

CHAPTER

11

**Long-term care
hospital services**

R E C O M M E N D A T I O N

- 11** The Secretary should eliminate the update to the payment rates for long-term care hospitals for fiscal year 2016.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Long-term care hospital services

Chapter summary

Long-term care hospitals (LTCHs) provide care to beneficiaries who need hospital-level care for relatively extended periods. To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals, and its Medicare patients must have an average length of stay greater than 25 days. In 2013, Medicare spent \$5.5 billion on care provided in LTCHs nationwide. About 122,000 beneficiaries had roughly 138,000 LTCH stays. On average, Medicare accounts for about two-thirds of LTCHs' discharges.

Assessment of payment adequacy

Beneficiaries' access to care—We have no direct measures of beneficiaries' access to needed LTCH services. Instead, we consider the capacity and supply of LTCH providers and changes over time in the volume of services they furnish. Trends suggest that access to care has been maintained.

- **Capacity and supply of providers**—Growth in the number of LTCHs filing Medicare cost reports slowed considerably in recent years because of the moratorium imposed by the Medicare, Medicaid, and SCHIP Extension Act of 2007 and subsequent legislation in effect through December 28, 2012. Even in the absence of the moratorium, we estimate that the number of LTCHs and LTCH beds decreased by about 1 percent in 2013.

In this chapter

- Are Medicare payments adequate in 2015?
- How should Medicare payments change in 2016?
- LTCHs will need to change their cost structures to maintain positive Medicare margins under the revised payment system

- **Volume of services**—From 2012 to 2013, the number of LTCH cases decreased by 1.9 percent. Controlling for growth in the number of fee-for-service beneficiaries, we found that the number of LTCH cases per beneficiary declined by 2.2 percent between 2012 and 2013. This decrease in per capita admissions is consistent with that seen in other inpatient settings.

Quality of care—LTCHs only recently began submitting quality of care data to CMS. Those data are not yet available for analysis. Using claims data, we found stable or declining non-risk-adjusted rates of readmission, death in the LTCH, and death within 30 days of discharge for almost all of the top 25 diagnoses in 2013.

Providers' access to capital—For the past few years, the availability of capital to LTCHs has not reflected current Medicare payment rates but, rather, uncertainty regarding possible changes to Medicare's regulations and legislation governing LTCHs. The criteria to receive the higher LTCH payment rate specified in the Pathway for SGR Reform Act of 2013, beginning with cost reporting periods starting October 1, 2015, provide more regulatory certainty for the industry compared with recent years. However, payment reductions implemented by CMS and a congressional moratorium on new LTCH beds and facilities through September 2017 continue to limit future opportunities for growth and reduce the industry's need for capital.

Medicare payments and providers' costs—Since 2007, LTCHs have held cost growth below the rate of increase in the market basket index, a measure of inflation in the prices of goods and services LTCHs buy to provide care. Between 2012 and 2013, Medicare payments continued to increase, albeit more slowly than provider costs, resulting in an aggregate 2013 Medicare margin of 6.6 percent compared with 7.4 percent in 2012. Financial performance in 2013 varied across LTCHs, reflecting differences in cost control and responses to payment incentives.

We estimate that LTCHs' aggregate Medicare margin will be 4.6 percent in 2015. This estimate reflects current policy, including sequestration. If sequestration were to be lifted, we would expect the margin to be about 2 percentage points higher.

On the basis of these indicators, the Commission concludes LTCHs can continue to provide Medicare beneficiaries with access to safe and effective care and accommodate changes in their costs with no update to LTCH payment rates in fiscal year 2016.

This update recommendation applies to the Medicare LTCH prospective payment system base payment rate. Thus, this recommendation applies to payments for

discharges that meet the criteria specified in the Pathway for SGR Reform Act of 2013 and to the portion of the blended payment that reflects the LTCH payment rate for discharges that do not meet the specified criteria. If the Congress implements the Commission's recommendation for LTCH payment reform, our recommendation would apply to Medicare's payment rate for chronically critically ill cases in LTCHs. ■

Background

Patients with chronic critical illness—those who exhibit metabolic, endocrine, physiologic, and immunologic abnormalities that result in profound debilitation and often ongoing respiratory failure—frequently need hospital-level care for extended periods. Nationwide, most chronically critically ill (CCI) patients are treated in acute care hospitals (ACHs), but a growing number are treated in long-term care hospitals (LTCHs).¹ These facilities can be freestanding or colocated with other hospitals, as hospitals-within-hospitals (HWHs) or satellites. To qualify as an LTCH for Medicare payment, a facility must meet Medicare’s conditions of participation for ACHs, and its Medicare patients must have an average length of stay greater than 25 days.² By comparison, the average Medicare length of stay in ACHs is about five days. There are no other criteria defining LTCHs, the level of care they provide, or the patients they treat. In 2013, Medicare spent \$5.5 billion on care provided in LTCHs nationwide. About 122,000 beneficiaries had roughly 138,000 LTCH stays. On average, Medicare FFS beneficiaries account for about two-thirds of LTCHs’ discharges.

Since October 2002, Medicare has paid LTCHs prospective per discharge rates based primarily on the patient’s diagnosis and the facility’s wage index.³ Under this prospective payment system (PPS), LTCH payment rates are based on the Medicare severity long-term care diagnosis related group (MS–LTC–DRG) patient classification system, which groups patients primarily according to diagnoses and procedures. MS–LTC–DRGs are the same groups used in the acute care hospital inpatient PPS (IPPS) but have relative weights specific to LTCH patients, reflecting the average relative costliness of cases in the group compared with that of the average LTCH case. The LTCH PPS has outlier payments for patients who are extraordinarily costly.⁴ The LTCH PPS pays differently for short-stay outlier cases (patients with shorter than average lengths of stay), reflecting CMS’s contention that Medicare should adjust payment rates for patients with relatively short stays to reflect the reduced costs of caring for them (see text box discussing short-stay outliers, pp. 266–267). In addition, CMS uses the so-called “25-percent rule”—which prohibits an LTCH from having any more than 25 percent of its patients at any one time admitted from one referring hospital—to discourage LTCHs from admitting too many patients from any one referring hospital (generally an ACH).

Beginning October 1, 2015, Medicare will pay differently for cases that do not meet certain criteria specified in

the Pathway for SGR Reform Act of 2013 (see text box discussing recent legislation, p. 269). Medicare will pay the LTCH rate only for (1) cases that have an ACH stay that includes at least three days in an intensive care unit (ICU) or (2) discharges assigned to the MS–LTC–DRG based on the receipt of mechanical ventilation services for at least 96 hours. The remaining “site-neutral” cases will receive the lesser of either an IPPS-comparable amount or 100 percent of cost for the case.

In contrast, the Commission recommended in March 2014 that LTCHs be paid LTCH rates only for cases that received eight or more days of care in an ICU or received prolonged mechanical ventilation services during the previous ACH stay (see text box discussing Commission recommendations, pp. 270–271). The Commission is concerned that the three-day threshold mandated in the Pathway for SGR Reform Act of 2013 is too low to distinguish the truly chronically critically ill patients treated in LTCHs and that Medicare thus will continue to pay too much for many cases that could be cared for appropriately in other settings at a lower cost to the program.

Are Medicare payments adequate in 2015?

To address whether payments for 2015 are adequate to cover the costs that providers incur in providing services to Medicare beneficiaries and how much providers’ costs are expected to change in the coming year (2016), we examine several indicators of payment adequacy. Specifically, we assess beneficiaries’ access to care (by examining the capacity and supply of LTCH providers and changes over time in the volume of services furnished), quality of care, providers’ access to capital, and the relationship between Medicare payments and providers’ costs.

