



Advising the Congress on Medicare issues

Improving payment for chronically critically ill patients in hospital settings

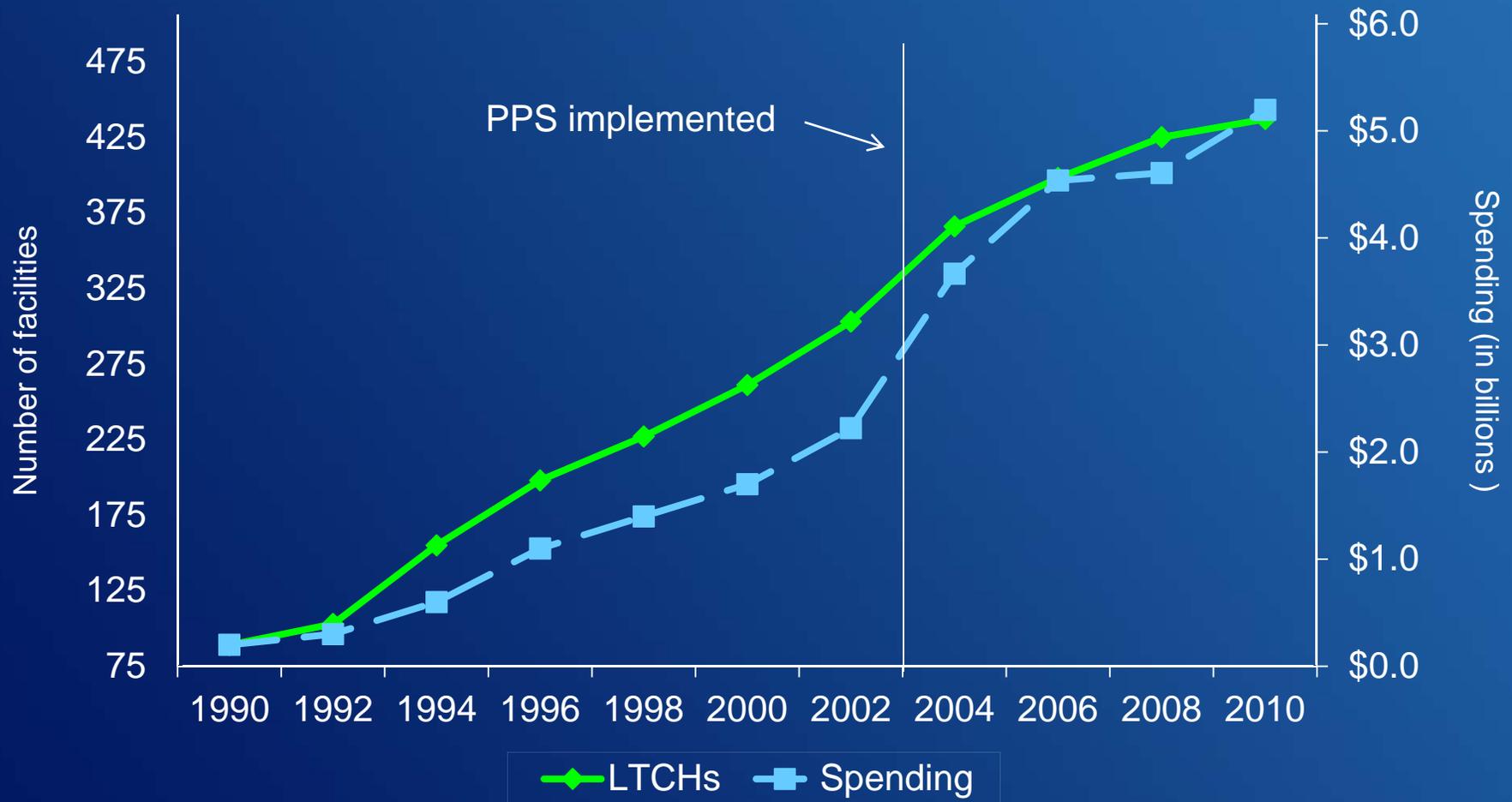
