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109TH CONGRESS
2D SESSION

H. R. 6236

To amend title XVIII of the Social Security Act to ensure and foster continued patient quality of care by establishing facility and patient criteria for long-term care hospitals and related improvements under the Medicare Program.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 28, 2006

Mr. ENGLISH of Pennsylvania (for himself and Mr. POMEROY) introduced the following bill; which was referred to the Committee on Ways and Means

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A BILL

To amend title XVIII of the Social Security Act to ensure and foster continued patient quality of care by establishing facility and patient criteria for long-term care hospitals and related improvements under the Medicare Program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Long-Term Care Hospital Improvement Act of 2006''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) Long-term care hospitals (in this section referred to as ''LTCHs'') serve a valuable role in the post-acute care continuum by providing care to medically complex patients needing long hospital stays.

(2) The Medicare program should ensure that patients receive post-acute care in the most appropriate setting. The use of additional certification criteria for LTCHs, including facility and patient criteria, will promote the appropriate placement of severely ill patients into LTCHs. Further, patient admission screening tools and continued stay and discharge assessment tools can guide appropriate patient placement.

(3) Certain long-term care diagnosis related groups (LTC–DRGs) are associated with higher severity of illness levels, as measured by the APR–DRG system, and that patients grouped into those LTC–DRGs are predicted to be appropriate for LTCH services.

(4) Measuring and reporting on quality of care is an important function of any Medicare provider and that a national quality initiative for LTCHs should be similar to short-term general acute care hospitals in the Medicare program.

(5) To conform the prospective payment system for LTCHs with certain aspects of the prospective payment system for short-term general acute care hospitals and promote payment stability, the Secretary of Health and Human Services (in this Act referred to as the ''Secretary'') should—

(A) perform an annual market basket update;

(B) conduct the LTC–DRG reweighting and wage level adjustments in a budget neutral manner each year;

(C) not perform a proposed one-time budget neutrality adjustment, and

(D) not extend the 25 percent limitation on reimbursement of co-located hospital patient admissions to freestanding LTCHs.

SEC. 3. NEW DEFINITION OF A LONG-TERM CARE HOSPITAL WITH FACILITY AND PATIENT CRITERIA.

(a) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Long-Term Care Hospital

''(ccc) The term 'long-term care hospital' means an institution which—

''(1) is primarily engaged in providing inpatient care, by or under the supervision of a physician, to medically complex patients needing long hospital stays;

''(2) has an average inpatient length of stay (as determined by the Secretary) for Medicare beneficiaries of greater than 25 days, or as otherwise defined in section 1886(d)(1)(B)(iv);

''(3) satisfies the requirements of paragraphs (2) through (9) of subsection (e), except the first sentence of paragraph (9);

''(4) meets the following facility criteria:

''(A) the institution has a patient review process, documented in the patient medical record, that screens patients prior to admission, validates within 48 hours of admission that patients meet admission criteria, regularly evaluates patients throughout their stay, and assesses the available discharge options when patients no longer meet the continued stay criteria;

''(B) the institution applies a standard patient assessment tool, as determined by the Secretary, that is a valid clinical tool appropriate for this level of care, uniformly used by all long-

term care hospitals, to measure the severity of illness and intensity of service requirements for patients for the purposes of making admission, continuing stay and discharge medical necessity determinations taking into account the medical judgment of the patient's physician, as provided for under sections 1814(a)(3) and 1835(a)(2)(B);

''(C) the institution has active physician involvement with patients during their treatment through an organized medical staff, on-site physician presence and physician review of patient progress on a daily basis, and consulting physicians on call and capable of being at the patient's side within a moderate period of time, as determined by the Secretary;

''(D) the institution has interdisciplinary team treatment for patients, requiring interdisciplinary teams of health care professionals, including physicians, to prepare and carry out an individualized treatment plan for each patient; and

''(E) the institution maintains a minimum staffing level of licensed health care professionals, as determined by the Secretary, to en-

sure that long-term care hospitals provide an intensive level of care that is sufficient to meet the needs of medically complex patients needing long hospital stays; and

''(5) meets patient criteria relating to patient mix and severity appropriate to the medically complex cases that long-term care hospitals are uniquely designed to treat, as measured under section 1886(m).''.

(b) NEW PATIENT CRITERIA FOR LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT.—Section 1886 of such Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(m) PATIENT CRITERIA FOR PROSPECTIVE PAYMENT TO LONG-TERM CARE HOSPITALS.—

''(1) IN GENERAL.—To be eligible for prospective payment as a long-term care hospital, a long-term care hospital must discharge the percentage established in paragraph (4) of each hospital's total patients who are entitled to benefits under part A and who were admitted with one or more of the medical conditions specified in paragraph (2).

''(2) SELECTION OF LTC-DRGS.—The Secretary shall determine the long-term care diagnosis related groups (LTC–DRGs) under section 307(b) of the

Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, that are associated with a high severity of illness for the following specified medical conditions:

''(A) Circulatory conditions.

''(B) Digestive, endocrine, and metabolic conditions.

''(C) Infectious disease.

''(D) Neurological conditions.

''(E) Renal conditions.

''(F) Respiratory conditions.

''(G) Skin conditions.

''(H) Other medically complex conditions as defined by the Secretary.