Beneficiaries’ access to care: Growth over time in supply of providers and volume of services suggests continued access to care

We have no direct measures of beneficiaries’ access to needed LTCH services. There are no clear criteria describing the need for care provided in LTCHs, and the absence of LTCHs in many areas of the country makes it particularly difficult to assess the adequacy of supply (since beneficiaries in areas without LTCHs have access to similar services in other settings). Instead, we consider the overall capacity and supply of LTCH providers and changes over time in the volume of services they furnish.

Payment for short-stay outliers in long-term care hospitals

In the long-term care hospital (LTCH) payment system, Medicare may adjust payments for cases with short stays. CMS defines a short-stay outlier (SSO) case as having a length of stay less than or equal to five-sixths of the geometric average length of stay for the case type. The SSO policy reflects CMS's contention that patients with lengths of stay similar to those in acute care hospitals (ACHs) should be paid at rates comparable with those under the ACH inpatient prospective payment system (IPPS). About 26.3 percent of LTCH discharges received SSO payment adjustments in fiscal year 2013, but this share varied across types of LTCHs. For example, in fiscal year 2013, 25.6 percent of for-profit LTCHs' cases were SSOs compared with 30.5 percent of nonprofit LTCHs' cases.

The amount Medicare pays to LTCHs for an SSO case is the lowest of:

- 100 percent of the cost of the case,
- 120 percent of the per diem amount for the Medicare severity long-term care diagnosis related group (MS-LTC-DRG) multiplied by the patient's length of stay,
- the full MS-LTC-DRG payment, or
- a blend of the IPPS amount for the same type of case and 120 percent of the MS-LTC-DRG per diem amount. The LTCH per diem payment amount makes up more of the total amount as the patient's length of stay increases.

Since December 29, 2012, CMS has applied a different standard to cases with the shortest lengths of stay—those with stays less than or equal to the IPPS average stay for the same type of case plus one standard

deviation. These cases are also paid the lowest of the four payment amounts: the first three listed previously or an amount comparable with the IPPS payment rate, rather than a blended amount. After December 29, 2012, about 13.1 percent of LTCH discharges were very short-stay outliers (VSSOs). In fiscal year 2013, 47 percent of VSSOs received payment equal to 100 percent of costs, and another 43 percent received an amount equal to the IPPS per diem payment. As with SSOs, the share of VSSOs varied across type of LTCH. For example, in fiscal year 2013, 13 percent of for-profit LTCHs' cases were VSSOs compared with 14.6 percent of nonprofit LTCH cases. The Commission estimates that in fiscal year 2015, 45.2 percent of SSO cases—or 12.3 percent of all LTCH cases—will be VSSOs.

Compared with cases that were not SSOs, SSO and VSSO cases were more likely to be of an extreme severity level and to require prolonged mechanical ventilation. Many LTCH SSO and VSSO cases were short because the beneficiary was readmitted to an ACH or died. Twenty-seven percent of VSSO cases were readmitted to an ACH, while 14 percent of SSOs and only 5 percent of longer stay cases were readmitted. Similarly, 42 percent of VSSO cases died in the LTCH compared with 20 percent of SSO cases and 6 percent of longer stays. When VSSO cases were discharged alive, only 26 percent were still living one year after discharge compared with more than half of SSO and non-SSO cases.

Generally, for the same case type, the IPPS payment is substantially less than the payment under the LTCH prospective payment system. As an example, for a case assigned to MS-LTC-DRG 207 (respiratory system diagnosis with prolonged mechanical ventilation), the standard IPPS payment in 2015 is \$31,376, while the

(continued next page)

Capacity and supply of providers: Supply stabilized during the congressionally mandated moratorium

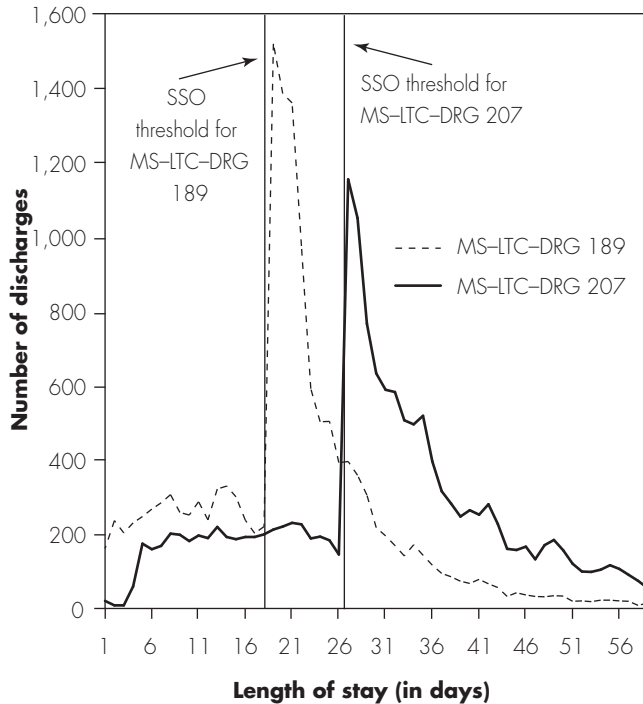
The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and subsequent legislation imposed

a limited moratorium on new LTCHs and new beds in existing LTCHs from December 29, 2007, through December 28, 2012. During this time, new LTCHs were able to enter the Medicare program only if they met specific exceptions to the moratorium.⁵ The Pathway

Payment for short-stay outliers in long-term care hospitals (cont.)

FIGURE 11-1

Many LTCH cases in fiscal year 2013 were discharged in the period immediately after the short-stay outlier threshold



Note: LTCH (long-term care hospital), SSO (short-stay outlier), MS-LTC-DRG (Medicare severity long-term care diagnosis related group). Cases in MS-LTC-DRG 207 are those with a respiratory system diagnosis that received prolonged mechanical ventilation. Cases in MS-LTC-DRG 189 are those with pulmonary edema and respiratory failure.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

standard LTCH payment is \$79,128. LTCHs therefore have a strong financial incentive to keep patients until their lengths of stay exceed the SSO threshold for the relevant case type, and they appear to respond to that incentive (Figure 11-1). Analysis of lengths of stay by MS-LTC-DRG for 2013 shows that the number of discharges rose sharply immediately after the SSO threshold. This pattern held true across MS-LTC-DRGs and for every category of LTCH. The data strongly suggest that LTCHs' discharge decisions are influenced at least as much by financial incentives as by clinical indicators.

CMS could substantially reduce these financial incentives by lowering the payment penalty for discharging patients before the SSO threshold. For example, short-stay cases could be defined as cases with a covered length of stay that is more than one day shorter than the geometric average length of stay for the MS-LTC-DRG. As with the transfer policy for short-stay cases in the IPPS, payment for the first day of a short-stay LTCH case could be two times the per diem payment rate for the MS-LTC-DRG; payment for each additional day would then be set at the per diem rate, up to the maximum of the full standard per discharge payment (which would be reached one day before the average length of stay for the MS-LTC-DRG). This formula would reduce the substantial cliff in payments that exists under current policy and better match incremental payments for short-stay cases to the provider's incremental costs. ■

for SGR Reform Act of 2013 and subsequent legislation reinstated the moratorium from April 1, 2014, through September 30, 2017.⁶

It is difficult to determine the precise number of LTCHs because of discrepancies in Medicare's data sources on these facilities. The Commission has found inaccuracies in the ownership data in Medicare's Provider of Services file, so we examined Medicare cost report data from 2004 to 2013 to assess the number of LTCH beds and facilities. We consistently found that growth in the number of LTCHs filing Medicare cost reports slowed considerably in the later years of the moratorium (Table 11-1, p. 268).