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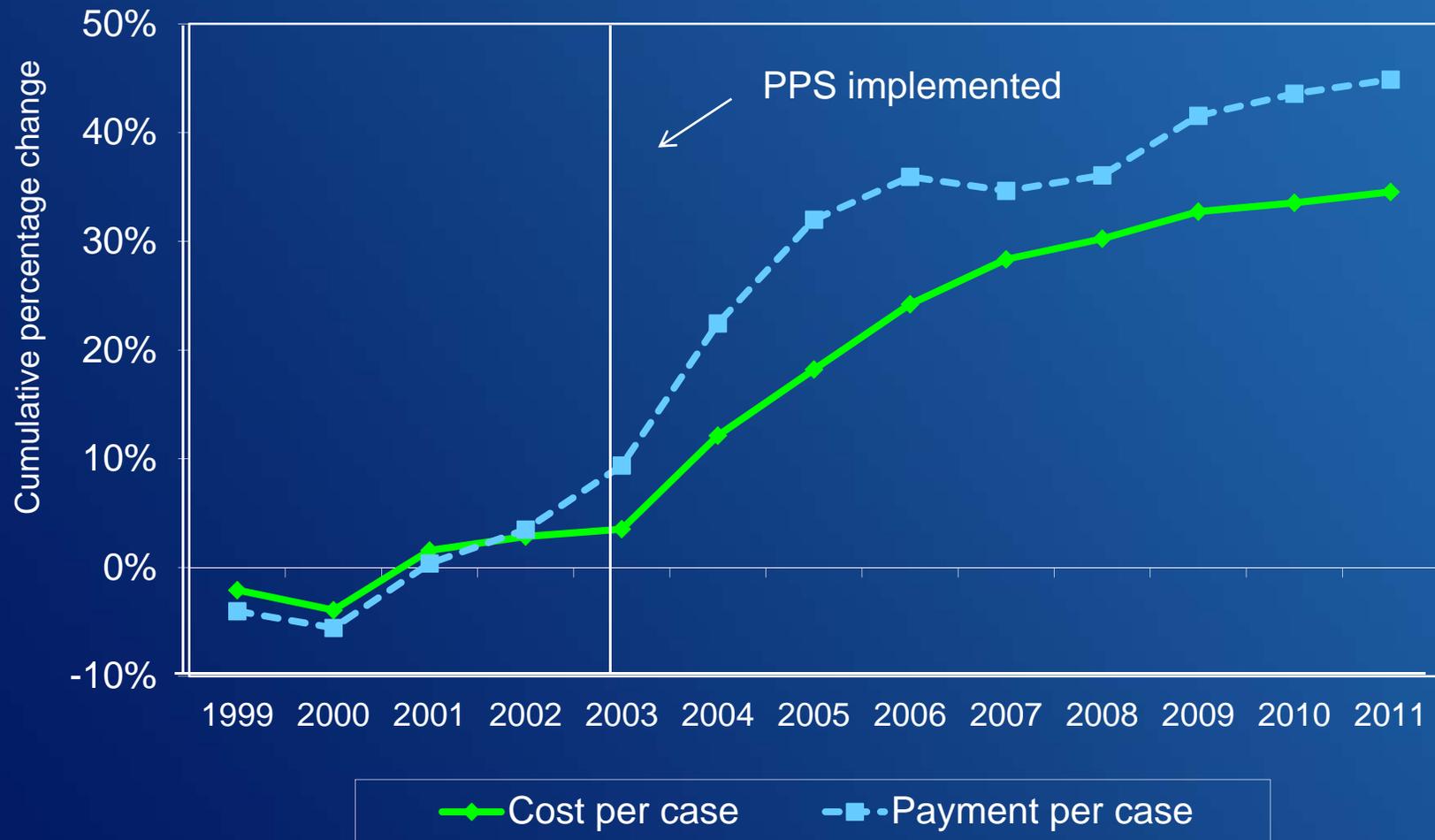
Why does Medicare pay differently for hospital services in acute care hospitals (ACHs) and LTCHs?

