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Finger Lakes Health Systems Agency
Rochester, NY

Prepared by

Kathryn McCabe Votava, PhD, RN

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**EXTENDED ACUTE CARE:
COMMUNITY NEED
FOR LONG-TERM CARE HOSPITAL/S
IN THE FINGER LAKES REGION**

September 2007

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Table 1 FLHSA Long-Term Care Hospital Community Needs Assessment Project Staff

Sarah Trafton, JD	Associate Executive Director
Lynn Varricchio, MPH, MTH	Senior Planner
Arthur Streeter, MHA	Senior Planner and Director of Review
Melinda Whitbeck, MBA	Director of Health information and Data Services
Margaret Clark, MPA	Associate Director, Planning and Capacity Analysis
Susan Touhsaent, MSW	Senior Research Associate
Gary Stevens, BA	Research Associate and Manager of Information Technology



Executive Summary

This report is designed to enhance the understanding of and assess the community need for Long-Term Care Hospital/s (LTCH) in the Finger Lakes region of Upstate New York. The report grows out of community experience that some patients need extended acute care beyond the average for acute hospital Length of Stay (LOS). These patients require very complex medical care, skilled nursing care and rehabilitation care. Many of these patients are also experience psycho-behavioral as either their primary problem or as a comorbidity that further complicates their plan of acute care. It can not be emphasized enough that the care of patients experiencing an extended acute hospital stay is the result of an aggregate of need that is extensive and beyond that of most acute hospital patients.

Both qualitative and quantitative methods were used to answer the community needs assessment questions. Interviews with experts within the healthcare delivery system, healthcare providers, and healthcare regulators were conducted. Quantitative analyses were conducted using selected elements from the 2003 through 2006 New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS) data from acute care hospital episodes for patients 18 years of age and over. This study used a three stage method with the first stage including all patients in the Finger Lakes region with long hospital stays resulting in N = 44,634 patients who experienced acute hospital stays. The second and third stages were sub-samples of those patients included in the first stage. The second stage of the community needs assessment used a sub-sample of all those "Finger Lakes Region Acute Hospital Long LOS Patients." That sample was modeled to resemble patients with very long LOSs that would qualify for admission to a LTCHs. That second stage yielded an "Extended Acute Care" sample of N= 7,045 acute hospital episodes.

While the largest age group represented in the "Extended Acute Care" was at least 75 years of age and older, at 42.8%, a large number, 39.4%, of patients

were under the age of 65, therefore, emphasizing the issue that extended acute hospital care is experienced by people across the age spectrum. Also, the results confirmed the complex clinical nature of the patient care required with 73% had 8 diagnoses and 19% of the patients had 14 diagnoses. These patients had many procedures with 34.2% having three procedures and 18% having had five. The leading Acute Hospital DRG represented in the sample was Psychoses, 17%, followed by Heart Failure, 10% and Pneumonia, 8%.

In order to facilitate health services planning, the episodes were categorized into one of three Extended Acute Care (EAC) groups based on clustering DRGs together with similar skilled care needs:

- Complex – including DRGs, such as wound care, infectious disease, heart failure, musculoskeletal, neurological
- Respiratory or Ventilator
- Psycho-Behavioral

The third stage of the community needs assessment was modeled to draw a sub-sample that might meet the LTCH Clinical Admission Criteria, which are in line with prevailing clinical judgment and are consistent with the Medicare LTCH criteria. These LTCH Clinical Admission Criteria were applied as a screen to the EAC sample using an estimate that 80% of the acute patient episodes would meet those criteria and be appropriate for admission to a LTCH. The result was a sample of “LTCH candidates” that was randomly selected from the EAC categories: “Medical EAC” Total groups (Respiratory/Ventilator and Complex combined) and Psycho-Behavioral group. The LTCH candidates sub-sample yielded N = 4,651 patients in the Medically EAC and N = 987 in the Psycho-Behavioral group for a total N = 5638. Acute hospital days saved estimates and LTCH bed need estimates were made on a sliding scale based on estimates of patients’ “Acute Hospital Discharge Clinical Readiness.”

The results of this third stage of the community needs assessment, using this LTCH Candidate sub-sample, showed a clear need for LTCH beds in the Finger

Lakes region. There is a need for 82 to 104 LTCH beds to care for patients with “Medical EAC” needs, i.e. wound care, ventilator care, etc. as well as a need for 23 to 30 Psycho-Behavioral LTCH beds. The total need estimate for LTCH beds in the Finger Lakes region is between 105 to 134 beds.

What is less clear is the type and distribution of LTCH beds that may be needed within the Finger Lakes subareas to effectively care for patients’ clinical needs and give families adequate access to support those patients. In order to clarify this matter, the LTCH candidates sub-sample was analyzed by EAC group within the Finger Lakes subareas. Based on these estimates, there is a need in the Monroe and Livingston subarea for between 37 and 47 Complex Clinical care beds, 15 and 19 Respiratory/Ventilator beds as well as 17 and 22 Psycho-Behavioral beds. The only other subarea demonstrating an economy of scale to support a LTCH is the Southern Tier subarea which demonstrated a need for between 17 to 21 LTCH beds for medically complex patients. Most notable are the small number of all of the EAC Clinical Groups in the Central and Western subareas as well as the Psycho-Behavioral Clinical Group in the Southern Tier.

Even if all of these LTCH beds are developed, there will still be a shortage of between 13 to 17 beds for patients with complex medical needs as well as 5 to 8 Psycho-Behavioral beds throughout the Finger Lakes region. A solution proposed is to increase the number of beds recommended in the larger subareas to absorb the need from the smaller subareas. The disadvantage of increasing beds in larger subareas to accommodate patients from smaller subareas is that the patients will be further from their homes and sources of usual care after the LTCH stay. Families’ access to the LTCH discharge planning process and the teaching they need to care for patients at home will be limited by geographic barriers.

Regardless of LTCH location and assuming that LTCH rates can be negotiated with Medicaid and private insurers, there are two major threats to the economic viability of LTCH operations. Those threats are: 1. Medicare 25% referral

limitation from an acute care hospital that owns a LTCH; 2. the potential for patients to back up in LTCH beds once they have met the criteria for Medicare discharge and yet continue to need complex care. The Medicare 25% referral restriction limits the possibilities of existing acute care hospitals to develop a Hospital-within-Hospital (HWHs). This is a particular concern in the Southern Tier as a free standing LTCH the size of 17 to 21 beds for those with medically complex care needs is not economically feasible.

There is a distinct possibility that LTCH patients' care needs will extend beyond the Medicare LTCH reimbursement criteria. This situation has proven to be problematic for LTCHs around the country as well as in New York State. While a negotiated Medicaid daily rate may alleviate the reimbursement and placement problem for some patients, it will not for all. Therefore, an LTCH bed block situation would still exist resulting in the circumstance of an LTCH back-up.

A piece of the solution to the existing acute hospital bed back-up and potential LTCH back-up problems lie in addressing the structure, function and reimbursement mechanisms in other levels of care such as Skilled Nursing Facilities and Home Care services. It is also important to note that the need for extended acute care, as part of the continuum of care, might, in fact, be met in a variety of settings outside of the acute care hospital depending on the patient's care needs and other community supports available to them. It may be possible that with some redesign of the sites of care, i.e., LTCHs, Skilled Nursing Facilities (SNF) and home and community-based care; as well as regulatory structures and reimbursement programs that patients could receive the rest of the extended acute care that they need and reach their maximum health potential in a variety of settings.

This report also includes Certificate of Need review criteria for LTCHs, including LTCH Clinical Admission criteria, staffing recommendations and LTCH operational recommendations. The criteria will help potential LTCH planners and potential

service providers to develop CON applications to meet the needs of patients in the Finger Lakes region.

The impact of approving LTCHs in the Finger Lakes region falls into two main areas: 1. the positive opportunity margin for traditional acute care hospitals, and 2. the potential for improved patient outcomes for EAC patients who are treated at LTCHs. First, if LTCHs were in operation in the Finger Lakes region, EAC patients would not back up in the acute hospital to the extent that they do now. As a result, the traditional acute hospitals would be in the position to discharge EAC patients expeditiously to the LTCH and thereby be able to admit another patient in need of traditional acute care to that hospital. The affect of enhancing the flow of patients through traditional acute hospitals would result in decreasing the number of patients waiting admission to traditional acute hospitals and buffer the need to build additional acute hospital beds in the Finger Lakes region. A study from Connecticut demonstrated cost effectiveness of using discharging patients to LTCHs from traditional acute hospitals.

There is a real potential to improved patient care outcomes if LTCHs were available in the region. First, those patients awaiting traditional acute hospital care would benefit from the decreased wait from a bed. Also, and quite importantly, there is evidence from national studies that some patients' outcomes are better in LTCHs when compared to traditional acute hospital care. Patients are weaned from ventilators earlier and have longer survivability after discharge from a LTCH than from traditional acute care alone. This phenomenon is most evident with patients who have been ventilator dependent (Gage, B., Bartosch, W., & Green, B.A., 2007). In summary, it is possible that all stakeholders, patients, traditional acute hospitals, LTCHs and acute care payors can benefit if LTCHs operate in the market place.

As the Finger Lakes region moves forward in the health planning and implementation process for extended acute care patients' needs, the region has the opportunity,

through effective health planning, to redesign regulations and reimbursement structures to allow health care service providers to usher in a wider variety of care options tomorrow than are available today. Therefore being directly in line with the goal of the Finger Lakes Health Systems Agency which is to “to provide all people the right care, at the right time, in the right place for the right price.”

SECTION 1. Background and Significance

Introduction

This report is designed to enhance the understanding of and assess the community need for Long-Term Care Hospital/s (LTCH) in the nine county Finger Lakes region in Upstate New York including Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, and Yates counties. The report was initiated because of a community concern that some patients remain in acute care for extended periods of time which may not be the optimal site of care for their health and they block the use of beds for others with acute care needs. These patients require very complex medical, skilled nursing and rehabilitation care. Many of these patients also have psycho-behavioral considerations which further complicates their plan of acute care.

Key aspects of extended acute care and the role that LTCHs may play in meeting those care needs are addressed in this report. The report includes a review of the literature, interviews with experts, and an analysis of patients who have experienced an extended acute care hospitalization in the Finger Lakes region. The report concludes with Certificate of Need (CON) review criteria.

1.1 What Is “Extended Acute Care”?

As a concept, “Extended Acute Care” (EAC) is acute care that continues beyond the norm of the current Medicare Prospective Payment System (PPS). For example, Medicare expects that patients diagnosed with Skin Ulcers have a geometric mean LOS of 5.6 days in an acute care hospital and 26.5 days in a LTCH (Appendix B). Patients with these longer LOSs have more complex care needs and require a longer period of acute care. Their care requirements may be different from typical acute hospital care, i.e., complex ventilator weaning requiring extended care and therapy.

It is important to clarify the terminology used within the report. Medicare uses the terminology of Long-Term Care Hospital to categorize this type of an extended acute care hospital. Another term used interchangeably with “LTCH” is Long-Term Acute Care Hospital or “LTACH.” For the purposes of this report, the two terms will mean the same thing and the terminology of Long-Term Care Hospital (LTCH) is used exclusively throughout.

1.2 What is a Medicare Certified Long-Term Care Hospital and who are the patients that are cared for there?

A Medicare certified LTCH is an acute care hospital with an Average Length of Stay (ALOS) of at least 25 days for its Medicare patients. In fact, the only distinction that Medicare makes between an acute care hospital and a LTCH is the ALOS requirement of 25 days. That said, LTCH patients are more complex in their care needs than their diagnostic counter parts in acute care hospitals. LTCHs typically furnish extended medical and rehabilitative care for patients who are clinically complex and have multiple acute or chronic conditions. Generally speaking, Medicare patients in LTCHs were in an acute care hospital just prior to admission to the LTCH. Patients can also be admitted from other sites of care.

In order to set the stage for thinking about the community need for a LTCH it is important to fully appreciate the intricate nature of these patients who have multifaceted medical, skilled nursing, rehabilitation and mental health care needs. Patients who receive care in LTCHs have a greater number of health problems and require a longer period of time to recuperate. As a group, these patients have primary diagnoses including extensive wounds and burns, resistant infectious diseases, serious respiratory conditions, neurological disorders, orthopedic problems, major trauma, sepsis, multisystem complications, severe cardiovascular disease or diabetes. The key distinction between patients who are might be cared for in a LTCH is not the diagnosis per se but rather the multiplicity of diagnoses and problems leading to an aggregate of care need that extends well beyond the capabilities of a typical acute care hospital.

Most patients in LTCHs have several diagnosis codes on their Medicare claims. Patients are generally less stable upon admission to a LTCH than ALC patients or patients admitted to other post-acute care facilities such as complex skilled nursing facilities. LTCHs have a higher proportion of patient cost associated to ancillary services (i.e., pharmacy, laboratory, and radiology services).