However, between 2012 and 2013, a larger than usual number of mergers and acquisitions resulted in midyear changes to cost reporting periods for more than 20 facilities. Cost report data therefore indicate 408 LTCHs filed valid cost reports in 2013, 18 fewer than 2012, on net. These data also show that the number of LTCH beds nationwide decreased about 4 percent in 2013. The anomalous cost reporting trends during this period make it impossible to accurately compare changes in the number of LTCH facilities and LTCH beds using cost report data. Using data from Medicare's Provider of Services file, the Commission estimates that between 2012 and 2013, the

**TABLE
11-1**

Growth in the number of LTCHs has stabilized over the past several years

Type of LTCH	Congressionally imposed moratorium							Average annual change		
	2004	2005	2009	2010	2011	2012	2013*	2004–2005	2005–2009	2009–2012
All	315	366	411	416	421	426	408	16.2%	2.9%	1.2%
Urban	299	342	388	389	395	399	380	14.4	3.2	0.9
Rural	16	24	23	27	26	27	28	50.0	-1.1	5.5
Nonprofit	67	78	79	82	77	79	71	16.4	0.3	0.0
For profit	229	265	313	314	326	329	320	15.7	4.2	1.7
Government	19	23	19	20	18	18	17	21.1	-4.7	-1.8

Note: LTCH (long-term care hospital). The Medicare, Medicaid, and SCHIP Extension Act of 2008 and subsequent legislation imposed a moratorium on new LTCHs and new LTCH beds in existing facilities from December 29, 2007 through December 29, 2012.
 *2013 data should not be compared with prior years, given an anomalous number of facilities that underwent an acquisition and change in cost reporting period. Using the Provider of Services file, the Commission estimates that the number of facilities decreased from 437 in 2012 to 432 in 2013 (data not shown).

Source: MedPAC analysis of cost report data from CMS.

number of LTCHs and number of beds decreased by about 1 percent.⁷ The Commission found that most of the new LTCHs filing cost reports in 2013 were for-profit facilities. Consistent with historical trends, the Commission estimates that in 2013, more than 75 percent of LTCHs were for profit and 93 percent were located in urban areas.

Volume of services: Number of LTCH users decreased slightly

Beneficiaries' use of LTCH services suggests that access is adequate. Growth in the number of LTCH cases was high in the first years of the LTCH PPS, but it declined from 2005 to 2007 (Table 11-2). Much of this decrease

**TABLE
11-2**

The number of Medicare LTCH cases and users decreased between 2012 and 2013

	2004	2005	2007	2011	2012	2013	Average annual change			
							2004–2005	2005–2007	2007–2012	2012–2013
Cases	121,955	134,003	129,202	139,715	140,463	137,827	9.9%	-1.8%	1.7%	-1.9%
Cases per 10,000 FFS beneficiaries	33.4	36.4	36.3	38.2	37.7	36.8	9.0	-0.1	0.7	-2.2
Spending (in billions)	\$3.7	\$4.5	\$4.5	\$5.4	\$5.5	\$5.5	21.6	0.0	4.3	-0.4
Spending per FFS beneficiary	\$101.3	\$122.2	\$126.5	\$147.9	\$148.8	\$147.6	20.7	1.7	3.3	-0.8
Payment per case	\$30,059	\$33,658	\$34,769	\$38,664	\$39,493	\$40,070	12.0	1.6	2.6	1.5
Average length of stay (in days)	28.5	28.2	26.9	26.3	26.2	26.5	-1.1	-2.3	-0.5	1.0
Users	108,814	119,282	114,299	122,838	123,652	121,532	9.6	-2.1	1.6	-1.7

Note: LTCH (long-term care hospital), FFS (fee-for-service).

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS and the annual report of the Boards of Trustees of the Medicare trust funds.

Recent legislation

The Pathway for SGR Reform Act of 2013 included several provisions related to long-term care hospitals (LTCHs), including changes to payment rates for some cases, changes to the 25-percent rule, and a moratorium on new LTCHs.

“Site-neutral” payments

The Pathway for SGR Reform Act of 2013 established “site-neutral” payments for specified cases in LTCHs, beginning in fiscal year 2016. Under the law, the LTCH payment rate will apply only to LTCH discharges that had an acute care hospital (ACH) stay immediately preceding LTCH admission and for which:

- the ACH stay included at least 3 days in an intensive care unit or
- the discharge is assigned to the Medicare severity long-term care diagnosis related group (MS–LTC–DRG) based on the receipt of mechanical ventilation services for at least 96 hours.

All other LTCH discharges—including any discharges assigned to psychiatric or rehabilitation MS–LTC–DRGs, regardless of intensive care unit use—will be paid an amount based on Medicare’s ACH payment rates under the inpatient prospective payment system or 100 percent of the costs of the case, whichever is lower. These site-neutral payments will be phased in over a two-year period. Beginning with cost reporting periods starting in fiscal years 2016 and 2017, cases that do not meet the specified criteria will receive a blended rate of one-half the standard LTCH payment and one-half the site-neutral payment. These cases receive 100 percent of the site-neutral payment rate beginning with cost reporting periods starting on or after October 1, 2017. Given LTCH’s varying cost reporting periods, the Commission expects fiscal year 2019 to be the first full year in which this policy is completely phased in.

New criteria to receive the LTCH payment rate

Currently, to qualify as an LTCH for Medicare payment, a facility must meet Medicare’s hospital conditions of participation and its Medicare patients must have an average length of stay greater than 25 days. Under the Pathway for SGR Reform Act of 2013, beginning in fiscal year 2016, the LTCH average length of stay will

be calculated only for Medicare fee-for-service cases that are not paid the site-neutral rate. In addition, for cost reporting periods starting on or after October 1, 2019, to continue to receive the LTCH payment rate for eligible cases, an LTCH must have no more than 50 percent of its cases paid at the site-neutral rate.

The “25-percent rule”

The Pathway for SGR Reform Act of 2013 continues to delay the full phase-in of the so-called 25-percent rule for most LTCH hospitals-within-hospitals (HWHs) and LTCH satellites until October 1, 2016. In fiscal year 2005, CMS established the 25-percent rule in an attempt to prevent LTCHs from functioning as units of ACHs; decisions about admission, treatment, and discharge in both ACHs and LTCHs were to be made for clinical rather than financial reasons. The 25-percent rule uses payment adjustments to create disincentives for LTCHs to admit a large share of their patients from a single ACH.

The 25-percent rule initially applied only to LTCH HWHs and LTCH satellites. In July 2007, CMS extended the 25-percent rule to apply also to freestanding LTCHs. The Congress has delayed full implementation of the 25-percent rule so that most HWHs and satellites will be paid standard LTCH rates for eligible patients admitted from their host hospitals as long as the percentage of Medicare admissions from the host hospital does not exceed 50 percent (instead of the more restrictive 25 percent threshold). In addition, the Secretary is prohibited from applying the 25-percent rule to freestanding LTCHs before cost reporting periods that begin on or after July 1, 2016. The law requires the Secretary to submit a report to the Congress on the necessity of a 25-percent rule by October 1, 2015.