- 84 hospitals with very long average length of stay (ALOS) originally excluded from the IPPS
- Cost-based payments until 2003
 - Inherently inflationary, while IPPS encouraged cost control
- Under LTCH PPS:
 - Rates based on inflated costs
 - Payment policies distort resource use
 - Length of stay requirement (ALOS > 25 days)
 - Short-stay outlier policy

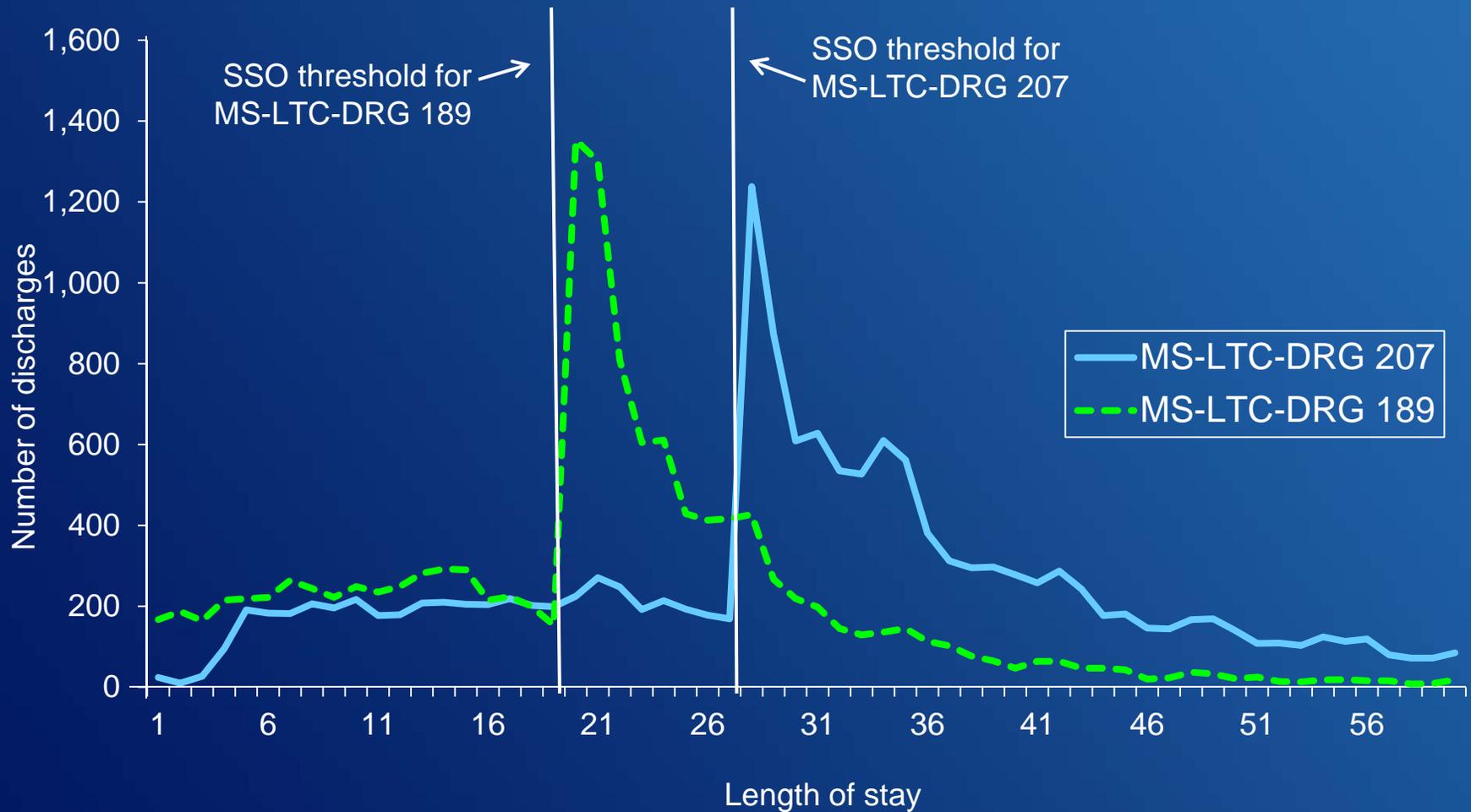
LTCHs: Growth in facilities & spending, 1990-2010



LTCHs' per case payments and costs, 1999-2011



Many LTCH cases discharged immediately after SSO threshold, FY2011



Concerns about LTCHs

- No established criteria for admission
 - IPPS hospitals can unbundle care by transferring costly patients
 - LTCHs can admit any patient needing hospital-level care as long as $ALOS > 25$ days
- Uneven geographic distribution
 - Oversupply in some markets may encourage admission of less complex cases
 - In areas without LTCHs, similar patients receive care in other settings

Does use of LTCHs cost Medicare more?

Studies have consistently shown that Medicare payments are considerably higher for most episodes that include LTCH.

- Where studies have found lower payments for episodes with LTCH, it has been *only for the most medically complex patients.*

Do LTCHs improve rates of survival or readmission?

Possibly. Some studies have shown improved outcomes for the most medically complex patients.

CARE demonstration:

- Risk-adjusted results indicated LTCHs had lower rate of re-admission within 30 days of ACH discharge compared with other PAC providers
 - better performance may be due to LTCHs' ability to provide hospital-level care
 - re-admission rates 30 days after ACH discharge may be worse

Are LTCH patients the most medically complex?

CMS-sponsored research found 2 major types of LTCH cases:

- High acuity/CCI
 - overlap with ACH ICU patients
 - about 1/3 to 1/2 of LTCH cases
- Sub-acute
 - overlap with SNF patients
 - about 15% of LTCH cases

Identifying CCI patients

- Which patients are CCI?
 - Direct CCI = 8+ ICU/CCU days
 - Indirect CCI = transferred from another hospital after 8+ ICU/CCU days

CCI cases

- 6 percent of all IPPS cases are CCI
 - 48% of IPPS CCI episodes use institutional PAC (SNF, IRF, or LTCH)
 - Only 9% of IPPS CCI cases use LTCH
- Most LTCH cases are not CCI
 - Direct CCI = 5%
 - Indirect CCI = 35%
 - Non-CCI = 60%

Concerns about payment for CCI patients

- Different payments across settings for similar patients
- Payments don't match the resource needs of patients
- Misaligned incentives across settings
- Unnecessary transitions between care settings