Regardless, it is still useful and appropriate to categorize potential LTCH patients into clinical sub groups. Patients who are typically better served by LTCHs are those with:

- Complex pulmonary and ventilator weaning needs
- Extensive wound care needs
- Infectious disease needs
- Neurological needs
- Orthopedic needs
- Complex needs, i.e., cardiovascular and diabetic
- Psychiatric and behavioral needs

As an example, the complex pulmonary and ventilatory weaning patients need specialized care for acute respiratory disorders that have not responded quickly to the care available in the acute care setting. It can not be emphasized enough that LTCHs care for patients with an aggregate of care whose needs are extensive and therefore requiring longer hospital stays. The LTCH care programs are designed to meet those needs and enhance the patients' opportunities to convalesce and return to the highest level of health possible for them.

"The Devil's in the Details" - Rules and Regulations

The LTCH needs to meet several sets of rules and regulations in order to operate. In addition to fundamental health services rules and regulations, i.e.,

Health Insurance Portability and Accountability Act (HIPAA), LTCHs must comply with the rules, regulations, standards and criteria of:

- The Centers for Medicare and Medicaid (CMS)
- New York State Health of Department, Article 28
- The Quality Improvement Organization (QIO)
- The Joint Commission

The Medicare rules, regulations, standards, and criteria are discussed in this report most extensively, as Medicare is the primary drivers of the structure and organization of LTCHs in the United States. Medicare is the preverbal “tail that wags the dog.”

1.3 Medicare LTCH Regulatory Requirements

Information about the regulatory requirements for LTCHs certified under Medicare is available on the Centers for Medicare and Medicaid (CMS) LTCH website (2007) as well as the CMS training manual (2007). A synopsis of that information is included in this report and a more detailed discussion is presented in Appendix A. According to Medicare, LTCHs are short-term, acute-care hospitals which have been excluded from the Inpatient Acute Care Hospital Prospective Payment System. Appendix A contains more detailed information about key Medicare LTCH rules, regulations and procedures.

Medicare LTCHs must meet all of the following criteria:

- Certification under Medicare as a short-term acute-care hospital, which has been excluded from the inpatient acute care hospital prospective payment system (IPPS).
- State licensure requirements for acute care.
- A provider agreement with Medicare.
- An ALOS for Medicare patients of greater than 25 days.
- An agreement for Medical Necessity review with a QIO.

LTCHs may be free standing or co-located with acute-care hospitals and other Medicare providers. By statute, while there are no LTCH units; there are satellite and hospital-within-hospital (HWH) LTCHs. To be exempt from the Interim Payment System (IPPS), a LTC-HWH must have a separate governing body, chief executive officer, chief medical officer, and medical staff and meet the following criteria:

- Perform basic functions independently from the host hospital
- Incur no more than 15 percent of its total inpatient operating costs for items and services supplied by the hospital in which it is located
- Admit no more than 25% of its patients from the co-located hospital

Satellite LTCHs need to maintain separate utilization statistics. While the statistics can be combined for cost reporting and billing, the statistics tracking beds, days, and discharges of patients treated in the satellite LTCH have to be tracked separately (CMS, 2007).

1.3.1 Factors Effecting Medicare Long-Term Care - DRG Payments

Medicare LTCH PPS payments are based on the Long-Term Care (LTC)-DRG, QIO medical necessity determination, area wage and other local adjustments. It is important to note that the Medicare LTCH PPS methodology does not allow the following “typical” adjustments to the standard Federal rate found in other PPSs: rural location, geographic reclassification, disproportionate share (DSH) or indirect medical education (IME) costs. Other excluded costs are bad debts, blood clotting factors, some anesthesia services, QIO required patient care record photocopying and mailing costs.

The Medicare LTC-DRG scheme does allow for adjustment to the LTC rate for short-stay outliers, interrupted stays and high cost outlier cases. Short-stay outliers have stays that are 5/6 of the ALOS for the LTC-DRG to which the case is grouped. Short-stay outliers are also eligible for high cost outlier payments if

their costs exceed the outlier threshold. An interrupted stay is a case in which an LTCH patient is discharged and admitted directly to an inpatient acute care hospital, an Intermediate Rehabilitation Facility (IRF), a Skilled Nursing Facility (SNF) or a swing-bed and then returns to the same LTCH within a fixed period of time. For example, if a LTCH patient develops a septicemia, very high fever, and clinical instability beyond the capability of the LTCH, that patient is transferred to an acute care hospital. If the acute hospitalization lasts for nine days or less and patient returns to the LTCH, Medicare considers this to be an “interrupted stay.” The interrupted stay is treated as one discharge for the purposes of payment and only one LTCH PPS payment is made to the LTCH. Additional payments are also made for high cost outlier cases.

In addition to the Medicare LTC-DRG payments, Medicare B also provides coverage for some patient care services while a person is hospitalized in a LTCH. Medicare B covers Physician, Nurse Practitioner (NP), and Physician Assistant (PA), Clinical Nurse Specialist (CNS), and Psychologist and Anesthetist services during a LTCH stay.

1.3.2 Medicare Beneficiary Financial Liability for LTCH Costs

Once a stay triggers a full LTC-DRG payment, the beneficiary cannot be billed for the difference between Medicare payments and the cost of care, even if the Medicare payment is below the actual cost of care. Beneficiaries (or their Medigap insurance) are still responsible for all non-covered days. Beneficiaries can be charged when a LTCH receives less than the full payment as in the case of a short stay patient.

1.4 Quality Improvement Organization

Medicare requires the QIO operating in each state to review LTCHs on an ongoing basis for the following specific areas:

- Medical necessity, reasonableness and appropriateness of the LTCH admission and discharge
- Care for which outlier payments are sought
- Validity of the diagnostic and procedural information
- Completeness, adequacy and quality of the services
- Need for other medical or clinical services billing by LTCHs

The QIO in New York State uses the InterQual[®] Clinical Decision Support Tools from McKesson (2007) as review criteria for medical necessity of LTCH ventilator patient stays. The InterQual[®] Clinical Decision Support Tool for Long-Term Acute Care Criteria for Ventilator Weaning covers major aspects of clinical care as well as discharge standards:

- Severity of illness necessitating daily Physician, NP or PA assessment or intervention.
- Intensity of service with very specific clinical criteria regarding weaning.
- Discharge screens covering discharge to home, skilled medical care, or sub-acute care.

1.5 New York State Health Department, Article 28, Hospital Regulations

Because LTCHs are acute hospitals, the NYSDOH Article 28 Hospital Regulations apply to them. The oversight and review of compliance with these regulations is often achieved through The Joint Commission accreditation and review process if the hospital has “deemed status”. As a result, a LTCH must become accredited by The Joint Commission in order to operate in NYS if it has “deemed status”. If not, the NYSDOH will directly survey the LTCH.

1.6 The Joint Commission

The Joint Commission (formerly JCAHO) is the accrediting body that certifies LTCHs in the United States. The Joint Commission accreditation is required

by the New York State Department of Health (NYSDOH) to assure that basic standards are met in accordance with the NYSDOH article 28 hospital regulations. This accreditation is gained by a hospital through the Joint Commission survey conducted regularly on an unannounced basis. The Joint Commission uses the acute care hospital standards (Joint Commission, 2006) in their surveys of LTCHs. The Joint Commission does not use any additional standards for LTCH surveys (Misenko, personal communication, July 25, 2007).

SECTION 2. Community Needs Assessment Study

A community needs assessment study was conducted to evaluate the potential to meet the needs of extended acute care patients for LTCH/s. This study was designed to address the questions that follow here. The study methods, design and results are presented subsequently.

Study Questions

The following questions were developed by the FLHSA project team for this community needs assessment. In the context of the capacity of home care and skilled nursing facility ability to accept patients with complex behavioral and medical needs who are at nursing facility level of care, should one or more Long-Term Care Hospital units be created in the Finger Lakes region? Those questions are:

1. What are the typical DRGs of patients appropriate for care in an LTCH?
2. Clinically, what are the diagnostic groupings these patients would fall into?
3. How many regular hospital beds might be opened by putting appropriate patients into LTCH?
4. What are the reimbursement projections for patients who are a good fit for LTCH?
 - a. How would these compare to costs for the same patients in an acute hospital?
5. If one or more LTCHs are appropriate for the Finger Lakes region, given the origin of patients appropriate for such care, where and how many LTCH units should there be?
6. What are the staffing requirements for LTCH?

7. What would the capital requirements be to retrofit the former St. Mary's Hospital for an LTCH unit? What would be the costs of establishment of an LTCH, given the need for autonomy, restrictions on percent of patients coming from a sponsoring hospital, and separate governance, management, and medical staff requirements?
8. Given the number of LTCH beds needed in the region, are there any economies of scale, either in terms of clinical care or cost savings?
9. Are patients with behavioral health problems appropriate for LTCH? Should they be in a separate LTCH unit?
 - a. Would it be better to find a solution for long-term behavioral health patients in acute care that would include step down to nursing facility-level care from the outset?
10. What happens when patients are ready for discharge from LTCH - would available home care and/or nursing facilities be capable of caring for these patients long-term?
11. What is the experience of LTCHs in New York State:
 - a. How many LTCHs operate in NYS?
 - b. What types of patients do they care for?
 - c. What has been their reimbursement experience?
 - d. What are their staffing recommendations?
12. What is the potential community need for LTCH/s in the Finger Lakes region based on experience within the region with extended acute care hospital patient stays?

Methods

Both qualitative and quantitative methods were used to answer the community needs assessment questions. Interviews were conducted with experts within the healthcare delivery system, healthcare providers, and healthcare regulators. Quantitative analysis of selected elements from the NYS DOH Statewide Planning and Research Cooperative System (SPARCS) data were used to answer these important questions.

2.1 Interview Methods

Experts in the field of LTCH operations, regulation and certification were sought out. Telephone interviews were conducted with these experts by Dr. Votava.

2.2 Quantitative Analysis Design

SPARCS is the NYS comprehensive health care data reporting system that collects patient level detail on patient characteristics, diagnoses and treatments, services, and charges for every hospital discharge, ambulatory surgery patient, and emergency department admission in NYS that is used for health planning. A retrospective analysis the 2003 through 2006 SPARCS data was conducted by constructing an analytical data set for by abstracting specific data elements from the SPRCA data file. This study used a three stage method (Figure 1). The first stage included all patients who met the following inclusion criteria. The second and third stages were sub-samples of those patients included in the first stage.

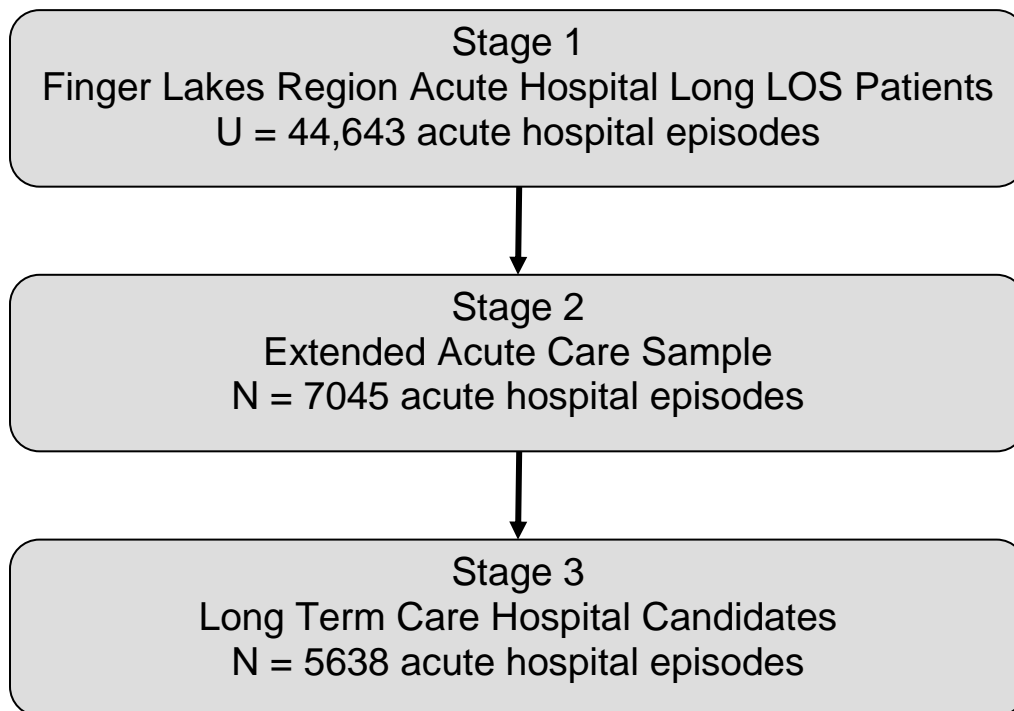
2.3 Stage 1

A group of patients was drawn from the SPARCS data with the objective to most closely model a population of patients who have experienced extended acute hospital care in the Finger Lakes region who might meet the criteria for admission to a Medicare certified LTCH. The inclusion criteria were:

- Acute hospital patient discharges recorded in the SPARCs data set during 2003, 2004, 2005 or 2006
- Patients over the age of 17 years
- Patients discharged either:
 - From the nine county Finger Lakes region acute care hospitals, or
 - Patient residence within the nine county Finger Lakes region discharged from hospitals outside the region
- Patients discharged with one of the top 50 DRGS found in LTCHs in other areas of the United States (Appendix B)
- Patients discharged with an acute hospital care LOS $\geq 75^{\text{th}}$ percentile

The sample is a duplicated count, meaning that for patients with more than one discharge during the study timeframe, each discharge was treated as a separate episode of an acute care hospital stay. These data include demographic, diagnostic, and utilization per episode and were not unduplicated.