Moratorium on new LTCHs

The Protecting Access to Medicare Act of 2014 amended the Pathway for SGR Reform Act of 2013 by imposing a moratorium on new facilities and new beds in existing facilities beginning April 1, 2014. The moratorium allows certain exceptions for new LTCHs but not for increases in the number of certified beds in existing LTCHs or satellite facilities. The moratorium expires on September 30, 2017.⁸ ■

Commission recommendations for long-term care hospitals

The Commission has maintained that long-term care hospitals (LTCHs) should serve only the most medically complex patients—the chronically critically ill (CCI)—and has determined that the best available proxy for intensive resource needs in LTCH patients is intensive care unit (ICU) length of stay during an immediately preceding acute care hospital (ACH) stay. The Commission has also long held that payments to providers should be properly aligned with patients’ resource needs. Further, subject to risk differentials, payment for the same services should be comparable regardless of where the services are provided. In March 2014, the Commission recommended that the LTCH payment system be reformed to better align payments for both CCI and non-CCI cases across LTCH and ACH settings.

The research supporting this recommendation consistently describes CCI patients as having long ACH stays with heavy use of intensive care services (Carson et al. 2008, Donahoe 2012, Macintyre 2012, Nelson et al. 2010, Wiencek and Winkelman 2010, Zilberberg et al. 2012, Zilberberg et al. 2008). Further, in site visits and technical expert panel discussions conducted by Kennell and Associates Inc. and RTI under contract with CMS, LTCH representatives and ACH critical care physicians agreed that medically stable post-ICU patients are appropriate candidates for LTCH care (Centers for Medicare & Medicaid Services 2013, Dalton et al. 2012). In CMS’s Post-Acute Care Payment Reform Demonstration, length of stay in the ICU was significantly associated with post-acute care case complexity, and long ICU stays were a distinguishing characteristic of LTCH patients (Gage et al. 2011).

The Commission maintains that CCI cases are a small share of overall Medicare ACH cases and that the ICU length-of-stay threshold identifying CCI cases should be set accordingly. The Commission therefore recommended that the Congress limit standard LTCH payments to cases that spent eight or more days in an ICU during an immediately preceding ACH stay. The Commission’s analysis of inpatient prospective payment system (IPPS) claims data found that cases with eight or more days in an ICU accounted for

about 6 percent of all Medicare discharges and had a geometric mean cost per discharge that was four times that of other IPPS cases. Further, these cases were concentrated in a small number of Medicare severity–diagnosis related groups that correspond with the “ideal” LTCH patients described by LTCH representatives and critical care clinicians (Dalton et al. 2012). Previous studies have found such severely ill patients more likely to benefit from LTCH care (Kennell and Associates Inc. 2010, Medicare Payment Advisory Commission 2004).

Setting the ICU length of stay threshold for CCI cases at eight days captures a large share of LTCH cases requiring prolonged mechanical ventilation—a service specialty of many LTCHs. However, the Commission is concerned that LTCH care may be appropriate for some patients requiring mechanical ventilation, even if they did not spend eight or more days in an ICU during an immediately preceding ACH stay. The Commission’s analysis of 2012 LTCH claims found that about 22,000 cases (15.8 percent of all LTCH discharges) received prolonged mechanical ventilation services during the LTCH stay. Of these cases, 69.7 percent had an immediately preceding ACH stay that included eight or more days in an ICU, while 15.6 percent had an ACH stay with fewer than eight days in an ICU. (An additional 14.7 percent did not have an ACH stay within three days of admission to the LTCH.)

For LTCH cases that did not spend eight or more days in an ICU during an immediately preceding ACH stay, the Commission recommended that the Secretary of Health and Human Services set the payment rates equal to those of ACHs. The Commission recommended that savings from this policy be used to create additional inpatient outlier payments for CCI cases in IPPS hospitals.

The Commission’s analysis of IPPS claims for patients who were discharged alive from ACHs in 2012 found that about 103,000 cases received prolonged mechanical ventilation services during their ACH stay. Of these cases, 79 percent would have met the CCI criterion because they spent eight or more days

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Commission recommendations for long-term care hospitals (cont.)

in an ACH ICU. The exception to the 8-day ICU threshold for cases that received prolonged mechanical ventilation in the ACH would thus have increased the potential pool of CCI-eligible cases in LTCHs in 2012 by 21,000 nationwide.

The Pathway for SGR Reform Act of 2013 mandated changes to the LTCH PPS, including limiting standard LTCH payments to cases that spent at least three days in an ICU during an immediately preceding ACH stay or to discharges that received an LTCH principal diagnosis indicating prolonged mechanical ventilation. Our analysis of IPPS claims data from 2012 found that

22.8 percent of IPPS discharges spent three or more days in an ICU.

The Commission is concerned that a threshold of fewer than eight days is too low to distinguish the truly CCI patients and thus will allow Medicare to continue to pay too much for many cases that could be cared for appropriately in other settings at a lower cost to the program. The Commission is also concerned that the savings from this policy was not redistributed to ACHs to treat CCI cases, thus perpetuating the wide payment differential for similar CCI cases across hospital settings. ■

is consistent with the decline in beneficiaries' enrollment in FFS Medicare because of their increased enrollment in Medicare Advantage plans. CMS regulations that reduced payments for LTCH services also likely slowed growth in LTCH admissions during that period and beyond. From 2007 to 2012, the number of LTCH cases increased by an annual average rate of 1.7 percent. However, between 2012 and 2013, the number of LTCH cases decreased by 1.9 percent. On a per capita basis (per 10,000 FFS beneficiaries), the decline was 2.2 percent in part because the number of FFS beneficiaries grew at a somewhat faster pace between 2012 and 2013. This decrease in per capita admissions is consistent with the decreases observed in other inpatient settings.

Compared with all Medicare beneficiaries, those admitted to LTCHs are disproportionately disabled (under age 65), over age 85, or diagnosed with end-stage renal disease. They are also more likely to be African American. The higher rate of LTCH use by African American beneficiaries may be due to the concentration of LTCHs in areas of the country with larger African American populations (Dalton et al. 2012, Kahn et al. 2010). Another contributing factor may be a greater incidence of critical illness in this population (Mayr et al. 2010). At the same time, African American beneficiaries may be more likely to opt for LTCH care since they are less likely to choose withdrawal from mechanical ventilation in the ICU, have do-not-resuscitate orders, or elect hospice care (Barnato et al. 2009, Borum et al. 2000, Diringer et al. 2001).

LTCH discharges are concentrated in a relatively small number of diagnosis groups. In fiscal year 2013, the top 25 LTCH diagnoses made up about 64 percent of all LTCH discharges (Table 11-3, p. 272). The most frequently occurring diagnosis was MS-LTC-DRG 207, respiratory system diagnosis with ventilator support for 96 or more hours. Nine of the top 25 diagnoses, representing 36 percent of LTCH cases, were respiratory conditions or involved prolonged mechanical ventilation.

Quality of care: Meaningful measures are not available, but trends for gross indicators are stable

Unlike most of the other types of health care facilities covered by Medicare, LTCHs only recently began reporting to CMS on a limited set of quality measures (see text box discussing quality measures, p. 273); those data are not yet available for analysis. Therefore, the Commission assesses aggregate trends in the quality of LTCH care by examining in-facility mortality rates, mortality within 30 days of discharge, and readmissions from LTCHs to ACHs. We do not risk adjust these outcome measures like we do for other provider types because the available claims data do not provide the level of clinical detail needed to adequately adjust for the comparatively small differences in patient severity and clinical complexity across LTCH patients. LTCH cases are highly concentrated in a few MS-LTC-DRGs, and the vast majority of LTCH patients have multiple diagnoses and comorbidities.

