

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**LONG-TERM CARE
HOSPITALS-WITHIN-HOSPITALS**



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⚡ A B S T R A C T

Medicare regulations define long-term care hospitals as having an average length of stay greater than 25 days. Medicare excludes these hospitals from the acute care hospital prospective payment system. Long-term care hospitals-within-hospitals (HwHs) are physically located inside acute care hospitals (host hospitals). The co-location of an HwH and its host hospital creates potentially inappropriate financial incentives. As a result, the Centers for Medicare & Medicaid Services (CMS) imposes payment limits on HwHs that readmit more than 5 percent of patients discharged to their host hospitals over the course of the HwH's fiscal year. CMS also requires that HwHs be organizationally and financially independent from their hosts.

We found that 19 of 87 HwHs exceeded the annual 5 percent threshold for readmissions from their host hospitals at least once during their fiscal years ending in September 2000 through December 2002. Currently, CMS lacks a system to detect readmissions over the 5 percent threshold. Many of these readmissions involved high cost diagnosis-related groups (DRGs). As Medicare's prospective payment system for long-term care hospitals is fully implemented, paying HwHs that are over the 5 percent readmission level could result in increased costs to the Medicare program.

In addition, CMS has no ongoing mechanism to determine whether HwHs are financially and organizationally separate from their host hospitals.

We recommend that (1) CMS develop a system to monitor HwHs' compliance with the 5 percent readmission rule, and (2) CMS require HwHs to demonstrate their organizational and financial independence on a continuing basis.

In its response to our draft report, CMS generally supports our findings and the thrust of our recommendations. The agency indicated that it is moving forward with programs to address the concerns that we identified.

OBJECTIVES

To assess the rate at which long-term care hospitals-within-hospitals readmit patients discharged to their host hospitals, and whether that rate exceeds the 5 percent threshold for full Medicare reimbursement.

To document the nature and extent of the Centers for Medicare & Medicaid Services's (CMS's) controls to determine if hospitals-within-hospitals meet the criteria for exclusion from the Medicare acute care hospital prospective payment system (PPS).

BACKGROUND

Medicare regulations require that long-term care hospitals have an average length of stay greater than 25 days. Medicare excludes these hospitals from the acute care hospital PPS. Long-term care hospitals-within-hospitals (HwHs) are physically located inside acute care hospitals (host hospitals). Between 1995 and 2002, the number of HwHs quadrupled from 32 to 132, while Medicare payments to them rose from \$135 million to \$817 million. Medicare beneficiaries treated in HwHs increased 7-fold, to over 34,000.

The co-location of an HwH and its host raises concerns about potentially inappropriate financial incentives. For example, the proximity of an HwH and its host creates an incentive for an HwH to discharge patients to the host hospital and then readmit the same patient for additional care. The HwH would receive two separate Medicare payments—one for each admission—and the host hospital would also receive a payment. The co-location of the HwH and its host also raises concerns about the degree to which transactions between them are conducted on an arms-length basis.

As a result of these concerns, CMS set out specific regulatory requirements for HwHs. An HwH that readmits more than 5 percent of its patients from its host over the course of a fiscal year faces limits on the Medicare payments it receives. Under the cost-based payment system, in effect prior to October 2002, HwHs over the 5 percent readmission threshold were paid on the basis of their average cost per discharge, up to a ceiling amount. Under the new long-term care hospital PPS, if an HwH's readmission rate exceeds 5 percent, the HwH would receive only one DRG payment per patient for all admissions from the host hospital regardless of the number of readmissions from the host hospital. This payment limitation applies to the fiscal year in

which the HwH exceeded the 5 percent threshold. CMS also requires that an HwH meet specific organizational and financial criteria in order to be excluded from the acute care hospital PPS.

We determined readmission rates through analysis of Medicare's 100 Percent Inpatient Hospital File. We reviewed files on 80 HwHs at 2 CMS regional offices and the fiscal intermediary that serves the majority of HwHs. We also interviewed staff from CMS central office and four regional offices, three fiscal intermediaries, and three national long-term care hospital chains.

Our inspection focused on HwHs established from October 1995 to January 2002. Our analysis of readmission rates examined admissions for fiscal years beginning in October 1999 through January 2002, when HwHs were paid under a cost-based system. During this period, HwHs were supposed to face financial penalties in their cost report settlement if they exceeded the 5 percent readmission threshold. Because HwHs faced this threshold under the cost-based system, it is useful to examine how HwHs responded to the threshold as a potential predictor of behavior under the new PPS system.

FINDINGS

Nineteen of 87 HwHs exceeded the annual 5 percent threshold for readmissions from their host hospitals at least once during their fiscal years ending in September 2000 through December 2002.

Because HwH fiscal years commence at the beginning of different months, the available data allow us to analyze complete 2000 and 2001 fiscal years, and a subset of 2002 fiscal year data. This subset of fiscal year 2002 data comprises those HwHs with fiscal years ending between September and December 2002. Nine HwHs exceeded the 5 percent threshold in multiple fiscal years, including two that exceeded it in all 3 years of our analysis.

CMS lacks a system to detect readmissions over the 5 percent threshold.

CMS has not made monitoring readmissions a priority. Cost reports do not contain data necessary to monitor readmissions. Many HwHs and host hospitals have different fiscal intermediaries and different fiscal years, so intermediaries do not have access to data needed to verify readmission rates. The cost reports for HwHs have not yet been settled for fiscal years since the 5 percent readmission threshold was imposed in 1999. As a result, at this point in time we

cannot determine whether the appropriate adjustments in payments to HwHs have been or will be made.

Many readmissions in the hospitals-within-hospitals over the 5 percent threshold involved high cost diagnosis-related groups.

As Medicare's PPS for long-term care hospitals is fully implemented, paying HwHs that are over the 5 percent readmission level could result in increased costs to the Medicare program. In our analysis of fiscal years 2000 and 2001 data, and a subset of fiscal year 2002 data, three high cost diagnosis-related groups (DRGs) dominated in HwHs over the 5 percent readmission threshold. In addition to having a higher base payment under the long-term care hospital PPS than under the acute care PPS, all three of these DRGs are multiplied by relative weights greater than 1.0, with two of the DRGs having weights greater than 2.0. The high cost of these DRGs is exacerbated when a patient is readmitted, because two DRG payments are made to the HwH.

CMS provides limited oversight of hospital-within-hospital compliance with the exclusion criteria.