Figure 1 LTCH Community Needs Assessment Three Stage Method



2.4 Analytical Data Set Stages 2 and 3

An analytical data set was formed using the SPARCS data from years 2003, 2004, 2005 and 2006. Specific data fields that were abstracted from the SPARCS data files, included: basic demographic information, diagnostic and procedure information, DRG information, LOS, and hospital identification information (Appendix E). Also, total non-covered charge information was abstracted from the 2005 and 2006 SPARCS data files. The U for this first stage of the analytical data set included 44,643 acute hospital patient episodes.

A sensitivity analysis was conducted with this universe of “Finger Lakes Region Acute Hospital Long LOS Patients” to select episodes clustered within each DRG with LOSs corresponding to the Medicare geometric mean for LTCH episodes nationally (Appendix A) for the second stage of the analysis. The 75th, 80th, 82.5th, 85th, and 90th LOS percentiles were examined. This sensitivity analysis showed that the 82.5th percentile of LOS within DRGs from this universe of Finger Lakes Region Acute Hospital Long LOS Patients yielded an analytical sample that most closely resembled a potential LTCH patient population when compared to national norms. The second stage of the needs assessment yielded the “Extended Acute Care Sample” with N = 7045 acute hospital patient episodes.

The Stage 3 sample “Long Term Care Hospital Candidates” sample was drawn from the Stage 2 sample using LTCH clinical admission criteria developed for this study as a screen. This resulted in a “LTCH Candidates” sub-sample including Medical EAC Total groups (Respiratory/Ventilator and Complex combined) N= 4,651 and N = 987 in the Psycho-Behavioral group for a total N = 5638.

2.5 LTCH Operations Interviews

Dr. Votava conducted three interviews with experts within New York State about LTCH operations. Those interviews were with Renato Estrella, QIO; Aldo Troiani, Summit Park Hospital; and Florentino DeBlois, Coler-Goldwater. Mr. Estrella stated there are two operating LTCHs in New York State. He reported that at one point, there were four LTCHs in New York State, but that two have closed. Mr. Estrella was not clear on why the two had closed. Mr. Estrella provided the contact information for the two NYS LTCHS, one is Summit Park Hospital in Rockland County, New York and the other is Coler-Goldwater Hospital on Roosevelt Island in New York City.

Aldo Troiani, Acting Commissioner of Hospitals and Patient Services Administrator from the Summit Park Hospital in Pomona, NY was interviewed for his experience and advice in operating a LTCH in New York State. Summit Park Hospital has 57 of its beds approved as a LTCH. Mr. Troiani reports that Summit Park focuses its LTCH mainly on wound care and infectious disease patients. While they have no ventilator beds, they are considering adding ventilator beds in the future but would require a new physical plant to provide that type of care. Physicians see patients every other day. He discussed the staffing requirements and the standard is that patients receive 6 to 5.5 hours per day of nursing care Summit Park LTCH has an all RN staff. Summit Park's experience is that LPNs have not worked out well given the complex nature of patient care within their LTCH.

A telephone interview was conducted with Mr. Florentino DeBlois from the Coler-Goldwater Hospital on Roosevelt Island in New York City. Mr. DeBlois is involved in Utilization Review and talked at length about switching over to the prospective payment system for Long-Term Care Hospitals. Coler-Goldwater has a full range of patient types; including ventilator patients, wound care, and infectious disease, and psycho-behavioral. Coler-Golderwater has found it particularly difficult to maintain the finances for the ventilator patients because

the PPS for Medicare ventilator patients in Long-Term Care Hospitals cuts off before patients are ready for discharge. At that point, unless the patient is on Medicaid, the LTCH patient is without a source of reimbursement and no other site of care to be discharged to. That results in a financial loss for the institution as well as a bed block for prospective LTCH patient. Mr. DeBlois reports that the QIO will be using the InterQual[®] standards review ventilator patients. He emphasized the importance of selecting the right patients upon admission and working on the discharge plan from the moment of admission. Mr. DeBlois says that they have negotiated a Medicaid rate for LTCH patients, including ventilator patients, and are not having any problems with those finances.

Table 2 Health Care Experts Interviewed

Name	Organization	Title	Area of Expertise
Florentino DeBlois	Coler-Goldwater Hospital; NY, NY	Utilization Review	Long-Term Care Hospital Utilization Review, LOS, ventilator care.
Renato Estrella	Quality Improvement Organization (QIO); Lake Success, NY	Manager of Health Information Systems	LCTH QIO Review
Steven Misenko	Joint Commission; Chicago, IL	Vice President	Joint Commission Hospital Review and Accreditation process
Julian Pettengill	Medicare Payment Advisory Commission (MEDPAC); Washington, DC	Acute Hospital DRG Staff	Medicare Acute Care DRGs
Aldo Troiani	Summit Park Hospital; Pomona, NY	Acting Commissioner of Hospitals, Patient Services Administrator	Long-Term Care Hospital Operations
Carrie Whitcher	Excellus; Buffalo, NY	Director, Performance Improvement	Community Health Planning Task Force

Quantitative Results

Selected results from the Stage 2 EAC analytical data set, N = 7045 patient acute hospital episodes are presented here. Rounding may result in variant percentages

2.6 Demographics

The demographics of the sample are displayed here in Tables 3 through 5. While the largest age group represented in the sample was that of patients 75 years of age and older (42.8%) 39.4%, of patients were under the age of 65.

Table 3 EAC Patient's Sex 2003-2006

Sex	# of Patients	Percent
Female	3,764	53.4
Male	3,281	46.6
Total	7,045	100.0

Table 4 EAC Patient's Age Groups 2003–2006

Age Group	# of Patients	Percent
75+	3,015	42.8
65-74	1,253	17.8
45-64	1,712	24.3
25-44	832	11.8
18-24	233	3.3
Total	7,045	100.0

Table 5 EAC Patient's Ethnic Group 2003–2006

Ethnic Group	# of Patients	Percent
White NH	5,878	83.4
Black NH	934	13.3
Hispanic	115	1.6
Other	118	1.6
Total	7,045	100.0

2.7 EAC Patient's Types of Illness

The sample demonstrated a wide variety of primary and secondary diagnoses. Over the course of the acute hospitalization 73% of the patients had 8 diagnoses and 19.4% of the sample had 14 diagnoses. Procedures occurred with 34.2% of patients having had 3 and 17.7% having had 5. Table 6 displays the top ten Acute Hospital DRGs found in the sample. The leading Acute Hospital DRG represented in the sample was Psychoses with 16.6%. A more detailed list of the top Acute Hospital 50 DRGs is included in Appendix B.

Table 6 EAC Patient's Top Ten DRGs 2003–2006

DRG	#	%	Cumulative %
Psychoses	1,167	16.6	16.6
Heart Failure & Shock	681	9.7	26.2
Pneumonia W Cc	552	7.8	34.1
Rehabilitation	476	6.8	40.8
Esophagitis, Gastroent & Misc Digest Disorders W Cc	425	6.0	46.9
COPD	367	5.2	52.1
Intracranial Hemorrhage or Infarction	266	3.8	55.8
Kidney & Urinary Infection W Cc	234	3.3	59.2
Nutritional & Metabolic Disorder W Cc	227	3.2	62.4
Septicemia	210	3.0	65.4
TOTAL	4,605	65.40	

2.8 Major Diagnostic Categories

The leading Major Diagnostic Category found in the study was Respiratory, 21%, followed by Mental Diseases and Disorders at 17.6%.

Table 7 EAC Patient's Major Diagnostic Categories 2003-2006

MDC	#	%	Cumulative %
Respiratory	1,477	21.0	21.0
Mental Diseases and Disorders	1,238	17.6	38.5
Circulatory	957	13.6	52.1
Digestive	583	8.3	60.4
Factors Influencing Health Status	535	7.6	68.0
Kidney Urinary	478	6.8	74.8
Nervous	454	6.4	81.2
Endocrine Nutrition Metabolic	376	5.3	86.6
Infectious Parasitic	313	4.4	91.0
Skin Subcutaneous Tissue and Breast	240	3.4	94.4
Musculoskeletal Connective Tissue	209	3.0	97.4
Hepatobiliary Pancreas	126	1.8	99.2
Injuries Poison Drug Toxicities	48	.7	99.8
Blood, Blood Forming Organs Immunological	4	.1	99.9
ENT	2	.0	99.9
Burns	2	.0	100.0
Male Reproductive	1	.0	100.0
Female Reproductive	1	.0	100.0
Pregnancy Childbirth	1	.0	100.0
Total	7,045	100.0	

The acute hospital DRGs were then subcategorized into groups that are cared for within LTCHs. The categories were formed by grouping DRGs together based on similarities of skilled care need. For example, the respiratory and ventilator care DRGs were grouped together. As a result, three EAC Clinical Groups were defined:

- Complex – including DRGs, such as wound care, infectious disease, heart failure, musculoskeletal, neurological
- Respiratory or Ventilator
- Psycho-Behavioral

2.9 Acute Hospital Reimbursement Sources

Table 8 Acute Hospital Primary and Secondary Reimbursement by EAC Group 2003-2006

EAC Clinical Group	Reimbursement Type	Primary Reimbursement %	Secondary Reimbursement %
Complex	Medicare	69.6	26.6
	Private Insurance	16.5	21.9
	Medicaid	8.5	10.0
	Other	5.4	41.5
	EAC Group Total	100.0	100.0
Respiratory or Ventilator	Medicare	80.3	33.1
	Private Insurance	12.6	23.7
	Medicaid	4.9	10.7
	Other	2.2	32.5
	EAC Group Total	100.0	100.0
Psycho-Behavioral	Medicare	55.6	17.9
	Medicaid	29.6	20.7
	Private Insurance	8.4	7.6
	Other	6.5	53.7
	EAC Group Total	100.0	100.0

SECTION 3. LTCH Community Need Recommendation

LTCH Bed Need Analysis

The LTCH bed need analysis was performed using a sub-sample of the EAC episodes selected to model the Community need for LTCH beds. The LTCH Clinical Admission Criteria (Section 3.3.1), that are in line with prevailing clinical judgment and are consistent with Medicare LTCH criteria, were applied as a screen to the full EAC sample using an estimate, based on expert opinion, that 80% of the EAC sample would meet those criteria. This resulted in an 80% “LTCH Candidates” sub-sample, randomly selected from the EAC categories: Medical EAC Total groups (Respiratory/Ventilator and Complex combined) and Psycho-Behavioral group. The LTCH Candidates sub-sample yielded N = 4,651 patients in the Medically EAC group and N = 987 in the Psycho-Behavioral group for a total N = 5638. The LTCH Candidates sub-sample was compared to the full EAC sample on all study descriptive variables, including demographic, diagnostic and geographic characteristics, for comparability to the full EAC sample.

Comparability was established and then the estimates were made with the following assumptions:

- Medicare allows an acute hospital to recoup the full DRG payment if the patient remains in the acute hospital for the Medicare geometric mean LOS minus 1 day. There is as an economic incentive to keep a patient in an acute hospital at least until the timeframe to recoup the full DRG. After that timeframe, there is an economic incentive for the acute care hospital to discharge the patient to another site of care.
- The LTCH occupancy rate was assumed at the 90% level.

The Acute Hospital Days saved (Figure 1) were calculated by subtracting the 2007 Medicare geometric mean acute hospital LOS (Appendix B) as well as subtracting 1 additional day from the acute hospital LOS experienced by EAC patients in the sample and multiplying that figure by a range of LTCH Clinical Admission Eligibility.

Figure 2 Acute Hospital Days Saved Estimate Formula

$$\text{Acute Hospital Days Saved} = \sum_{k=1}^n [\text{Acute Hospital LOS} - (\text{2007 Medicare Geometric Mean LOS} - 1 \text{ day})] \text{ Acute Hospital Discharge Clinical Readiness}$$

Percent Additional Acute Hospital LOS	Acute Hospital Discharge Clinical Readiness
5%	Prompt Clinical Readiness
10%	Prompt to Mid Clinical Readiness
15%	Mid-Range Clinical Readiness
20%	Mid to Late Clinical Readiness
25%	Late Clinical Readiness

The Acute Hospital Discharge Readiness was estimated under the assumption that patients would meet the LTCH Clinical Admission Criteria at some point after the “average” acute hospital DRG LOS. That point was estimated by setting the Acute Hospital Discharge Clinical Readiness parameter at various LOSs beyond the “average” acute hospital DRG LOS as a percentage of the patients’ entire LOS above the acute hospital DRG average LOS. That estimate was applied as a sliding scale within the formula.

