



December 12, 2005

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By email and U.S. Mail

Re: Public Comment for LTACH Subcommittee of
Inpatient Rehab Technical Advisory Committee

I appreciate the opportunity to comment on the issues currently before the LTACH Subcommittee assisting the Inpatient Rehab Technical Advisory Committee (Rehab TAC).

In my role at WellStar Health System, I serve as the Administrator of Windy Hill Hospital which is licensed as a Long Term Acute Care Hospital (LTACH). I also have System-wide responsibility for Post Acute Services, including Rehabilitation. The Rehab department provides services at all levels of care at all 5 WellStar Hospitals. Included in this department are Inpatient Rehab Units at both Cobb and Kennestone Hospitals.

I also serve as a member of the Board of Directors of the National Association of Long Term Hospitals (NALTH).

My comments address specific points relating to the Rehab TAC's current work as well as the working draft of Certificate of Need (CON) rules addressed by the LTACH Subcommittee in their meeting on December 8, 2005.

The remaining background material (Attachment A and enclosed publications) is provided for the benefit of those wanting a better understanding of the LTACH industry, including its relationship with Inpatient Rehab Facilities (IRFs).

A. Definition of LTACHs

The proposed definition contained in the working draft of LTACH Rule 111-2-2-.40(2) is appropriate. It would replace the current Rule 111-2-2-.36(2).

My only further comment is that this definition could be located within Rule 111-2-2-.20(2) establishing LTACHs as a sub-category of acute care hospitals.

B. Bed Need for LTACHs

LTACH beds should be a component of the general (short-stay) acute care bed need analysis. There should be no separate need analysis for LTACH beds.

Across the country, there is a wide variation in the number of LTACH beds per population statistic. There are a number of states which have no LTACHs at all. Conversely, some states such as Louisiana have quite a large number of LTACH beds. Obviously, acutely ill patients requiring the services that LTACHs typically provide are commonly cared for by short-stay hospitals or IRFs.

The Department of Community Health (DCH) should review a CON application for LTACH beds based on the overall need for acute care beds within a planning area. An exception should be allowed for an applicant that can demonstrate that a specific patient population is being underserved.

C. Alternative Methodology for Calculating LTACH Beds Used for Rehab

Irrespective of whether DCH decides to create a special bed need category for LTACHs, a simple methodology can be employed to determine the number/proportion of LTACH beds that are used for rehab services. DCH can use this methodology as part of its desire to more accurately reflect the inventory of Rehab beds when considering an application for CON to provide Comprehensive Inpatient Physical Rehabilitation (CIPR) services.

1. Define a group of LTACH-DRGs that would be considered overlapping with IRFs (the LTACH Rehab DRG Group).
2. Review publicly available claims data by LTACH to determine the % of patient discharges where the LTACH-DRG falls into the LTACH Rehab DRG Group. This should be a review over a 12-month timeframe.
3. Multiply this % times the number of licensed beds for that LTACH. The resulting number of beds is included in the CIPR bed need inventory.

The DRGs which comprise the LTACH Rehab DRG Group should be reviewed periodically (at least every five years) to update for changes in coding.

The LTACH component of the CIPR bed need inventory should likewise be reviewed periodically. If desired, DCH could require LTACHs to self report this number as part of the Annual Hospital Questionnaire.

D. LTACH Planning Areas

If there is a need for establishing LTACH-specific bed need, there need to be defined planning areas for LTACHs. Building on the observation that there are many areas of the country without LTACHs, it is recommended that there be one (statewide), or at most,

three LTACH planning areas. I suggest combining groups of existing Georgia State Service Delivery Regions (SSDR). Attached is the map from the DCH website.

A slight modification of one of the maps discussed in the most recent LTACH Subcommittee meeting would include three planning areas:

- LTACH Planning Area 1: SSDRs 1-5
- LTACH Planning Area 2: SSDRs 6,8 & 10
- LTACH Planning Area 3: SSDRs 7,9,11 & 12

Regardless of the final number of planning areas, the ten counties comprising Metro Atlanta (SSDR 3) should remain in the same LTACH planning area.

E. Provider Definition to Determine CON Requirements

Currently, both LTACHs and IRFs provide rehabilitation services. LTACHs that do not meet the requirements for a CIPR CON may, nonetheless, be the most appropriate setting for “sick” rehab patients whose inability to withstand three hours of rehab daily makes them ineligible for IRF admission.

There is a need to define the circumstances under which an LTACH should be required to apply for a CON to provide CIPR services. LTACHs that provide a limited amount of rehab services should not be required to obtain this type of CON. We recommend that a “predominance” threshold be established as follows:

- **Rehab LTACH:** > 70% of patient discharges/year fall into the LTACH Rehab DRG Group (defined above). LTACH hospitals that intend to provide a significant level of CIPR services should be required to obtain a CON for CIPR services. LTACHs receiving this CON should maintain this minimum level of rehab services as a condition of their CON.
- **Medical:** < 30% of patient discharges/year falls into the LTACH Rehab DRG Group. While these hospitals provide rehab services, they do not require a specific CON requirement to provide CIPR services. An LTACH that has not received a CIPR CON cannot provide more than 30% of their annual patient discharges under the LTACH Rehab DRG Group.

