Open Meeting on Rules Redevelopment

Illinois Health Facilities Planning Board

January 8, 2007

“Long Term (Acute) Care Hospitals”

James R. Thompson Center
Conference Room 031
160 West Randolph Street
Chicago, Illinois

Teleconference:
Illinois Department of Public Health
2nd Floor Conference Room
525 West Jefferson Street
Springfield, Illinois
Rules Process

- Open Meetings/Public Participation-Input
- Draft Rules Reviewed and Approved by Board
- Submission to JCAR
- Publication in the Illinois Register
- Formal Public Hearings and Comment Period
- Reconsideration by the Board
- Consideration and approval by JCAR
Meeting Protocols

- Comments/Discussion Limited to Current Topic
- All Interested Parties Invited to Participate
- Written Comments Requested
- Time Limitations - As Required
- Check with website
  http://www.idph.state.il.us/about/hfpb/hfpbrules.htm
Statutory Authority

Health Facilities Planning Act - 2004:

- **Purpose of the Act**
  - Establish a procedure designed to reverse the trends of increasing costs of health care resulting from unnecessary construction or modification of health care facilities.
  - Improve the financial ability of the public to obtain necessary health services.
  - Establish an orderly and comprehensive health care delivery system which will guarantee the availability of quality health care to the general public.

- **The Procedure**
  - Requires a person establishing, constructing or modifying a health care facility to have the qualifications, background, character and financial resources to adequately provide a proper service for the community,
  - Promotes orderly and economic development of health care facilities that avoids unnecessary duplication of such services.
  - Promotes planning for and the development of health care facilities needed for comprehensive health care, especially in areas where the health planning process has identified needs.
  - Carries out these purposes in coordination with the Agency and the comprehensive State health plan developed by that Agency.
Meeting Objectives

- **Review the definition and characteristics of a Long-Term (Acute) Care Hospital “LTCH”**.
- **Discuss bed need formula and outline rules to address LTCH**.
- **The discussion will be limited to the topic identified**.
- **Identify opportunities for improvement**.
  - Satisfy statutory requirements, while meeting the needs of the stakeholders: applicants, staff, Board Members and public.
  - Identify experts in subject fields to assist IHFPB in updating policies.
Agenda

- Background
- RTI Recommendations (Follow-up to MedPac Report)
- Current Illinois Rules
- Review of other States’ Rules
- Need Projection Discussion – Ken Pawola, RML Specialty Hospital
- General Discussion
Background

General Definition

- “Long Term (Acute) Care Hospitals are designed to provide extended medical and rehabilitation care for patients who are clinically complex and have multiple acute or chronic conditions.”
  

- “Long-Term care hospitals provide intensive care to patients who have multiple comorbidities (coexisting conditions) and use inpatient hospital care for an extended period of time.”

  Source: MedPac Report to the Congress: Variation and Innovation in Medicare, June 2003

Qualification for Medicare Payment (LTCH)

- Facilities must meet the conditions of participation for acute hospitals.
- LTCHs must have an average Medicare length of stay greater than 25 days.
- Admission is not based upon diagnosis or measure of care intensity, as in other services.
Background

History of LTCHs
- Old – Established before 1983
  - Evolved from tuberculosis and chronic disease hospitals
- Middle – Certified after October 1983 – September 1993
  - Move toward proprietary ownership
  - Focus on respiratory care
- Current – Certified after September 1993
  - Significant growth in hospitals within hospitals

Three Distinct types of LTCHs
- The majority of LTCHs specialize in what they consider to be medically complex patients (including many respiratory and ventilator-dependent patients), and some of those have ICU-type units;
- In some regions LTCHs may focus on rehabilitation patients; and
- In other areas, LTCHs may be primarily treatment for patients who could otherwise be in IPFs.

