SECTION 4C

Long-term care hospital services

RECOMMENDATION

The Congress should eliminate the update to payment rates for long-term care hospital services for 2007.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

SECTION 4C

Long-term care hospital services

Section summary

The Medicare Payment Advisory Commission (MedPAC) assesses the adequacy of payment for long-term care hospitals (LTCHs) and recommends an update for the coming year for the first time. LTCHs provide care to patients with clinically complex problems, such as multiple acute or chronic conditions, who need hospital-level care for relatively extended periods of time. Medicare is the predominant payer for long-term care hospital services. Spending for LTCHs was $3.3 billion in 2004, and Medicare accounted for 73 percent of discharges.

We find that Medicare payments for LTCH services are more than adequate. Our conclusion is based on the following measures:

- ***Access to care***—We have no direct indicators of access to LTCH care. However, the number of beneficiaries who used long-term care hospitals rose 13 percent per year from 2001 to 2004.

In this section

- ***Supply of facilities***—The supply of LTCHs increased by 9 percent per year from 2001 to 2004. During the same years, the supply of LTCHs organized as hospitals within hospitals (HWHs) rose more than twice as fast (14 percent per year) as freestanding facilities (6 percent per year).
- ***Volume of services***—From 2001 to 2004, the volume of services increased by 12 percent annually, while Medicare spending for these facilities went up at more than double that pace—25 percent per year. In 2004 alone, spending increased almost 38 percent.
- ***Quality***—The evidence on changes in quality is mixed: Deaths in LTCHs and readmissions to acute care hospitals decreased from 2001 to 2004, but patient safety measures—as indicated by decubitus ulcers, infection due to medical care, postoperative pulmonary embolism or deep vein thrombosis, and postoperative sepsis—suggest that quality may have worsened.
- ***Access to capital***—Long-term care hospitals appear to have adequate access to capital, as demonstrated by for-profit LTCHs' ability to borrow and the rapid entry of both for-profit and nonprofit facilities into the program.
- ***Payments and costs***—The Medicare margin for 2004 was 9.0 percent and is projected to be 7.8 percent for 2006 (reflecting 2007 policy except the update). This does not include proposed rulemaking.

Long-term care hospitals should be able to accommodate cost changes in 2007. This finding as well as the other factors the Commission considers leads us to recommend that the Congress should eliminate the update to payment rates for LTCH services for 2007.

Recommendation 4C

COMMISSIONER VOTES:
YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

The Congress should eliminate the update to payment rates for long-term care hospital services for 2007.

We make our recommendation to the Congress. We recognize that the Secretary also has the authority to update payment rates for long-term care hospitals. However, the Secretary has no obligation to act; thus we make this recommendation to the Congress, which if it acts, has the force of law. ■

Background

Patients with clinically complex problems, such as multiple acute or chronic conditions, may need hospital-level care for relatively extended periods. Some of these patients are treated in long-term care hospitals (LTCHs). Because these facilities are not distributed evenly throughout the nation, policymakers have questioned how beneficiaries who need this type of care are treated in areas where there are no LTCHs. Medicare Payment Advisory Commission (MedPAC) studies have found that acute care hospitals and skilled nursing facilities are the principal alternatives to LTCHs (MedPAC 2004).

Medicare payments to LTCHs have increased rapidly—from $398 million in 1993 to about $3.3 billion in 2004—and continue to rise. This spending represents less than 1 percent of Medicare spending, although Medicare accounts for a substantial share of LTCHs' business—73 percent of discharges, on average, in 2004.

To qualify as a long-term care hospital for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals. In addition, an LTCH must also have an average length of stay (ALOS) greater than 25 days for its Medicare patients.

In our 2004 study, we found that before the prospective payment system (PPS) for these facilities was implemented, patients using LTCHs cost Medicare more than similar patients using alternative settings. In the analysis, the cost differences narrowed considerably when LTCHs targeted care to patients who were most likely to need this level of care. We recommended defining LTCHs by facility and patient criteria to ensure patients admitted to these facilities are medically complex and have a good chance of improvement. We also recommended that quality improvement organizations (QIOs) review LTCH admissions for medical necessity and monitor whether facilities comply with the criteria. The urgency of implementing criteria for LTCHs is underscored by results of a QIO medical record review which found that 29 percent of 1,400 randomly selected LTCH Medicare admissions in 2004 did not need hospital-level care (Votto 2005). CMS is assessing the feasibility of implementing our recommendations.