The bed need analysis was then conducted at three levels. The full detail of these estimates is included in Appendix G. A summary of those estimates follows here. First, the LTCH beds needed, on an annual basis, and sub categorized by EAC Clinical Group were estimated (Table 10). This estimate shows that there is a community need for between 59 and 79 Medically Complex as well as between 23 and 30 Psycho-Behavioral LTCH beds in the Finger Lakes region.

Table 9 LTCH Beds Needed Estimate in the Finger Lakes Region by EAC Clinical Group

Extended Acute Care Group	Community Need Measures	Prompt Clinical Readiness	Prompt to Mid Clinical Readiness	Mid-Range Clinical Readiness	Mid to Late Clinical Readiness	Late Clinical Readiness
Complex	LTCH LOS Estimate	31.6	30.0	28.3	26.6	25.0
	LTCH Beds Needed Estimate	74	70	66	62	59
Respiratory or Ventilator	LTCH LOS Estimate	35.2	33.3	31.5	29.6	27.8
	LTCH Beds Needed Estimate	30	29	27	26	24
Medical EAC Total	LTCH LOS Estimate	32.6	30.9	29.1	27.4	25.7
	LTCH Beds Needed Estimate	104	99	93	88	82
<hr/>						
Psycho-Behavioral	LTCH LOS Estimate	43.4	41.1	38.8	36.5	34.2
	LTCH Beds Needed Estimate	30	28	26	25	23

The estimate was then subdivided into subareas within the Finger Lakes region to determine community need for LTCHs in various subareas. The subareas were defined as:

- Monroe/Livingston = Monroe and Livingston Counties
- Southern Tier = Chemung, Schuyler and Steuben Counties
- Central Region = Ontario, Seneca, Wayne and Yates Counties
- Western Region = Genesee, Orleans and Wyoming Counties

Patient episodes were assigned to the subarea by the county in which the patient resided. Those patients who were not from the Finger Lakes region were assigned to the county in which they experienced their acute hospital stay. The results of this estimate shows the number LTCH beds needed, on an annual basis, in the Finger Lakes region and subareas (Table 11 and Appendix G.2). The trends in this estimate follow the expected trends based on population distribution within the Finger Lakes Subareas.

Table 10 LTCH Beds Needed Estimate by Finger Lakes Subarea

Finger Lakes Subarea	Community Need Measures	Prompt Clinical Readiness	Prompt to Mid Clinical Readiness	Mid-Range Clinical Readiness	Mid to Late Clinical Readiness	Late Clinical Readiness
Monroe/Livingston	LTCH LOS Estimate	36.0	34.1	32.2	30.4	28.5
	LTCH Beds Needed Estimate	88	83	79	74	70
Southern Tier	LTCH LOS Estimate	31.0	29.4	27.7	26.1	24.5
	LTCH Beds Needed Estimate	25	24	22	21	20
Central Region	LTCH LOS Estimate	31.1	29.5	27.8	26.2	24.6
	LTCH Beds Needed Estimate	15	14	13	13	12
Western Region	LTCH LOS Estimate	38.0	36.0	34.0	32.0	30.0
	LTCH Beds Needed Estimate	6	6	5	5	5
Total	LTCH LOS Estimate	34.5	32.6	30.8	29.0	27.2
	LTCH Beds Needed Estimate	134	127	119	113	107

The LTCH candidates sub-sample was analyzed by EAC group within the Finger Lakes subareas. The matrix in Table 12 contains the detail of that estimate. Based on these estimates, there is a need in the Finger Lakes region for 82 to 104 LTCH beds to care for patients with medically complex care, i.e. wound care, ventilator care, etc. There is a need in the Monroe and Livingston subarea for between 37 and 47 Complex Clinical care beds, 15 and 19 Respiratory/Ventilator beds as well as 17 and 22 Psycho-Behavioral beds. The only other subarea demonstrating an economy of scale to support a LTCH is the Southern Tier subarea which demonstrated a need for between 17 to 21 LTCH beds for medically complex patients. Most notable are the small number of all of the EAC Clinical Groups in the Central and Western subareas as well as the Psycho-Behavioral Clinical Group in the Southern Tier.

Table 11 LTCH Beds Needed Estimate by Finger Lakes Subarea and EAC Clinical Group

Finger Lakes Subarea	Extended Acute Care Group	Community Need Measures	Prompt Clinical Readiness	Prompt to Mid Clinical Readiness	Mid-Range Clinical Readiness	Mid to Late Clinical Readiness	Late Clinical Readiness
Monroe/Livingston	Complex	LTCH LOS Estimate	32.6	30.9	29.2	27.5	25.7
		LTCH Beds Needed Estimate	47	44	42	40	37
	Respiratory &/or Ventilator	LTCH LOS Estimate	38.5	36.5	34.4	32.4	30.4
		LTCH Beds Needed Estimate	19	18	17	16	15
	Medical EAC Total	LTCH LOS Estimate	34.1	32.3	30.5	28.7	27.0
		LTCH Beds Needed Estimate	66	63	59	56	52
	Psycho-Behavioral	LTCH LOS Estimate	43.5	41.2	38.9	36.6	34.3
		LTCH Beds Needed Estimate	22	21	19	18	17
	Southern Tier	Complex	LTCH LOS Estimate	30.8	29.2	27.5	25.9
LTCH Beds Needed Estimate			16	15	14	13	13
Respiratory &/or Ventilator		LTCH LOS Estimate	27.8	26.3	24.8	23.4	21.9
		LTCH Beds Needed Estimate	5	5	5	4	4
Medical EAC Total		LTCH LOS Estimate	30.0	28.4	26.8	25.2	23.7
		LTCH Beds Needed Estimate	21	20	19	18	17
Psycho-Behavioral		LTCH LOS Estimate	38.0	36.0	34.0	32.0	30.0
	LTCH Beds Needed Estimate	4	4	3	3	3	

Finger Lakes Subarea	Extended Acute Care Group	Community Need Measures	Prompt Clinical Readiness	Prompt to Mid Clinical Readiness	Mid-Range Clinical Readiness	Mid to Late Clinical Readiness	Late Clinical Readiness
Central Region	Complex	LTCH LOS Estimate	26.6	25.2	23.8	22.4	21.0
		LTCH Beds Needed Estimate	8	7	7	6	6
	Respiratory &/or Ventilator	LTCH LOS Estimate	32.8	31.1	29.3	27.6	25.9
		LTCH Beds Needed Estimate	4	4	4	4	3
	Medical EAC Total	LTCH LOS Estimate	28.5	27.0	25.5	24.0	22.5
		LTCH Beds Needed Estimate	12	11	11	10	10
	Psycho-Behavioral	LTCH LOS Estimate	49.9	47.2	44.6	42.0	39.4
		LTCH Beds Needed Estimate	3	3	3	2	2
	Western Region	Complex	LTCH LOS Estimate	36.3	34.4	32.5	30.6
LTCH Beds Needed Estimate			4	3	3	3	3
Respiratory &/or Ventilator		LTCH LOS Estimate	36.3	34.4	32.5	30.6	28.6
		LTCH Beds Needed Estimate	1	1	1	1	1
Medical EAC Total		LTCH LOS Estimate	36.3	34.4	32.5	30.6	28.7
		LTCH Beds Needed Estimate	5	5	4	4	4
Psycho-Behavioral		LTCH LOS Estimate	49.2	46.6	44.0	41.4	38.9
	LTCH Beds Needed Estimate	1	1	1	1	1	

3.1 Limitations

The SPARCS data set is an administrative database that is constructed and maintained by the NYS DOH for the purpose of monitoring health service utilization within acute hospitals in New York State. The database does not include some variables that would be very helpful to refine the analysis and further enhance the ability of this community needs assessment to predict the number of acute care beds that might be saved if LTCHs were available to care for EAC patients. These variables, such as the need for 24 hour availability of laboratory services, respiratory therapy services and skilled nursing care, are discussed later in this report under the LTCH Clinical Admission Criteria section. This report recommends collecting data on patients' status meeting the LTCH Clinical Admission Criteria in order to refine LTCH estimation modeling.

3.2 LTCH Business Case

Many factors affect a potential business case for LTCHs. These factors include the community need, geographic distribution, potential reimbursement, capital equipment, renovation and construction costs.

3.2.1 Geographic Distribution of LTCHs

The results of this report have demonstrated the need for extended acute care and the potential for LTCHs address at least a portion of that need. The operational structure and location of a LTCH is further complicated by Medicare's requirement that for a HWH LTCH model, no more than 25% of patients admitted to that LTCH can come from the host hospital. An alternative is a free standing LTCH. The freestanding LTCH may not be appealing as it congregates the service in one geographic location making it less accessible to family caregivers who are an integral part of the care process. This would be a particular concern for those outside of the Monroe/ Livingston region and yet, within the Monroe/Livingston subarea, a free standing LTCH might be an option.

This issue is a particular concern given the Finger Lakes subarea need analysis. It is not feasible to develop a unit in an existing hospital in the subareas, with the exception of Monroe/Livingston, that could economically survive within the 25% referral restriction. The alternative of establishing a freestanding LTCH in those subareas is cost prohibitive as it would lack the economy of scale required to operate an acute care hospital.

3.2.2 Financial Viability of a LTCH

Reimbursement sources, other than Medicare, would need to be established to pay for LTCH stays for patients covered by other insurances. Also, Medicare provides LTCH coverage within sets limits based on the bundled Medicare LTCH schedule. There will be patients who are admitted to a LTCH who no longer meet the Medicare LTCH criteria and yet may not be able to move to another site of care. Coler-Golderwater has experienced this, particularly with ventilator dependent patients. It is likely that some patients admitted to a LTCH will out stay their Medicare benefit and remain in that LTCH bed causing that bed to be blocked from accepting a new patient admission.

Neither private insurance nor Medicaid currently provides LTCH coverage in the Finger Lakes region. Unlike Medicare, NYS Medicaid had a precedent, set with the LTCHs in NYS, to pay daily rates for LTCH care. Those rates are not bound to the episode of care method of payment as is Medicare and therefore useful to provide payment for those patient's who's care needs extend beyond Medicare coverage, i.e., ventilator patients who no longer meet the Medicare criteria for LTCH coverage and yet are not able to move to another site of care upon Medicare discharge.

Rates would need to be negotiated with private insurance to cover a LTCH stay. It is most likely that private insurance would follow the Medicare LTCH PPS method of admission, discharge and reimbursement criteria. Therefore, some private insurance patients will exhaust their private insurance coverage before they are able

to be discharged from the LTCH. Those patients will need to have another source of payment for their continued care. Just as is the case with Medicare patients, patients with private insurance might occupy a LTCH beyond the predicted episode LOS and block the bed for admission of a new patient.

In order to prevent a potential patient backup in LTCHs, further health system adjustments in the Finger Lakes region could alleviate this situation. It is reasonable to think that patients who stabilize to the level where they are no longer Medicare LTCH eligible, i.e., the patient's condition is stable and not anticipated to change in the foreseeable future, could actually be cared for at a different level of care from the LTCH. Those patients, who still require extended complex care such as ventilator care or chronic wound care management, could be cared for in Skilled Nursing Facilities or at home with Certified Home Care services.

Some of this type of patient flow may happen naturally after a LTCH stay as patients and their family caregivers will be in the position to manage the care needed after the LTCH stay. Regardless, some of this type of patient flow will not happen naturally and could be encouraged by enhancing reimbursement for patient services at these alternative levels of care. Enhancing reimbursement for these alternative levels of care would provide an incentive those providers to admit patients with extended complex care that currently exceeds the cost constraints within which they function.

3.2.3 Capital, Construction and Renovation Costs

Construction and renovation costs figure significantly into the LTCH business case. The unit cost per bed to develop a LTCH is often lower when using existing space and modifying it to include the features needed for the LTCH. Generally speaking, the cost to renovate existing hospital space is \$200,000 per bed. This is not always the case, given the age and prior use of the space.

There are several facilities in the Finger Lakes region that might be considered for renovation and adaptation to function as LTCHs. Those facilities include, but are not limited to: underutilized hospitals and hospitals have not been closed or converted to an alternative use.

3.2.4 Traditional Acute Hospital Opportunity Cost

Another aspect of the business case, from the community perspective, is the opportunity cost to traditional acute care hospitals of keeping EAC patients in hospital longer than DRG norms. We examined revenue and LOS experience data for the top 50 DRGs typically found in LTCHs and compared these data with episodes for similar DRGs for patients who had experienced an acute hospital episode, including those who were outliers and those who were not. MedPAR data (2004) was used. Across all DRGs the revenue per day for a patients who experienced an acute hospital outlier episode was lower than the revenue per day for patients who were not outliers (Appendix F). This analysis demonstrates that acute hospitals experience a negative opportunity cost when an outlier patient occupies a bed that a nonoutlier patient could occupy if that bed were available.