CMS requires HwHs to demonstrate annual compliance with the 25-day average-length-of-stay criterion in order to maintain their status as long-term care hospitals. However, CMS has no ongoing mechanism to determine whether HwHs are meeting the organizational or financial independence criteria. Further, HwHs self-report data, which CMS does not independently verify.

RECOMMENDATIONS

The potential for improper Medicare payments to HwHs due to their co-location with host hospitals makes strong oversight critical. We found that CMS lacks such oversight of HwHs, creating a vulnerability for the Medicare program. Therefore, we recommend that CMS:

Develop a system to monitor hospital-within-hospital compliance with the 5 percent readmission threshold.

- CMS could require HwHs to submit annual discharge, admissions, and readmissions data to their fiscal intermediaries.
- CMS could use that data to monitor HwH's readmission rates.
- CMS could develop a system to facilitate data sharing between fiscal intermediaries.

Require hospitals-within-hospitals to demonstrate ongoing compliance with the organizational and financial independence criteria.

- CMS could specify what supporting documentation HwHs must submit to demonstrate ongoing organizational independence.
- CMS could require HwHs to submit financial independence data annually to their fiscal intermediaries.
- CMS could conduct a focused review of a sample of HwHs to assess their compliance with the exclusion criteria.

AGENCY COMMENTS

We received comments on our draft report from the Centers for Medicare and Medicaid Services (CMS). CMS generally supports our findings and the general thrust of our recommendations. The agency indicates that it is moving forward with programs to address the concerns that we identified.

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OBJECTIVES

To assess the rate at which long-term care hospitals-within-hospitals readmit patients discharged to their host hospitals, and whether that rate exceeds the 5 percent threshold for full Medicare reimbursement.

To document the nature and extent of the Centers for Medicare & Medicaid Services's controls to determine if hospitals-within-hospitals meet the criteria for exclusion from the Medicare acute care hospital prospective payment system (PPS).

BACKGROUND

Long-Term Care Hospitals

Medicare regulations require that long-term care hospitals have an average length of stay greater than 25 days.¹ These hospitals focus on patients with medically complex conditions or multiple conditions (comorbidities). Types of patients treated in long-term care hospitals include those who are ventilator dependent, need multiple rehabilitative therapies, suffer from organ failure, or have infectious diseases.

A long-term care hospital must first operate as a Medicare-certified acute care hospital for at least 6 months. After 6 months, the hospital may apply to be reclassified as a long-term care hospital. The Centers for Medicare & Medicaid Services (CMS) determines the status of a long-term care hospital at the beginning of each subsequent annual cost reporting period.²

Hospitals-within-Hospitals: Hospitals-within-hospitals (HwHs) are physically located inside an acute care hospital, referred to as the host hospital. The vast majority of HwHs are long-term care hospitals; in this report, our use of the term HwH refers only to long-term care HwHs. Typically, an HwH leases unused space from the host hospital. Even though an HwH is located in the same building as its host, it is a separate hospital, organizationally independent from its host, with its own Medicare provider number, not a unit of the host hospital. Regulatory requirements for HwHs are found at 42 C.F.R. § 412.22.

Reimbursement Policies: Long-term care hospitals generally treat medically complex patients with long stays. As a result, CMS excludes them from the acute care hospital PPS. Prior to October 1, 2002, CMS paid all long-term care hospitals on a cost basis, up to a ceiling based on costs per discharge. CMS is currently phasing in a long-term care

hospital PPS that uses diagnosis-related groups (DRGs). These DRGs are identical to the acute care hospital DRGs. However, CMS applies a larger base payment and generally higher relative weights to the long-term care hospital DRGs, thus taking into account the specialized care offered by long-term care hospitals.

Rapid growth: Over the past decade, long-term care hospitals have grown more rapidly than any other post-acute setting. From 1995 to 2002, Medicare payments to long-term care hospitals and the number of beneficiaries treated in that setting more than doubled (see Table 1). The number of facilities increased by over 100, from 178 to 295.

Table 1						
Growth of Long-term Care Hospitals (LTCHs) and Hospitals-within-Hospitals (HwHs)						
1995-2002						
	Medicare Payments (\$ Millions)		Number of Facilities		Medicare Beneficiaries Discharged	
	1995	2002	1995	2002	1995	2002
All LTCHs*	\$836	\$2,193	178	295	42,339	98,678
HwHs (% of all LTCHs)	\$135 (16%)	\$817 (37%)	32 (18%)	132 (45%)	4,621 (11%)	34,592 (35%)
* includes HwHs and freestanding LTCHs						
Data sources: CMS's HCFA Customer Information System (HCIS) and OIG analysis of HwHs						

HwHs account for much of the growth in long-term care hospitals. Between 1995 and 2002, the number of HwHs more than quadrupled, from 32 to 132. In 1995, HwHs constituted 18 percent of all long-term care hospitals; by 2002 they comprised 45 percent. Similarly, Medicare payments to them rose from \$135 million (16 percent of payments to all long-term care hospitals) to \$817 million (37 percent of all long-term care hospital payments). Between 1995 and 2002, the number of beneficiaries treated in HwHs increased 7-fold, from just under 5,000 to over 34,000. Our interviews with industry observers, both among providers and in Government, suggest that these trends will continue.

Concerns About Hospitals-within-Hospitals

Relationship with Host Hospital: Hospitals, including HwHs, accept overall responsibility for a patient’s care and furnish all services required. The hospital discharges a patient only after completing the full course of treatment.

The co-location of an HwH and its host raises concerns about potentially inappropriate financial incentives. For example, the proximity of an HwH and its host creates an incentive for an HwH to discharge patients to the host hospital and then readmit them for additional care. The HwH would receive two separate Medicare payments—one for each admission—and the host hospital would also receive a payment.

Furthermore, the payment system creates a financial incentive for the host hospital to transfer patients to the HwH without having completed a full course of treatment. In those cases, Medicare would make two payments for the same patient: the host hospital would receive full payment, even if it had not completed the full course of treatment; and the HwH also would receive full payment for the care it provides.

Finally, the co-location of an HwH and its host raises concerns about the degree to which they operate as separate facilities. These concerns include whether management decisions, such as lease agreements and purchase of services, are arms-length transactions based on fair market value.

Aggressive marketing to acute care hospitals: Many HwHs are part of chain organizations that aggressively market their services to potential hosts. We reviewed web sites and marketing materials of several chain organizations and found they stress the financial incentives described above. These materials include the following claims:

- A host hospital will have “increased cash flow by realizing lease and purchased services revenue” from an HwH.
- A host can gain as much as \$1.8 million per year in extra revenues though partnering with an HwH.
- An HwH offers “solutions to problems that are faced daily, including large outlier financial costs and financial losses from Medicare PPS restrictions.”