Since October 2002, Medicare has paid LTCHs predetermined per discharge rates based primarily on the patient's diagnosis and the facility's wage index.[1] Before that, long-term care hospitals were paid under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) on the basis of their average costs per discharge, subject to an annually adjusted limit calculated for each facility. As of May 2005, CMS estimates that 97 percent of LTCHs are paid entirely at PPS rates.

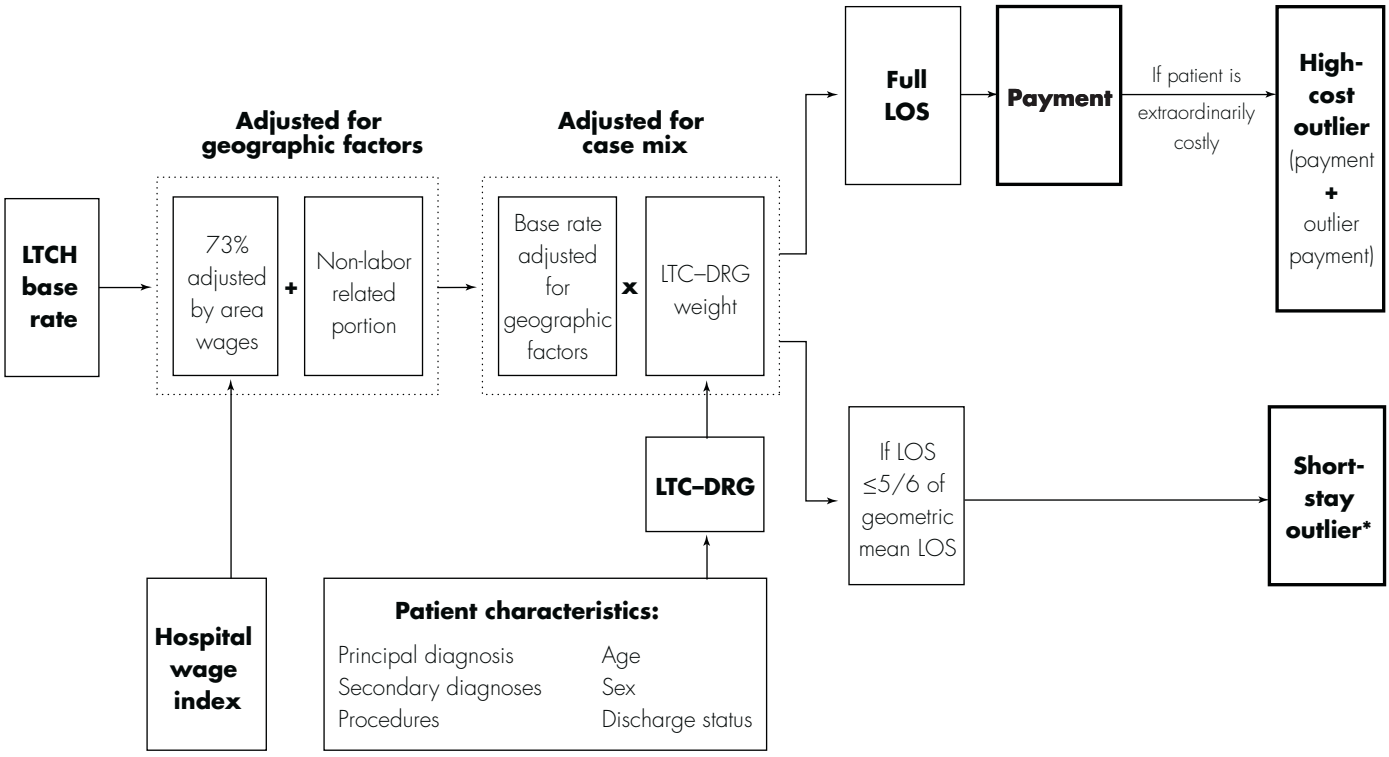
Under the LTCH PPS, patients are assigned to one of more than 500 long-term care diagnosis related groups (LTC–DRGs) based on their characteristics. The LTCH PPS uses the same DRGs as those used to classify patients for the acute inpatient PPS, although the relative weights differ. To calculate a rate, the base rate ($38,086 for the 2006 rate year) is adjusted for geographic factors (Figure 4C-1, p. 212).[2] The labor-related portion is adjusted by the facility's area wage index and added to the nonlabor-related portion. The resulting base rate is then multiplied by the relative weight for the patient's LTC–DRG assignment to create the payment rate. Weights range from 0.4113 to 3.1869 for fiscal year 2006 payments. For an LTCH with a wage index of 1.0, payment rates range from $15,665 to $121,376. Medicare also adjusts payments for high-cost or short-stay outliers.