**TABLE
11-3**

The top 25 MS-LTC-DRGs made up two-thirds of LTCH discharges in 2013

MS-LTC-DRG	Description	Discharges	Percentage
207	Respiratory system diagnosis with ventilator support 96+ hours	16,221	11.8%
189	Pulmonary edema and respiratory failure	15,179	11.0
871	Septicemia without ventilator support 96+ hours with MCC	8,458	6.1
177	Respiratory infections and inflammations with MCC	4,324	3.1
592	Skin ulcers with MCC	3,650	2.6
208	Respiratory system diagnosis with ventilator support < 96 hours	3,135	2.3
949	Aftercare with CC/MCC	3,003	2.2
539	Osteomyelitis with MCC	2,877	2.1
190	Chronic obstructive pulmonary disease with MCC	2,439	1.8
682	Renal failure with MCC	2,292	1.7
919	Complications of treatment with MCC	2,235	1.6
559	Aftercare, musculoskeletal system and connective tissue with MCC	2,123	1.5
314	Other circulatory system diagnoses with MCC	2,038	1.5
862	Postoperative and post-traumatic infections with MCC	2,026	1.5
193	Simple pneumonia and pleurisy with MCC	1,979	1.4
4	Tracheostomy with ventilator support 96+ hours or primary diagnosis except face, mouth, and neck without major OR	1,925	1.4
166	Other respiratory system OR procedures with MCC	1,917	1.4
870	Septicemia with ventilator support 96+ hours	1,817	1.3
570	Skin debridement with MCC	1,711	1.2
291	Heart failure and shock with MCC	1,664	1.2
853	Infectious and parasitic diseases with OR procedure with MCC	1,556	1.1
981	Extensive OR procedure unrelated to principal diagnosis with MCC	1,541	1.1
638	Diabetes with CC	1,447	1.0
560	Aftercare, musculoskeletal system and connective tissue with CC	1,414	1.0
602	Cellulitis with MCC	1,398	1.0
	Top 25 MS-LTC-DRGs	88,369	64.1
	Total	137,846	100.0

Note: MS-LTC-DRG (Medicare severity long-term care diagnosis related group), LTCH (long-term care hospital), CC (complication or comorbidity), MCC (major complication or comorbidity), OR (operating room). MS-LTC-DRGs are the case-mix system for LTCH facilities. The sum of column components may not equal the stated total due to rounding.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

For this report, we analyzed readmission and mortality rates for the top LTCH diagnoses from 2008 to 2013. Although rates of readmission and death can vary from year to year, over the 5-year period we found stable or declining rates of readmissions to ACHs and stable or declining mortality rates for these diagnoses, both in facility and 30 days postdischarge.

In 2013, 9 percent of LTCH cases were readmitted to an ACH, 13 percent died in the LTCH, and another 12 percent died within 30 days of discharge from the LTCH. Mortality rates varied markedly by diagnosis group.

Among patients with a principal diagnosis of septicemia with prolonged ventilator support, 37 percent died in the LTCH and 14 percent died within 30 days of discharge. By comparison, among patients with a principal diagnosis of cellulitis without major complications or comorbidities, only 1 percent died in the LTCH and an additional 3 percent died within 30 days of discharge. Among the highest volume MS-LTC-DRGs in 2013, patients with a diagnosis of complications of treatment with major complication or comorbidity (MS-LTC-DRG 919) had the highest readmission rate (17 percent).⁹

Quality measures for long-term care hospitals

The Patient Protection and Affordable Care Act of 2010 (PPACA) required CMS to establish a quality reporting program for long-term care hospitals (LTCHs) by fiscal year 2014 and further stipulated that LTCHs not participating in the program would have their annual payment update reduced by 2 percentage points starting in 2014. Beginning October 1, 2013, LTCHs receive a full payment update only if they successfully report on three quality measures—catheter-associated urinary tract infections (CAUTIs), central line-associated bloodstream infections (CLABSIs), and new or worsened pressure ulcers. Data on incidences of CAUTIs and CLABSIs are collected through the National Healthcare Safety Network (NHSN), an Internet-based surveillance system maintained by the Centers for Disease Control and Prevention (CDC). The data elements needed to calculate the pressure ulcer measure are collected using a data collection instrument called the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set. These data are not yet available for analysis.

In 2014, CMS added two measures to the LTCH quality reporting program: the share of LTCH patients assessed for and appropriately given influenza vaccine and influenza vaccination coverage among facility health care personnel. Using the LTCH CARE Data Set, facilities collect data on the share of patients assessed for and appropriately given influenza vaccine, while the

CDC's NHSN collects data on influenza vaccination coverage among LTCH health care personnel. Payment updates for fiscal year 2016 and after will be affected by LTCHs' reporting on these two measures.

In 2015, LTCHs will be required to begin reporting facility-acquired cases of methicillin-resistant *Staphylococcus aureus* and *Clostridium difficile* through the CDC NHSN. Reductions of LTCH payment updates for reporting on these two measures will begin in fiscal year 2017. Also beginning in 2017, CMS plans to start using claims data to calculate LTCHs' rates of all-cause unplanned readmissions to acute care hospitals. Provider feedback on readmission rates will begin in January 2016, before public reporting.

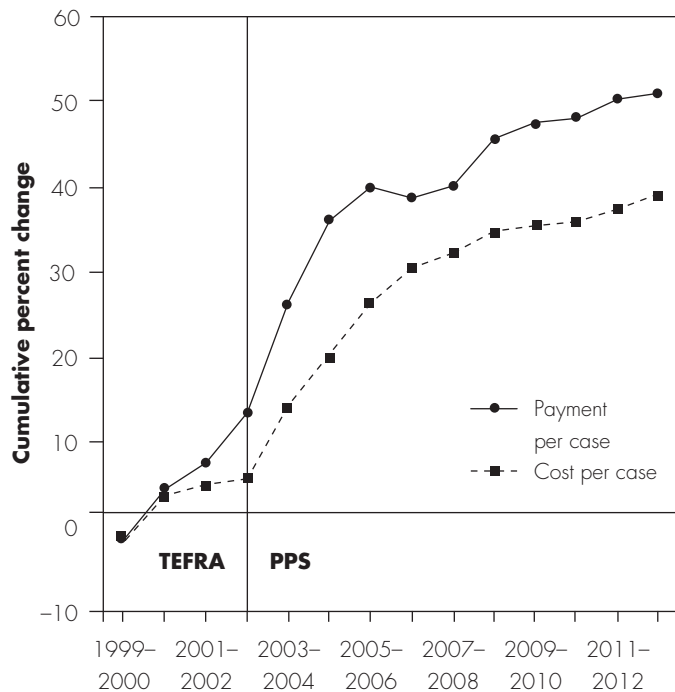
CMS intends to add 4 more measures to the program beginning in fiscal year 2018, which will bring the total number of measures to 12. In January 2016, LTCHs must begin reporting on ventilator-associated events (such as pneumonia, sepsis, and pulmonary embolism) through the CDC NHSN. Starting in April 2016, CMS will begin collecting data on the following three measures using the LTCH CARE Data Set: share of patients experiencing one or more falls resulting in major injury, change in mobility among LTCH patients who require ventilator support, and share of LTCH patients with an admission and discharge assessment and care plan that address patient function. ■

Providers' access to capital: Uncertainty about possible policy changes slows investment

Access to capital allows LTCHs to maintain, modernize, and expand their facilities. If LTCHs were unable to access capital, it might in part reflect problems with the adequacy of Medicare payments since Medicare accounts for about half of LTCH total revenues. However, for the past few years, the availability of capital said more about uncertainty regarding changes to regulations and legislation governing LTCHs than it did about current Medicare payment rates. The criteria to receive the higher LTCH payment rate specified in the Pathway for SGR Reform Act of 2013,

beginning with cost reporting periods starting October 1, 2015, provide more regulatory certainty for the industry compared with recent years. However, payment reductions implemented by CMS and congressional moratoriums on new LTCH beds and facilities from December 2007 through December 2012 and from April 2014 through September 2017 continue to limit future opportunities for growth and reduce the industry's need for capital.