CMS’s Hospital-within-Hospital Regulations

Because of the concerns described above, CMS issued regulations that address the readmission of patients from the host hospital to the HwH,

as well as the organizational and financial independence of the HwH from the host hospital.

5 Percent Readmission Threshold: CMS addressed the vulnerability presented by readmissions from the host hospital in a 1999 regulation. This regulation allows—over the course of an HwH’s fiscal year—up to 5 percent of discharges from the HwH to its host to be readmitted to the HwH without an intervening discharge to another setting. Under the cost-based system in effect prior to October 2002, HwHs were paid on the basis of their average cost per discharge, up to a ceiling amount. CMS set the ceiling rate at \$39,850 for HwH fiscal years beginning on or after October 1, 1999; \$41,745 for years beginning on or after October 1, 2000; and \$44,009 for years beginning on or after October 1, 2001. Payments to HwHs exceeding the 5 percent threshold were to be decreased by excluding all readmissions from the host from the calculation of the average cost per discharge regardless of the number of readmissions from the host hospital. This payment limitation applies to the fiscal year in which the HwH exceeds the 5 percent threshold.³

Effective for fiscal years beginning October 1, 2002, all long-term care hospitals, including HwHs, are being paid under a new long-term care PPS. The new PPS, which uses DRGs for payment, is being phased in over a 5-year period. Under the new PPS, if the readmission rate exceeds 5 percent over the course of an HwH’s fiscal year, the HwH would receive only one DRG payment per patient for all admissions from the host hospital regardless of the number of readmissions from the host hospital. This payment limitation applies to the fiscal year in which the HwH exceeds the 5 percent threshold.⁴

Exclusion Criteria: In a 1995 regulation, CMS required that HwHs meet three criteria to be excluded from Medicare’s acute care hospital PPS.

1. Average length of stay. HwHs must maintain an average length of stay greater than 25 days. This is required of all long-term care hospitals.
2. Organizational independence. The organizational independence criterion is designed to ensure that an HwH operates as an independent hospital, rather than just a unit of a host hospital.⁵ They must keep the following administrative components separate from their hosts:
 - *Governing body.* The governing body must not be under the control of the host or a third party with control of both hospitals.

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- *Chief medical officer.* The chief medical officer must not be employed by, or under contract with, the host or a third party with control of both hospitals.
- *Medical staff.* The medical staff must be directly accountable to the HwH governing body. The medical staff adopts and enforces bylaws governing medical staff activities. It is also involved in the granting of privileges to individual practitioners.
- *Chief executive officer.* The chief executive officer must not be employed by, or under contract with, the host or a third party with control of both hospitals.

Medicare regulations define control to exist “if an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.”⁶

3. Financial independence. The financial independence criterion is intended to address incentives that could lead to unnecessary transfer of patients from the host hospital or excessive purchase of services from the host hospital.⁷ HwHs must meet one of three criteria:

- They must perform basic hospital functions (quality assurance, medical staffing, utilization review, infection control, and nursing, medical record, pharmacy, radiology, and laboratory services) independently from the host.
- The costs of services purchased from the host hospital must be no more than 15 percent of the HwH’s total inpatient operating costs.
- At least 75 percent of the HwH’s inpatient population must come from a source other than the host hospital.

HwHs in operation prior to October 1995 do not need to meet the organizational or financial independence criteria.⁸

SCOPE AND METHODOLOGY

This inspection focuses on HwHs established between October 1995 and January 2002. HwHs established before October 1995, while still subject to the 5 percent readmission threshold, are not required to meet CMS’s organizational and financial independence criteria. As of October 1995, 32 HwHs were in operation and are exempt from these criteria. We do not include those 32 HwHs in our analysis.

Because CMS data systems do not identify the universe of HwHs, we first developed our own list. We obtained a listing of all long-term care and acute care hospitals from CMS's Online Survey Certification and Reporting (OSCAR) system. We then matched addresses of long-term care hospitals and acute care hospitals. If we could not make an exact match, we used the Internet to identify which long-term care hospitals were HwHs. We did this by visiting long-term care hospital web sites, host hospital sites, industry-related sites, news sites, HwH chain organization sites, and mapping sites to determine which long-term care hospitals were HwHs. When we could not determine whether a long-term care hospital was an HwH, we contacted the facility directly.

Our analysis identified 87 HwHs beginning operation between October 1995 and January 2002.

Compliance with 5 percent readmission threshold: This analysis focused on assessing compliance with requirements that payments to HwHs exceeding the 5 percent readmission threshold were to be decreased by excluding all readmissions from the host from calculation of the average cost per discharge. These requirements were in effect for HwH fiscal years commencing on or after October 1, 1999.⁹

We analyzed readmission rates for each HwH for each of those fiscal years, because the payment limitation was to have applied to the fiscal year in which the HwH exceeded the 5 percent threshold. To determine readmission rates, we analyzed the National Claims History 100 Percent Inpatient File for HwHs and their hosts for fiscal years beginning on or after October 1, 1999. We selected that date because it corresponded to the effective date of Medicare's 5 percent threshold on readmissions from the host to the HwH.

We used SAS®, a statistical analysis package, to determine an HwH's total discharges, discharges to its host, and readmissions from the host. We then calculated the readmission rate for each HwH's fiscal year by dividing readmissions by total discharges.

Our analysis included a total of 87 HwHs—66 with a fiscal year ending between September 30, 2000 and August 31, 2001; an additional 18 began operations in the following year, for a total of 84; and an additional 3 HwHs began operations in the first 4 months of the following fiscal year (ending December 31, 2002), for a total of 87. The increase in HwHs for each year is a result of new HwHs being established.

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We truncated the analysis with fiscal years ending December 31, 2002, because more current data were not available at the time we conducted our analysis. Because HwH fiscal years commence at the beginning of different months, the available data allow us to analyze only a subset of 2002 fiscal year data. This subset of 38 HwHs comprises those with fiscal years ending between September and December 2002.

Oversight of Exclusion Criteria: To determine the extent of CMS's oversight of the exclusion criteria, we visited the Chicago and Dallas regional offices, which have jurisdiction over 53 of the 87 HwHs in our scope. We reviewed files on 52 of these facilities and interviewed staff at both regions. We also interviewed staff in the Atlanta and Philadelphia regional offices, which have jurisdiction over 25 additional HwHs.

