112TH CONGRESS
1ST SESSION

S. _____

To amend title XVIII of the Social Security Act to clarify and expand on criteria applicable to patient admission to and care furnished in long-term care hospitals participating in the Medicare program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

Mr. ROBERTS (for himself, Mr. NELSON of Florida, Mr. CRAPO, Mr. WYDEN, Mr. TOOMEY, and Mr. HELLER) introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act to clarify and expand on criteria applicable to patient admission to and care furnished in long-term care hospitals participating in the Medicare program, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Long-Term Care Hospital Improvement Act of 2011''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. SPECIFICATION OF CRITERIA FOR PATIENT PREADMISSION, ADMISSION, AND CONTINUING STAY ASSESSMENTS.

(a) IN GENERAL.—Section 1861(ccc) of the Social Security Act (42 U.S.C. 1395x(ccc)) is amended—

(1) in paragraph (4)(A)—

(A) by inserting ''in accordance with paragraph (2)'' after ''screens patients prior to admission for appropriateness of admission to a long-term care hospital'';

(B) by striking ''validates within 48 hours of admission'' and inserting ''validates, in accordance with paragraph (3), within 24 hours of admission'';

(C) by inserting ''in accordance with paragraph (4)'' after ''regularly evaluates''; and

(D) by inserting ''in accordance with paragraph (5)'' after ''assesses the available discharge options'';

(2) in paragraph (4), by redesignating subparagraphs (A), (B), and (C) as clauses (i), (ii), and (iii), respectively;

(3) by redesignating paragraphs (1), (2), (3), and (4) as subparagraphs (A), (B), (C), and (D), respectively;

(4) by inserting ''(1)'' after ''(ccc)''; and

(5) by adding at the end the following new paragraphs:

''(2) An institution provides for screening of patients prior to admission in accordance with this paragraph by using a standardized preadmission patient screening process that meets the following criteria:

''(A)(i) Preadmission patient screening shall be conducted by a clinical health care professional (as defined in clause (ii)) who is licensed or certified by the State in which the institution is located and permitted to conduct preadmission patient screening (as defined in subparagraph (C)) within the scope of practice of the professional under such State law.

''(ii) For purposes of clause (i), the term 'clinical health care professional' means a physician, a registered professional nurse, a licensed practical or licensed vocational nurse, a physician assistant, a respiratory therapist, and such other clinical health care professionals as the Secretary may specify.

''(B)(i) Except as provided in clause (ii), preadmission patient screening shall be conducted

during the 36-hour period preceding admission of the patient to the institution.

''(ii) In the case of preadmission patient screening that takes place before the 36-hour period described in clause (i), such screening shall be updated by telephone or otherwise during such 36-hour period.

''(C) In this paragraph, the term 'preadmission patient screening' means a process, with respect to a patient, for the determination whether admission to a long-term care hospital for care is medically reasonable and necessary for the patient based on the following:

''(i) The medical status of the patient.

''(ii) The planned level of improvement in the condition of the patient if admitted to the institution.

''(iii) Estimation of the expected length of stay of the patient in the institution to achieve health care goals with respect to the patient.

''(iv) Evaluation of risk for clinical complications of the patient.

''(v) The primary and secondary diagnoses of the patient for which treatment in the institution is appropriate.

"(vi) Identification of the primary treatments the patient will need in the institution.

"(vii) Evaluation of whether there is a more appropriate treatment setting for the patient at a lower level of care instead of in the institution.

"(viii) The anticipated post-institutional discharge settings and available treatments.

"(ix) Such other clinical rationale for the admission of the patient that the clinical health care professional determines to be appropriate.

"(D) A patient may not be admitted to the institution unless a physician (as defined in subsection (r)(1)) reviews and concurs with the most current results of the preadmission patient screening with respect to the patient and approves, in advance, the admission of the patient to the institution.

"(3) An institution validates patients meeting admission criteria in accordance with this paragraph if, not later than 24 hours from the time of admission of a patient to the institution, the institution provides for a face-to-face evaluation of the patient by a physician (as defined in subsection (r)(1)) and, with respect to patients who are identified as medically appropriate for admission to the institution based on such evaluation, the physician attests

that the patient meets the following patient admission criteria and provides in the medical record of the patient for the documentation of such attestation as well as any additional clinical rationale that the physician determines to be appropriate that establishes the medical reasonableness and necessity of furnishing care to the patient in the institution based on such admission criteria:

''(A) The patient has two or more active secondary diagnoses.