While this does not affect the business case of a LTCH, given Medicare's 25% referral restriction, it does affect the operating budgets of acute care hospitals and therefore the health care economics of acute care hospitals in the Finger Lakes region. The result to the acute care hospital is that, in the absence of LTCHs as is the case currently, there may be a lower economic yield for a bed that is blocked by an extended acute care patient. If the bed had been available sooner to admit a new patient and recoup the reimbursement of an inlier DRG the opportunity cost to the acute care hospital would be lower.

3.2.5 Market Impact of LTCH

The impact of approving LTCHs in the Finger Lakes region falls into two main areas: 1. the positive opportunity margin for traditional acute care hospitals, and 2. the potential for improved patient outcomes for EAC patients who are treated at LTCHs. First, if LTCHs were in operation in the Finger Lakes region, EAC patients would not back up in the acute hospital to the extent that they do now. As a result, the traditional acute hospitals would be in the position to discharge EAC patients expeditiously to the LTCH and thereby be able to admit another patient in need of traditional acute care to that hospital. The affect of enhancing the flow of patients through traditional acute hospitals would result in decreasing the number of patients waiting admission to traditional acute hospitals and buffer the need to build additional acute hospital beds in the Finger Lakes region. A study from Connecticut demonstrated cost effectiveness of using discharging patients to LTCHs from traditional acute hospitals (Vogel, C. A., 2007).

There is a real potential to improved patient care outcomes if LTCHs were available in the region. First, those patients awaiting traditional acute hospital care would benefit from the decreased wait from a bed. Also, and quite importantly, there is evidence from national studies that some patients do better in LTCHs when compared to traditional acute hospital care. Patients are weaned from ventilators earlier and have longer survivability after discharge from a LTCH than from traditional acute care alone. This phenomenon is most evident with patients who have been ventilator dependent (Gage, B., Bartosch, W., & Green, B.A., 2007).

In summary, it is possible that all stakeholders, patients, traditional acute hospitals, LTCHs and acute care payors can benefit if LTCHs operate in the market place.

3.3 FLHSA LTCH Certificate of Need Criteria

This section addresses the NYS Certificate of Need (CON) requirements in the context of the findings of the FLHSA community LCTH needs assessment. CON applications are reviewed against the following criteria:

- Public Need is based upon a variety of factors, including population demographics, service utilization patterns, epidemiology of selected diseases and conditions and access to services.
- Financial Feasibility is based on expenses, projected revenues, current financial status and capacity to retire debt.
- Character and Competence is based upon experience and past performance in operating a health care service including records of violations, if any, and whether a substantially consistent high level of care was maintained. Applicants without experience in health care services are evaluated based on compliance with laws and practices pertinent to their professional experience.
- Construction Buildings must comply with Title 10, Chapter V, Article 2 (Parts 710-717) of the Official Compilation of the Rules and Regulations of the State of New York.

3.3.1 LTCH Clinical Admission Criteria

The LTCH Clinical Admission criteria have been developed through this community needs assessment process. These LTCH Clinical Admission criteria have been developed in the context of clinical expertise as well as the InterQual[®] Clinical Decision Support Tool Long-Term Acute Care (2007). This report recommends that a LTCH CON application address these criteria in the structure and process of the operations plan.

The LTCH Clinical Admission criteria are:

- All LTCH patients must demonstrate:

- Cardiovascular stability:
 - Hemodynamically stability:
 - Not require hemodynamic monitoring
 - Not require vaso active medications or temporary cardiac assist devices to maintain blood pressure
 - Have no untreated life threatening cardiac arrhythmias
 - Not require cardiac monitoring
- Metabolic stability, including the absence of severe or uncontrolled acid-base, fluid, electrolyte or other metabolic disorders
- Medical stability and absence of:
 - Acute sepsis with no untreated major systemic infection
 - Acute bleeding or clotting problem
 - Uncontrolled renal failure
 - Other disorder/s requiring continued management in a critical care unit
- May require sophisticated nutritional support including TNP
- LTCH Ventilator patient admissions:
 - Require mechanical ventilation for at least six hours per day
 - Absence of episodes of severe dyspnea or rapid deterioration of respiratory function that requires frequent ventilator changes
 - Require access to blood work around the clock
 - Require 24 Respiratory Therapy
- Other Pulmonary complex patient admissions, i.e., trachostomy, pneumonia, etc.:
 - Require 24 Respiratory Therapy
- Infectious Disease patient admissions:
 - Require access to blood work around the clock

- Wound Care or other complex skilled treatment need patient admissions that require 24 hr. per day hands-on-care and assessment that can not be provided in another level of care
- Psycho-Behavioral:
 - Psychiatrically stable to the level of not a being a danger to self or others

3.3.2 LTCH Operational and Staffing Recommendations

Effective interdisciplinary patient care teams need to be organized by the LTCH in order to provide patient care. Each patient is assigned a Case Manager to work with the patient and family from admission through discharge. The Case Manager will be available to answer questions, assist with insurance and to plan for a safe, timely and appropriate discharge. Interdisciplinary Team Meetings will be held regularly to review the patient's progress and to set new goals. LTCH discharge will be arranged when the acute medical and skilled nursing needs of the patient have been met and he or she is ready for the next level of care or return home.

LTCH interdisciplinary care teams provide an array of services to their patients including:

- Individualized Plan of Care
- Daily Nurse Practitioner, Physician Assistant or Physician Visits
- Advanced Cardiac Life Support (ACLS) Certified Nursing Care
- Multi-Specialty Medical and Nurse Practitioner Staff
- 24-hour Respiratory Care
- Rehabilitation Therapies – Physical, Occupational & Speech
- Medical Social Work
- Psycho-behavioral therapists
- Diagnostic Radiology
- 24 hour Laboratory Services
- Registered Dietician & Nutritional Counseling

- Clinical Pharmacy Services
- Specialized Monitoring
- Pastoral Care
- Patient/Family Education
- Case Management & Discharge Planning
- Dedicated Wound Care: Debridement, Enterostomal Nursing Services, Prescribed dressing changes, Photo documentation
- Interdisciplinary Team meetings held regularly as determined by the patient care requirements

Staffing recommendations (Table 12) have been developed as a result of interviews with experts and review of the literature (UC Davis Center for Health Services Research in Primary Care, MEDPAC, 2004; 2002; Public Policy Associates, 2004). The recommendations are intended as guidelines to be customized by LTCHs to meet the care requirements of the patient population served by that unit. The levels and types of staff will vary depending on the clinical focus of the unit. Most of the staffing recommendations are based on a LTCH unit designed for ten to twelve patients per unit. Units could be designed and operated in multiples of ten to twelve patients. Some of the staffing recommendations can cover multiple LTCH patient units, i.e. management and supervision might cover two units as opposed to one.

Table 12 LTCH Staffing Recommendations

Staffing Categories	Recommendation
Management & Supervision	1 FTE
Registered Nurses (RN)	6.5 – 10 patient care hrs./patient/day
Licensed Practical Nurses (LPN)	Substitute a portion of the RN time ^a
Physicians ^b	0.5 FTE
Nurse Practitioners, Physicians' Assistants or Nurse Clinical Specialist ^c	1 FTE/ 2 shifts/day
Social Worker	0.5 FTE
Respiratory Therapist	1 FTE/ all shifts/day
Physical Therapists	0.5 – 1 FTE
Occupational Therapists	0.25 - .5 FTE as needed for specific patient population
Speech Therapists	0.25 - .5 FTE as needed for specific patient population
Psychologist	1 FTE
Pastoral Care	0.25 - .5 FTE as needed for specific patient population
Infection Control, Environment and Food Service	As per host institution standards
Clerical & Other Administrative	As per host institution standards

Note: ^a A portion of the RN time can be substituted with LPN time. The substitution rate depends on the size of LTCH unit. The NYS LPN scope of practice includes the care of 0patients such as those admitted to a LTCH with RN supervision of that care. While the Summit Park Hospital reports poor results using LPN care, LPNs routinely provide skilled nursing care in homes for patients with ventilator care and other complex care needs. The key to effective PLN utilization is the supervision and training program within the facility.

^b Physician services need to be available 24 hrs./day on call. Physician visits can be interchanged with NP, PA, or CNS visits.

^c Clinicians need to be qualified and skilled in the area of expertise required to care for the specific patient population, i.e., a wound care CNS for a unit that accepts wound care patients, an NP with respiratory and ventilator patient care background for a ventilator weaning unit.

Conclusion

It is clear that there is a need to explore alternatives for patients whose acute care needs extend beyond the typical acute care hospital LOS in the Finger Lakes region of Upstate New York. There is a need for 82 to 104 LTCH beds to care for patients with “Medical EAC” needs, i.e. wound care, ventilator care, etc. as well as a need for 23 to 30 Psycho-Behavioral LTCH beds. The total need estimate for LTCH beds in the Finger Lakes region is between 105 to 134 beds.

The bigger question is what type of LTCH beds are needed within the subareas in order to make care more accessible to patients and their families. In order to answer that question, the LTCH Candidates sub-sample was analyzed by EAC group within the Finger Lakes subareas. Based on these estimates, there is a need in the Monroe and Livingston subarea for between 37 and 47 Complex Clinical care beds, 15 and 19 Respiratory/Ventilator beds as well as 17 and 22 Psycho-Behavioral beds. The only other subarea demonstrating an economy of scale to support a LTCH is the Southern Tier subarea which demonstrated a need for between 17 to 21 LTCH beds for medically complex patients. Most notable are the small number of all of the EAC Clinical Groups in the Central and Western subareas as well as the Psycho-Behavioral Clinical Group in the Southern Tier.

Even if all of these LTCH beds are developed, there will still be a shortage of between 13 to 17 beds for patients with complex medical needs as well as 5 to 8 Psycho-Behavioral beds throughout the Finger Lakes region. A solution in this case may be to increase the number of beds recommended in the larger subareas to absorb the need from the smaller subareas. The downside of increasing beds in larger subareas to accommodate those patients from smaller subareas is that patients will be further from their homes and sources of usual care after the LTCH stay. Families’ access to the LTCH discharge planning process and the teaching they need to care for patients at home will be limited by geographic barriers.

Regardless of LTCH location and assuming that LTCH rates can be negotiated with Medicaid and private insurers, there are two major threats to the economic viability of LTCH operations. Those threats are: 1. Medicare 25% referral limitation from an acute care hospital that owns a LTCH; 2. the potential for patients to back up in LTCH beds once they have met the criteria for Medicare discharge and yet continue to need complex care. The Medicare 25% referral restriction limits the possibilities of existing acute care hospitals to develop HWHs. This is an even more serious concern in the Southern Tier as a free standing LTCH the size of 17 to 21 beds for those with medically complex care needs is not economically feasible.

There is a distinct possibility that LTCH patients' care needs will extend beyond the Medicare LTCH reimbursement criteria. This situation has been problematic for LTCHs around the country as well as in New York State (DeBlois, personal communication, August 8, 2007). While a negotiated Medicaid daily rate may alleviate the reimbursement and placement problem for some patients, it will not for all. Therefore a LTCH a bed block situation would still exist.

A solution to the potential LTCH back-up problem lies in addressing the structure, function and reimbursement mechanisms in other levels of care such as Skilled Nursing Facilities and Home Care services. It is also important to note that the need for extended acute care, as part of the continuum of care, might, in fact, be met in a variety of settings outside of the acute care hospital depending on the patient's care needs and other community supports available to them. It may be possible that with some realignment of the sites of care, i.e., LTCHs, Skilled Nursing Facilities (SNF) and home and community-based care; as well as regulatory structures and reimbursement programs that patients could receive the rest of the extended acute care that they need and reach their maximum health potential in a variety of settings.

As the Finger Lakes region moves forward in the health planning and implementation process for extended acute care patients' needs, the region has the opportunity, through effective health planning, to redesign regulations and reimbursement structures to allow health care service providers to usher in a wider variety of care options tomorrow than

are available today. Therefore being directly in line with the goal of the Finger Lakes Health Systems Agency which is to “to provide all people the right care, at the right time, in the right place for the right price.”

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Appendix A

Medicare Long-Term Care Hospital Rules & Regulations

This appendix provides an overview of key Medicare LTCH rules and regulations.

Co-Located Providers

There is a special payment policy for Medicare providers that have the same location or that are on the same campus as an LTCH. A co-located LTCH is a long-term care hospital that occupies space in a building used by another provider, i.e., acute hospital, or in one or more entire buildings on the same campus of buildings used by another provider. The LTCH itself may also be a satellite facility or a hospital-within-a-hospital. Co-located providers include hospitals-within-hospitals (HWH), satellite facilities, and on-site SNF swing beds.

If the rate of discharges and readmissions between the LTCH and a co-located acute hospital exceeds five percent, only one LTC-DRG is made to the LTCH for all such discharges and readmissions during that cost reporting period. If an LTCH is co-located with other Medicare providers, there is an additional five percent threshold for all such discharges and readmissions to the LTCH.