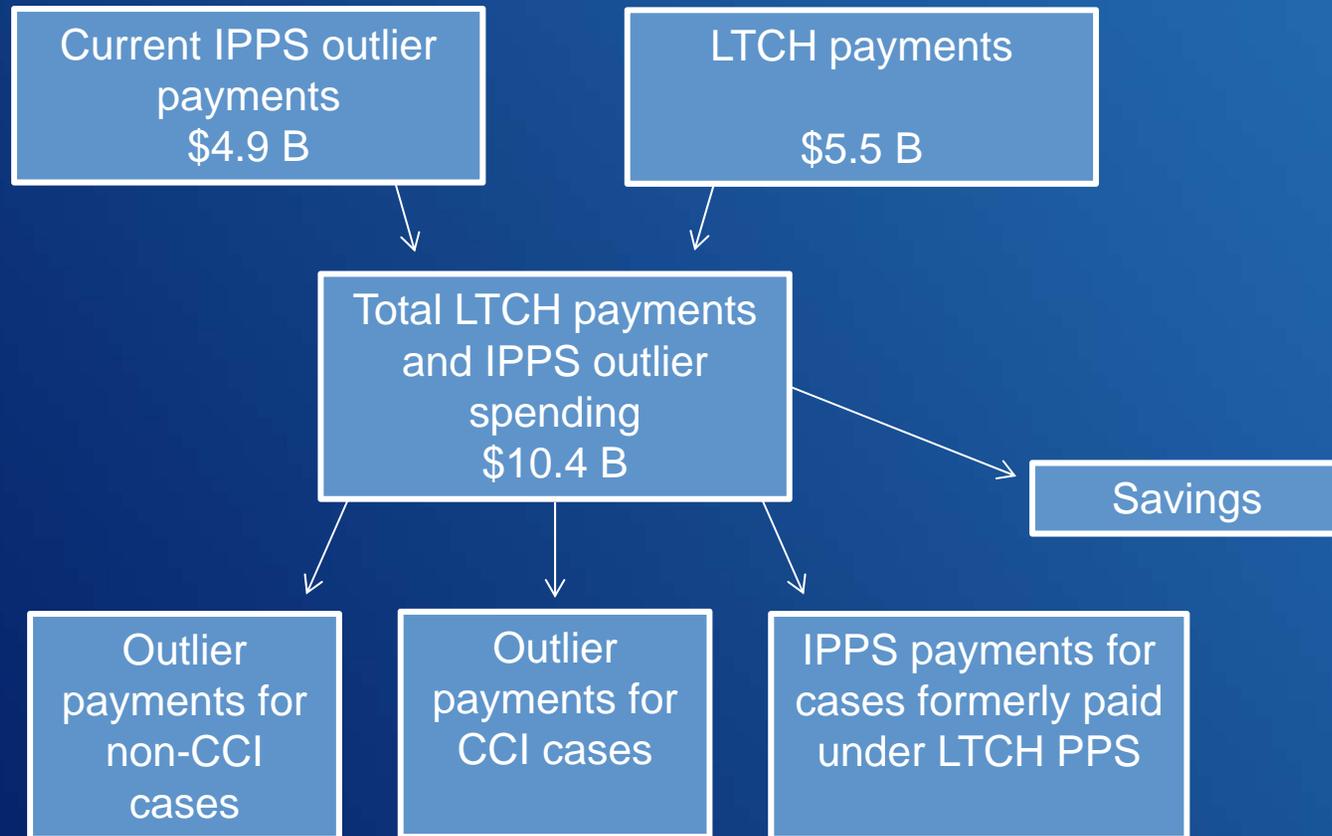
Design concept

- Make payments site-neutral and patient-centered
 - Pay for all ACH and LTCH cases in the IPPS
 - Modify the IPPS to better align payments and costs for CCI patients
- Payment would be based on patient—not facility—characteristics; and would be more consistent with patients' resource needs