Patient Population
- Heterogeneous
Background

Admissions
- 70% of LTCH admissions are from acute care facilities

Growth

Location
- Uneven distribution
- Concentration in southern and eastern states
- Large concentration in Massachusetts, Texas and Louisiana

Types of Facilities
- Free-standing
- Hospital within a Hospital “HwH”
- Satellite
Background

Payment Source
- Medicare paid for 71% of discharges (1997)
- Medicaid 9% (1997)

Medicare Spending
- Year 1993 - $398 million
- Year 2001 - $1.9 billion
- Year 2004 - $2.8 billion (estimate)

Medicare Reimbursement
- Prior to 2003 – Cost based system
- Fiscal Year 2003 – Prospective Payment System
  - 5-year transition period to phase-in the PPS cost-based reimbursement to 100 percent Federal prospective payment.
  - Each discharge is assigned to 518 case-mix categories
  - Each case-mix category has its own payment rate
## Background

### Top 7 LTCH Hospital Discharged by DRG and Census Region, 2003

*(based on the RTI Draft Report)*

<table>
<thead>
<tr>
<th>DRG</th>
<th>New England</th>
<th>Mid Atlantic</th>
<th>E. North Central</th>
<th>W. North Central</th>
<th>South Atlantic</th>
<th>E. South Central</th>
<th>W. South Central</th>
<th>Western Mountain</th>
<th>Pacific</th>
</tr>
</thead>
<tbody>
<tr>
<td>475 Respiratory System Diagnosis with Ventilator Support</td>
<td>428</td>
<td>800</td>
<td>2,676</td>
<td>605</td>
<td>1,595</td>
<td>664</td>
<td>1,980</td>
<td>590</td>
<td>802</td>
</tr>
<tr>
<td>462 Rehabilitation</td>
<td>185</td>
<td>786</td>
<td>733</td>
<td>160</td>
<td>704</td>
<td>863</td>
<td>3,307</td>
<td>206</td>
<td>187</td>
</tr>
<tr>
<td>12 Degenerative Nervous System Disorders</td>
<td>869</td>
<td>334</td>
<td>455</td>
<td>600</td>
<td>411</td>
<td>248</td>
<td>2,568</td>
<td>164</td>
<td>197</td>
</tr>
<tr>
<td>271 Skin Ulcers</td>
<td>99</td>
<td>271</td>
<td>751</td>
<td>302</td>
<td>584</td>
<td>249</td>
<td>2,523</td>
<td>288</td>
<td>281</td>
</tr>
<tr>
<td>249 Aftercare, Musculoskeletal System &amp; Connective Tissue</td>
<td>917</td>
<td>316</td>
<td>415</td>
<td>71</td>
<td>490</td>
<td>190</td>
<td>2,450</td>
<td>168</td>
<td>221</td>
</tr>
<tr>
<td>87 Pulmonary Edema &amp; Respiratory Failure</td>
<td>253</td>
<td>370</td>
<td>832</td>
<td>374</td>
<td>809</td>
<td>227</td>
<td>1,214</td>
<td>346</td>
<td>438</td>
</tr>
<tr>
<td>88 Chronic Obstructive Pulmonary Disease</td>
<td>850</td>
<td>229</td>
<td>54</td>
<td>175</td>
<td>434</td>
<td>164</td>
<td>2,043</td>
<td>195</td>
<td>242</td>
</tr>
<tr>
<td>Total</td>
<td>3,601</td>
<td>3,106</td>
<td>6,386</td>
<td>2,287</td>
<td>5,027</td>
<td>2,605</td>
<td>16,085</td>
<td>1,957</td>
<td>2,368</td>
</tr>
</tbody>
</table>
### Background