LTCHs and LTCH companies have been positioning themselves for the changing payment environment in which CCI cases will be eligible for the LTCH payment rate and non-CCI cases will be paid a different, lower rate. For example, in this primarily for-profit industry, Kindred

**FIGURE
11-2****LTCHs' per case costs increased at a rate faster than payments in 2013**

Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Percent changes are calculated based on consistent two-year cohorts of LTCHs.

Source: MedPAC analysis of Medicare cost report data from CMS.

Healthcare, which owns about 20 percent of all LTCHs, has continued to pursue an “integrated care market” strategy. The company operates skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, outpatient rehabilitation providers, and LTCHs within a single market to position itself as an integrated provider of post-acute care (Kindred Healthcare 2013).¹⁰ Kindred hopes this approach will make the company a natural partner for ACHs and accountable care organizations (Barclays 2013). This strategy is also intended to improve the chain’s ability to control its mix of patients and costs and limit the impact of payment policy changes in any one post-acute care sector. As part of this strategy, in the past year the company reached an agreement to acquire Gentiva Health Services, a large provider of home health and hospice care, and Centerre Healthcare Corporation, an inpatient rehabilitation hospital company (Cain Brothers 2014, Kindred Healthcare 2014).

Medicare’s payments and providers’ costs: Cost growth exceeded payment growth for the first time since 2008

Since 2007, LTCHs have held cost growth below the rate of increase in the market basket index, a measure of inflation in the prices of goods and services LTCHs buy to provide care. Between 2012 and 2013, Medicare payments continued to increase, albeit more slowly than provider costs, resulting in an aggregate 2013 Medicare margin of 6.6 percent compared with 7.4 percent in 2012. Financial performance in 2013 varied across LTCHs, reflecting differences in cost control and response to payment incentives.

Reductions in the LTCH base rate slowed spending growth in 2012 and 2013

In the first three years of the LTCH PPS, Medicare spending for LTCH services grew rapidly, climbing an average of 29 percent per year. CMS’s subsequent changes to LTCH payment policies slowed growth in spending between 2005 and 2008 to less than 1 percent per year. MMSEA halted or rolled back the implementation of some CMS regulations designed to address issues of excessive payments to LTCHs. As a result, between 2008 and 2010, spending jumped more than 6 percent per year.¹¹ Although some of the MMSEA provisions continued through fiscal year 2013, spending growth between 2010 and 2013 slowed to 2.1 percent, in part because of mandated reductions in Medicare’s LTCH payment rate beginning in 2011.¹²

LTCHs continued to restrain cost growth, but less so than in recent years

LTCHs appear to be responsive to changes in payment, adjusting their costs per case when payments per case change. In the first years of the PPS, cost per case increased rapidly after a surge in payment per case (Figure 11-2). Between 2005 and 2007, growth in cost per case slowed considerably because regulatory changes to Medicare’s payment policies for LTCHs slowed growth in payment per case to an average of 1.3 percent per year.

Since 2007, LTCHs have held cost growth below the rate of market basket increases, likely because of ongoing concerns about possible changes to Medicare’s payment policies for LTCH services. The slowest growth in average cost per case occurred between 2009 and 2011, when the average cost per case increased less than 1 percent per year. Between 2011 and 2012, average cost per case increased by 1.5 percent. Between 2012 and

**TABLE
11-4**

The aggregate average LTCH Medicare margin fell in 2013

Type of LTCH	Share of discharges	2005	2006	2007	2008	2009	2010	2011	2012	2013
All	100%	11.9%	9.7%	4.7%	3.7%	5.7%	6.8%	6.9%	7.4%	6.6%
Urban	95	12.0	9.9	4.9	3.9	6.0	7.1	7.0	7.5	6.8
Rural	5	10.2	4.7	-0.4	-3.2	-3.0	-0.2	2.9	3.5	2.4
Nonprofit	14	9.1	6.5	1.4	-2.5	-0.7	-0.2	0.4	-0.6	-1.7
For profit	85	13.1	10.9	5.6	5.3	7.4	8.3	8.4	9.0	8.4
Government	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: LTCH (long-term care hospital), N/A (not applicable). Margins for government-owned providers are not shown. They operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of Medicare cost report data from CMS.

2013, the average cost per case further increased by 1.8 percent while the annual market basket update, including adjustments required by the Patient Protection and Affordable Care Act of 2010 (PPACA), equaled 2 percent. However, in 2013, CMS began implementing a downward adjustment in response to unexpected changes in coding practices that increased payments to LTCHs relative to CMS’s estimates in the first year of the PPS, fiscal year 2003. These adjustments, intended to bring payments to LTCHs more in line with what would have been spent under the previous payment method, decrease the standard federal payment rate by about 3.75 percent over three years. In addition, the reductions from sequestration further reduced growth in payments.

Aggregate LTCH margins decreased

After the LTCH PPS was implemented in 2003, margins rose rapidly for all LTCH provider types, climbing to 11.9 percent in 2005 (Table 11-4). At that point, margins began to fall as growth in payments per case leveled off. From 2009 through 2012, LTCH margins began to climb again as providers consistently held cost growth below that of payment growth. In 2013, the aggregate LTCH margin fell from 7.4 percent to 6.6 percent, primarily because of the first year of a three-year phase-in of the downward adjustment for budget neutrality and the effect of sequestration beginning on April 1, 2013.

Nonprofit LTCHs may be less successful at controlling costs

Financial performance in 2013 varied across LTCHs. At 8.4 percent, margins were highest for for-profit LTCHs,

which account for more than three-quarters of all LTCHs and 85 percent of all LTCH cases. The aggregate margin for nonprofit LTCHs fell from 0.4 percent in 2011 to -0.6 percent in 2012 and then to -1.7 percent in 2013. This decline was due to cost growth that exceeded growth in payments. Between 2012 and 2013, per case costs for nonprofit LTCHs grew almost twice as fast as costs for for-profit LTCHs.

The comparatively poor financial performance of nonprofit LTCHs reflected a number of differences that can affect providers’ ability to control their costs. First, though occupancy rates in 2013 for the two groups were fairly similar (65 percent for nonprofit LTCHs vs. 67 percent for for-profit LTCHs), nonprofit LTCHs were smaller and had fewer total cases than for-profit LTCHs (an average of 461 vs. 518). About 70 percent of nonprofit LTCHs had fewer than 50 beds compared with about half of for-profit LTCHs. Nonprofit LTCHs were therefore less likely than for-profit LTCHs to benefit from economies of scale. In addition, nonprofit LTCHs may be less able to control their input costs than for-profit LTCHs that are members of large chains. Those for-profit LTCH chains that own other types of post-acute care providers within a market area likely have a distinct advantage over other LTCHs because they are better able to control their mix of patients and lengths of stay. Nonprofit LTCHs had a larger share of cases with extraordinarily high costs (18.6 percent of nonprofit LTCHs cases qualified for high-cost outlier payments vs. 11.6 percent of for-profit LTCHs’ cases), although it is not clear whether this difference stems from differences in efficiency, case complexity, or

**TABLE
11-5**

LTCHs in the top quartile of Medicare margins in 2013 had lower costs

Characteristics	High-margin quartile	Low-margin quartile
Mean margin	20.2%	-12.4%
Mean total discharges (all payers)	522	423
Medicare patient share	69%	64%
Average length of stay (in days)	26	27
Occupancy rate	74%	57%
Mean CMI	1.13	1.09
Mean per discharge:		
Standardized costs	\$28,352	\$39,119
Standard Medicare payment*	37,832	35,401
High-cost outlier payments	1,579	5,461
Share of:		
Cases that are SSOs	25%	29%
Medicare cases from		
primary-referring ACH	35	38
LTCHs that are for profit	93	64

Note: LTCH (long-term care hospital), CMI (case-mix index), SSO (short-stay outlier), ACH (acute care hospital). Includes only established LTCHs—those that filed valid cost reports in both 2012 and 2013. “High-margin quartile” LTCHs were in the top 25 percent of the distribution of Medicare margins. “Low-margin quartile” LTCHs were in the bottom 25 percent of the distribution of Medicare margins. Standardized costs have been adjusted for differences in case mix and area wages. The primary-referring ACH is the acute care hospital from which the LTCH receives a plurality of its Medicare patients. Government providers were excluded.
*Excludes outlier payments.