Long-term care hospitals typically specialize in providing care to patients with complex conditions and multiple comorbidities—for example, a ventilator-dependent patient requiring ongoing treatment for several underlying diagnoses or a patient with severe skin ulcers generally resulting from prolonged bed confinement acquired during treatment for an unrelated principal diagnosis. The top 15 diagnoses made up almost two-thirds of all discharges from these facilities in 2004; 5 of the top 15 LTC–DRGs were respiratory related (Table 4C-1, p. 213). However, LTCH cases are widely dispersed—only two DRGs had more than 5 percent of cases in 2004.

LTCHs can be either freestanding facilities or located within hospitals, when they are called hospitals within hospitals (HWHs). CMS established a new policy intended to protect the integrity of the inpatient PPS by attempting to ensure that HWHs do not function as step-down units of host hospitals and that decisions about admission, treatment, and discharge patterns are made for clinical rather than financial reasons (the text box on p. 214 describes this policy).

FIGURE 4C–1

Long-term care hospital prospective payment system



Note: LTCH (long-term care hospital), LTC–DRG (long-term care diagnosis related group), LOS (length of stay).
*LTCHs are paid for short-stay outliers the least of: 120% of the cost of the case, 120% of the LTC–DRG specific per diem amount multiplied by the length of stay for that case, or the full LTC–DRG payment.

Are Medicare payments adequate in 2006?

We examine the following factors in determining the adequacy of Medicare payments to LTCHs:

- access to care
- supply of facilities
- volume of services
- quality
- access to capital
- payments and costs

We have no direct evidence on beneficiaries' access to LTCH care, although we do find increasing use of LTCH care by beneficiaries. Long-term care hospitals continue to enter the Medicare program, suggesting that payment rates are attractive. The increasing supply of LTCH beds results in increases in volume of discharges, the number of beneficiaries using these facilities, and Medicare spending. The rapid increase in LTCHs and beds suggests that LTCHs have adequate access to capital. Medicare margins are 9 percent in 2004 and an estimated 7.8 percent in 2006. Overall, our analysis finds that payments to LTCHs are more than adequate.

Changes in beneficiaries' access to care

Unlike for home health or physicians, we have no direct indicators of beneficiaries' access to LTCH care. However, the number of beneficiaries using LTCHs has continued to increase since the implementation of the PPS in fiscal year 2003. From 2001 to 2004, the number of beneficiaries who used LTCH care increased 13 percent per year and the number of cases went up a similar amount. The supply of LTCHs rose 9 percent annually during the same period while the number of beds per beneficiary rose by 5 percent.

TABLE 4C–1 **The top 15 LTC–DRGs in 2004 made up almost two-thirds of LTCH discharges**

LTC–DRG	Description	Discharges	Percentage
475	Respiratory system diagnosis with ventilator support	13,007	10.6%
249	Aftercare, musculoskeletal system and connective tissue	6,212	5.1
12	Degenerative nervous system disorders	5,802	4.7
271	Skin ulcers	5,594	4.6
462	Rehabilitation	5,072	4.1
88	Chronic obstructive pulmonary disease	4,980	4.1
87	Pulmonary edema and respiratory	4,960	4.1
89	Simple pneumonia and pleurisy with CCs	4,826	3.9
466	Aftercare without history of malignancy as secondary diagnoses	4,497	3.7
79	Respiratory infections and inflammations with CCs	4,449	3.6
416	Septicema	4,144	3.4
263	Skin graft and/or debridement for skin ulcer with CCs	3,739	3.1
127	Heart failure and shock	3,699	3.0
316	Renal failure	2,360	1.9
430	Psychoses	2,355	1.9
	Total discharges	**122,320**	**61.9**

Note: LTCH (long-term care hospital), LTC–DRG (long-term care diagnosis related group), CC (complication or comorbidity).

Source: MedPAC analysis of MedPAR data from CMS.

The increase in beds per beneficiary between 2001 and 2004 varied geographically. The largest increases in beds per beneficiary were in the East South Central (13 percent per year), Middle Atlantic (10 percent per year), and West South Central (9 percent per year) census regions.

Changes in supply of facilities

The number of LTCHs participating in the Medicare program has increased substantially. We examine growth in LTCHs from a historical perspective and also from a pre-PPS versus post-PPS perspective.

From 1990 to 2004, the number of LTCHs quadrupled from 90 to 357 (Figure 4C-2, p. 215). The growth in the number of long-term care hospitals has accelerated in recent years. From 2002 to 2004, 71 new facilities entered the program.