LTCHs must inform their Fiscal Intermediaries (FIs) of co-located facilities. Payment reconciliation will occur at the end of the cost report period. LTCHs are required to notify their FIs about the providers with which they are co-located within 60 days of their first cost reporting period. A change in co-located status must also be reported to the FIs within 60 days of such event.

Hospital-Within-Hospital

HWH is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital. A HWH LTCH that shares space with a separate acute care hospital, is considered co-located with that acute care hospital, as are on-site rehabilitation and psychiatric hospitals or units, swing-beds or skilled nursing facility HWH must meet the criteria at CFR 412.22 (e) to qualify for exclusion from the IPPS unless it is exempted in CFR 412.22 (f) which is basically a 'grandfathering clause' for hospitals exempted from IPPS on or before September 30, 1995.

To be exempt from IPPS, a HWH must have a separate governing body, chief executive officer, chief medical officer, and medical staff and meet one of the following criteria:

- Perform basic functions independently from the host hospital
- Incur no more than 15 percent of its total inpatient operating costs for items and services supplied by the hospital in which it is located
- Have an inpatient load of which at least 75 percent of patients are admitted from sources other than the host hospital
- Satellite LTCH Provider

Satellite providers are a HWH type facility that is owned by separate, existing LTCH. LTCHs have established satellites that share space in a building or on a campus occupied by another hospital in order to establish additional locations that are an excluded hospital (specifically an LTCH). These additional LTCH locations may be either freestanding hospitals or HWHs.

For providers to be excluded from the acute care hospital PPS, a LTCH satellite must meet all the criteria in CFR §412.22(h). Given these requirements, providers will need to maintain separate utilization statistics for the satellite. This does not mean that the numbers cannot be combined for cost reporting and billing, but the

beds, days, and discharges for patients treated in the satellite have to be tracked separately in a way that can be verified by audit, to comply with the satellite rules.

CFR §412.22(H) Criteria to be excluded from IPPS, a satellite of a hospital must:

- Must maintain admission and discharge records that are separately identified from those of the hospital in which it is located;
- Cannot commingle beds with beds of the hospital in which it is located;
- Must be serviced by the same fiscal intermediary as the hospital of which it is a part;
- Must be treated as a separate cost center of the hospital of which it is a part;
- For cost reporting purposes, must use an accounting system that properly allocates costs and maintains adequate data to support the basis of allocation;
- Must report costs in the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as that hospital;
- Must independently comply with the qualifying criteria for exclusion from the acute care hospital inpatient prospective payment system; and
- Must have a separate governing body and chief executive officer from that of the hospital in which it is located.
- Provides inpatient care through the use of medical personnel who are separate from the medical staff or chief medical officer of the hospital in which it is located.

Factors Effecting Medicare Long-Term Care - DRG Payments

PPS payments to LTCHs are based on a standardized amount per patient discharge, a Federal payment rate. The per discharge Federal rates under the prospective payment system are based on average LTCH costs in a base year updated for inflation to the first effective period of the system. The prospective payment system is updated annually. Payment under LTCH PPS is dependent on determining the patient classification. The patient discharge is assigned to a particular Long-Term Care Diagnosis Related Group (LTC-DRG). The relative weight of the LTC-DRG and Federal payment rate are also included in the LTCH PPS rate.

Patient Classification System

In general, a patient discharge is grouped based on the clinical characteristics of the Medicare beneficiary. These patient classification system groupings are called LTC-DRGs. The LTC-DRGs are based on the existing DRGs used in the IPPS. Each patient discharge is grouped using ICD-9-CM codes based on the principal diagnosis, up to eight additional diagnoses, up to six procedures performed during the stay, age, sex and the discharge status of the patient. The same GROUPE software developed for the inpatient PPS is used, but with LTCH specific relative weights.

Payment Rate

Payments to LTCHs under the LTCH PPS is based on a single standard Federal rate for both the inpatient operating and capital-related costs, but not certain pass-through costs. This single standard Federal rate is updated annually by the excluded hospital with capital market basket index.

Payment Adjustments

It is important to note that, the Medicare LTCH PPS methodology does not include the following “typical” adjustments to the standard Federal rate found in other prospective payment systems: rural location, geographic reclassification, disproportionate share (DSH) or indirect medical education (IME). The LTCH PPS does include some other typical adjustments to reflect differences in area wages. Additional payments are also made for high cost outlier cases that exceed the outlier threshold (LTC-DRG payment + fixed-loss amount).

Case-Level Medicare LTCH Payment Adjustments

Payments are based on the LTC-DRG assigned as well as possible adjustments specific to the case and/or the facility. More than one case-level adjustment may apply to the same case, such as:

- Short-stay outliers
- Interrupted stays
- High cost outlier cases, i.e., exceed the outlier threshold

Payments to LTCHs are based on the LTC-DRG as well as adjustments specific to the case. Unlike Medicare's Inpatient Rehabilitation Facility (IRF) PPS, there are no special payment policies for transfer cases or deaths. Therefore, if a patient in LTCH "A" is discharged and then admitted to LTCH "B," each LTCH will receive a separate LTC-DRG payment based on the number of days the patient is in the respective LTCH.

Short-Stay Outliers

Short-stay outliers have stays of considerably less than the ALOS. A short-stay outlier is a case that has a LOS less than or equal to 5/6 of the ALOS for the LTC-DRG to which the case is grouped. A short-stay outlier is paid the least of:

- 120 percent of the cost of the case; or,
- 120 percent of the LTC-DRG specific per diem payment.
- Short-stay outliers are also eligible for high cost outlier payments if their costs exceed the outlier threshold.

Interrupted Stays

An interrupted stay is a case in which an LTCH patient is discharged and then admitted directly to an inpatient acute care hospital, an IRF, a Skilled Nursing Facility (SNF) or a swing-bed and then returns to the same LTCH within a fixed period of time. The fixed period of time for each provider type is as follows:

- Acute care hospital – 9 days or less
- IRF – 27 days or less
- SNF – 45 days or less
- Swing-bed hospital – 45 days or less

If the LOS at the receiving provider is equal to or less than the applicable fixed period of time prior to returning to the LTCH, it is an interrupted stay. An interrupted stay is treated as one discharge for the purposes of payment and only one LTCH PPS payment is made to the LTCH.

High Cost Outliers

Additional payments are made for those cases that are high cost outliers; that is, they have unusually high costs. A case will fall into this category if the estimated cost of the case exceeds the outlier threshold. High cost outlier cases are paid 80 percent of costs above the outlier threshold. The outlier threshold is the LTC-DRG payment plus a fixed-loss amount. The fixed-loss amount is determined such that projected outlier payments are equal to eight percent of total LTCH PPS payments.

Area Wage Adjustment

The LTCH PPS wage adjustment is made by multiplying the labor-related share of the standard Federal rate by the applicable wage index value.

Medical Necessity and the LTCHs Average Length of Stay

For payment purposes, Medicare will not cover any patient stay, even if the patient has remaining Medicare days, if that stay has been determined not to have met the medical necessity, reasonableness, and appropriateness standards of the medical review procedure. The medical necessity review is conducted by the Quality Improvement Organization (QIO) (formerly IPPRO). The days of a stay failing medical review are excluded from the provider's 25-day ALOS computation for the LTCHs cost reporting period.

Medicare Part A costs not paid for under the LTCH PPS are subject to the interim payment provisions including:

- Medicare costs of an approved medical education program
- Bad debts
- Blood clotting factors
- Anesthesia services by hospital-employed non-physician anesthetists or obtained under arrangement
- Costs of photocopying and mailing medical records requested by the QIO

Medicare PRICER Software

The Medicare PRICER is computer software provided by CMS to calculate Medicare LTCH payments. LTC-DRG relative weights and the geometric average lengths of stay are maintained in the LTCH PRICER program. Payment for short-stay outliers is also determined in the PRICER logic.

LTC-DRG assignment made by the GROUPER

- Standard Federal rate
- Applicable facility-level adjustments
- Applicable case-level adjustments

Determining the Medicare Cost-to-Charge Ratio

This section describes the appropriate data sources for computing an overall Medicare hospital-specific cost-to-charge ratio for the purpose of determining short-stay outlier payments at §412.529 and high cost outlier payments at §412.525(a) under the LTCH PPS. Total Medicare charges for LTCHs are the sum of inpatient routine charges and the sum of inpatient ancillary charges (including capital). Total Medicare costs will consist of the sum of inpatient routine costs (net of private room differential and swing-bed) plus the sum of ancillary costs plus capital-related pass-through costs only. Overall Medicare LTCH cost-to-charge ratios are based on the latest settled cost report data unless such data are either unavailable or outside the ranges noted below.

A Medicare Patient in a LTCH is considered discharged when:

- The patient is formally released to home or another site of care
- The patient stops receiving Medicare LTCH services, as determined by QIO standards
- The patient dies

Medicare B Coverage During LTCH Stays

Claims for the Part B Carrier can also be submitted by the provider for the following services:

- Physician services

- Nurse Practitioners (NP) services
- Physician Assistant (PA) services
- Clinical Nurse Specialist (CNS) services
- Qualified psychologist services
- Anesthetist services

Medicare Beneficiary Financial Liability for LTCH Costs

Once a stay triggers a full LTC-DRG payment, the beneficiary cannot be billed for the difference between Medicare payments and the cost of care, even if the Medicare payment is below the cost of care. Beneficiaries (or their Medigap insurance) are still responsible for all non-covered days. LTCH providers can charge beneficiaries for:

- Deductibles
- Coinsurance (days 61-90)
- Lifetime reserve days coinsurance
- Non-covered services (i.e., telephone and television, etc.)
- Services furnished and not covered under Medicare due to benefits being exhausted or no entitlement to Part A
- Beneficiaries can also be charged when a LTCH receives less than the full LTC-DRG payment as in the case of a short-stay outlier

Appendix B

DRG Relative Weights for Top 50 LTCH DRGs in Acute Hospitals and LTCHs FY 2007

DRG	DRG Label	FY2007 Relative Weight		FY2007 Geometric Mean LOS	
		Acute	LTCH	Acute	LTCH
475	Respiratory System Diagnosis With Ventilator Support	3.83	# N/A	7.9	# N/A
249	Aftercare, Musculoskeletal System & Connective Tissue	0.82	0.64	2.8	24.0
271	Skin Ulcers	1.24	0.83	5.6	26.9
12	Degenerative Nervous System Disorders	1.01	0.68	4.4	25.1
87	Pulmonary Edema & Respiratory Failure	1.53	1.03	4.9	24.8
462	Rehabilitation	1.58	0.58	8.4	22.1
88	Chronic Obstructive Pulmonary Disease	0.96	0.64	4.0	19.3
89	Simple Pneumonia & Pleurisy Age >17 W Cc	1.13	0.68	4.6	20.6
79	Respiratory Infections & Inflammations Age >17 W Cc	1.73	0.82	6.7	22.8
466	Aftercare W/O History Of Malignancy As Secondary Diagnosis	0.78	0.67	2.7	21.7
416	Septicemia Age >17	1.83	# N/A	5.7	# N/A
263	Skin Graft &/Or Debrid For Skn Ulcer Or Cellulitis W Cc	2.27	1.27	8.3	38.0
127	Heart Failure & Shock	1.06	0.68	4.1	21.2
316	Renal Failure	1.35	0.83	4.8	22.9
430	Psychoses	1.23	0.40	5.9	23.1
418	Postoperative & Post Traumatic Infections	1.19	0.80	4.7	24.1
277	Cellulitis Age > 17 W Cc	1.00	0.61	4.5	20.9
238	Osteomyelitis	1.55	0.86	6.5	28.4
76	Other Resp System O.R. Procedures W Cc	2.74	2.40	8.2	42.5
144	Other Circulatory System Diagnosis W Cc	1.38	0.77	4.2	22.1