Source: MedPAC analysis of LTCH cost reports and Medicare Provider Analysis and Review data from CMS.

both. Nonprofit LTCHs also had more short-stay outliers than did for-profit LTCHs (31 percent vs. 26 percent, respectively) and thus received reduced payments for a larger share of their Medicare patients.

Differences between nonprofit and for-profit LTCHs in the mix of cases are difficult to evaluate. By some measures, nonprofit LTCHs appear to care for a somewhat sicker patient population. For example, a higher share of cases in nonprofit LTCHs qualified for high-cost outlier payments. Similarly, nonprofit LTCHs had a higher share of cases that were high-cost outliers during their immediately

preceding ACH stay (16.6 percent compared with 13.3 percent of for-profit LTCHs’ cases). Another indicator suggesting a sicker patient population is length of stay: The average Medicare-covered stay was two days longer in nonprofit LTCHs than in for-profit ones (28 days vs. 26 days). However, longer stays also could result from inefficient care. Other indicators of patient mix suggest fewer differences between the two types of facilities. The average case mix in both nonprofit and for-profit LTCHs was similar. Nonprofit LTCHs also had a similar share of cases that had long ICU stays during an immediately preceding ACH stay (36 percent compared with 35 percent of for-profit LTCHs’ cases).

High-margin LTCHs had lower unit costs

In 2013, higher unit costs were the primary driver of differences in financial performance between LTCHs with the lowest and highest Medicare margins (those in the bottom and top 25th percentiles of Medicare margins) (Table 11-5).¹³ After accounting for differences in case mix and local market input price levels, low-margin LTCHs had standardized costs per discharge that were 38 percent higher than high-margin LTCHs (\$39,119 vs. \$28,352). Low-margin LTCHs likely benefited less from economies of scale. Compared with their high-margin counterparts, low-margin LTCHs had fewer cases overall (an average of 423 compared with 522 for high-margin LTCHs) and lower occupancy rates (57 percent vs. 74 percent). Notably, high-margin LTCHs had a higher average Medicare share of discharges than did low-margin LTCHs (69 percent vs. 64 percent), which suggests that Medicare patients are desirable.

Although the total Medicare payment per discharge was similar for low-margin and high-margin LTCHs, outlier payments made up a larger share of total payments to low-margin LTCHs. High-cost outlier payments per discharge for low-margin LTCHs averaged more than three times the amount paid to high-margin LTCHs (\$5,461 vs. \$1,579). When these outlier payments were removed from total payments, we found that the standard payment per discharge for low-margin LTCHs was 6 percent lower than that for high-margin LTCHs (\$35,401 vs. \$37,832). This difference was in part because the low-margin LTCHs had a lower average case mix (1.09 vs. 1.13 for high-margin LTCHs) and in part because they cared for a disproportionate share of short-stay outlier cases, which often are paid at reduced rates. Such cases made up 29 percent of low-margin LTCHs’ cases compared with 25 percent in high-margin LTCHs.

How should Medicare payments change in 2016?

To estimate 2015 payments, costs, and margins with 2013 data, the Commission considered policy changes effective in 2014 and 2015. Those that affect our estimate of the 2015 Medicare margin include:

- a market basket increase of 2.5 percent for 2014, offset by PPACA-mandated reductions totaling 0.8 percent, for a net update of 1.7 percent;
- a market basket increase of 2.9 percent for 2015, offset by PPACA-mandated reductions totaling 0.7 percent, for a net update of 2.2 percent; and
- budget-neutrality adjustments in 2013, 2014, and 2015 to account for changes in coding practices that resulted in higher than expected LTCH spending in the first year of the PPS. These adjustments, intended to bring spending more in line with what would have been spent under the previous payment method, will decrease payments by about 3.75 percent over three years.

We project that LTCHs' aggregate Medicare margin will be 4.6 percent in 2015. The Secretary has the discretion to update payments for LTCHs; there is no congressionally mandated update. We expect cost growth to be slightly higher than payment growth. The 4.6 percent margin reflects current policy including the effect of sequestration, which currently reduces Medicare program payments to LTCHs by about 2 percentage points. If sequestration were to be lifted, we would expect margins to be about 2 percentage points higher.

On the basis of our review of payment adequacy for LTCHs, the Commission recommends that the Secretary eliminate the update to the LTCH payment rate in 2016. This recommendation applies to payment for discharges that meet the criteria specified in the Pathway for SGR Reform Act of 2013 and the portion of the blended payment that reflects the LTCH payment rate for discharges that do not meet the specified criteria. If the Congress implements the Commission's recommendation for LTCH payment reform, this recommendation would apply to Medicare's payment rate for CCI cases in LTCHs.

Update recommendation

RECOMMENDATION 11

The Secretary should eliminate the update to the payment rates for long-term care hospitals for fiscal year 2016.

RATIONALE 11

The supply of facilities and beds decreased slightly during 2013. The number of LTCH cases decreased both in total and per capita. Notably, on a per FFS beneficiary basis, the decline in the number of LTCH cases was smaller than that seen in the ACH setting and similar to that seen in the skilled nursing facility setting. These trends suggest that access to care in LTCHs has been maintained because a majority of LTCH cases come directly from ACHs. The limited quality trends that we measure appear to be stable. The availability of capital to LTCHs reflects the implementation of a moratorium on new facilities and beds, rather than current payment rates. Medicare margins for 2013 were positive. These trends suggest that LTCHs are able to operate within current payment rates. Therefore, the 2016 LTCH base payment rate should be the same as the 2015 rate.

IMPLICATIONS 11

Spending

- Because CMS typically uses the market basket as a starting point for establishing updates to LTCH payments, this recommendation would decrease federal program spending by between \$50 million and \$250 million in one year and by less than \$1 billion over five years.

Beneficiary and provider

- This recommendation is not expected to affect Medicare beneficiaries' access to care or providers' ability to furnish care.

LTCHs will need to change their cost structures to maintain positive Medicare margins under the revised payment system

The Pathway for SGR Reform Act of 2013 will decrease payments for non-CCI cases to LTCHs beginning in fiscal year 2016 with a two-year phase-in period. Under current law, LTCHs with cost reporting periods beginning on or after October 1, 2015, will be paid the lesser of cost or

an IPPS-comparable rate for non-CCI cases. Without any change in behavior, the Commission would expect a reduction in payment for roughly 40 percent of current LTCH discharges. However, the Commission anticipates substantial changes in behavior that should significantly lower LTCHs' costs for non-CCI cases and therefore reduce the impact on LTCHs' profits. The LTCH industry has repeatedly demonstrated its responsiveness to payment policy changes, and the Commission expects the response to LTCH payment reform to be swift and dramatic.

