affairs
BlueCross BlueShield
of the Rochester Region

Page -2-

Susan Saunders
Director of Strong Health Care Management
Strong Memorial Hospital

Arthur Streeter
Assistant Director
Finger Lakes Health Systems Agency

Carol Tegas
Network Relations Representative
Rochester Community IPA

Robert H. Thompson
President/CEO
Monroe Plan for Medical Care

Deborah T. Zimmermann, MS, RN
Vice President, Clinical Operations
Via/Health/Rochester General Hospital