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Acute Short Term</th>
<th>LTCH</th>
<th>IFP</th>
<th>Psychiatric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Populations Treated</td>
<td>Acutely ill or injured</td>
<td>Medically Complex</td>
<td>Medically stable, primarily rehabilitation</td>
<td>Medically stable Psychiatry</td>
</tr>
<tr>
<td></td>
<td>Intensive Care</td>
<td>Rehabilitation Psychiatric</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient Surgical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Coverage</td>
<td>Acute</td>
<td>Acute</td>
<td>Acute Rehab Therapy: 3 hours/d/5 days</td>
<td>Acute Psychiatric Harmful to self or others</td>
</tr>
<tr>
<td>LOS Criterion</td>
<td>None</td>
<td>25 days or longer</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Type of Condition</td>
<td>None</td>
<td>None</td>
<td>50-75 percent in 13 diagnostic groups</td>
<td>100 percent with MH primary diagnosis</td>
</tr>
<tr>
<td>Year PPS</td>
<td>1983</td>
<td>2002</td>
<td>2002</td>
<td>2005</td>
</tr>
<tr>
<td>Base Rate/Discharge/2007</td>
<td>$5,308</td>
<td>$38,086</td>
<td>$12,952</td>
<td>Per Diem</td>
</tr>
<tr>
<td>Case Mix Groups</td>
<td>DRG</td>
<td>DRG-LTCH</td>
<td>RIC-based CMG</td>
<td>DRG</td>
</tr>
<tr>
<td>Individual Adjusters</td>
<td>Surgery Complicating Comorbidities</td>
<td>Surgery Complication Comorbidities</td>
<td>Functional Impairment Lev., Complicating</td>
<td>Surgery Complicating Comorbidities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Comorbidities</td>
<td></td>
</tr>
<tr>
<td>Medical Staffing</td>
<td>Emergency Medicine Surgeons</td>
<td>Pulmonologists</td>
<td>Physiatrists Internists</td>
<td>Psychiatrists Internists</td>
</tr>
<tr>
<td></td>
<td>Surgeons Internists</td>
<td>Infectious Disease Internists</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Physiatrists Internists</td>
<td></td>
</tr>
<tr>
<td>Nursing Specialty</td>
<td>Medical Nurses</td>
<td>Medical Nurses Wound Care RN</td>
<td>Rehab Nurses Wound Care RN</td>
<td>Psychiatric Nurses</td>
</tr>
<tr>
<td>Other Staffing</td>
<td>Physical Therapists Occupational Therapists</td>
<td>Respiratory Therapists PT/OT Speech</td>
<td>Physical Therapists Occupational Therapists</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Speech Pathologists</td>
<td>Pathologists</td>
<td>Speech Pathologists</td>
<td></td>
</tr>
</tbody>
</table>

Source: Long-Term Care Hospital Payment System Monitoring Evaluation - October 2006
### Background

Physician and nursing hours in LTCHs, IRFs, and SNFs

<table>
<thead>
<tr>
<th></th>
<th>LTCH</th>
<th>IRF</th>
<th>SNF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>Daily 2-3 per week</td>
<td>2-3 per week Close medical supervision</td>
<td>General Supervision At least every 14-30 days</td>
</tr>
<tr>
<td>Consulting Physician</td>
<td>2-3 per week</td>
<td>Frequent</td>
<td>As needed</td>
</tr>
<tr>
<td>Nursing Hours</td>
<td>12-16 hrs. per day</td>
<td>6.5 hrs. rehab RN</td>
<td>2.5-4 hrs. per day</td>
</tr>
</tbody>
</table>

Source: Long-Term Care Hospital Payment System Monitoring Evaluation - October 2006
Patient-Level Recommendations

- Restrict LTCH admissions to cases that meet certain medical conditions, including having a primary diagnosis that is medical in nature, not function or psychiatric, and meeting a certain level of medical complexity that reflects severely ill populations.
- Require LTCH Admissions to be discharged if not having diagnostic procedures or improving with treatment, such as those receiving long term ventilator management.
- Develop a list of criteria to measure medical severity for hospital admissions.
- Require LTCHs to collect functional measures as well as physiologic measures on all patients receiving physical, occupational, or speech and language pathology services.

Facility Level Recommendations

- Standardize conditions of participation and set staffing requirements to ensure appropriate staff for treating medically complex cases.
- Keep the 25 day average length of stay requirements in place to limit LTCH’s incentives to unbundle and clearly delineate between general and long term acute patients.

Note: CMS awarded a contract to Research Triangle Institute, International (RTI) in 2004 to develop patient and facility-level criteria and to determine the feasibility of developing a more clinically sophisticated admissions policy in order to distinguish Medicare patients who could most benefit from LTCH treatment.
Illinois

- Under current State Board rules a category of service for LTCH has not been defined or established.
- Applications are reviewed under 77 IAC 1110.530 - Medical Surgical-Pediatric-ICU Review Criteria and 77 IAC 1110.320 – Bed Related Review Criteria
- LTCHs in Illinois
  - Current facilities: RML Specialty – Hinsdale, Kindred Hospital – Sycamore, Kindred Hospital – Northlake, Kindred Hospital – Central Chicago, Kindred Hospital – Chicago, Holy Family – Des Plaines, Kindred Hospital – Springfield, Advocate Bethany Hospital – Chicago, Regency Hospital – Rockford
Other States - Definitions