Changes in Provider Status

With increasing Medicare enforcement of IRF rules and the possible adoption of more restrictive Medicare LTACH rules, there should be specific CON rule provisions relating to both voluntary and involuntary changes in provider type. Three examples illustrate this need:

- The Medicare Payment Advisory Commission (MedPAC) has recommended that LTACHs be restricted from providing much of the same intensive rehab services

found in an IRF program. If enacted, a Rehab LTACH may decide to convert to an IRF.

- Enforcement of the so-called 75/25 rule applicable to IRFs operating as Distinct Part Units (DPU) may result in their loss of exemption from the Inpatient Prospective Payment System (IPPS).
- An LTACH may lose its IPPS exemption if it fails to qualify as under the Medicare 25-day average length of stay rule.

Rules currently exist that address Hospital-In-Hospital (HIH) beds reverting to the host hospitals official inventory of available short-stay beds [111-2-2-.20(1)(d)]. Similar guidance should be provided for other anticipated changes, such as a situation for example, where a hospital (such as Warm Springs or Shepherd Center) could no longer practically meet Medicare LTACH requirements.

Thank you again for the opportunity to comment on the development of rules for Long Term Acute Care Hospitals.

Sincerely,

Lou Little
VP, Post Acute Services &
Administrator, WellStar Windy Hill Hospital

Attachment A

Background and History of Long Term Acute Care Hospitals

In deciding how LTACHs should “fit” into our system of healthcare, it is useful to understand how this small segment of acute care came into being and how it has changed over time. Attached to this letter is an article which helps in this regard [Liu, K., et. al.: *Long-Term Care Hospitals Under Medicare: Facility-Level Characteristics*. Health Care Financing Review. Winter 2001, Volume 23, Number 2].

Fundamentally, LTACHs were acute care hospitals whose long average lengths of stay did not work well within the short term Inpatient Prospective Payment System (IPPS) being developed by HCFA (now CMS). In order to improve the accuracy of the IPPS, the decision was made in the early 1980’s to exempt these long-stay acute care hospitals with the intent to return at a later date to address prospective payment for this small acute hospital segment.

The primary reason providers chose to be paid under a long-stay payment system is that it fit their patient population better. Many of these hospitals focused on providing comprehensive inpatient rehabilitation services; today, many of the nation’s premier rehab hospitals are LTACH providers.

Medicare Responds to Changes in Provider Behavior

Major changes in payment systems drive providers to organize their services with the intent that healthcare is provided more efficiently and paid for equitably.

The Medicare Payment Advisory Commission (MedPAC) is responsible for monitoring the provision of healthcare and reporting its findings and recommendations to Congress. For those wanting a more in-depth understanding of the issues within the LTACH industry, including the overlap with IRFs, attached are of chapters from two annual MedPAC Reports to Congress (June 2003, Chapter 5 - Monitoring Post-Acute Care; and June 2004, Chapter 5 - Defining Long-Term Care Hospitals).

Current Environment

LTACHs are now reimbursed under Medicare using a Prospective Payment System designed specifically for this provider group. Implementation of PPS for both LTACHs and Inpatient Rehab Facilities (IRF) occurred within the last few years. IRF implementation occurred about two years before LTACH implementation.

CMS has become more restrictive of the types of rehab patients that can be treated in IRFs. For example, CMS believes patients who receive an uncomplicated unilateral Total Joint Replacement (knee or hip) should receive rehab services in the short term acute care setting. If further rehab is needed post-discharge, they should receive either Outpatient,

Subacute or Home Health rehab. They do not agree that these patients need to receive intensive rehab services found in an IRF setting.

CMS' recent changes to restrict these and other patients previously seen in IRFs are resulting in a significant decrease in IRF utilization in Georgia. The fact that there is an overlap in patients between LTACHs and IRFs is well known to members of the Inpatient Rehab TAC.

Similarly, CMS and MedPAC are moving to restrict the types of Medicare patients LTACHs can serve. In particular, with respect to caring for rehab patients, MedPAC recommends that patients who fit the IRF criteria for intensive acute rehabilitation be treated in that setting, not in an LTACH. Discussion continues at the Federal level on the appropriateness of LTACH admission for "sick" rehab patients whose inability to withstand three hours of rehab daily make them ineligible for IRF admission. However, it is clear that any move to establish patient level criteria by Medicare (as MedPAC recommends) will result in some restrictions placed on the range of rehab services that LTACHs can provide.