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Fighting Medicare Fraud in Long-Term Care Hospitals-within-Hospitals: OIG Documents Ongoing Failures while Industry Groups Complain

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Fighting Medicare Fraud in Long-Term Care Hospitals-within-Hospitals: OIG Documents Ongoing Failures while Industry Groups Complain

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Medicare's reimbursement system – under which the act of admission to a hospital triggers federal payment obligations – opens the door to potential abuse in situations in which related hospitals can "churn" patients. A recent report (http://oig.hhs.gov/oei/reports/oei-01-02-00630.pdf) by the U.S. Department of Health and Human Services Office of Inspector General (the "OIG") suggests that this problem may have manifested itself in long-term care hospitals-within-hospitals ("HwHs").[1] The report bolsters arguments by the Centers for Medicare & Medicaid Services ("CMS") for increased regulation of such HwHs[2] and tends to undercut a chorus of industry complaints about proposed regulations.

For Medicare purposes, a long-term care hospital is an institution whose average length of patient stay is longer than 25 days.[3] Typical patients need significant long-term medical assistance, such as ventilators, and often have organ failure or infectious diseases.[4] Before October 2002, such institutions received cost-based Medicare reimbursement.[5] Since then, CMS has been phasing in a prospective payment system ("PPS") for such institutions, similar to the PPS that applies to acute care hospitals, but using a higher base payment rate to reflect the higher average costs of caring for patients

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[1] See, e.g., *Hospitals, Lawmakers Voice Opposition to CMS' LTCH Admissions Proposal*, HEALTH LAWYERS WEEKLY, July 16, 2004, *available at* http://www.healthlawyers.org/hlw/printerfriendly.cfm?f=/hlw/issues/040716/040716_12_mm_LTCH.cfm.
[2] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, LONG-TERM CARE HOSPITALS-WITHIN-HOSPITALS, Report No. OEI-01-02-00630 (July 2004) [hereinafter *OIG Report*], *available at* http://oig.hhs.gov/oei/reports/oei-01-02-00630.pdf.
[3] 42 C.F.R. § 412.23(e)(2)(i).
[4] *See, e.g.*, OIG Report, *supra* note 2, at 1.
[5] *Id.*

in long-term care hospitals.[6] Under a PPS, a hospital receives a fixed amount for a patient's care, calculated by Medicare based on average costs for treatment of patients with a similar diagnosis, generally without adjustment to reflect the hospital's actual costs incurred in treating the individual patient. The PPS approach allows Medicare to exert some level of cost control while encouraging hospitals to provide efficient care. However, the introduction of the PPS for long-term care HwHs has increased the possibility of fraud due to the relationship of such HwHs with the acute care hospitals (so-called "host hospitals") in which the HwHs physically reside.

Because the relationship between long-term care HwHs and their host hospitals is necessarily close, the two institutions could easily work together to circumvent the cost control intent of Medicare's PPS payments. For example, an HwH could discharge a patient to its host hospital and then readmit the same patient, each time receiving a new PPS payment from Medicare and also triggering a Medicare payment to the host hospital. Similarly, a host hospital could reduce its own costs by transferring a patient to the related HwH before the patient had actually received all the care intended to be covered by Medicare's PPS payment to the host hospital.[7] To avoid these issues, CMS regulations require a high level of organizational separation between host hospitals and HwHs, including separate governing bodies, separate chief medical and chief executive officers, and separate medical staffs.[8] CMS regulations also require financial independence. For example, HwHs must satisfy one of the following: (1) the HwH must perform basic hospital functions such as quality assurance, utilization review, medical record and laboratory services separately from their host hospitals, (2) the cost of services

[6] *Id.* at 2.
[7] *Id.* at 3.
[8] 42 C.F.R. § 412.22(e)(1)(i)-(iv).

that an HwH obtains from its host hospital must not exceed 15% of the HwH's total inpatient operating costs, or (3) at least 75% of the HwH's inpatient population must have been referred to the HwH from an institution other than its host hospital.[9]

CMS has also attempted directly to counter collusion between HwHs and their host hospitals by limiting payments to HwHs for any fiscal year in which more than 5% of the discharges from an HwH to its host hospital are readmitted directly back to the HwH from the host hospital.[10] If the HwH readmits more than 5% of its discharges to its host hospital, the HwH will receive only one PPS payment per patient for all admissions from the host hospital during the fiscal year in which the 5% threshold is exceeded.[11]

The OIG looked carefully at the implementation of the 5% threshold rule, evaluating 87 HwHs during the period from October 1, 1999, through December 31, 2002.[12] The OIG also evaluated CMS' oversight of long-term care HwH compliance with both the 5% threshold rule and with other criteria for qualifying for the long-term care Medicare PPS.[13] The review determined that more than 20% of the long-term care HwHs had violated the 5% threshold in at least one of the fiscal years under review, but that CMS does not have any system to detect these violations and impose the regulatory payment limitations.[14] Apparently, CMS considered monitoring the 5% threshold as the responsibility of the Medicare fiscal intermediaries, yet failed to notify the fiscal intermediaries of this responsibility.[15] The OIG Report recommended that CMS develop

[9] 42 C.F.R. § 412.22(e)(1)(v).
[10] 42 C.F.R. § 413.40(a)(3).
[11] 42 C.F.R. § 412.532(c).
[12] OIG Report, *supra* note 2, at 6.
[13] *Id.* at 7.
[14] *Id.* at 8.
[15] *Id.* at 9.

an effective system to monitor HwH compliance with the 5% readmission threshold.[16] In light of the OIG Report, CMS has indicated that it intends to address the issue.[17]

In the same month as the publication of the OIG Report, industry groups were urging CMS to revisit a proposed rule that would limit long-term care HwH patient admissions from the HwH's host hospital to no more than 25% of the total inpatient admissions to the HwH.[18] The 25% limit is currently one of three alternative ways for a long-term care HwH to satisfy CMS' financial independent requirements. The proposed rule eliminates the other two alternatives,[19] one of which – the requirement that the HwH provide almost all of its own services separately from the host hospital – has been the primary way in which HwHs have satisfied the financial independence requirement.[20] The hospital industry argues generally that the change will severely limit HwHs' ability to survive.[21]

Despite the complaints of the hospital industry, CMS' ongoing efforts to limit referrals between host hospitals and long-term care HwHs reflect a broader problem inherent in the relationship between HwHs and their host hospitals. This problem is highlighted by the significant failures described in the OIG Report. Given the ongoing violations of the 5% threshold for readmissions that the OIG Report documents, imposing

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[16] *Id.* at iv.
[17] *Id.* at v, 24
[18] *See, e.g.*, Rick Pollack, American Hospital Association, *Proposed Changes to Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates; CMS-1428-P – Long Term Care Hospital and Hospital within Hospital Provisions, available at* http://www.healthlawyers.org/hlw/issues/040716/AHA_comment.pdf (July 7, 2004); *see also* Ellen J. Kugler, National Association of Urban Hospitals, *CMS-1428-P Hospitals Within Hospitals, available at* http://www.nauh.org/docs/p11/hospital_within_hosp.pdf (July 9, 2004) [collectively, hereinafter *Hospital Letters*].
[19] 69 Fed. Reg. 28196 (May 18, 2004).
[20] *See* Hospital Letters, *supra* note 19.
[21] *Id.*

a flat limit on the percentage of HwH admissions from the HwH's host hospital may prove an effective way to reduce Medicare fraud in this area.