Supporting Statement For Paperwork Reduction Act Submissions

A. Background

Many long-term care hospitals (LTCHs) are co-located with other Medicare providers (acute care hospitals, IRFs, SNFs, psychiatric facilities), which leads to potential gaming of the Medicare system based on patient shifting. In regulations at 42 CFR 412.22(e)(3) and (h)(6) and 412.532(i), CMS is requiring LTCHs to notify fiscal intermediaries K(FIs), Medicare Administrative Contractors (MACs) and CMS of co-located providers in order to establish policies to limit payment abuse that will be based on FIs tracking patient movement among these co-located providers.

B. Justification

1. Need and Legal Basis

Many LTCHs are co-located with other Medicare providers (acute care hospitals, IRFs, SNFs, psychiatric facilities), which leads to potential gaming of the Medicare system based on patient shifting. CMS is requiring LTCHs to notify FIs , MACs, and CMS of co-located providers and establish policies to limit payment abuse that will be based on FIs and MACs tracking patient movement among these co-located providers 42 CFR 412.22(e)(6) and (h)(5).

2. Information Users

Based upon being able to identify co-located providers, FIs, MACs, and CMS will be able to track patient shifting between LTCHs and other in-patient providers which will lead to appropriate payments under §412.532. This regulation, limits payments to LTCHs where over 5% of admissions represent patients who had been sequentially discharged by the LTCH, admitted to an on-site provider, and subsequently readmitted to the LTCH. Since each discharge triggers a Medicare payment, CMS implemented this policy to discourage payment abuse.

3. Use of Information Technology

CMS is requiring that FIs and MACs monitor co-location among their LTCHs but has not established any format for information storage.

The LTCH Prospective Payment System (PPS) was implemented on October 1, 2002. CMS anticipates that as policies and procedures are refined, there will be increasing use of electronic information gathering and storage.

4. Duplication of Efforts

These information collections do not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

This does not have a significant economic impact on small businesses.

6. Less Frequent Collection
LTCHs are required to report their present co-located status with information describing the facilities with which they are co-located. If this status changes, i.e., another hospital is built adjacent to the LTCH, the LTCH is required to notify its FI/MAC and CMS in writing prior to the end of the cost reporting period. Specific payment policies under the LTCH PPS will be unenforceable without collection of this data as set forth in the LTCH PPS August 30, 2002 final rule.

7. Special Circumstances
There are no special circumstances.

8. Federal Register/Outside Consultation
The 60-day Federal Register notice for this information collection published December 18, 2009.

9. Payments/Gifts to Respondents
There are not payments or gifts to respondents.

10. Confidentiality
We pledge confidentiality to the extent provided by law.

11. Sensitive Questions
There are no questions of a sensitive nature.

12. Burden Estimates (Hours & Wages)
The requirement regarding collection of information at §412.22 concerning a LTCH's (or a LTCH satellite's) notification to its Medicare FI, MAC, and CMS of its co-located status continues to be very important in order for Medicare to appropriately pay co-located hospitals within hospitals (HwHs) and satellites. Under §§412.22(e)(6) and (h)(5), a LTCH or a satellite of a LTCH that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital must notify its fiscal intermediary and CMS in writing of its co-location within 60 days of its first cost reporting period that began on or after October 1, 2002.

We estimate that the burden associated with this provision is the time it would take for a LTCH or a satellite of a LTCH to prepare and submit its notification to its FI and CMS. Because of payment adjustments, there was a significant decrease in the number of co-located LTCH HwHs and satellites developed between FY 2005 and FY 2009. This decrease is understood to be a result of payment adjustment policies that discouraged the for-profit LTCH industry from continuing to develop large numbers of LTCHs. With the enactment of section 114(c) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) amended by the ARRA and by the ACA, which modifies the payment adjustment noted

above, there has been an increase in the number of LTCHs and LTCH satellites established since 2007, all of which have met the exceptions to the LTCH and LTCH satellite moratorium established under section 114(d) of the MMSEA, amended by the ARRA and by t he ACA. At this time, we estimate that 25 new LTCHs and satellites of LTCHs will take 15 minutes each to comply with these provisions for a total burden of 6.25 hours.