We visited Mutual of Omaha, the fiscal intermediary that services 74 HwHs within our scope. We reviewed files on 68 HwHs and interviewed relevant staff. We also interviewed staff at two other fiscal intermediaries. Between our visits to Mutual of Omaha and the Chicago and Dallas regional offices, we reviewed files on 80 of the 87 HwHs in our scope.

The interviews and the file reviews focused on how CMS ensures that HwHs are meeting the 5 percent readmission threshold and the criteria for exclusion from the acute care hospital PPS. Appendix A provides full details on our methodology.

We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

‡ FINDINGS

Nineteen of 87 HwHs exceeded the annual 5 percent threshold for readmissions at least once during their fiscal years ending in September 2000 through December 2002.

In fiscal year 2000, 14 of 66 HwHs operating at that time discharged to their hosts and then readmitted more than 5 percent of patients. In fiscal year 2001, 10 of 84 HwHs readmitted patients over the 5 percent threshold. In a subset of HwHs with complete fiscal year data for 2002, 6 of 38 readmitted more than 5 percent of their patients.* Appendix B provides a summary of readmission data by year.

During their fiscal years ending in September 2000 through December 2002, the readmission rates for those 19 HwHs ranged from just over 5 percent to 10.7 percent.

Nine HwHs exceeded the 5 percent threshold in multiple fiscal years, including two that exceeded it in all 3 years of our analysis. This shows a continuing pattern of readmission in these HwHs. Among them, however, we found no consistent factors that might provide an explanation. For example, the HwHs came from several different chain organizations.

The geographic distribution of the HwHs over 5 percent parallels the national distribution of all HwHs, with 13 of the 19 HwHs located in Louisiana, Michigan, Ohio, Pennsylvania, and Texas.

CMS lacks a system to detect readmissions over the 5 percent threshold.

Under the cost-based system in effect prior to October 2002, payments to HwHs exceeding the 5 percent threshold were to be limited by excluding all readmissions from the calculation of their cost per discharge. At this point in time, however, we cannot determine whether the appropriate adjustments to HwHs' cost ceilings have been or will be made. Fiscal intermediaries make those adjustments during the cost report settlement process, which occurs 2 to 3 years after the close of a hospital's fiscal year; that process has not yet been completed.

* Because HwH fiscal years commence at the beginning of different months, the available data allow us to analyze only a subset of 2002 fiscal year data. This subset of 38 HwHs comprises those with fiscal years ending between September and December 2002.

Identifying readmissions is not a priority.

CMS has no edits in its claims payment system or under development that would identify HwHs over the 5 percent readmission threshold. Nor has CMS instructed fiscal intermediaries, in either the Medicare Intermediary Manual or the Provider Reimbursement Manual, to identify and deal with HwHs over the 5 percent readmission threshold.

In our discussion with CMS regional offices, staff told us that reviewing compliance with the 5 percent threshold is the responsibility of the fiscal intermediaries. However, CMS’s fiscal integrity branch, which sets yearly priorities for reviews by the fiscal intermediaries, has not instructed them to identify HwHs over the 5 percent threshold. Fiscal intermediary staff we interviewed corroborated this lack of instruction.

Medicare cost reports lack information needed to identify HwHs over the 5 percent threshold.

Even had CMS instructed the fiscal intermediaries to identify HwHs over the 5 percent threshold, it would be difficult to do so. First, cost reports do not contain information on the source of admissions or readmission rates, making it impossible for the fiscal intermediaries to calculate that rate.

Second, even if the HwH included the readmission rate in its own calculations, the fiscal intermediaries would be able to verify this rate only by examining billing data for both the host and HwH. However, the host and HwH are separate hospitals, each filing its own cost report. Consequently, fiscal intermediaries do not conduct such examinations.

Many HwHs and host hospitals have different intermediaries and different fiscal years.

Fifty-one HwHs have different fiscal intermediaries than their host hospitals. This means that the HwH’s intermediary would not have access to data about admissions to and discharges from the host. This problem is compounded further when the HwH and host hospital have different fiscal years.

Many readmissions in the hospitals-within-hospitals over the 5 percent threshold involved high-cost DRGs.

On October 1, 2002 CMS began phasing in a DRG-based payment system for long-term care hospitals, including HwHs. HwHs

that exceed the 5 percent readmission threshold are supposed to receive only one DRG payment for all their admissions from the host hospital

regardless of the number of readmissions from the host hospital. This payment limitation applies to the fiscal year in which the HwH exceeds the 5 percent threshold. (HwHs below the 5 percent threshold would receive two payments, one for the initial admission and one for the readmission.) Not having a system in place to identify those HwHs that exceed the 5 percent threshold means that Medicare risks making two payments to HwHs over that threshold (one for the initial admission and a subsequent payment for the readmission).

Our analysis is based on data from the period immediately preceding the implementation of the long-term care hospital PPS. During this period, however, HwHs were supposed to face financial penalties in their cost report settlement if they exceeded the 5 percent readmission threshold from the host hospital regardless of the number of readmissions from the host hospital. This payment limitation applies to the fiscal year in which the HwH exceeds the 5 percent threshold. As shown above, we found that CMS lacked a system to identify readmissions. In the absence of such a system, it is useful to examine how HwHs responded to that threshold as a potential predictor of behavior under the new PPS system.

Three high cost DRGs accounted for 155 of the 425 readmissions in these facilities—more than 36 percent.

For fiscal years ending September 2000 through December 2002, three DRGs dominated in HwHs over the 5 percent threshold. All three of these DRGs have relative weights greater than 1.0, the base weight that applies to the “average” DRG.¹⁰ Medicare reimbursement for July 1, 2003 through June 30, 2004 for that average DRG is \$35,726.18, referred to as the standard Federal rate. Appendix B shows the distribution of and costs associated with the most common DRGs for readmissions.

The most common DRG for readmissions among HwHs over the 5 percent threshold was DRG 271 (skin ulcers), accounting for 53 readmissions (12.5 percent of the total readmissions in these HwHs); its relative weight of 1.2354 yields a per discharge payment of \$44,136.

The second most common was DRG 475 (respiratory system diagnosis with ventilator support), which accounted for 52 (12.2 percent) readmissions in HwHs over the 5 percent threshold. DRG 475 has a relative weight of 2.3043. Multiplied by the standard Federal rate, this DRG yields a payment of \$82,324, more than \$46,600 over the payment for the average DRG.