As shown in the hypothetical example in Table 11-6, in the first year of the transition to the new policy, an LTCH could reduce the length of stay for a non-CCI case by five days and still maintain a positive margin under the IPPS-based payment rate. LTCHs could reduce lengths of stay in a number of ways. They could admit non-CCI cases later in their course of illness, after they have spent a few more days in the acute care hospital. In addition, they could discharge non-CCI cases earlier to lower levels of care. ■

**TABLE
11-6**

Policy reforms will create incentives for LTCHs to reduce lengths of stay for non-CCI cases

Hypothetical LTCH non-CCI case

	Current policy	First year of transition to new policy
Payment per case	\$40,000	\$30,360
Cost per day	\$1,500	\$1,500
Length of stay (in days)	25	20
Cost per case	\$37,500	\$30,000

Note: LTCH (long-term care hospital), CCI (chronically critically ill). Non-CCI cases are those that did not have an immediately preceding acute care hospital stay that included eight or more days in an intensive care or coronary care unit.

Endnotes

- 1 Over the past decade, both the number and the share of critically ill patients transferred from ACHs to LTCHs have grown markedly. Kahn and colleagues (2010) found that, although the overall number of Medicare admissions to ACH intensive care units fell 14 percent between 1997 and 2006, the number of Medicare patients discharged to LTCHs after ACH intensive care stays almost tripled during the period.
- 2 The Medicare, Medicaid, and SCHIP Extension Act of 2007 also requires LTCHs to have a patient review process that screens patients to ensure appropriateness of admission and continued stay, physician on-site availability on a daily basis, and interdisciplinary treatment teams of health care professionals.
- 3 More information on the prospective payment system for LTCHs is available at <http://www.medpac.gov/documents/payment-basics/long-term-care-hospitals-payment-system-14.pdf>.
- 4 Medicare pays LTCHs outlier payments for patients who are extraordinarily costly. High-cost outlier cases are identified by comparing their costs with a threshold that is the MS–LTC–DRG payment for the case plus a fixed loss amount (\$14,972 in 2015). Medicare pays 80 percent of the LTCH’s costs above the threshold. In fiscal year 2013, about 12.7 percent of LTCH cases received high-cost outlier payments. The prevalence of high-cost outlier cases differed by LTCH ownership. About 11.6 percent of cases in for-profit LTCHs were high-cost outliers compared with 18.6 percent of cases in nonprofit LTCHs. Historically, some case types have been far more likely to be high-cost outliers than others. For example, almost a quarter of cases assigned to MS–LTC–DRG 4 (tracheostomy with prolonged mechanical ventilation) typically receive high-cost outlier payments each year.
- 5 MMSEA and subsequent legislation allowed exceptions to the moratorium for (1) LTCHs that began their qualifying period (demonstrating an average Medicare length of stay greater than 25 days) on or before December 29, 2007; (2) entities that had a binding or written agreement with an unrelated party for the construction, renovation, lease, or demolition of an LTCH, with at least 10 percent of the estimated cost of the project already expended on or before December 29, 2007; (3) entities that had obtained a state certificate of need on or before December 29, 2007; (4) existing LTCHs that had obtained a certificate of need for an increase in beds, issued on or after April 1, 2005, and before December 29, 2007; and (5) LTCHs, located in a state with only one other LTCH, that sought to increase beds after the closure or decrease in the number of beds of the state’s other LTCH.
- 6 The Pathway for SGR Reform Act of 2013 as amended by the Protecting Access to Medicare Act of 2014 allows exceptions to the moratorium for (1) LTCHs that began their qualifying period (demonstrating an average Medicare length of stay greater than 25 days) on or before April 1, 2014; (2) entities that had a binding or written agreement with an unrelated party for the construction, renovation, lease, or demolition of an LTCH, with at least 10 percent of the estimated cost of the project already expended on or before April 1, 2014; and (3) entities that had obtained a state certificate of need on or before April 1, 2014.
- 7 Historically, the Commission has found that Medicare’s Provider of Services (POS) file includes a larger number of facilities than are found in the cost report file. The cost report file provides a more conservative estimate of total capacity because some LTCHs may not yet have filed a cost report for the applicable year when we completed our analysis, while others may be exempt from filing cost reports because of low Medicare volume. However, POS data may overstate the total number of LTCHs because facilities that close may not be immediately removed from the file.
- 8 The Pathway for SGR Reform Act extended the moratorium on the establishment of any new LTCHs or additional beds at existing LTCHs from January 1, 2015, through September 30, 2017. The act provided no exceptions. Subsequently, the Protecting Access to Medicare Act of 2014 changed the moratorium extension start date to April 1, 2014, and allowed exceptions on the establishment and classification of new LTCHs. This law still strictly prohibits increases in the number of Medicare-certified LTCH beds in existing facilities.
- 9 We observed a higher readmission rate (19.7 percent) for cases with respiratory diagnoses with mechanical ventilation lasting less than 96 hours (MS–LTC–DRG 208). However, a higher rate of readmission is expected for this group because it is defined in part by the length of time a service (mechanical ventilation) is received. Any patient with a respiratory principal diagnosis with use of mechanical ventilation who is readmitted to a short-term ACH within 4 days is assigned to MS–LTC–DRG 208, while a similar patient who stays in the LTCH for a longer period likely is assigned to MS–LTC–DRG 207 (respiratory diagnosis with mechanical ventilation lasting more than 96 hours). When we combined cases assigned to MS–LTC–DRGs 207 and 208 and recalculated the rate of readmission, we found that 12.6 percent of these cases were readmitted in 2013.
- 10 In 2013, over 75 percent of LTCHs were for profit; these for-profit facilities accounted for approximately 85 percent of LTCH cases.

- 11 Another factor was growth in the reported patient case-mix index (CMI), which measures the expected costliness of a facility's patients (Centers for Medicare & Medicaid Services 2010, Centers for Medicare & Medicaid Services 2009, Centers for Medicare & Medicaid Services 2008, Centers for Medicare & Medicaid Services 2007, Centers for Medicare & Medicaid Services 2006). Refinements to the LTCH case-mix classification system, implemented in October 2007, likely led to more complete documentation and coding of the diagnoses, procedures, services, comorbidities, and complications that are associated with payment, thus raising the average CMI, even though patients may have been no more resource intensive than they were previously (Centers for Medicare & Medicaid Services 2009, Medicare Payment Advisory Commission 2009, RAND Corporation 1990). Although some part of the increase in LTCHs' CMI between 2008 and 2009 was due to growth in the intensity and complexity of the patients admitted, CMS estimated that the case-mix increase attributable to documentation and coding improvements was 2.5 percent (Centers for Medicare & Medicaid Services 2010, Centers for Medicare & Medicaid Services 2009). Those improvements contributed to growth in payments to providers without corresponding increases in providers' costs. CMS reduced the update to the LTCH base payment rate in fiscal years 2010 and 2011 to partly offset payment increases due to documentation and coding improvements between 2007 and 2009.
- 12 The Patient Protection and Affordable Care Act of 2010 (PPACA) specified that the annual update to the LTCH standard payment rate in 2011 be reduced by half a percentage point. That requirement, combined with a CMS offset to the 2011 update to account for past improvements in documentation and coding, resulted in a negative update to the LTCH payment rate in 2011. PPACA also mandated reductions in the LTCH standard payment rate to be 1.1 percent in 2012, 0.8 percent in 2013, 0.8 percent in 2014, and 0.7 percent in 2015.
- 13 Many new LTCHs operate at a loss for a period after opening. For this analysis of high-margin and low-margin LTCHs, we examined only LTCHs that submitted valid cost reports in both 2012 and 2013. We excluded government-owned LTCHs.

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