''(3) CHANGE TO DIFFERENT PATIENT CLASSIFICATION SYSTEM.—If the Secretary changes the patient classification system for the long-term care hospital prospective payment system (LTCH PPS) to a classification system other than the long-term care diagnosis related group (LTC–DRG) system, the Secretary shall determine the new patient classification categories that are associated with a high severity of illness for the medical conditions specified in paragraph (2) in a manner that maintains the same proportion of Medicare discharges as the long-

term care diagnosis related groups (LTC–DRGs) in effect at the time.

''(4) PERCENTAGE OF MEDICARE PATIENT DISCHARGES.—

''(A) IN GENERAL.—Subject to subparagraph (B), for each long-term care hospital, the proportion of discharges from the long-term care diagnosis related groups (LTC–DRGs) determined under paragraph (2), or other patient classification categories designated pursuant to paragraph (3) if applicable, in a cost reporting year must be a percentage, as determined by the Secretary, that is not less than 50 percent and not greater than 75 percent.

''(B) TRANSITION PERIOD.—The Secretary shall provide for a three-year transition period beginning on October 1, 2007, for hospitals that were certified as long-term care hospitals before such date. The applicable proportion of cases in the first year of the transition period shall be not less than 50 percent.

''(5) NONCOMPLIANCE.—If a long-term care hospital in a cost reporting year does not discharge more than the applicable proportion of cases specified in paragraph (4), then the hospital must dem-

onstrate in a period of five out of six consecutive months at the end of the hospital's next cost reporting year that it meets the applicable proportion of cases in paragraph (4). If the hospital cannot make such a demonstration, then the hospital shall be paid for all cases after the hospital's next cost reporting year as a subsection (d) hospital under subsection (d).''.

(c) NEGOTIATED RULEMAKING TO DEVELOP LTCH FACILITY AND PATIENT CRITERIA.—The Secretary shall promulgate regulations to carry out the amendments made by this section on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2007.

SEC. 4. LTCH QUALITY IMPROVEMENT INITIATIVE.

(a) STUDY TO ESTABLISH QUALITY MEASURES.—The Secretary shall conduct a study (in this section referred to as the ''study'') to determine appropriate quality measures for Medicare patients receiving care in LTCHs.

(b) REPORT.—The Secretary shall report to Congress by October 1, 2007, on the results of the study.

(c) SELECTION OF QUALITY MEASURES.—Subject to subsection (e), the Secretary shall choose 3 quality measures from the study to be reported by LTCHs.

(d) REQUIREMENT FOR SUBMISSION OF DATA.—

(1) IN GENERAL.—LTCHs must collect data on the three quality measures chosen under subsection (c) and submit all required quality data to the Secretary.

(2) FAILURE TO SUBMIT DATA.—Any LTCH which does not submit the required quality data to the Medicare program in any fiscal year shall have the applicable LTCH market basket under section 1886 reduced by not more than 0.4 percent.

(e) EXPANSION OF QUALITY MEASURES.—The Secretary may expand the number of quality indicators required to be reported by LTCHs under the study. If the Secretary adds other measures, the measures shall reflect consensus among the affected parties. The Secretary may replace any measures in appropriate cases, such as where all hospitals are effectively in compliance or where measures have been shown not to represent the best clinical practice.

(f) AVAILABILITY OF DATA TO PUBLIC.—The Secretary shall establish procedures for making the quality data submitted under this section available to the public.

SEC. 5. CONFORMING LTCH PPS UPDATES TO THE INPATIENT PPS.

(a) REQUIRING ANNUAL UPDATES OF BASE RATES AND WAGE INDICES AND ANNUAL UPDATES AND REWEIGHTING OF LTC–DRGS.—The second sentence of section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 is amended by inserting before the period at the end the following: ", and shall provide (consistent with updating and reweighting provided for subsection (d) hospitals under paragraphs (2)(B)(ii), (3)(D)(iii), and (3)(E) of section 1886 of the Social Security Act) for an annual update under such system in payment rates, in the wage indices (in a budget neutral manner), in the classification and reweighting (in a budget neutral manner) of the diagnosis-related groups applied under such system". Pursuant to the amendment made by paragraph (1), the Secretary shall provide annual updates to the LTCH base rate, as is specified for the IPPS at section 1886(d)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(B)(ii)). The Secretary shall annually update and reweight the LTC–DRGs under section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 or an alternative patient classification system in a budget neutral manner, consistent with such updating and reweighting applied under section 1886(d)(3)(D)(iii)

of the Social Security Act (42 U.S.C. 1395ww(d)(3)(D)(iii)). The Secretary shall annually update wage levels for LTCHs in a budget neutral manner, consistent with such annual updating applied under section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)).

(b) ELIMINATION OF ONE-TIME BUDGET NEUTRALITY ADJUSTMENT.—The Secretary shall not make a one-time prospective adjustment to the LTCH PPS rates under section 412.523(d)(3) of title 42, Code of Federal Regulations, or otherwise conduct any budget neutrality adjustment to address such rates during the transition period specified in section 412.533 of such title from cost-based payment to the prospective payment system for LTCHs.

(c) NO APPLICATION OF 25 PERCENT PATIENT THRESHOLD PAYMENT ADJUSTMENT TO FREESTANDING LTCHS.—The Secretary shall not extend the 25 percent (or applicable percentage) patient threshold payment adjustment under section 412.534 of title 42, Code of Federal Regulations, or any similar provision, to freestanding LTCHs.

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