<table>
<thead>
<tr>
<th>South Carolina</th>
<th>West Virginia</th>
<th>New Jersey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Care (LTC) hospitals provide diagnostic and medical treatment of rehabilitation to patients with chronic diseases or complex medical conditions with an average stay of 25 days or longer. Although these patients are no longer in need of general acute care, they still require extensive lengths of stay in a setting, which can provide highly skilled nursing, therapy and medical treatment. The LTC hospital provides a level of care designed to minimize secondary medical conditions prior to discharge to nursing facilities, outpatient rehabilitation, or home health services. They must have a Medicare provider agreement to participate as a hospital and must maintain a minimum 25-day average length of stay. Examples of the type of conditions that fall into this category are strokes, cardiac care, HIV, ventilator dependency, general debilitation, wound care, respiratory infections, and post-surgical care. These patients are medically complex, often requiring life support and/or extended ICU care. Required intensive support services may include invasive monitoring, cardiac telemetry, transfusion therapy, dialysis, central line placement, nutritional support, and hemodynamic monitoring.</td>
<td>An acute care hospital that cares for patients who have been in an intensive care or short-term acute care setting that requires an extended length of stay (greater than twenty-five days). LTACHs are referred to as a “hospital within a hospital.” The host hospital must delicense any acute care beds used in the development of the LTACH. If the LTACH would cease to exist, would terminate its services, or would not offer its services for a period of twelve months, any beds delicensed by a host hospital to establish the LTACH would revert back to the host hospital.</td>
<td>Long Term Acute Care Hospital means a category of special hospital that provides acute care through a broad spectrum of clinical care services for acutely ill/medically complex patients requiring, on average, a 25 day or greater length of stay. A long term acute care hospital may either be freestanding or a hospital within a hospital. A Special Hospital means any hospital which assures the provision of comprehensive specialized diagnosis, care, treatment and rehabilitation where applicable on an inpatient basis for one or more specific categories and for a hospital that provides long term acute care through a broad spectrum of clinical care services for acutely ill/medically complex patients requiring, on average, a 25 day or greater length of stay. Special hospitals do not include hospitals or hospital units providing comprehensive rehabilitation services and licensed in accordance with the provision of N.J.A.C. 8:43H.</td>
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<tbody>
<tr>
<td>“Long term care hospital” means a freestanding hospital or a hospital located within a general acute care hospital, which, in the case of an existing facility, has an average length of stay of greater than 25 days and is certified by the Center for Medicare and Medicaid Services (“CMS”) as a long term care hospital or, which, in the case of an applicant proposed to establish a long term care hospital, proposes to have an average length of stay of greater than 25 days and proposes to be certified by CMS as a long term care hospital.</td>
<td>A long-term acute care (LTAC) hospital is a free-standing, Medicare-certified hospital with an average length of inpatient stay greater than 25 days that is primarily engaged in providing chronic or long-term medical care to patients who do not require more than three hours of rehabilitation or comprehensive rehabilitation per day.</td>
<td>“Long-term (acute) care hospital,” for purposes of these standards, means a hospital has been approved to participate in the Title XVIII (Medicare) program as a prospective payment system (PPS) exempt hospital in accordance with 42 CFR Part 412. “Host hospital,” for purposes of these standards, means an existing licensed hospital, which delicenses hospital beds, and which leases patient care space and other space within the physical plan of the host hospital, to allow a long-term (acute) care hospital, or alcohol and substance abuse hospital, to begin operation.</td>
</tr>
</tbody>
</table>
**Other States - Rules**