13. Capital Costs
There are no capital costs.

14. Cost to Federal Government
The reporting requirements do not entail any costs to the Federal Government.

15. Changes to Burden
The 5-year phase in of the LTCH PPS are no longer relevant since the policy, governed by our regulations at 42 CFR §412.533, is no longer in effect. Specifically, when we implemented the LTCH PPS for cost reporting periods beginning on or after October 1, 2003, under the authority of section 307(b) of the Balanced Budget Refinement Act, we provided a 5-year phase in to full payments under the Federal payment rates calculated under the LTCH PPS. For each of those 5 years, as we lowered the percentage of payments based upon the Tax Equity and Fiscal Responsibility Act system 20 percent, we increased the payments based upon the PPS Federal payment rate by 20 percent so that for cost reporting periods beginning on or after October 1, 2006, 100 percent of payments under the LTCH PPS were based on the Federal payment rate. Since there is no longer any transition policy, the information collection requirement section regarding this policy is no longer in effect. Therefore, the number of responses decreased by 94, which is the number of LTCHs that were expected to respond under the previous policy. A further decrease of 75 responses is expected due to policies developed since the last collection in 2007 discouraging the development of large numbers of co-located LTCHs. As a result of these changes, the total number of respondents has decreased from 194 to 25.

16. Publication/Tabulation Dates
FIs/MACs and CMS ROs keep records on co-located LTCHs for which they are responsible.

17. Expiration Date
This collection does not lend itself to the displaying of an expiration date.

18. Certification Statement
No exceptions are requested.

B. Collections of Information Employing Statistical Methods

This collection does not employ statistical methods.

Sec. 412.**22** Excluded hospitals and hospital units: General rules.

(a) Criteria. Subject to the criteria set forth in paragraph (e) of this section, a hospital is excluded from the prospective payment systems specified in Sec. 412.1(a)(1) of this part if it meets the criteria for one or more of the excluded classifications described in Sec. 412.23.

(b) Cost reimbursement. Except for those hospitals specified in paragraph (c) of this section and Secs. 412.20(b) and (c), all excluded hospitals (and excluded hospital units, as described in Secs. 412.23 through 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this subchapter, and are subject to the ceiling on the rate of hospital cost increases described in Sec. 413.40 of this subchapter.

(c) Special payment provisions. The following classifications of hospitals are paid under special provisions and therefore are not generally subject to the cost reimbursement or prospective payment rules of this chapter.

(1) Veterans Administration hospitals.

(2) Hospitals reimbursed under State cost control systems approved under part 403 of this chapter.

(3) Hospitals reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Public Law 92-603 (42 U.S.C. 1395b-1 (note)).

(4) Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

(d) Changes in hospitals' status. For purposes of exclusion from the prospective payment systems under this subpart, the status of each currently participating hospital (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any changes in the status of the hospital are made only at the start of a cost reporting period.

(e) Hospitals within hospitals. Except as provided in paragraph (f) of this section, for cost reporting periods beginning on or after October 1, 1997, a hospital that occupies space 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, must meet the following criteria in order to be excluded from the prospective payment systems specified in Sec. 412.1(a)(1):

(1) Separate governing body. The hospital has a governing body that is separate from the governing body of the hospital occupying space in the same building or on the same campus. The hospital's governing body is not under the control of the hospital occupying space in the same building or on the same campus, or of any third entity that controls both hospitals.

(2) Separate chief medical officer. The hospital has a single chief medical officer who reports directly to the governing body and who is responsible for all medical staff activities of the hospital. The chief medical officer of the hospital is not employed by or under contract with either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(3) Separate medical staff. The hospital has a medical staff that is separate from the medical staff of the hospital occupying space in the same building or on the same campus. The hospital's medical staff is directly accountable to the governing body for the quality of medical care provided in the hospital, and adopts and enforces bylaws governing medical staff activities, including criteria and procedures for recommending to the governing body the privileges to be granted to individual practitioners.