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DRG 87 (pulmonary edema and respiratory failure), the third most frequent DRG, with 50 (11.7 percent) readmissions has a relative weight of 2.4202, yielding a per discharge payment of \$86,465.

We focused this analysis on these 3 DRGs because the numbers of readmissions in other DRGs fall sharply down to 17 readmissions for the fourth most frequent DRG.

Appendix B contains data on the 9 DRGs in which 10 or more patients were readmitted to HwHs over the 5 percent threshold during the time covered by our analysis. These nine DRGs account for 55 percent of all readmissions to these facilities.

The high cost of these DRGs is exacerbated when a patient is readmitted. Without an effective oversight system in place that limits payments for readmissions over the 5 percent threshold, Medicare would pay three times for a patient whom the HwH discharges to the host and then readmits to the HwH—two DRG payments to the HwH (for the first admission and the subsequent readmission) plus a third payment to the host hospital for its treatment in the interim. In other words, for a patient who was readmitted with DRG 271, Medicare would pay the HwH \$88,272; for patients with DRG 475, Medicare would pay \$164,648. The host hospital would receive an additional payment for its services to that patient.

One possible explanation for the high readmission rates among these high cost DRGs is that the clinical condition of these patients necessitates discharge to an acute care hospital at a greater rate than for patients with other diagnoses.

Another plausible explanation, however, is that the high revenue potential of these DRGs makes patients with those conditions potentially vulnerable to readmission for financial rather than clinical reasons.

CMS provides limited oversight of hospital-within-hospital compliance with the exclusion criteria.**CMS requires HwHs to demonstrate annually that they meet the 25-day average-length-of-stay criterion.**

Two months prior to the end of an HwH's fiscal year, its fiscal intermediary requires the HwH to submit data showing their average length of stay. The fiscal intermediary confirms for CMS that the HwH maintains an average length of stay greater than 25 days, as is required of all long-term care hospitals.¹¹

We corroborated that all HwHs met this criterion for their most recently filed cost reporting period through an analysis of cost report data from CMS's Healthcare Cost Report and Information System. Prior to the long-term care hospital PPS, CMS and the fiscal intermediaries included all patients in calculating the average length of stay. The new long-term care hospital PPS makes that determination for Medicare patients only. As a result, the fiscal intermediaries can now assess compliance using Medicare claims payment data, rather than self-reported cost report information.

However, CMS's State Operations Manual does not specify what data should be submitted. In our file review at Mutual of Omaha, the fiscal intermediary servicing 74 of the 87 HwHs within our scope, we found that the level of detail submitted by HwHs varied widely. Some HwHs submitted only the total number of discharges and patient days, together with a simple calculation showing they had an average length of stay greater than 25 days. Others provided a complete listing of their patient census, including all admissions and discharges. That complete census listing provides an opportunity for the fiscal intermediary to verify the length-of-stay calculation.

From our interviews at Mutual of Omaha, we found that the fiscal intermediary's auditors lacked access for more than 2 years to Medicare data that would aid in verifying average length of stay. This gap resulted from conflicts between shared claims processing systems. When auditors gained access to the data, they performed an analysis on a small number of HwHs. They compared average length of stay based on self-reported data and Medicare cost report data. The test revealed that the sample met the criterion, and Mutual of Omaha did not expand its review further.

Currently, CMS has no ongoing mechanism to determine whether HwHs are complying with the organizational and financial independence criteria.

CMS determines an HwH's compliance with these criteria only once, when the agency first classifies it as a long-term care hospital. At this initial classification, HwHs submit documentation demonstrating independence to the CMS regional office or State agency that conducts Medicare surveys.

However, CMS does not specify the time in this process at which an HwH must submit documentation. Many chain organizations submit documentation when their HwHs first enter Medicare; in other cases, the CMS regional office requests it when the HwHs convert to long-term care status.

This initial submission is the only time CMS requires HwHs to submit such documentation. CMS does not require them to demonstrate ongoing compliance with the independence criteria.

Further, data supporting compliance with the organizational and financial independence criteria are self-reported and not independently verified.

CMS does not independently verify the initial documentation HwHs submit through site visits, audits, or requests for supporting evidence. Additionally, CMS has never developed guidelines on what evidence is needed to demonstrate compliance. The State Operations Manual does not offer instructions on what would demonstrate HwH independence from the host. The manual states that a CMS regional office makes the determination "on a case-by-case basis...using whatever procedure it deems appropriate."¹² As a result, there is no consistency in the amount, type, and detail of information available to CMS and State agencies as they make their decisions.

To demonstrate organizational independence, some HwHs submit organizational charts, management information, information about their corporate parent, and copies of their leases, bylaws, and purchased services agreements. Some HwHs also submit information concerning their hosts, including the host's board of governors and senior management.

Others, however, provide significantly less documentation—in some cases omitting any information about the host hospital, the HwH's own governing board, or corporate parent. Some HwHs submit a statement that their medical staff is separate from the host's staff, but do not include any additional documentation.

F I N D I N G S

Another avenue for potential verification of organizational independence is an accreditation survey, which an HwH can choose instead of a State survey. The Joint Commission on Accreditation of Healthcare Organizations may review organizational arrangements during the accreditation process, but that is not required, nor is information necessarily shared with CMS.

HwHs also vary in the amount of documentation they submit to demonstrate their financial independence. HwHs must show that they meet 1 of 3 criteria—that they perform basic hospital functions independently from the host; that at least 75 percent of their admissions come from a source other than the host; or that they limit their purchase of services from the host to no more than 15 percent of HwH expenses. Nearly all choose to meet the 15 percent criterion. To demonstrate compliance with this criterion, some HwHs submit detailed financial summaries, including a complete breakdown of services purchased from their hosts, while others submit only the total dollar value of purchased services. Further, some HwHs send CMS a letter stating they plan to meet the criterion, with no supporting data.

While some CMS regional office staff told us that HwHs send detailed information on their purchases from the host to their fiscal intermediaries, none of the intermediaries we spoke with receive or review such data.

‡ R E C O M M E N D A T I O N S

The co-location of an HwH and its host hospital raises concerns about potentially inappropriate financial incentives. These incentives make strong CMS oversight of the relationship between an HwH and its host hospital critical. Yet, such oversight is lacking. In fact, CMS lacks a system to detect readmissions over the 5 percent threshold. As payment transitions to a prospective DRG-based system, the financial threat posed by failing to detect these readmissions could be significant since CMS would continue to make two DRG payments, rather than one payment, to HwHs over the 5 percent readmission threshold. The lack of a mechanism to determine whether HwHs are complying with the organizational and financial independence criteria means that CMS has no effective way of determining whether HwHs and their hosts are, in fact, separate facilities. Compounding this vulnerability is the ongoing rapid growth of HwHs.