DRG	DRG Label	FY2007 Relative Weight		FY2007 Geometric Mean LOS	
		Acute	LTCH	Acute	LTCH
452	Complications Of Treatment W Cc	1.14	0.93	3.5	25.7
320	Kidney & Urinary Tract Infections Age >17 W Cc	0.95	0.62	4.1	21.7
188	Other Digestive System Diagnoses Age >17 W Cc	1.18	0.96	4.1	24.4
296	Nutritional & Misc Metabolic Disorders Age >17 W Cc	0.90	0.71	3.6	22.3
415	O.R. Procedure For Infectious & Parasitic Diseases	4.14	# N/A	11.0	# N/A
468	Extensive O.R. Procedure Unrelated To Principal Diagnosis	3.81	2.15	9.6	40.5
182	Esophagitis, Gastroent & Misc Digest Disorders Age > 17 W Cc	0.90	0.79	3.4	21.8
217	Wnd Debrid & Skn Grft Except Hand, For Muscskelet & Conn Tiss Dis	3.14	1.24	9.0	36.5
465	Aftercare W History Of Malignancy As Secondary Diagnosis	0.62	0.69	2.5	21.2
294	Diabetes Age >35	0.86	0.70	3.3	23.9
463	Signs & Symptoms W Cc	0.77	0.61	3.1	22.9
461	O.R. Proc W Diagnoses Of Other Contact W Health Services	1.54	1.15	3.3	32.7
483	Trach W Mech Vent 96+ HRS	0.00	# N/A	0.0	# N/A
82	Respiratory Neoplasms	1.43	0.82	5.1	21.4
126	Acute & Subacute Endocarditis	2.55	0.89	9.0	26.3
34	Other Disorders Of Nervous System W Cc	1.03	0.70	3.6	23.4
243	Medical Back Problems	0.87	0.60	3.6	22.3
120	Other Circulatory System O.R. Procedures Other Musculoskeletal System & Connective Tissue	2.31	1.09	6.0	31.4
256	Diagnoses	0.96	0.71	3.9	23.6
269	Other Skin, Subcut Tiss & Breast Proc W Cc	1.88	1.21	6.0	34.7

DRG	DRG Label	FY2007 Relative Weight		FY2007 Geometric Mean LOS	
		Acute	LTCH	Acute	LTCH
172	Digestive Malignancy W Cc Skin Grafts & Wound Debrid For Endoc, Nutrit & Metab	1.46	0.85	5.1	21.8
287	Disorders	2.04	1.04	7.6	33.0
331	Other Kidney & Urinary Tract Diagnoses Age >17 W Cc	1.16	0.78	4.2	22.5
101	Other Respiratory System Diagnoses W Cc	0.91	0.81	3.2	22.2
429	Organic Disturbances & Mental Retardation	0.96	0.53	4.4	24.0
440	Wound Debridements For Injuries	2.01	1.22	5.6	34.4
14	Intracranial Hemorrhage Or Cerebral Infarction	1.25	0.68	4.3	24.9
204	Disorders Of Pancreas Except Malignancy	1.17	0.89	4.1	22.1

NOTES: DRGs sorted in descending order by frequency in LTCH claims.

SOURCE: Centers for Medicare and Medicaid Website, as reported in RTI (2007) Report pp. 15-16.

<http://cms.hhs.gov/AcuteInpatientPPS/FFD> (2007 acute weights).

<http://www.cms.hhs.gov/LongTermCareHospitalPPS/> (2007 LTCH weights).

Appendix C

Glossary

Discharged	A Medicare patient in a long-term care hospital is considered discharged when the patient is formally released or the patient dies in the long-term care facility. For payment purposes, discharge occurs when Medicare days are exhausted.
Fiscal Intermediary (FI)	The intermediary that processes Medicare reimbursements to providers from CMS.
Geometric Mean	A mathematical measure of central tendency that is similar to the typical “average.” This measure of central tendency is calculated differently from the typical “average” and is often used for skewed distributions such as health care expenditure data. Medicare uses the Geometric Mean as a standard in defining LTCH DRGs.
High Cost Outlier Payment	An additional payment beyond the standard Federal prospective payment for cases with unusually high costs.
Hospital-Within-A-Hospital (HWH)	Part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.
ICD-9 codes	International Statistical Classification of Diseases and Related Health Problems, Clinical Modification (ICD-9-CM) is used to code and classify morbidity data from the inpatient and outpatient records, physician offices, and most National Center for Health Statistics (NCHS) surveys.
LTC – DRG	The diagnosis-related group used to classify patient discharges from a long-term care hospital based on clinical characteristics and average resource use, for prospective payment purposes.
Major Diagnostic Category (MDC)	Categorizes all ICD-9-CM diagnoses into 25 mutually exclusive diagnoses groups.
Satellite Provider	A hospital-within-a-hospital type facility that is owned by separate, existing LTCH.
Short-stay Outlier	A case that has a LOS between one day and up to and including 5/6 of the ALOS for the LTC-DRG to which the case is grouped.

Appendix D
EAC Acute Hospital DRGs in the NYS
Finger Lakes Region 2003–2006

DRG	#	%	Cumulative %
Psychoses	1,167	16.6	16.6
Heart Failure & Shock	681	9.7	26.2
Pneumonia W Cc	552	7.8	34.1
Rehabilitation	476	6.8	40.8
Esophagitis, Gastroent & Misc Digest Disorders W Cc	425	6.0	46.9
COPD	367	5.2	52.1
Intracranial Hemorrhage or Infarction	266	3.8	55.8
Kidney & Urinary Infection W Cc	234	3.3	59.2
Nutritional & Metabolic Disorder W Cc	227	3.2	62.4
Septicemia	210	3.0	65.4
Renal Failure	186	2.6	68.0
Cellulitis W Cc	172	2.4	70.4
Respiratory Infections W Cc	171	2.4	72.9
No Longer Valid	149	2.1	75.0
Diabetes Age >35	132	1.9	76.9
Respiratory w Ventilator	131	1.9	78.7
Oth Circ Diagnosis W Cc	122	1.7	80.5
Medical Back Problems	121	1.7	82.2
Degenerative Nervous System	112	1.6	83.8
Pancreas exp Malignancy	112	1.6	85.4
Oth Digestive W Cc	100	1.4	86.8
Pulmonary Edema & Respiratory Failure	85	1.2	88.0

DRG	#	%	Cumulative %
Organic Dx & Mental Retardation	71	1.0	89.0
Respiratory Neoplasm	69	1.0	90.0
Peripheral Vasc Dx	67	1.0	90.9
O.R. Infectious & Parasitic Dis	55	.8	91.7
Extensive O.R. Procedure	51	.7	92.4
Oth Kidney & Urinary W Cc	47	.7	93.1
Postop & Post Trauma Infection	41	.6	93.7
Digestive Cancer W Cc	39	.6	94.2
Signs & Symptoms W Cc	38	.5	94.8
Other Nervous System W Cc	36	.5	95.3
Skin Graft Or Debrid W Cc	35	.5	95.8
Comp Of TX W Cc	35	.5	96.3
Oth Resp O.R. Procedures W Cc	31	.4	96.7
Wnd Debrid & Skn Grft Except Hand	31	.4	97.1
Oth Resp. Dx W Cc	30	.4	97.6
Oth Circ O.R. not Musculoskeletal System	30	.4	98.0
O.R. W Diagnoses Oth Contact W Health Services	19	.3	98.3
Musculoskeletal	18	.3	98.5
Nervous System Infection	16	.2	98.8
Osteomyelitis	16	.2	99.0
Skin Ulcers	16	.2	99.2
Other Skin, Subcut Tiss & Breast Proc W Cc	15	.2	99.4
Wound Debride Injury	11	.2	99.6
Acute & Subacute Endocarditis	9	.1	99.7
Diagnoses	8	.1	99.8
Skin Graft W Metabolic Dx	8	.1	99.9

DRG	#	%	Cumulative %
Resp. Dx W Exceptions W Cc	3	.0	100.0
Aftercare HX Malignancy Secondary DX	1	.0	100.0
Aftercare W/O Malignancy	1	.0	100.0
Total	7,045	100.0	

Appendix E
NYS DOH SPARCS Data File Code Book
Updated: August 20, 2007

2006 ENHANCED EDITED INPATIENT FILES VI

SPARCS Region 1

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Appendix F

Average LOS and Medicare Revenue by Provider Type for Top 50 LTCH DRGs in Descending Order by Acute Outlier Revenue Per Day

DRG Code	DRG Name	LTCH Episode			Acute Hospital Outlier Episode			Acute Hospital Non-outlier Episode		
		Revenue per Episode \$	Average LOS Days	Revenue Per Day \$	Revenue per Episode \$	Average LOS Days	Revenue Per Day \$	Revenue per Episode \$	Average LOS Days	Revenue Per Day \$
483	Tracheostomy except for Face, Mouth & Neck Diagnosis	89,984	62.4	1,442	139,271	64.5	2,159	76,372	27.9	2,737
468	Extensive O.R. Procedure Unrelated to Principal Diagnosis	57,159	48.1	1,188	41,436	34.3	1,208	20,102	13.0	1,546
475	Respiratory System Diagnosis With Ventilator Support	53,897	38.4	1,404	36,459	30.6	1,191	19,636	10.6	1,852
415	O.R. Procedure for Infectious & Parasitic Diseases	43,641	39.8	1,097	43,632	37.9	1,151	20,192	12.7	1,590
020	Nervous System Infection except Viral Meningitis	28,451	29.9	952	30,182	28.2	1,070	14,866	9.4	1,581
076	Other Resp System O.R. procedures w CC	67,380	52.0	1,296	35,138	34.7	1,013	15,517	10.8	1,437
403	Lymphoma & Non-Acute Leukemia w CC	22,613	22.7	996	28,604	30.3	944	10,348	8.0	1,294
217	Wnd Debrid 7 Skn Grft except hand, for Muscskelet & Cohn Tiss Dis	39,547	41.9	944	40,235	43.5	925	16,735	11.5	1,455
416	Septicemia Age > 17	23,988	24.1	995	23,842	26.8	890	8,391	7.9	1,062
120	Other Circulatory System O.R. Procedures	34,924	34.5	1,012	31,709	36.2	876	12,818	9.4	1,364
126	Acute & Subacute Endocarditis	24,351	25.7	948	30,276	34.6	875	13,745	10.8	1,273
461	O.R. Proc w Diagnosis of Other Contact w Health Services	35,456	36.7	966	28,236	32.9	858	6,720	7.2	933
477	Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis	46,003	38.3	1,201	27,903	34.5	809	10,477	10.1	1,037
452	Complications of Treatment w CC	27,097	27.0	1,004	23,017	29.0	794	5,812	6.0	969
269	Other Skin, Subcut Tiss & Breast Proc w CC	37,340	40.1	931	26,387	34.3	769	9,514	9.2	1,034
440	Wound Debridements for Injuries	40,378	39.6	1,020	35,278	46.5	759	10,383	8.3	1,251
204	Disorders of Pancreas except Malignancy	25,426	23.4	1,087	20,451	27.8	736	6,082	6.1	997

DRG Code	DRG Name	LTCH Episode			Acute Hospital Outlier Episode			Acute Hospital Non-outlier Episode		
		Revenue per Episode \$	Average LOS Days	Revenue Per Day \$	Revenue per Episode \$	Average LOS Days	Revenue Per Day \$	Revenue per Episode \$	Average LOS Days	Revenue Per Day \$
331	Other Kidney & Urinary Tract Diagnosis Age > 17 w CC	22,149	23.0	963	19,096	26.2	729	5,705	6.1	935
316	Renal Failure	24,408	23.1	1,057	20,277	28.3	717	6,932	6.9	1,005
144	Other Circulatory System Diagnosis w CC	21,511	22.6	952	20,068	28.1	714	6,674	6.5	1,027
034	Other Disorders of Nervous System w CC	22,866	27.4	835	19,827	28.5	696	5,245	5.3	990
172	Digestive malignancy w CC	21,958	22.3	985	21,484	31.3	686	7,978	7.6	1,050
014	Specific Cerebrovascular Disorders except TIA	24,410	31.3	780	18,102	27.0	670	6,117	5.8	1,055
012	Degenerative Nervous System Disorders	22,288	27.5	810	18,234	27.3	668	4,381	5.2	843
188	Other Digestive System Diagnoses Age > 17 w CC	27,418	25.8	1,063	19,470	30.1	647	5,984	6.4	935
087	Pulmonary Edema & Respiratory Failure	35,705	27.5	1,298	19,108	29.7	643	6,955	7.2	966
127	Heart failure & Shock	20,493	21.5	953	16,837	26.5	635	5,170	5.8	891
248	Tendonitis, Myositis & Bursitis	18,235	21.8	836	18,181	28.8	631	4,324	5.3	816
130	Peripheral Vascular Disorders w CC	20,546	23.9	860	15,893	25.8	616	4,822	5.9	817
418	Postoperative & Post-Traumatic Infections	23,237	25.9	897	19,598	31.8	616	5,893	6.8	867
082	Respiratory Neoplasms	19,723	20.8	948	18,135	29.8	609	7,620	7.5	1,016
243	Medical back Problems	18,617	23.4	796	16,974	28.2	602	3,661	5.1	718
263	Kin Graft &/or Debrid for Skn Ulcer or Cellulitis w CC	39,627	43.5	911	28,676	47.7	601	10,978	10.3	1,066
294	Diabetes Age > 35	22,380	26.7	838	17,160	29.4	584	3,955	4.7	841
277	Cellulitis Age > 17	19,105	21.8	876	17,240	29.8	579	4,381	5.9	743
079	Respiratory Infections & Inflammations Age > 17 w CC	24,685	23.9	1,033	19,156	33.6	570	8,351	8.6	971
132	Atherosclerosis w CC	20,128	22.1	911	20,800	36.5	570	3,238	3.5	925
182	Esophagitis, Gastroent & Misc Digest Disorders Age > 17 w CC	22,856	23.4	977	16,425	29.2	563	4,141	5.3	781
256	Other Musculoskeletal System & Connective Tissue Diagnoses	21,809	26.3	829	15,810	28.3	559	4,284	5.4	793
287	Skin Grafts & Wound Debrid for Endoc, Nutrit & Metab Disorders	36,000	35.8	1,006	23,249	42.0	554	10,242	9.5	1,078
242	Septic Arthritis	23,801	27.8	856	21,275	39.7	536	5,926	7.1	835
465	Aftercare w History of Malignancy As	19,153	22.3	859	17,825	34.0	524	4,678	5.4	866