''(B) It is reasonable to expect that the patient will—

''(i) require the level of care furnished to an inpatient of a hospital;

''(ii) benefit from a medically necessary program of care furnished by the institution; and

''(iii) require an extended stay for care in a hospital that is typical of the extended stays for care provided by long-term care hospitals.

''(C)(i) The furnishing of intensive therapy (as defined in clause (ii)) to the patient is not the primary medical justification for the admission of the patient to the institution.

''(ii) For purposes of clause (i), the term 'intensive therapy' means a program of physical or occu-

pational therapy or speech-language pathology services furnished three hours per day, five days per week in such an institution or similar institution such as a rehabilitation facility (as described in section 1886(j)).

''(4) An institution regularly evaluates patients in accordance with this paragraph if—

''(A) not later than 7 days after the date of admission of the patient to the institution, and weekly thereafter until discharge, the institution provides for a face-to-face evaluation of the patient by a physician (as defined in subsection (r)(1)) to assess whether the continuation of the furnishing of inpatient hospital services to the patient is medically reasonable and necessary;

''(B) such an assessment is based on the medical reasonableness and necessity of the continuation of the furnishing of inpatient hospital services to the patient and is not based on the admission criteria described in paragraph (3) applicable to the patient; and

''(C) the physician performing the evaluation provides in the medical record of the patient for the documentation of the evaluation as well as any additional clinical rationale that the physician deter-

mines to be appropriate that establishes the medical reasonableness and necessity of the continuation of inpatient hospital services for the patient in the institution based on the outcome of each such evaluation.

''(5)(A) Subject to subparagraph (B), an institution assesses available discharge options in accordance with this paragraph if, upon a determination by a physician (as defined in subsection (r)(1)) that a patient admitted to the institution no longer requires the furnishing of hospital inpatient care, the patient is discharged from the institution when a safe and appropriate discharge option is available to the patient.

''(B)(i) In the case of a patient for whom a determination described in subparagraph (A) has been made but for whom a safe and appropriate discharge option is unavailable, such patient may continue as an inpatient of the institution for such period of days until a safe and appropriate discharge option is available to the patient.

''(ii) Clause (i) shall only apply if the institution—

''(I) notifies the patient that a determination described in subparagraph (A) has been made with respect to that patient; and

''(II) actively seeks to identify a safe and appropriate discharge option that is available to the

patient for the furnishing of post long-term care hospital care.

''(iii) Subject to clause (ii), the period of days described in clause (i) shall be included for purposes of paragraph (1)(B) (relating to determination of average inpatient length of stay) but, for purposes of section 1886(m) (relating to prospective payment for inpatient hospital services furnished by long-term care hospitals), such days shall be paid at the lesser of such prospective payment amount or cost.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall—

(1) take effect on the day that is six months after the date of the enactment of this Act; and

(2) apply with respect to cost reporting periods beginning on or after the effective date described in paragraph (1).

SEC. 3. SPECIFICATION OF CORE SERVICES AND PATIENT CARE REQUIREMENTS.

(a) IN GENERAL.—Section 1861(ccc) of the Social Security Act (42 U.S.C. 1395x(ccc)), as amended by section 2, is amended—

(1) in paragraph (1)(D)(ii), by inserting '', and meets the requirements of paragraph (6)'' before the semicolon; and

(2) by adding at the end the following new paragraph:

''(6) The following are the requirements of this paragraph applicable to an institution:

''(A) The types of items and services furnished to inpatients of the institution include at least the following items and services furnished by clinicians who are licensed or certified by the State in which the services are furnished to furnish such services:

''(i) Complex respiratory services, including the availability on site of respiratory therapists 24 hours a day, 7 days a week and access to consultation by pulmonologists 24 hours a day, 7 days a week.

''(ii) Complex wound services, including provision of wound care by registered nurses and access to consultations by physicians (as defined in subsection (r)(1)) for infectious disease.

''(iii) Care for patients with medically complex conditions.

''(iv) The availability on site 24 hours a day, 7 days a week of advanced cardiac life support furnished by health care personnel trained in advanced cardiac life support.

''(B) The institution develops a plan of care for each patient admitted to the institution which includes the following:

''(i) Not later than 24 hours after the time of admission of a patient to the institution, a physician (as defined in subsection (r)(1)) conducts an in-person evaluation of the patient; begins to develop a plan of care for the patient; and documents the clinical status of the patient.