These recommendations do not require new HwH-specific regulations. Rather, these recommendations to improve CMS's oversight of HwHs could be issued through instructions in program memoranda.

CMS should develop a system to monitor hospital-within-hospital compliance with the 5 percent readmission threshold.

We suggest three key directions that CMS could take toward this end:

CMS could require HwHs to submit annual discharge, admissions, and readmissions data to their fiscal intermediaries.

CMS requires fiscal intermediaries to obtain average-length-of-stay data 2 months prior to the end of the HwH's fiscal year end. CMS could also require the fiscal intermediaries to solicit readmission data at the same time it requests average-length-of-stay data. These readmission data could specify all patients admitted to the host from the HwH and then readmitted without an intervening stay.

CMS could use the data submitted to the fiscal intermediaries to monitor HwH readmission rates.

Data submission would enable the fiscal intermediaries and, by extension, CMS to monitor readmission rates annually rather than 3 years after the fact during the cost report settlement process. CMS could then have the intermediaries analyze these data to determine the number of readmissions from the host hospital to the HwH and whether this number exceeds the 5 percent threshold. Those HwHs found to be

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over the 5 percent threshold could then be subject to a thorough audit to determine whether Medicare must recoup any overpayment.

CMS could target for medical review those DRGs with large relative weights that tend to be associated with the most commonly readmitted patients. These include DRGs 271, 475, and 87. The purpose of this review would be to determine whether those DRGs are particularly vulnerable to abuse through upcoding or unnecessary discharge and readmission.

CMS also could analyze whether, in fact, 5 percent is the appropriate threshold at which payment adjustments should take place.

If CMS finds that abuse of the payment system is prevalent, it may wish to take more stringent measures, such as establishing some type of concurrent edits. Such edits could avoid overpayment, prospectively.

CMS could develop a system to facilitate data sharing between fiscal intermediaries.

CMS could work with fiscal intermediaries to develop a system to coordinate data sharing between intermediaries. This system could eliminate barriers that make it difficult to acquire host hospital claims data. Access to these data would be particularly useful since it would give fiscal intermediaries the raw data they need to verify their HwHs' readmission rate calculations.

CMS should require hospitals-within-hospitals to demonstrate ongoing compliance with the organizational and financial independence criteria.

Options for ensuring HwH organizational and financial independence include:

CMS could specify what supporting documentation HwHs must submit to demonstrate ongoing organizational independence.

When HwHs request classification as long-term care hospitals, they could submit a uniform package of documentation to the State agency or CMS regional office. HwHs already classified as long-term care hospitals could send this information before the start of their next cost-reporting period. The information could include:

- detailed descriptions of the HwH's and host's governing bodies
- detailed descriptions of any third parties that control both hospitals, and an explanation of how the third party controls them

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- information on the HwH's corporate parent, if applicable
- names of HwH and host CEOs and their employers
- detailed organizational charts, including chief medical officers from both facilities and where the medical officers are credentialed and privileged
- names of medical staffs and copies of medical staff bylaws

These initial submissions would serve as a baseline. CMS could then require HwHs to report any changes in their organizational structure to the regional office. These changes might include a new chief executive officer or chief medical officer, a change in corporate ownership, or a change in bylaws. This information could be provided at the same level of detail as the initial submission.

CMS could require HwHs to submit annual financial independence data to their fiscal intermediaries.

Two months prior to the end of their fiscal years, at the same time they are required to submit average-length-of-stay data, HwHs could submit data demonstrating financial independence. HwHs could specify which of the three criteria they meet, as well as provide summary data and raw calculations in support. We recommend that CMS define the specific data to be submitted to allow verification by the fiscal intermediary. HwHs could submit these data, readmissions data, and average-length-of-stay data to their fiscal intermediaries in one package. Annual reporting would allow CMS to monitor the purchased services agreements between HwHs and their hosts.

CMS could conduct a focused review of a sample of HwHs to assess their compliance with the exclusion criteria.

Because there are no Medicare conditions of participation specific to long-term care hospitals, certification surveys and accreditation surveys do not address CMS's long-term care hospital and HwH-specific criteria. An annual focused-review project of a sample of HwHs would determine the degree to which HwHs are complying with CMS criteria.

‡ A G E N C Y C O M M E N T S

We received comments on our draft report from the Centers for Medicare and Medicaid Services (CMS). CMS generally supports our findings and the general thrust of our recommendations.

With regard to the first recommendation, CMS indicates that it is presently formulating a program to enforce the 5 percent readmission threshold. We are encouraged that the agency is moving forward to address this area. We hope that our suggestions will be useful to the agency in developing an effective monitoring system.

With regard to the second recommendation, CMS indicates that determining ongoing compliance with the organizational and financial independence criteria is a problem, but cautions that annual review of each facility's articles of incorporation is not administratively feasible. The agency does, however, indicate it plans to strengthen oversight of these independence criteria by establishing a method that will allow an annual review. We support efforts to strengthen that oversight; our recommendation offered some options for doing so, but we welcome other ways of achieving that same goal. Our real concern is that the oversight system achieve some way of ensuring that an HwH is indeed a separate facility from its host in order to dispel the possibility of inappropriate financial transactions.

We also adopted technical comments that CMS suggested.

The full text of the CMS comments appears in Appendix C.



IDENTIFICATION OF HOSPITALS-WITHIN-HOSPITALS

We first developed a list of HwHs operating as of March 2003.¹³ We began by obtaining a listing of all long-term care hospitals and acute care hospitals from CMS's Online Survey Certification and Reporting (OSCAR) system. With this list we matched addresses of long-term care hospitals and acute care hospitals. If we could not make an exact match, we used the Internet to determine whether we could identify which long-term care hospitals were HwHs. We visited long-term care hospital web sites, host hospital sites, industry-related sites, news sites, HwH chain organization sites, and mapping sites to determine what long-term care hospitals were HwHs. When we could not determine whether a long-term care hospital was an HwH, we contacted the facility directly.

5 PERCENT READMISSION THRESHOLD

To determine HwH readmission rates, we obtained the National Claims History 100 Percent Inpatient File for HwHs, and their corresponding host hospitals, through CMS's Data Extract System. CMS instituted the 5 percent readmission threshold on October 1, 1999. HwHs were to limit their readmissions from their host hospitals in the fiscal year beginning on or after that date. Therefore, we focused on fiscal years commencing after that date. This came up with a total of 87 HwHs—66 with a fiscal year ending between September 30, 2000 and August 31, 2001; an additional 18 began operations in the following year, for a total of 84; and an additional 3 HwHs began operations in the first 4 months of the following year (ending December 31, 2002).