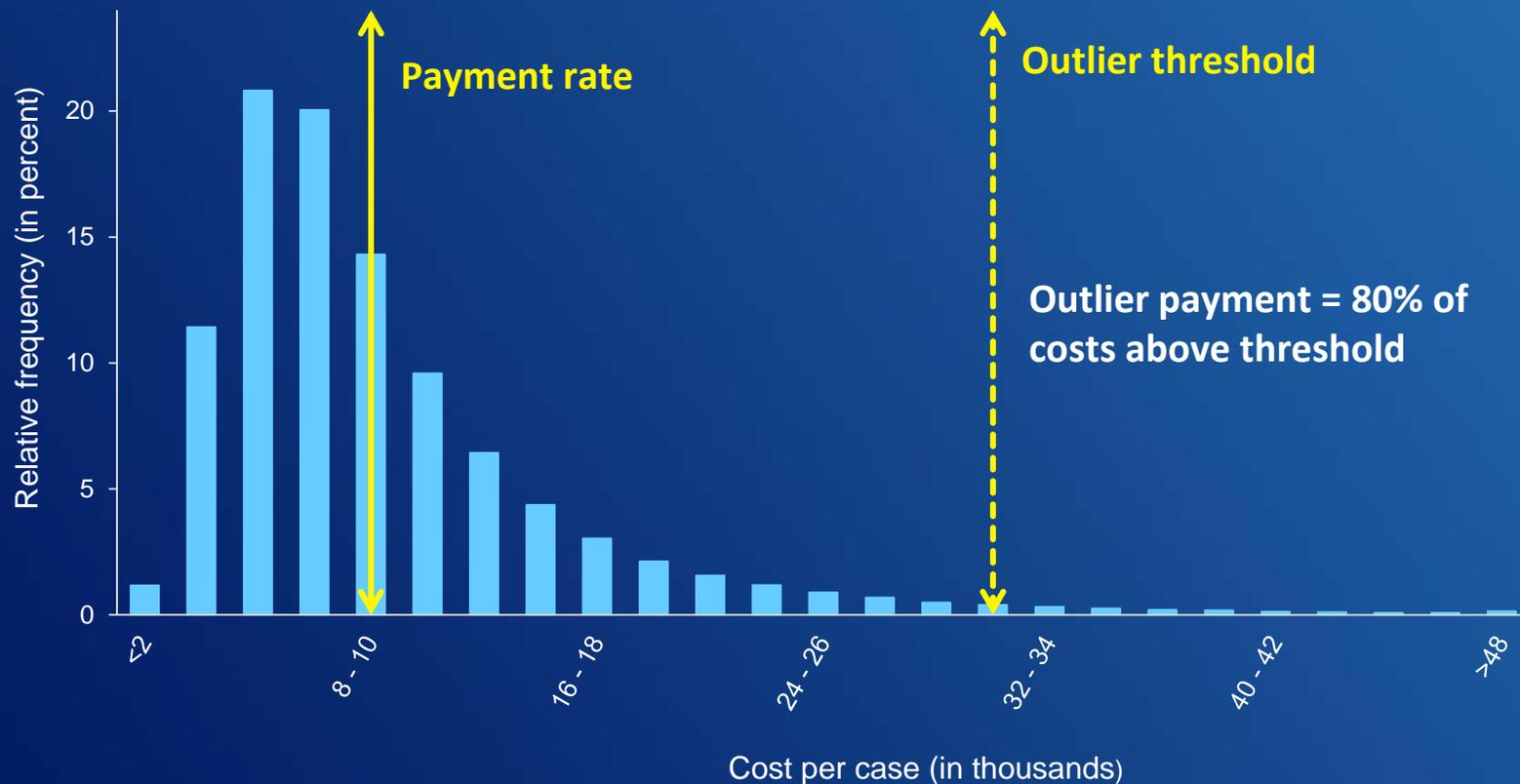
Two approaches for improving payment for CCI cases

- Changes within the IPPS:
 - Expand outlier policy for CCI cases in both ACHs and former LTCHs (Option 1)
 - Create new CCI MS-DRGs with higher weights + expand outlier policy for all cases (Option 2)