The number of long-term care hospitals rose in both urban and rural areas following the implementation of the PPS in fiscal year 2003. The rate of increase was greater in rural areas, which had fewer of these facilities to begin with (Table 4C-2, p. 215). The number of rural LTCHs grew by 18 percent per year from 2001 to 2004, compared with an overall annual growth rate of 9 percent.

The numbers of HWHs and freestanding LTCHs both increased following implementation of the PPS in 2003. During the same period, the rate of growth in HWHs was more than twice the rate for freestanding LTCHs. Both nonprofit and for-profit long-term care hospitals increased from 2001 to 2004, but nonprofits grew more slowly than for profits.

Changes in volume of services

The ALOS for LTCHs declined after PPS implementation, while the volume of discharges and Medicare spending increased (Table 4C-3, p. 216). Specifically, from 2001 (pre-PPS) to 2004 (post-PPS):

- The number of cases increased 12 percent annually.
- Medicare spending increased 25 percent per year. In 2004 alone, spending increased almost 38 percent.
- The average Medicare payment per case increased 10 percent annually.
- ALOS decreased by 4 percent per year, although the rate of decrease was somewhat slower under PPS.

The new rule for hospitals within hospitals limits admissions from host hospitals

The new 25 percent rule affects hospitals within hospitals (HWHs) (and 10 satellites that are treated the same as HWHs).[3] This rule establishes a threshold for Medicare patients admitted from the host hospital each year. The policy will be phased in over three years beginning in October 2005. HWHs will be paid long-term care hospital (LTCH) prospective payment system (PPS) rates for patients admitted from the host acute care hospital when those patients are within the applicable threshold. Patients from the host hospital who are outliers under the acute inpatient PPS before their transfer to the HWH do not count towards the threshold. For patients admitted from the host hospital above the applicable threshold, the LTCH will be paid the lesser of the LTCH PPS rate or an amount equivalent to the acute hospital PPS rate. The threshold is:

- 75 percent for fiscal year 2006
- 50 percent for fiscal year 2007
- 25 percent for fiscal year 2008

For example, in 2006, if a HWH admits 80 percent of its cases from its host hospital, the HWH will be paid the LTCH PPS rate for 75 percent of all cases admitted. In retrospective settlement at the end of its cost-reporting year, the HWH will be paid an amount equivalent to the acute inpatient PPS rate (if it is lower than the LTCH rate) for the remaining 5 percent.[4] For patients who are outlier cases in the host acute care hospital, the HWH will receive LTCH rates regardless of whether they exceed the 75 percent threshold.

There are some exceptions to the 25 percent rule. For rural HWHs, the applicable threshold is 50 percent. For HWHs that are located in the only hospital in their metropolitan statistical area (MSA) or in an MSA-dominant hospital—defined as having one-quarter or more of all acute care cases in the MSA—the threshold is between 25 percent and 50 percent, depending on the share of Medicare patients attributable to the host hospital. ■

Changes in quality

We use three different types of quality measures for LTCHs that can be calculated from routinely collected administrative data: deaths in the LTCH, readmissions to acute care hospitals, and selected Agency for Healthcare Research and Quality (AHRQ) patient safety indicators (PSIs). While not unambiguous, the proportion of patients who died in a facility or were readmitted to a hospital are frequently used as gross indicators of quality.

The results for the three types of quality measures are mixed. From 2001 to 2004, the percentage of LTCH patients who died in long-term care hospitals or were readmitted to acute care hospitals decreased. These data are not risk adjusted, so the differences could be explained by healthier patients being admitted to LTCHs. Of the four PSIs, risk-adjusted rates were worse for three, and relatively stable for the fourth.

The share of patients who died in an LTCH and the share of patients who were readmitted to an acute care hospital were 16 percent and 13 percent, respectively, in 2001 (Figure 4C-3, p. 216). Each share declined by 2 percentage points by 2004.

To supplement the above quality indicators, we investigated whether the AHRQ PSIs developed for acute care hospitals might be useful to assess patient safety for LTCHs. AHRQ has 25 hospital-level PSIs to identify potentially preventable adverse events resulting from acute hospital care (AHRQ 2003). We used all LTCH claims for 2003 and 2004 to calculate these PSIs for LTCHs. Four PSIs had enough observations for the two years and were thought to be relevant to the type of care LTCHs deliver—decubitus ulcers, infection due to medical care, postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT), and postoperative sepsis. Patients in LTCHs frequently have lengthy stays and without appropriate care may develop decubitus ulcers. Because of these lengthy stays, postoperative PE or DVT also appears to be a risk for patients who had surgery in the acute care hospital. Interestingly, the PSI for postoperative respiratory failure did not have enough cases to make this indicator useful for identifying patient safety issues for

LTCH patients, despite the emphasis on respiratory-related conditions in these facilities.