(4) Chief executive officer. The hospital has a single chief executive officer through whom all administrative authority flows, and who exercises control and surveillance over all administrative activities of the hospital. The chief executive officer is not employed by, or under contract with, either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(5) Performance of basic hospital functions. The hospital meets one of the following criteria:

(i) The hospital performs the basic functions specified in Secs. 482.21 through 482.27, 482.30, and 482.42 of this chapter through the use of employees or under contracts or other agreements with entities other than the hospital occupying space in the same building or on the same campus, or a third entity that controls both hospitals. Food and dietetic services and housekeeping, maintenance, and other services necessary to maintain a clean and safe physical environment could be obtained under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals.

(ii) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of patients in Sec. 412.23(d)(2) or the length-of-stay criterion in Sec. 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for a period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the cost of the services that the hospital obtained under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals, is no more than 15 percent of the hospital's total inpatient operating costs, as defined in Sec. 412.2(c). For purposes of this paragraph (e)(5)(ii), however, the costs of preadmission services are those specified under Sec. 413.40(c)(2) rather than those specified under Sec. 412.2(c)(5).

(iii) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of inpatients in Sec. 412.23(d)(2) or the length-of-stay criterion in Sec. 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for the period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the hospital has an inpatient population of whom at least 75 percent were referred to the hospital from a source other than another hospital occupying space in the same building or on the same campus.

(6) Notification of co-located status. A long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (e)(1)

through (e)(5) of this section must notify its fiscal intermediary and CMS in writing of its co-location within 60 days of its first cost reporting period that begins on or after October 1, 2002.

(f) Application for certain hospitals. If a hospital was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital, the criteria in paragraph (e) of this section do not apply to the hospital.

(g) Definition of control. For purposes of this section, control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(h) Satellite facilities. (1) For purposes of paragraphs (h)(2) through (h)(4) of this section, a satellite facility 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.

(2) Except as provided in paragraph (h)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment systems for any period:

(i) In the case of a hospital (other than a children's hospital) that was excluded from the prospective payment systems for the most recent cost reporting period beginning before October 1, 1997, the hospital's number of State-licensed and Medicare-certified beds, including those at the satellite facilities, does not exceed the hospital's number of State-licensed and Medicare-certified beds on the last day of the hospital's last cost reporting period beginning before October 1, 1997.

(ii) The satellite facility independently complies with--

(A) For psychiatric hospitals, the requirements under Sec. 412.23(a);

(B) For rehabilitation hospitals, the requirements under Sec. 412.23(b)(2);

(C) For children's hospitals, the requirements under Sec. 412.23(d)(2); or

(D) For long-term care hospitals, the requirements under Secs. 412.23(e)(1) through (e)(3)(i).

(iii) The satellite facility meets all of the following requirements:

(A) Effective for cost reporting periods beginning on or after October 1, 2002, it is not under the control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or chief medical officer of the hospital in which it is located.

(B) It maintains admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.

(C) It has beds that are physically separate from (that is, not commingled with) the beds of the hospital in which it is located.

(D) It is serviced by the same fiscal intermediary as the hospital of which it is a part.

(E) It is treated as a separate cost center of the hospital of which it is a part.

(F) For cost reporting and apportionment purposes, it uses an accounting system that properly allocates costs and maintains adequate statistical data to support the basis of allocation.

(G) It reports its costs on 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 the hospital of which it is a part.

(3) Except as provided in paragraph (h)(4) of this section, the provisions of paragraph (h)(2) of this section do not apply to--

(i) Any hospital structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the hospital continues operating under the same terms and conditions, including the number of beds and square footage considered, for purposes of Medicare participation and payment, to be part of the hospital, in effect on September 30, 1999; or

(ii) Any hospital excluded from the prospective payment systems under Sec. 412.23(e)(2).

(4) In applying the provisions of paragraph (h)(3) of this section, any hospital structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility if these changes are made necessary by relocation of a facility--

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

(5) Notification of co-located status. A satellite of a long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (h)(1) through (h)(4) of this section must notify its fiscal intermediary and CMS in writing of its co-location within 60 days of its first cost reporting period beginning on or after October 1, 2002.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 57 FR 39820, Sept. 1, 1994; 62 FR 46026, Aug. 29, 1997; 63 FR 26357, May 12, 1998; 64 FR 41540, July 30, 1999; 66 FR 41386, Aug. 7, 2001; 67 FR 50111, Aug. 1, 2002; 67 FR 56048, Aug. 30, 2002]