- Bundle expected PAC costs in new CCI MS-DRGs:
 - Hospital responsible for “make or buy” decision and payment for LTCH & SNF care; a portion of such PAC payments would be eligible for outlier payments (Option 3)

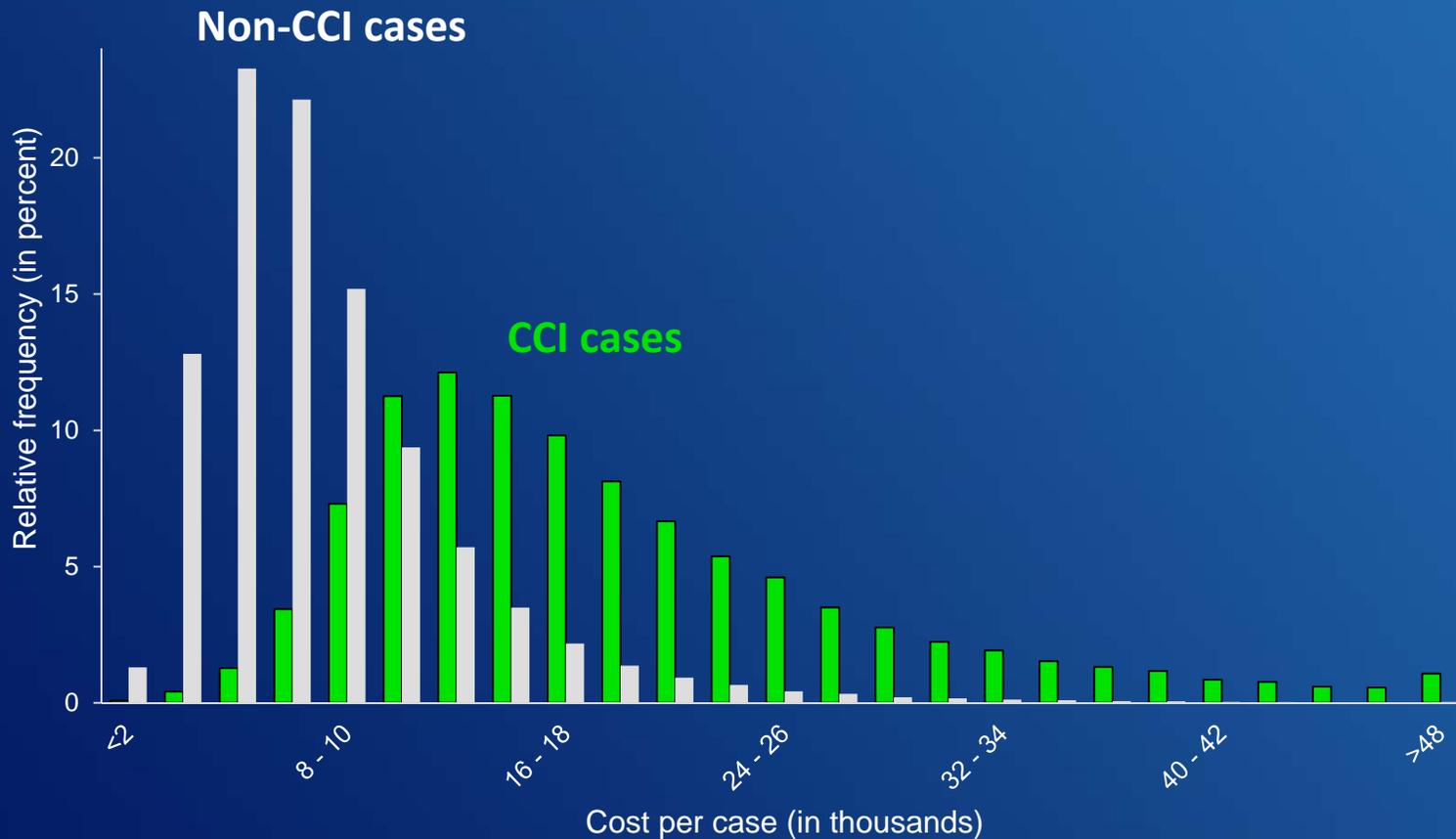
Funds available for expanding the outlier pool, FY 2013