We used all LTCH claims to identify patients with the four PSIs. To distinguish patients who developed a PSI diagnosis in the acute care hospital from those who developed the diagnosis in the LTCH, we included in the analysis only patients who did not have the pertinent diagnosis in the acute care hospital. Therefore, changes in rates should not be a result of LTCHs admitting more patients who had these conditions in the acute hospital. The PSIs are also risk adjusted so these indicators should not reflect a changing LTCH patient population over time. Changes in the PSI risk-adjusted rates per 1,000 Medicare LTCH patients are shown in Table 4C-4, p. 217. These rates suggest that for three of the PSIs, safety for LTCH patients under PPS payment has deteriorated. The rates for all four PSIs increased from 2003 to 2004, although the rate for postoperative PE or DVT increased only by 1 percent. Nevertheless, we need to be cautious about the interpretation of the PSIs—they were not developed for long-term care hospitals, and CMS has frequently discussed LTCHs' changes in coding, consistent with the incentives of the PPS.

TABLE 4C–2

The number of most types of long-term care hospitals has grown

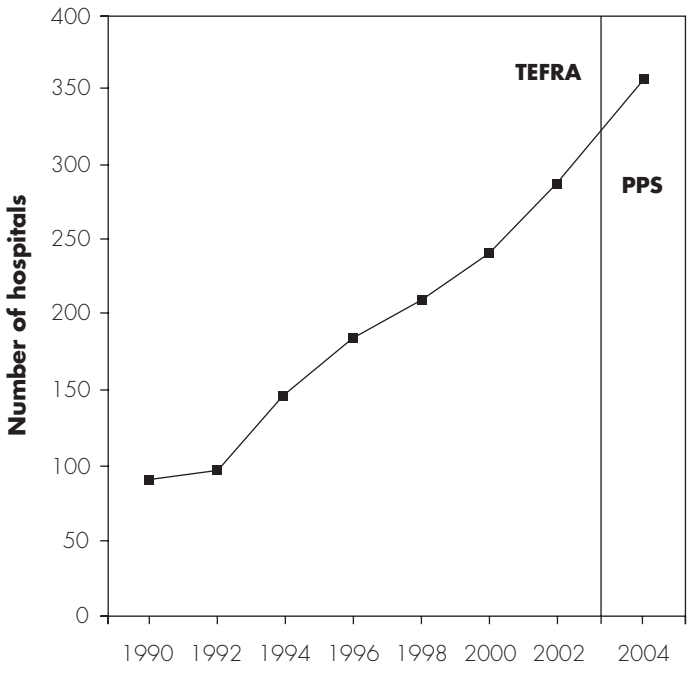
	TEFRA	PPS		Average annual change
LTCH group	2001	2003	2004	2001–2004
All LTCHs	273	319	357	9%
Urban	253	293	324	9
Rural	20	26	33	18
Freestanding	159	172	190	6
HWHs	114	147	167	14
Nonprofit	84	100	117	12
For profit	152	189	208	11
Government	37	30	32	–5

Note: TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system), LTCH (long-term care hospital), HWH (hospital within hospital).

Source: MedPAC analysis of Provider of Service files from CMS.

FIGURE 4C–2

The number of long-term care hospitals has grown rapidly since 1990



Note: TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system).

Source: MedPAC analysis of Provider of Service files from CMS.

Better measures of quality for long-term care hospitals are needed. Additional measures of quality at the hospital-specific level, probably not available from administrative data, may come from the LTCH industry. One association and a large chain report independent efforts to develop quality indicators. If the data for these indicators were available, CMS might use them to monitor LTCH care. For example, both organizations plan to measure rates of weaning from ventilators, pneumonia contracted while on a ventilator, decubitus ulcers acquired in the LTCH, blood stream inflections, falls, and use of restraints. However, the specific measures for these indicators differ widely between the two organizations.

In June 2004, the Commission recommended that the Congress and CMS define LTCH care by facility and patient criteria. One of the goals we outlined for the criteria was to encourage long-term care hospitals to provide high-quality care and to require these facilities to provide information about the quality of care they provide to patients. A standard patient assessment tool would facilitate measurement of outcomes. We are encouraged that the industry is starting to develop new quality indicators. Some next steps are CMS involvement, greater validation of the measures, and decisions on a data collection strategy.