We used SAS[®] to determine the number of instances in which Medicare patients were discharged from the HwH to its host hospital and then readmitted directly to the HwH. We also used SAS[®] to determine the total number of Medicare discharges during each HwH's fiscal year. We then divided the number of Medicare patients readmitted to an HwH from its host hospital by the HwH's total Medicare discharges to determine the HwH's readmission rate.

When we identified an HwH over the 5 percent readmission threshold, we further identified all Medicare patients readmitted to the HwH from its host hospital. Next, we used SAS[®] to obtain a summary of patients' claims history in the HwH and host hospital, which provided the DRG for each patient.

CMS CONTROLS TO ENSURE COMPLIANCE WITH THE EXCLUSION CRITERIA

Organizational and Financial Independence

CMS Regional Offices. We visited two CMS regional offices. The Chicago office is responsible for 28 HwHs in our scope, and the Dallas office is responsible for 25 HwHs in our scope. At these regional offices, we interviewed staff who deal with these HwHs, and we reviewed the files on 52 of these 53 HwHs. The Chicago Regional office was unable to locate files on one HwH. Both the interviews and the file reviews focused on how CMS ensures that HwHs are meeting the 5 percent readmission threshold and the criteria for exclusion from the acute care hospital PPS.

We also performed telephone interviews with 2 other CMS regional offices: Atlanta (14 HwHs in our scope) and Philadelphia (11 HwHs). Our interviews focused on how CMS ensures whether HwHs are meeting the 5 percent readmission threshold and the criteria for exclusion from the acute care hospital PPS.

Fiscal Intermediaries. We visited Mutual of Omaha, the fiscal intermediary that services 74 HwHs within our scope. During this site visit, we interviewed staff who regularly deal with HwHs, focusing on the role the fiscal intermediary plays in the oversight of HwHs. Additionally, we reviewed files on 68 HwHs, focusing on whether the files contained documentation related to the 5 percent readmission threshold or compliance with the criteria for exclusion from the acute care hospital PPS. While Mutual services 74 HwHs in our scope, we reviewed files on only 68 HwHs. At the time of our site visit to Mutual, CMS's HCFA Customer Information System (HCIS) did not have fiscal intermediary information for three HwHs. Only after our site visit did further investigation confirm that Mutual services these three HwHs. Additionally, Mutual was unable to furnish files on three HwHs.

We also interviewed two other fiscal intermediaries, Blue Cross Blue Shield of Oklahoma and AdminiStar Federal, Inc. of Indianapolis, by telephone and electronic mail. These two fiscal intermediaries service five HwHs, thus representing 5 percent of the HwHs within our scope. These interviews focused on their role in ensuring compliance with the 5 percent readmission threshold and the criteria for exclusion from the acute care hospital PPS.

Average Length of Stay

Healthcare Cost Report Information System. To verify the average length of stay for the HwHs in our scope, we analyzed the most recently filed HwH cost report data from CMS's Healthcare Cost Report Information System. From this data set, we were able to verify the average length of stay for HwHs within our scope. Specifically, we divided the total number of Medicare-covered days by the total number of Medicare discharges.

OTHER DATA SOURCES

Descriptive Statistics. We obtained descriptive statistics for HwHs from analysis of data contained in CMS's HCFA Customer Information System.

HwH Industry Groups. We visited the corporate offices of two for-profit HwH chains and one not-for-profit HwH chain. We also visited an HwH of one of the for-profit chains.

Additionally, we met with the two long-term care hospital associations, the Acute Long Term Hospital Association and the National Association of Long Term Hospitals.

⚡ A P P E N D I X ~ B : D A T A T A B L E S

Table B-1				
Readmissions to Hospitals-within-Hospitals (HwHs) from their Host Hospitals				
HwH Fiscal Years Ending September 2000 through December 2002				
Fiscal Year	Number of HwHs	Readmissions	Total Medicare Discharges	Readmission Percentage
2000	66	409	14,505	2.8%
2001	84	516	19,712	2.6%
2002*	38	318	10,037	3.2%

Table B-2						
Hospitals-within-Hospitals (HwHs) Exceeding 5 percent Readmission Threshold						
HwH Fiscal Years Ending September 2000 through December 2002						
Fiscal Year	Number of HwHs	Readmissions	Total Medicare Discharges	Readmission Percentage	Readmission Range	
					low	high
2000	14	178	2,497	7.1%	5.1%	10.7%
2001	10	132	1,998	6.6%	5.5%	8.5%
2002*	6	115	1,538	7.5%	5.2%	9.1%
Total	n/a	425	6,033	n/a	n/a	n/a

Fiscal Year (FY)2000: cost report periods ending September 2000 through August 2001
 FY2001: cost report periods ending September 2001 through August 2002
 *FY2002: cost report periods ending September 2002 through December 2002. Only 38 HwHs had fiscal years ending in that time frame.

Source: OIG Analysis of Medicare National Claims History 100 Percent Inpatient File

A P P E N D I X ~ B : D A T A T A B L E S

Table B-3
Nine Most Common Diagnosis-related Groups (DRGs) for Patients Readmitted
to Hospitals-within-Hospitals (HwHs) from Host Hospital
For HwHs Exceeding 5 percent Readmission Threshold

HwH Fiscal Years Ending September 2000 through December 2002

DRG	DRG Description	Long-Term Care Hospital Relative Weight	Discharges FY 2000	Discharges FY 2001	Discharges FY 2002	Total Discharges	Cumulative Percent	Payment per Discharge
271	SKIN ULCERS	1.2354	29	12	12	53	12.5%	\$ 44,136
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	2.3043	20	28	4	52	24.7%	\$ 82,324
087	PULMONARY EDEMA & RESPIRATORY FAILURE	2.4202	20	8	22	50	36.5%	\$ 86,465
416	SEPTICEMIA AGE >17	1.1222	7	7	3	17	40.5%	\$ 40,092
316	RENAL FAILURE	1.1553	8	6	1	15	44.0%	\$ 41,274
088	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.9390	5	3	6	14	47.3%	\$ 33,547
127	HEART FAILURE & SHOCK	0.8658	6	4	2	12	50.1%	\$ 30,932
014	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TRANSIENT ISCHEMIC ATTACK	1.0143	1	1	9	11	52.7%	\$ 36,237
130	PERIPHERAL VASCULAR DISORDERS WITH COMPLICATION OR COMORBIDITY	0.9391	4		6	10	55.1%	\$ 33,550

