Advising the Congress on Medicare issues

Assessing payment adequacy: Long-term care hospital services

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MEDPAC

Long-term care hospitals, 2011

- Users: 123,000 beneficiaries
- Cases: 139,700
- ALOS: 26 days
- Average payment: $38,600 per discharge
- Total spending: $5.4 billion
- Providers: 424

Concerns about LTCHs

- For many years, among the fastest growing providers
- No established criteria for admission
- Some areas have many, others have none
  - Oversupply in some markets may encourage admission of less complex cases
  - In areas without LTCHs, beneficiaries receive similar care in other settings

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Does use of LTCHs cost Medicare more?

Studies have consistently shown that:

- For the *most medically complex* patients, Medicare payments for the episode of care are the same or lower when the episode includes LTCH
- For other patients, Medicare payments are considerably higher for episodes that include LTCH

Do LTCHs improve rates of survival, readmissions, or discharge to the home?

Most studies have shown that:

- For the *most medically complex* patients, outcomes are the same or better when the episode includes LTCH
- For other patients, outcomes are the same or worse for episodes that include LTCH

CARE demonstration:

- Risk-adjusted results indicated LTCHs had lower rate of re-admission compared with other PAC
  - Better performance may be due to LTCHs' ability to provide hospital-level care

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Which LTCH patients might be most medically complex?

- Ventilator patients
  - 19% of LTCH patients received at least one vent-related service in 2011
- Patients with heavy use of ICU/CCU services during previous ACH stay
  - In 2010, of episodes that used LTCH
    - 49% had an index ACH stay with 5+ ICU/CCU days
    - 38% had an index ACH stay with 8+ ICU/CCU days
- Patients with multiple organ failure, severe infections, or severe wounds

Access: Growth in volume indicates increased access to LTCH care

- Moratorium has stabilized growth in LTCHs and beds
- LTCH cases per FFS beneficiary rose 2.8% between 2010 and 2011

Quality: Stable for limited available measures

- LTCHs began submitting quality data to CMS in October 2012
  - Mandated pay-for-reporting program beginning FY14
    - Catheter-associated UTIs
    - Central-line associated bloodstream infections
    - New or worsened pressure ulcers
- Readmission rates and mortality rates stable or declining for most of the top diagnoses

Access to capital: Moratorium limits activity

- 5-year moratorium on new facilities expires December 2012
- Uncertainty about regulatory oversight and possible Congressional action may continue to limit activity

LTCH Medicare margins, 2011

	% of LTCHs	% of cases	Margin
All LTCHs	100%	100%	6.9%
Bottom 25th	25	18	−9.2
Top 25th	25	23	20.6
Urban	94	95	7.1
Rural	6	4	1.1
For-profit	76	84	8.5
Nonprofit	19	14	−0.1

- Average margin since PPS is 7.2%

Government-owned LTCHs are not shown. Percentages may not sum to 100% due to rounding. Results are preliminary and subject to change.

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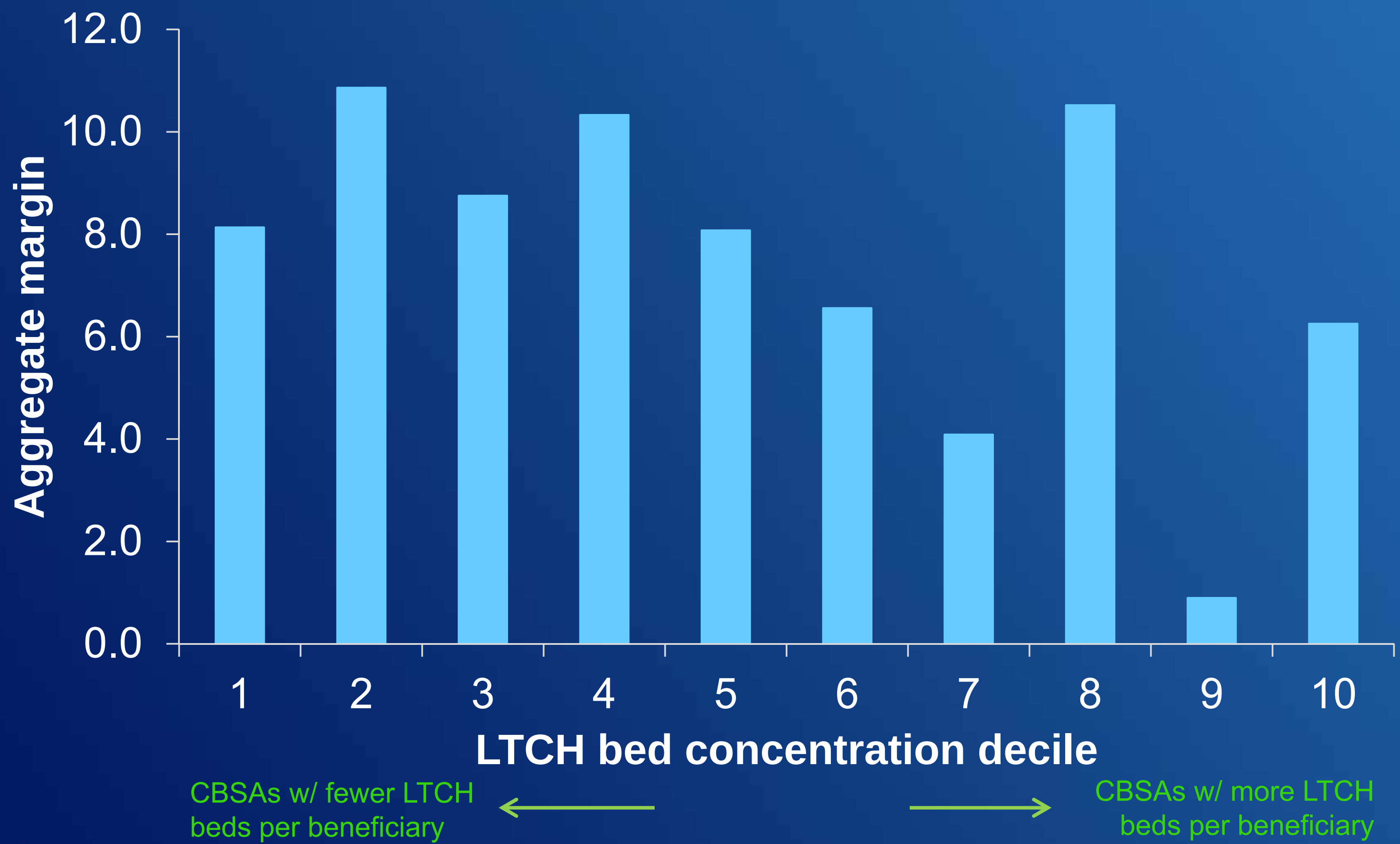
Source: MedPAC analysis of Medicare cost report data from CMS.

LTCH margins by markets' LTCH bed concentration, 2011



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The number of LTCH beds per beneficiary was calculated for each core-based statistical area (CBSA) in which LTCHs were located in 2011. The CBSAs were sorted into deciles based on their LTCH bed concentration ratio, and aggregate Medicare margins were calculated for each decile. Results are subject to change. Source: MedPAC analysis of Medicare cost report data from CMS.

Policy changes for modeling 2013 margins

- 2011 margin: 6.9 percent
- 2012 & 2013 updates: market basket minus PPACA adjustments
- 2013 reductions:
  - CMS adjustment for budget neutrality
  - Adjustment due to changes in short-stay outlier policy

- Projected margin for 2013: 5.9 percent