''(ii) Not later than 7 days after the date of admission of the patient to the institution, and weekly thereafter until discharge, a physician-directed interdisciplinary team establishes and updates, as appropriate, an individualized plan of care for the patient.

''(C) The institution provides that, 24 hours per day, 7 days per week, a physician (as defined in subsection (r)(1)) is on-site or is on call and immediately available by telephone or radio contact and available on site within 30 minutes (or 60 minutes in the case of an institution located in a rural area (as defined for purposes of section 1886(d))). If a physician (as so defined) is not on-site 24 hours per day, 7 days per week, the institution shall furnish

each patient (or their representative), at the beginning of their stay at the institution, notice of such fact. Such notice shall contain such information as the Secretary determines appropriate.

''(D) The institution provides for on-site registered nurses 24 hours per day, 7 days per week.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall—

(1) take effect on the day that is six months after the date of the enactment of this Act; and

(2) apply with respect to cost reporting periods beginning on or after the effective date described in paragraph (1).

SEC. 4. ADDITIONAL LONG-TERM CARE HOSPITAL PAYMENT CLASSIFICATION CRITERIA.

(a) IN GENERAL.—Section 1861(ccc) of the Social Security Act (42 U.S.C. 1395x(ccc)), as amended by sections 2 and 3, is amended—

(1) in paragraph (1)—

(A) by striking ''and'' at the end of subparagraph (C);

(B) by striking the period at the end of subparagraph (D) and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(E) meets the requirements of paragraph (7)(A).''; and

(2) by adding at the end the following new paragraph:

''(7)(A) With respect to a 12-month period specified by the Secretary (which may be a cost reporting period) of a long-term care hospital for a fiscal year, the hospital meets the requirements of this subparagraph if each of the discharges comprising not less than the applicable percent (as defined in subparagraph (B)) of the total discharges of Medicare fee-for-service beneficiaries (as defined in subparagraph (C)) of such hospital for such period meets one or more of the following criteria:

''(i) The discharge has a length of stay of 25 days or greater.

''(ii)(I) The discharge applies to an inpatient who was a short-term acute care hospital outlier (as defined in subclause (II)) immediately prior to admission to the long-term care hospital.

''(II) For purposes of subclause (I), the term 'short-term acute care hospital outlier' means an inpatient discharge of a subsection (d) hospital in which inpatient hospital services were furnished for a diagnosis-related group or groups for which a payment adjustment under section 1886(d)(5)(A) (relat-

ing to outlier payments for subsection (d) hospitals) was made to such subsection (d) hospital for such services furnished to such inpatient.

''(iii) The discharge applies to an inpatient who received ventilator services in the long- term care hospital.

''(iv) The discharge has three or more of any Medicare-Severity-Long-Term-Care- Diagnosis-Related-Group complications and comorbidities or major complications and comorbidities.

''(B) For purposes of subparagraph (A), the term 'applicable percentage' means—

''(i) with respect to the first 12-month period specified by the Secretary of a long-term care hospital, 50 percent;

''(ii) with respect to the 12-month period specified by the Secretary that begins after the 12-month period described in clause (i), 60 percent;

''(iii) with respect to the 12-month period specified by the Secretary that begins after the 12-month period described in clause (ii)—

''(I) in the case of a long-term care hospital that is government-owned and operated, 65 percent; and

''(II) in the case of a long-term care hospital other than such a hospital described in subclause (I), 70 percent; and

''(iv) with respect to the 12-month period specified by the Secretary that begins after the 12-month period described in clause (iii) and each succeeding 12-month period so specified, 70 percent.

''(C) For purposes of subparagraph (A), the term 'Medicare fee-for-service beneficiary' means an individual who is entitled to benefits under part A and enrolled under part B who is not enrolled in an Medicare Advantage plan under part C.

''(D)(i) In the case of a determination by the Secretary that a long-term care hospital does not meet the criteria under subparagraph (A) with respect to a 12-month period or the criteria under paragraph (1)(B) (relating to average inpatient length of stay (as determined by the Secretary) of greater than 25 days) with respect to a cost reporting period—

''(I) the Secretary shall provide notice to such long-term care hospital of such determination; and

''(II) the Secretary shall provide such long-term care hospital a cure period (as defined in clause (ii)) to comply with such criteria for purposes of such 12-

month period or cost reporting period, as the case may be.

''(ii) For purposes of clause (i)(II), the term 'cure period' means a 6-month period, beginning on the first day of the first month that begins after the date of a notice under clause (i)(I) during which the hospital meets the criteria under subparagraph (A) or paragraph (1)(B), as the case may be, for not less than 5 months.