DRG Code	DRG Name	LTCH Episode			Acute Hospital Outlier Episode			Acute Hospital Non-outlier Episode		
		Revenue per Episode \$	Average LOS Days	Revenue Per Day \$	Revenue per Episode \$	Average LOS Days	Revenue Per Day \$	Revenue per Episode \$	Average LOS Days	Revenue Per Day \$
	Secondary Diagnosis									
089	Simple Pneumonia & Pleurisy Age > 17 w CC	21,535	21.4	1,006	14,600	28.3	516	5,120	6.3	813
463	Signs & Symptoms w CC	19,599	24.6	797	15,200	29.6	514	3,468	4.1	846
296	Nutritional & Misc Metabolic Disorders Age > 17 w CC	21,831	24.0	910	16,053	31.3	513	4,246	5.1	833
249	Aftercare, Musculoskeletal System & Connective Tissue	21,558	25.8	836	16,292	31.8	512	3,553	4.1	867
466	Aftercare w/o History of Malignancy As Secondary Diagnosis	20,184	22.6	893	19,238	37.9	508	4,128	5.0	826
101	Other Respiratory System Diagnosis w CC	23,851	22.0	1,084	13,263	26.2	506	4,527	4.9	924
320	Kidney & urinary Track Infections Age > 17 w CC	20,310	23.5	864	15,857	31.6	502	4,319	5.6	771
238	Osteomyelitis	24,687	31.0	796	21,446	43.2	496	7,295	8.1	901
088	Chronic Obstructive Pulmonary Disease	19,905	20.2	985	13,329	30.2	441	4,415	5.5	803
271	Skin Ulcers	24,798	29.0	855	16,401	44.3	370	5,285	6.6	801
462	Rehabilitation	18,250	22.8	800	13,178	38.8	340	8,336	10.9	765
429	Organic Disturbances & Mental Retardation	19,564	34.9	561	10,685	45.1	237	3,744	5.1	734
430	Psychoses	14,361	26.4	544	11,206	59.6	188	3,923	7.4	530

SOURCE: Data source for Revenue and Average LOS from RTI analysis of 2004 MedPAR files (Gage, et al., 2004). Revenue per day analyses conducted for this report (Votava, 2007).

Appendix G

Finger Lakes Region Community Needs Assessment

Long-Term Care Hospital Beds Needed Estimate

G.1 LTCH Beds Needed Annually Estimate in the Finger Lakes Region by Extended Acute Care Clinical Group

Extended Acute Care Group	Community Need Measures	Prompt Clinical Readiness	Prompt to Mid Clinical Readiness	Mid-Range Clinical Readiness	Mid to Late Clinical Readiness	Late Clinical Readiness
Complex	LTCH LOS Estimate	31.6	30.0	28.3	26.6	25.0
	# of Patients	3,400	3,400	3,400	3,400	3,400
	Annual Acute Hospital Days Saved Estimate	107,523	101,864	96,205	90,546	84,887
	LTCH Beds Needed Estimate	74	70	66	62	59
Respiratory or Ventilator	LTCH LOS Estimate	35.2	33.3	31.5	29.6	27.8
	# of Patients	1,251	1,251	1,251	1,251	1,251
	Annual Acute Hospital Days Saved Estimate	43,978	41,663	39,349	37,034	34,719
	LTCH Beds Needed Estimate	30	29	27	26	24
Medical EAC Total	LTCH LOS Estimate	32.6	30.9	29.1	27.4	25.7
	# of Patients	4,651	4,651	4,651	4,651	4,651
	Annual Acute Hospital Days Saved Estimate	151,501	143,527	135,554	127,580	119,606
	LTCH Beds Needed Estimate	104	99	93	88	82
Psycho-Behavioral	LTCH LOS Estimate	43.4	41.1	38.8	36.5	34.2
	# of Patients	987	987	987	987	987
	Annual Acute Hospital Days Saved Estimate	42,793	40,541	38,289	36,037	33,784
	LTCH Beds Needed Estimate	30	28	26	25	23

G.2 LTCH Beds Need Estimate by Finger Lakes Subarea

Finger Lakes Subarea	Community Need Measures	Prompt Clinical Readiness	Prompt to Mid Clinical Readiness	Mid-Range Clinical Readiness	Mid to Late Clinical Readiness	Late Clinical Readiness
Monroe/Livingston	LTCH LOS Estimate	36.0	34.1	32.2	30.4	28.5
	# of Patients	3,543	3,543	3,543	3,543	3,543
	Annual Acute Hospital Days Saved Estimate	127,693	120,972	114,251	107,531	100,810
	LTCH Beds Needed Estimate	88	83	79	74	70
Southern Tier	LTCH LOS Estimate	31.0	29.4	27.7	26.1	24.5
	# of Patients	1,172	1,172	1,172	1,172	1,172
	Annual Acute Hospital Days Saved Estimate	36,326	34,414	32,502	30,590	28,678
	LTCH Beds Needed Estimate	25	24	22	21	20
Central Region	LTCH LOS Estimate	31.1	29.5	27.8	26.2	24.6
	# of Patients	696	696	696	696	696
	Annual Acute Hospital Days Saved Estimate	21,650	20,510	19,371	18,231	17,092
	LTCH Beds Needed Estimate	15	14	13	13	12
Western Region	LTCH LOS Estimate	38.0	36.0	34.0	32.0	30.0
	# of Patients	227	227	227	227	227
	Annual Acute Hospital Days Saved Estimate	8,626	8,172	7,718	7,264	6,810
	LTCH Beds Needed Estimate	6	6	5	5	5
Total	LTCH LOS Estimate	34.5	32.6	30.8	29.0	27.2
	# of Patients	5,638	5,638	5,638	5,638	5,638
	Annual Acute Hospital Days Saved Estimate	194,295	184,069	173,842	163,616	153,390
	LTCH Beds Needed Estimate	134	127	119	113	107

G.3 LTCH Beds Need Estimate by Finger Lakes Subarea and EAC Clinical Group

Finger Lakes Subarea	Extended Acute Care Group	Community Need Measures	Prompt Clinical Readiness	Prompt to Mid Clinical Readiness	Mid-Range Clinical Readiness	Mid to Late Clinical Readiness	Late Clinical Readiness	
Monroe/ Livingston	Complex	LTCH LOS Estimate	32.6	30.9	29.2	27.5	25.7	
		# of Patients	2,087	2,087	2,087	2,087	2,087	
		Annual Acute Hospital Days Saved Estimate	68,057	64,475	60,893	57,311	53,729	
		LTCH Beds Needed Estimate	47	44	42	40	37	
	Respiratory &/or Ventilator	LTCH LOS Estimate	38.5	36.5	34.4	32.4	30.4	
		# of Patients	732	732	732	732	732	
		Annual Acute Hospital Days Saved Estimate	28,175	26,692	25,209	23,727	22,244	
		LTCH Beds Needed Estimate	19	18	17	16	15	
	Medical EAC Total	LTCH LOS Estimate	34.1	32.3	30.5	28.7	27.0	
		# of Patients	2,819	2,819	2,819	2,819	2,819	
		Annual Acute Hospital Days Saved Estimate	96,233	91,168	86,103	81,038	75,973	
		LTCH Beds Needed Estimate	66	63	59	56	52	
	Psycho-Behavioral	LTCH LOS Estimate	43.5	41.2	38.9	36.6	34.3	
		# of Patients	724	724	724	724	724	
		Annual Acute Hospital Days Saved Estimate	31,460	29,804	28,149	26,493	24,837	

Finger Lakes Subarea	Extended Acute Care Group	Community Need Measures	Prompt Clinical Readiness	Prompt to Mid Clinical Readiness	Mid-Range Clinical Readiness	Mid to Late Clinical Readiness	Late Clinical Readiness	
		LTCH Beds Needed Estimate	22	21	19	18	17	
Southern Tier	Complex	LTCH LOS Estimate	30.8	29.2	27.5	25.9	24.3	
		# of Patients	747	747	747	747	747	
		Annual Acute Hospital Days Saved Estimate	22,996	21,786	20,576	19,365	18,155	
		LTCH Beds Needed Estimate	16	15	14	13	13	
	Respiratory &/or Ventilator	LTCH LOS Estimate	27.8	26.3	24.8	23.4	21.9	
		# of Patients	276	276	276	276	276	
		Annual Acute Hospital Days Saved Estimate	7,662	7,258	6,855	6,452	6,049	
		LTCH Beds Needed Estimate	5	5	5	4	4	
	Medical EAC Total	LTCH LOS Estimate	30.0	28.4	26.8	25.2	23.7	
		# of Patients	1,023	1,023	1,023	1,023	1,023	
		Annual Acute Hospital Days Saved Estimate	30,658	29,045	27,431	25,817	24,204	
		LTCH Beds Needed Estimate	21	20	19	18	17	
	Psycho-Behavioral	LTCH LOS Estimate	38.0	36.0	34.0	32.0	30.0	
		# of Patients	149	149	149	149	149	
		Annual Acute Hospital Days Saved Estimate	5,668	5,370	5,071	4,773	4,475	

Finger Lakes Subarea	Extended Acute Care Group	Community Need Measures	Prompt Clinical Readiness	Prompt to Mid Clinical Readiness	Mid-Range Clinical Readiness	Mid to Late Clinical Readiness	Late Clinical Readiness	
		LTCH Beds Needed Estimate	4	4	3	3	3	
Central Region	Complex	LTCH LOS Estimate	26.6	25.2	23.8	22.4	21.0	
		# of Patients	419	419	419	419	419	
		Annual Acute Hospital Days Saved Estimate	11,134	10,548	9,962	9,376	8,790	
		LTCH Beds Needed Estimate	8	7	7	6	6	
	Respiratory &/or Ventilator	LTCH LOS Estimate	32.8	31.1	29.3	27.6	25.9	
		# of Patients	193	193	193	193	193	
		Annual Acute Hospital Days Saved Estimate	6,327	5,994	5,661	5,328	4,995	
		LTCH Beds Needed Estimate	4	4	4	4	3	
	Medical EAC Total	LTCH LOS Estimate	28.5	27.0	25.5	24.0	22.5	
		# of Patients	612	612	612	612	612	
		Annual Acute Hospital Days Saved Estimate	17,461	16,542	15,623	14,704	13,785	
		LTCH Beds Needed Estimate	12	11	11	10	10	
	Psycho-Behavioral	LTCH LOS Estimate	49.9	47.2	44.6	42.0	39.4	
		# of Patients	84	84	84	84	84	
		Annual Acute Hospital Days Saved Estimate	4,189	3,968	3,748	3,527	3,307	

Finger Lakes Subarea	Extended Acute Care Group	Community Need Measures	Prompt Clinical Readiness	Prompt to Mid Clinical Readiness	Mid-Range Clinical Readiness	Mid to Late Clinical Readiness	Late Clinical Readiness
		LTCH Beds Needed Estimate	3	3	3	2	2
Western Region	Complex	LTCH LOS Estimate	36.3	34.4	32.5	30.6	28.7
		# of Patients	147	147	147	147	147
		Annual Acute Hospital Days Saved Estimate	5,335	5,055	4,774	4,493	4,212
		LTCH Beds Needed Estimate	4	3	3	3	3
	Respiratory &/or Ventilator	LTCH LOS Estimate	36.3	34.4	32.5	30.6	28.6
		# of Patients	50	50	50	50	50
		Annual Acute Hospital Days Saved Estimate	1,814	1,719	1,623	1,528	1,432
		LTCH Beds Needed Estimate	1	1	1	1	1
	Medical EAC Total	LTCH LOS Estimate	36.3	34.4	32.5	30.6	28.7
		# of Patients	197	197	197	197	197
		Annual Acute Hospital Days Saved Estimate	7,149	6,773	6,397	6,021	5,644
		LTCH Beds Needed Estimate	5	5	4	4	4
	Psycho-Behavioral	LTCH LOS Estimate	49.2	46.6	44.0	41.4	38.9
		# of Patients	30	30	30	30	30
		Annual Acute Hospital Days Saved Estimate	1,477	1,399	1,321	1,243	1,166

Finger Lakes Subarea	Extended Acute Care Group	Community Need Measures	Prompt Clinical Readiness	Prompt to Mid Clinical Readiness	Mid-Range Clinical Readiness	Mid to Late Clinical Readiness	Late Clinical Readiness
		LTCH Beds Needed Estimate	1	1	1	1	1