TABLE 4C–3

Volume of cases and Medicare spending increased under the LTCH prospective payment system

	TEFRA	PPS		
	2001	2003	2004	Average annual change 2001–2004
Number of cases	86,049	110,509	122,320	12%
Medicare spending	$1.7 billion	$2.4 billion	$3.3 billion	25
Payment per case	$22,452	$25,076	$30,180	10
Length of stay (in days)	32.1	29.2	28.7	–4

Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system).

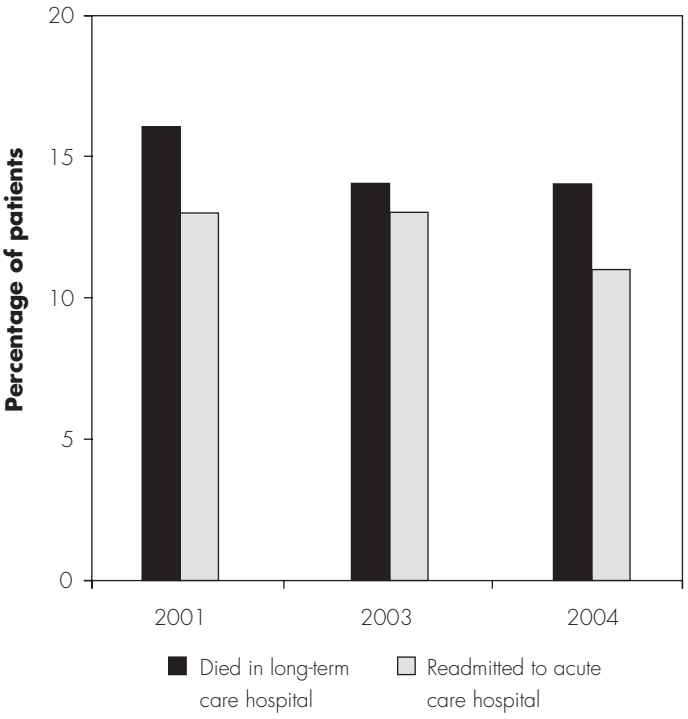
Source: MedPAC analysis of MedPAR data from CMS.

Long-term care hospitals' access to capital

Almost 60 percent of LTCHs are for-profit concerns, two-thirds of which are owned by two chains, Kindred Healthcare and Select Medical. For-profit chains can access capital through the equity market as well as by borrowing. Both firms appear to have adequate access to capital. For example, one of the firms plans to repurchase $100 million of its shares and purchase 19 facilities, including 6 LTCHs. The other borrowed $1.4 billion to finance its buyout by venture capitalists to take the company private (Select Medical 2005). The continued rapid expansion of both for-profit and nonprofit LTCHs demonstrates good access to capital for this sector as a whole.

FIGURE 4C–3

Selected outcomes for long-term care hospital patients have improved



Note: Data are not risk adjusted.

Source: MedPAC analysis of MedPAR data from CMS.

Payments and costs

To assess the adequacy of Medicare payment, we examine payments and costs. We also calculate an aggregate Medicare margin for LTCHs.

Under TEFRA, the change in payment per case was at or below the change in cost per case (Figure 4C-4). The year before PPS (2002), the change in payment per case was above zero for the first time since 1998.

After PPS implementation, payment per case rose rapidly: it increased 5.5 percent in 2003 and 13.2 percent in 2004. In 2004 alone, Medicare payments to LTCHs increased almost 38 percent. The case-mix index (CMI) also appears to be increasing for LTCH patients, but CMS points out that CMI increases are at least partially due to coding improvement with a comparatively larger number of cases being assigned to LTC–DRGs with higher relative weights (CMS 2005). Combinations of real CMI increases and coding improvements can result in large payment increases.

Evidence from cost reports suggests that the reported cost per case decreased in 2003, the first year of PPS

TABLE 4C–4

Changes in safety of care for long-term care hospital patients, 2003–2004

Patient safety indicator	Risk-adjusted rates per 1,000 eligible discharges			Observed adverse events 2004	Total number of patients
	2003	2004	Change in rate		
Decubitus ulcer	128.6	148.3	15%	14,624	94,368
Infection due to medical care	19.9	28.9	45	3,129	108,458
Postoperative PE or DVT	53.5	54.1	1	747	13,801
Postoperative sepsis	125.3	164.0	31	1,378	8,016

Note: PE (pulmonary embolism), DVT (deep vein thrombosis).

Source: MedPAC analysis of 100% of long-term care hospital MedPAR data from CMS.