''(iii) In the case of a hospital for which a determination is made under clause (i) and with respect to which the Secretary finds, during the cure period, fails to meet the criteria under subparagraph (A) or paragraph (1)(B), as the case may be, for not less than 5 months, the Secretary shall provide notice to such hospital of such finding. Any change in the payment classification of such hospital under this title from a long-term care hospital to a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as a result of a finding under this clause or a determination under clause (i), shall apply with respect to the next cost reporting beginning after the date of such finding.

''(iv) The provisions of section 1878 (relating to rights to a hearing before the Provider Reimbursement Review Board and judicial review) shall apply in the case of a long-term care hospital with respect to which the Secretary has made a determination under clause (i).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall—

(1) take effect on the day that is six months after the date of the enactment of this Act; and

(2) apply with respect to 12-month periods (as specified by the Secretary of Health and Human Services under section 1861(ccc)(7)(A) of the Social Security Act) beginning on or after the effective date described in paragraph (1).

(c) REGULATIONS.—

(1) SUBSTITUTION.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall promulgate regulations to carry out the amendments made by this section by substituting the criteria made applicable to long-term care hospitals and facilities by reason of paragraph (7) of section 1861(ccc) of the Social Security Act (42 U.S.C. 1395x(ccc)), as added by subsection (a)(2) (in this subsection referred to as the ''section 1861(ccc)(7) criteria''), for the payment adjustments applicable to such hospitals under sections 412.534 and 412.536 of title 42, Code of Federal Regulations (relating to 25 percent pa-

tient threshold payment adjustments), and under any related section of such title. The Secretary shall implement the substitution referred to in the preceding sentence in a seamless manner such that payment adjustments applicable to long-term care hospitals and facilities under such sections 412.534 and 412.536 , and other related sections, shall have no force or effect in law with respect to periods applicable to a long-term care hospital or facility that begin after the substitution by the Secretary of the section 1861(ccc)(7) criteria with respect to that hospital or facility.

(B) APPLICATION PRIOR TO SUBSTITUTION.—Until such time as the Secretary implements the substitution described in this subparagraph (A), the modifications to the payment adjustments under such sections 412.534 and 412.536, and other related sections, pursuant to Public Law 110-173 (42 U.S.C. 1395ww note), as amended, shall continue to apply.

(2) REPEAL.—Payment adjustments applicable to long-term care hospitals and facilities under section 412.529(c)(3)(i) of title 42, Code of Federal

Regulations, shall have no force or effect in law on or after the date of the enactment of this Act.

(3) PROHIBITION.—The Secretary shall not promulgate any payment adjustment that is similar to the payment adjustments referred to in paragraph (1) or (2).

(d) NO APPLICATION OF ADJUSTMENT TO STANDARD AMOUNT.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall not make a one-time prospective adjustment to long-term care hospital prospective payment rates under section 412.523(d)(3) of title 42, Code of Federal Regulations, or any similar provision.

(2) CONFORMING AMENDMENT.—Section 114(c)(4) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by sections 3106(a) and 10312(a) of the Patient Protection and Affordable Care Act (Public Law 111–148), is amended by striking ", for the 5-year period beginning on the date of the enactment of this Act,".

SEC. 5. APPLICATION OF CRITERIA FOR CERTAIN HOSPITALS.

(a) SECTION 1814(b)(3) HOSPITALS.—

(1) IN GENERAL.—Section 1861(ccc) of the Social Security Act (42 U.S.C. 1395x(ccc)), as amended by sections 2, 3 and 4, is amended by adding at the end the following new paragraph:

''(8) This subsection (other than paragraph (7)) shall apply to a long-term care hospital that is paid under section 1814(b)(3).''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall—

(A) take effect on the day that is six months after the date of the enactment of this Act; and

(B) apply with respect to cost reporting periods beginning on or after the effective date described in subparagraph (A).

(b) EXEMPTION OF SECTION 1886(d)(1)(B)(iv)(II) HOSPITALS.—Section 1861(ccc) of the Social Security Act (42 U.S.C. 1395x(ccc)), as amended by sections 2, 3 and 4, and subsection (a) of this section, is amended by adding at the end the following new paragraph:

''(9) Paragraphs (2) through (8) of this subsection shall not apply to a long-term care hospital described in section 1886(d)(1)(B)(iv)(II).''.