<table>
<thead>
<tr>
<th>South Carolina</th>
<th>West Virginia</th>
<th>New Jersey</th>
</tr>
</thead>
<tbody>
<tr>
<td>An application for a Long Term Care Hospital must be in compliance with the relevant standards of the licensing Standards for Hospital and Institutional General Infirmary. Long Term Care Hospital beds will not be considered a separate category for licensing or planning purposes. All LTCH beds remain part of the inventory of general acute care hospital beds. Long Term Acute Care hospital beds will only be approved if an existing hospital converts existing general acute care beds to LTCH beds or if there is a specific need for additional general acute care beds indicated in the State Plan.</td>
<td>Development of a LTACH shall be limited to existing space within an existing general acute care facility. Space within the existing acute care facility shall be specifically designated for the LTACH and shall be designed to accommodate the treatment requirements of the LTACH patients. The applicant shall delineate the service area for the LTACH by documenting the expected areas from which it is expected to draw patients. The applicant may submit documentation on the expected service area based upon national data or statistics, or upon projections generally relied on by professionals engaged in health planning or the development of health services. The applicant shall document expected utilization for the service to be provided. The applicant shall consider the number of discharges from acute care facilities within the proposed service area that have an average length of stay greater than twenty-five (25) days in making utilization projections. After establishing expected utilization or demand, the applicant shall document the number of existing LTACH providers within the service area and the extent to which the demand is being met by existing LTACH providers.</td>
<td>Minimum Size: 60 beds freestanding – 25 beds HwH Computed need is based upon potential LTAC days for 26 DRGs considered typical LTAC DRG codes. Application must demonstrate the ability to attain and maintain 80% occupancy through referral/transfer agreements form hospitals that agree to transfer patients eligible for LTAC. Hospitals shall be located within one hour travel time. Applicants requesting additional beds must demonstrate occupancy level of 85% for 6 quarters.</td>
</tr>
</tbody>
</table>
### Other States - Rules

<table>
<thead>
<tr>
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<th>West Virginia</th>
<th>New Jersey</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Continued-</td>
<td>The applicant must clearly demonstrate that individuals requiring inpatient treatment will be discharged as soon as they are able to function in less restrictive setting. New LTACH beds which would result in an increase in total licensed beds will not be approved when the licensed acute care beds exceed the Bed Need for the study area. Excess acute care beds within an existing acute care facility must be converted to fill any unmet for additional need LTACH beds. A LTACH shall not be less than 10 beds. The project must be shown to be consistent with the facility’s long range plan.</td>
<td></td>
</tr>
</tbody>
</table>
Other States - Rules

<table>
<thead>
<tr>
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<th>Mississippi</th>
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</tr>
</thead>
</table>
| A hospital that has been approved through the certificate of need process to use a certain number of short-stay hospital beds for long-term acute care (LTAC) beds shall have such LTAC bed removed from the official inventory of available short-stay beds once the LTAC is certified by Medicare; provided, however; that such beds will revert to the hospital’s official inventory of available short-stay beds at any point the LTAC ceases operation or is no longer certified by Medicare. | The applicant shall document a need for the proposed project. Documentation shall consist of the following:  
A minimum of 450 clinically appropriate restorative care admissions with an average length of stay of 25 days; and  
A projection of financial feasibility by the end of the third year of operation.  
The applicant shall document that any beds which are constructed/converted will be licensed as general acute care beds offering long-term care hospital services. | Requirements for approval - new beds in a hospital  
An applicant proposing to begin operation as a new long-term (acute) care hospital or alcohol and substance abuse hospital within an existing licensed, host hospital shall demonstrate that it meets all the following requirements:  
The patient care space and other space to establish the new hospital is being obtained through a lease arrangement between the applicant and the host hospital.  
The initial, renewed, or any subsequent lease shall specify at least all of the following:  
That the host hospital shall delicense the same number of hospital beds proposed by the applicant for licensure in the new hospital.  
That the proposed new beds shall be for use in space currently licensed as part of the host hospital. |
Need Projection Discussion

- Presentation by:
  Ken Pawola
  Vice President Operations and Planning
  RML Specialty Hospital
  Hinsdale, Illinois
General Discussion

- **Definition**
  - Long Term (Acute) Care Hospital

- **Need Determination**
  - Demand or Incidence Formula
  - Planning Areas
  - Utilization Targets
  - Use Rate Minimum

- **Review Standards (LTCH specific)**
  - Facility Size
  - Patient Mix and Scope of Services
  - Conversion (Short Term Acute to Long Term Acute)
  - Accessibility (travel time for services)
  - Assurances – CMS Certification
Resource Materials

- Certificate of Need Websites: South Carolina, West Virginia, Mississippi, Michigan, Georgia
- Federal Register, Department of Health and Human Services, August 11, 2004
- Federal Register, Department of Health and Human Services, May 6, 2005
- Federal Register, Department of Health and Human Services, January 27, 2006
- Long-Term Care Hospital (LTCH) Payment System Monitoring and Evaluation, RTI International, October 2006
- Medicare News, “Medicare Publishes Payment Changes for Long-Term Care Hospitals for Rate Year 2006”, April 29, 2005
- OLR Research Report, “Long Term Acute Care Hospitals” December 20, 2004