(by –0.1 percent), then jumped dramatically in the second year (by 8.9 percent). This 2004 increase is not easily explained, especially since the average length of stay decreased compared with 2003 and a decrease in ALOS generally is associated with a decrease in costs. More complicated LTCH patients could account for at least part of the increase in cost per case. However, the rapid rate of growth in costs could also be attributable to the rapid rate of increase in payments under the PPS which would have allowed LTCHs to spend more than under TEFRA.

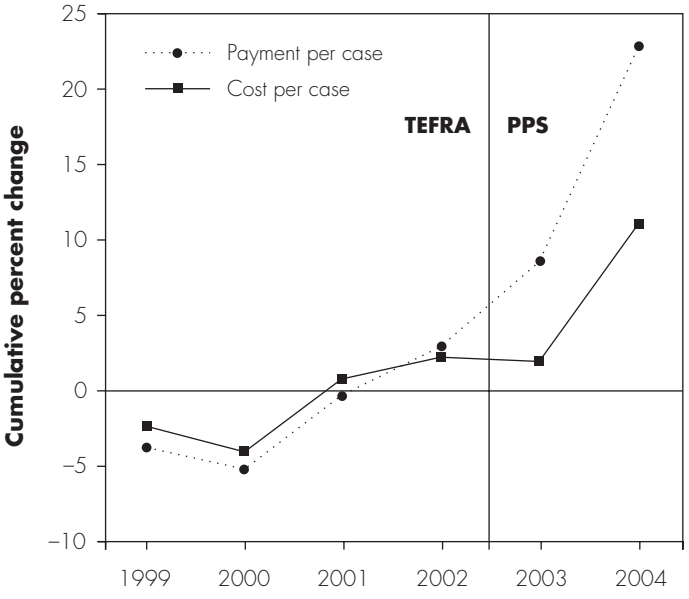
The Medicare margin is the difference between Medicare payments and providers' costs, as a percentage of Medicare payments. Conceptually, this margin represents the percentage of revenue the providers keep. LTCHs' Medicare margin under TEFRA remained below or slightly above zero (Table 4C-5, p. 218). The TEFRA margins are consistent with the payment system, which linked payments to costs. In the year before PPS was implemented (2002), margins became positive. After CMS implemented the PPS in 2003, margins rose rapidly for almost all groups of LTCHs. Only government-owned LTCHs had negative margins once the PPS was implemented, and these types of facilities frequently have few Medicare patients.

Our projection of the 2006 Medicare margin is affected by a number of payment policy changes. These changes do not include proposed administrative actions. The changes include:

- for 2005, a full market basket update of 3.1 percent minus a budget neutrality adjustment of 0.5 percent for a total increase of 2.6 percent;
- for 2006, a full market basket update and an increase resulting from changes in the outlier threshold for an estimated total increase of 5.7 percent; and
- for 2006, an adjustment of an estimated –4.2 percent to payment that results from changes to the case-mix groups and relative weights, implemented in a non-budget neutral manner.[5]

FIGURE 4C–4

Comparison of changes in LTCH payment and cost per case, 1999–2004



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

Source: MedPAC analysis of cost reports from CMS.

TABLE 4C–5 **Long-term care hospitals' Medicare margin, by group, 1998–2004**

	TEFRA					PPS	
LTCH group	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
All LTCHs	0.2%	–1.7%	–1.7%	–1.7%	–0.4%	5.4%	9.0%
Urban	0.6	–1.6	–1.6	–1.7	–0.3	5.5	9.0
Rural	–18.8	– 5.7	– 3.3	– 3.1	–4.5	0.8	8.6
Freestanding	–0.1	–1.4	–1.4	–1.1	0.3	5.2	8.7
HWHs	1.2	–2.6	–2.4	–3.4	–1.9	5.8	9.6
Nonprofit	–0.8	–1.4	–2.9	–1.7	–0.1	1.6	6.0
For profit	2.6	–0.9	–0.9	–1.6	–0.3	6.7	10.3
Government	–19.8	–15.7	–7.6	–4.8	–3.7	–1.9	–2.8

Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system), HWH (hospital within hospital).

Source: MedPAC analysis of cost reports from CMS.