Fiscal Year (FY) 2000: cost report periods ending September 30, 2000 through August 31, 2001

FY2001: cost report periods ending September 30, 2001 through August 31, 2002

FY2002: cost report periods ending September 30, 2002 through December 31, 2002

Source: OIG Analysis of Medicare National Claims History 100 Percent Inpatient File

‡ A P P E N D I X ~ C

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 10 2004

TO: Dara Corrigan
Acting Principal Deputy Inspector General
Office of Inspector General

FROM: Mark B. McClellan, M.D., Ph.D. *MM*
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: "Long-Term Care Hospitals-within-Hospitals" (OEI-01-02-00630)

Thank you for the opportunity to review and comment on the above-referenced OIG draft report, which assessed the compliance of hospitals involved in "hospital within a hospital" (HwH) arrangements with a 5 percent limit on discharges and readmissions of patients between the two hospitals over the course of a fiscal year. In general, payment rates for the HwH are higher than the rates paid to the host hospital under the inpatient prospective payment system (IPPS). Therefore, Medicare regulations reduce Medicare payment rates to HwHs that exceed the 5 percent readmission rate.

The CMS established regulations at 42 CFR 412.22(e) to address the payment implications when a hospital that is excluded from the IPPS, such as a long-term care hospital, is physically located within an inpatient acute care hospital, subject to the IPPS. The regulations require the HwH and the host hospital to be separately governed and to separately perform basic hospital functions in order to prevent the hospitals from gaming the Medicare system by inappropriately shifting patients and submitting duplicate claims by both hospitals for one episode of care. The CMS additionally promulgated an additional regulation at 42 CFR 413.40(a)(3)(B) establishing a ceiling on payments to HwHs by excluding discharges from the HwH to the host if the patient is subsequently readmitted to the HwH and the number of such "revolving door" cases exceeds five percent of the total number of HwH discharges during that cost reporting period.

The CMS appreciates the effort that went into this report. Our comments to the specific recommendations are outlined below.

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OIG Recommendation

CMS should develop a system to monitor hospital-within-hospital compliance with the 5 percent readmission threshold.

CMS Response

We generally support the report's first conclusion that CMS needs to establish a policy of strong oversight for enforcement of the on-site discharge and readmission policy under the long-term care hospital prospective payment system (LTCH PPS) (42 CFR 412.532). We are presently formulating an effective program on a systems-level, as well as on an administrative level, that will enable fiscal intermediaries (FIs) to enforce this policy. During this process we will evaluate the feasibility of the report's specific suggestions on this topic.

OIG Recommendation

CMS should require hospitals-within-hospitals to demonstrate ongoing compliance with the organizational and financial independence criteria.

CMS Response

We agree that the determination of on-going compliance with these requirements is a problem. Initial FI approval of an HwH/host arrangement represents a "snap-shot" in time, and there can be frequent business reorganizations, changes in ownership, and other corporate changes among such entities. However, reviewing such arrangements would require an analysis of each facility's Articles of Incorporation on an annual basis, which would be administratively infeasible. We plan to revisit our HwH requirements in an attempt to strengthen our separateness policy by establishing criteria that will allow an annual review by FIs.

Attachment

‡ A C K N O W L E D G M E N T S

This report was prepared under the direction of Mark R. Yessian, Ph.D., Regional Inspector General for Evaluation and Inspections in the Boston Regional Office, and Joyce M. Greenleaf, MBA, Assistant Regional Inspector General. Other principal Office of Evaluation and Inspections staff who contributed include:

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‡ E N D N O T E S

¹ 42 C.F.R. § 412.23(e)(2)(i). The criterion requires a long-term care hospital to have an average length of stay greater than 25.0 days. Prior to the October 2002 implementation of the long-term care hospital prospective payment system (PPS), the Centers for Medicare & Medicaid Services (CMS) calculated the average length of stay of all patients. After implementation of the long-term care hospital PPS, CMS calculates the average length of stay of all Medicare patients.

² 42 C.F.R § 412.22(d)

³ 42 C.F.R § 413.40(a)(3)

For example, a hospital-within-hospital (HwH) with 50 discharges and allowable costs of \$2 million, or \$40,000 per discharge, would be paid the full \$40,000 per discharge.

However, if the HwH exceeded 5 percent readmissions from its host, the allowable cost per discharge would be calculated as follows: Assume that 5 of those 50 discharges (10%) were readmissions from the host. Then the total allowable costs would be only \$1.8 million. In calculating the cost limits, the 5 readmissions would only be counted once, so the per-discharge limit would be based on 45 discharges.

⁴ 42. C.F.R. § 412.532(c)

⁵ 42 C.F.R. § 412.22(e)(1-4)

⁶ 42 C.F.R § 412.22(g)

⁷ 42 C.F.R. § 412.22(e)(5)

⁸ 42 C.F.R. § 412.22(f)

⁹ The requirements are found at 42 C.F.R.§ 413.40(a)(3)(B)

¹⁰ Under the long-term care PPS, CMS calculates a standard base rate that reflects average costs of caring for all patients in long-term care hospitals. For July 1, 2003 through June 30, 2004 that base rate is

\$35,726.18. A relative weight is calculated for each diagnosis-related group (DRG), depending on the complexity and resource utilization of patients in that DRG. To determine payment, the relative weight assigned to the DRG is multiplied by the standard base rate. Those DRGs that are less complex and that utilize fewer resources have a relative weight less than one; those DRGs that are complex and require significant resources have a relative weight greater than one.

¹¹ The fiscal intermediary requires this submission from all long-term care hospitals, both HwHs and free-standing hospitals. CMS is able to identify all long-term care hospitals, even though it cannot identify which are free standing and which are HwHs. Thus, its inability to identify which long-term care hospitals are HwHs does not prevent it from obtaining these data.

¹² Medicare State Operations Manual, § 3112.1 (March 1998)

¹³ October 1, 2002 regulations require that all co-located facilities, such as HwHs, notify their CMS regional office of their co-located status. Prior to issuing these regulations, CMS was unable to determine which long-term care hospitals were HwHs, unless an HwH volunteered that information. Therefore, since CMS did not have a list of long-term care HwHs, our study began by developing a list of long-term care hospitals that are HwHs.