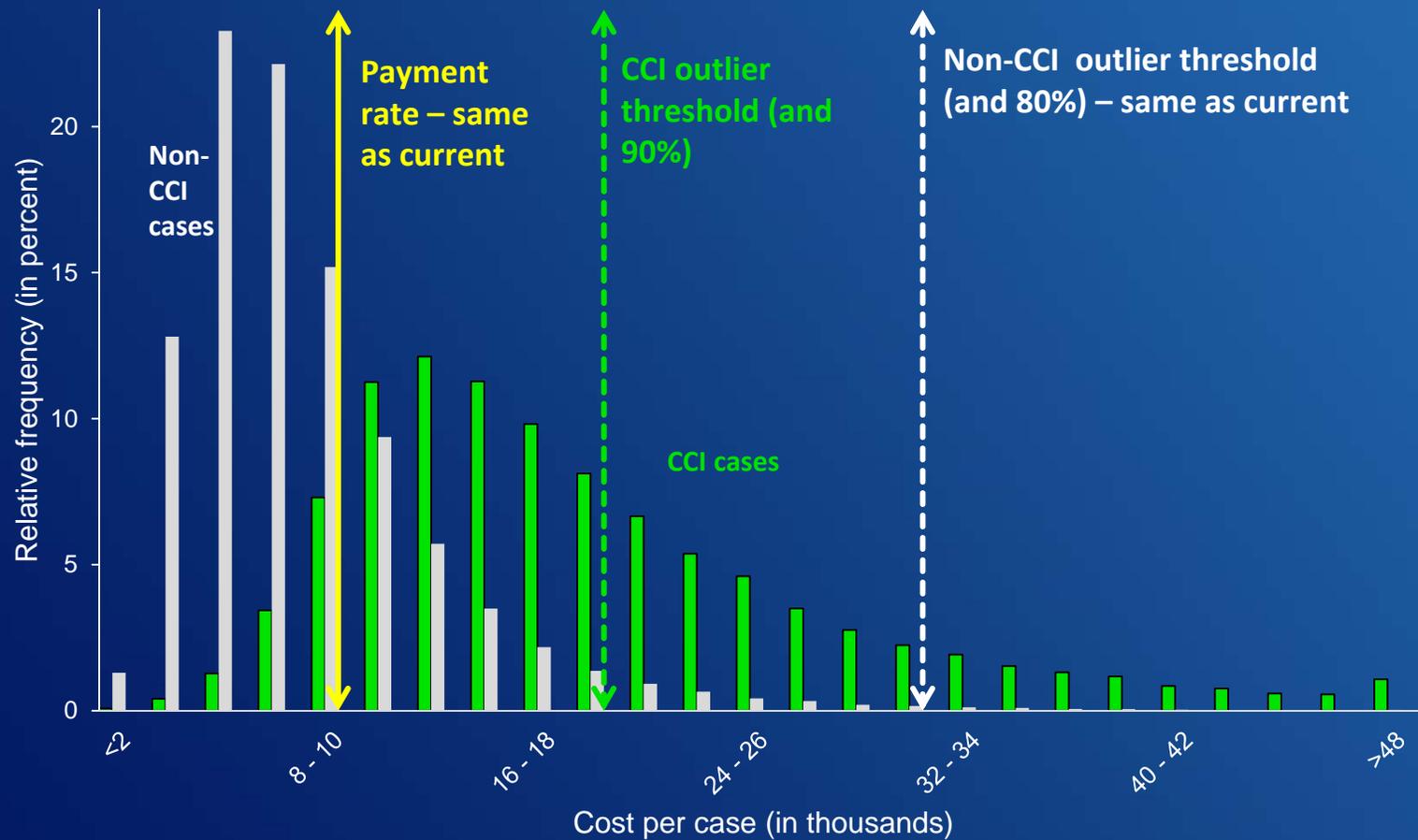
Payment under current IPPS policy



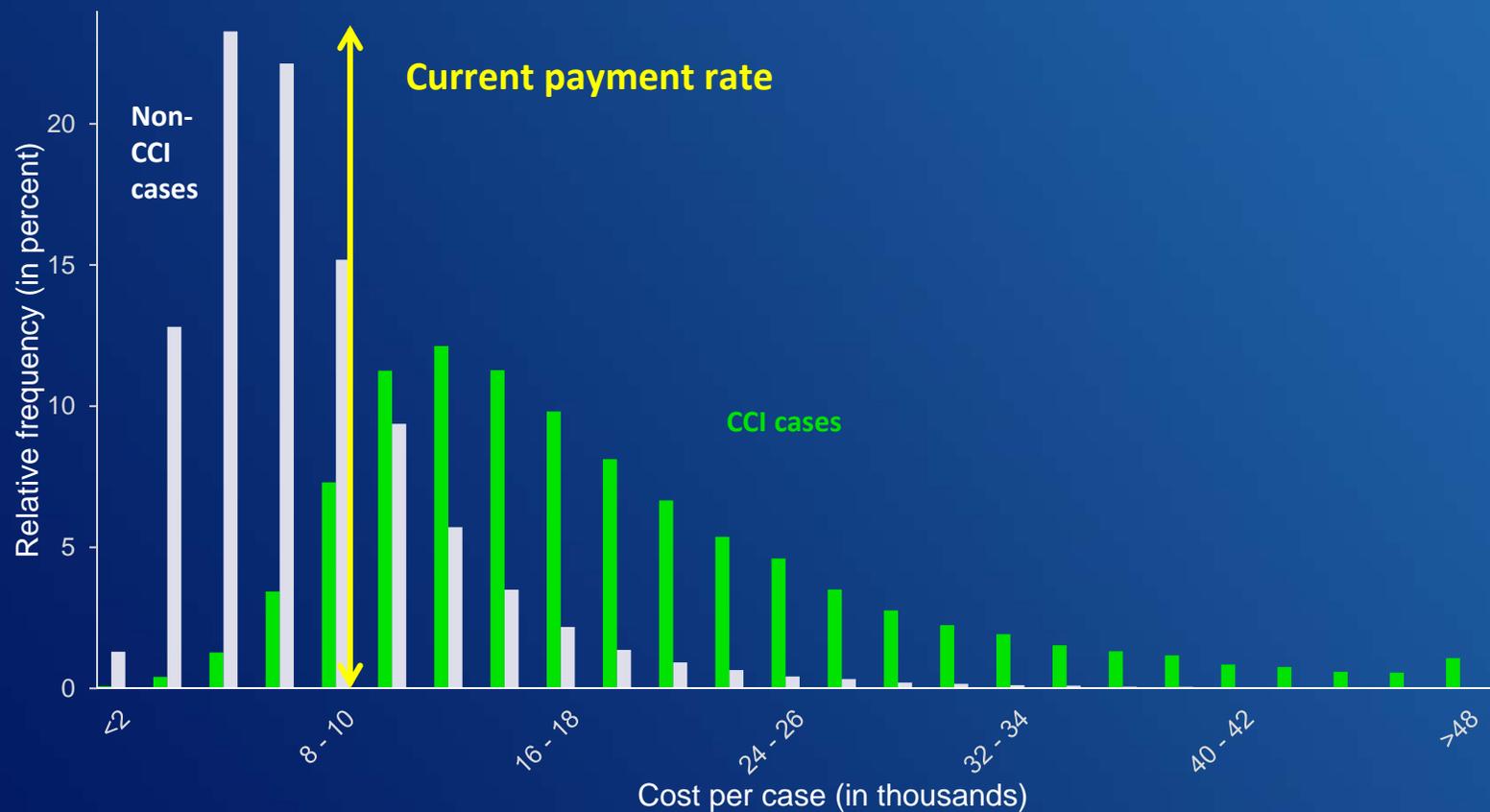
Non-CCI and CCI cases have different cost distributions



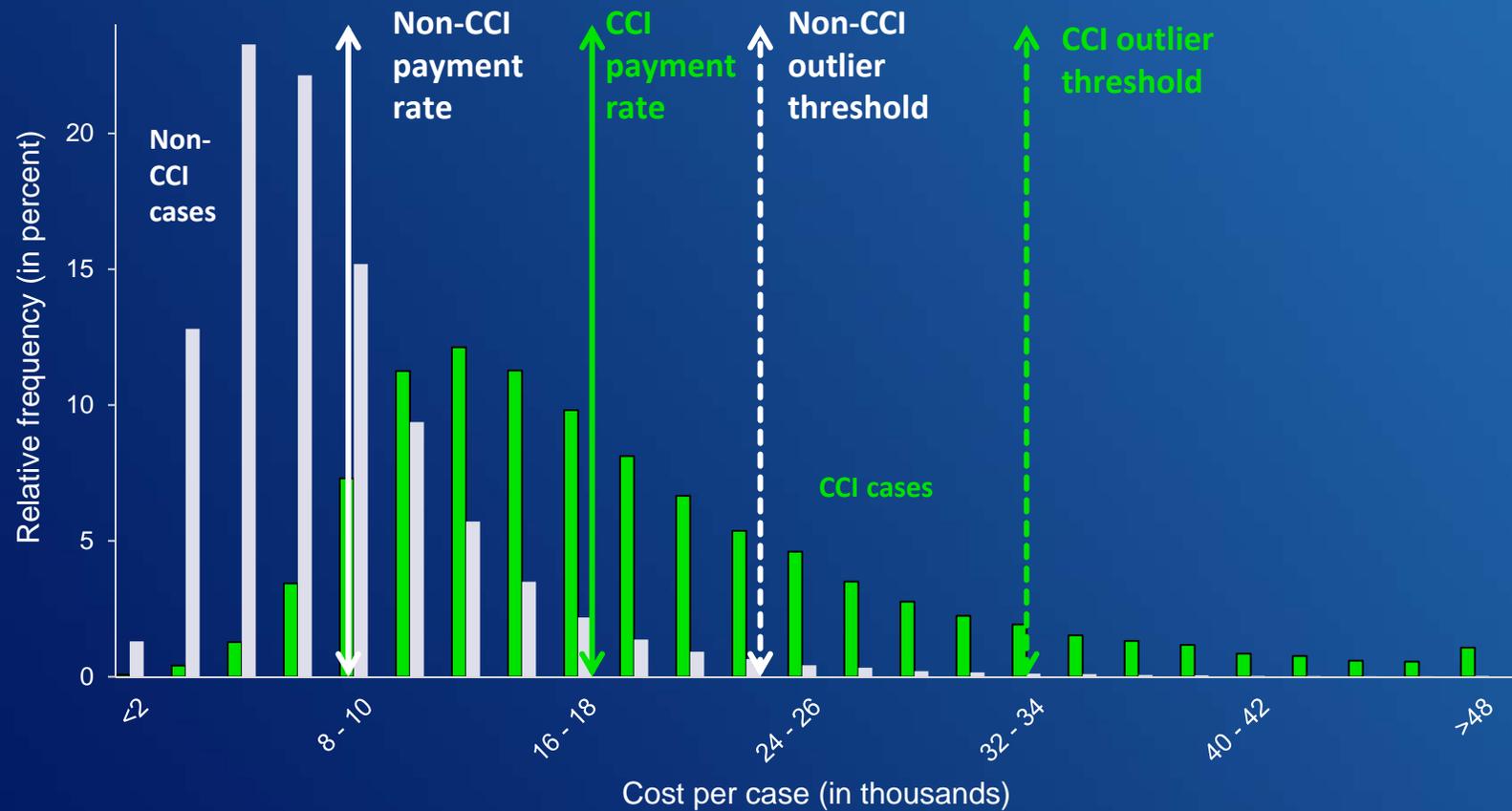
How option 1 would work



Option 2: Create new CCI MS-DRGs



How option 2 would work



Expected effects for option 1

- ACHs that serve CCI patients would receive higher payments
 - Large hospitals in urban areas
 - Major and other teaching hospitals
- Other ACHs would see little change
- Declines in payments to LTCHs would be partially offset by higher outlier payments

Expected effects for option 2

- New CCI MS-DRGs and weights would redistribute payments among hospitals
 - IPPS hospitals with many CCI patients likely would see higher payments
 - Declines in payments for hospitals with many non-CCI patients would be partially offset by higher outlier payments
 - LTCHs that serve mostly CCI patients would see smaller declines in aggregate payments than other LTCHs

Option tradeoffs

- Option 1
 - Modest increase in payment accuracy for CCI cases through more generous outlier payments
- Option 2
 - Greater payment accuracy for CCI and non-CCI cases
 - Increased risk of gaming

Next steps

- Refine models and estimates for options 1 and 2
- Develop estimates for bundled payment option
- Analyze gaming potential
- Estimate impacts