As discussed previously, between 2005 and 2007, CMS will phase in the 25 percent rule to limit the share of cases HWHs can admit from their host hospital. We cannot foresee how HWHs' behavior will change in response to this rule. CMS has discussed several scenarios (CMS 2005). For example, patients admitted to an HWH from the host hospital after becoming an outlier are not counted in the limit, thus HWHs may admit more outlier cases under this rule. Alternatively, host hospitals may discharge fewer patients to their HWHs because of constraints from the 25 percent rule, in which case HWHs' volume might fall. In cities where there is another LTCH, an acute care hospital might discharge patients to a different long-term care hospital than the one on its grounds. The Office of Inspector General or the QIOs may want to monitor acute care hospitals' and HWHs' behavior in response to the 25 percent rule. Rural HWHs and urban HWHs that have only one acute care hospital in their market area have a less stringent target, but probably will have a more difficult time attracting patients from farther away. Because we have no evidence of how HWHs will react, we have not modeled margins incorporating this policy change.

Using policies discussed above and 2007 policy (except the update), we project that LTCHs' aggregate margin for 2006 will be 7.8 percent (Table 4C-6).

TABLE 4C–6 **Long-term care hospitals' Medicare margin, 2004 and estimated 2006**

LTCH group	**2004**	**2006**
All LTCHs	9.0%	7.8%

Note: LTCH (long-term care hospital).

Source: MedPAC analysis of cost reports from CMS.

How should Medicare payments change in 2007?

For LTCHs, the update in current law for 2007 is a market basket update. CMS's latest forecast of the market basket for 2007 is 3.5 percent. However, evidence from the indicators we have examined suggests that LTCHs can accommodate the cost of caring for Medicare beneficiaries in 2007 without an increase in the base rate.

Update recommendation

Long-term care hospitals should be able to accommodate cost changes in rate year 2007 with the Medicare margin they have in 2006.

RECOMMENDATION 4C

The Congress should eliminate the update to payment rates for long-term care hospital services for 2007.

RATIONALE 4C

Although we have no direct indicators of beneficiaries' access to LTCHs, beneficiaries' increased use of long-term care hospitals suggests increases in their access to care. Long-term care hospitals continue to enter the Medicare program rapidly, consistent with payment rates being attractive. The increasing supply of LTCHs and beds results in increases in volume of discharges and Medicare spending. Spending grew almost 38 percent in 2004 alone. The rapid increase in LTCHs and beds suggests that LTCHs have adequate access to capital. Medicare margins are 9 percent in 2004 and an estimated 7.8 percent in 2006. Therefore, we conclude that payments to LTCHs are more than adequate.

We make our recommendation to the Congress. We recognize that the Secretary also has the authority to update payment rates for long-term care hospitals. However, the Secretary has no obligation to act; thus we make this recommendation to the Congress, which if it acts, has the force of law.

IMPLICATIONS 4C

Spending

- This recommendation decreases federal program spending relative to current law by between $50 million and $200 million in one year and less than $1 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to affect providers' ability to provide care to Medicare beneficiaries. ■

Endnotes

1 LTCHs began receiving payments under the new PPS at the beginning of their 2003 cost reporting periods. During a five-year transition period, Medicare pays LTCHs a blend of the PPS rate and their updated facility-specific rate. For example, in the first year of PPS, payments were made up of 20 percent PPS rates and 80 percent facility-specific rates; in the second year, payments were to be made up of 40 percent PPS rates and 60 percent facility-specific rates. LTCHs also could choose to be paid at 100 percent of the PPS rate; CMS estimates that 94 percent of LTCHs chose this option. Adjustment for geographic differences using the area wage index also was phased in over five years. For more detail on the PPS for long-term care hospitals, see http://www.medpac.gov/publications/other_reports/Dec05_payment_basics_LTCH.pdf.

2 LTCHs are paid on the basis of a rate year, from July 1 through June 30. Policy changes for the LTCH PPS, including the base rate, affect the rate year. Changes in the LTC–DRGs or the relative weights affect the federal fiscal year because the LTC–DRGs are the same DRGs used for the acute care hospital PPS.

3 Hospitals within hospitals are subject to few restrictions. They are required to have a governing body, chief executive officer, chief medical officer, and medical staff separate from the host hospital and are subject to limits on admissions transferred from their host hospital.

4 The threshold during the transition period is the lesser of the specified annual percentage or the percentage of Medicare patients admitted by an HWH from its host hospital in 2003 (the so-called "base year") that were not high-cost outliers for the host.

5 In developing the case-mix groups and relative weights for the LTCH PPS in 2006, CMS found that payments in aggregate would decrease by 4.2 percent in 2007 (CMS 2005). In examining this phenomenon, CMS found that 30 percent of the 115 regularly used LTC–DRGs had a real decrease in the average charge per case on which the relative weights are based. The agency attributed this change to a greater number of cases with relatively lower charges being assigned to LTC–DRGs with higher relative weights, which would bring the averages down, consequently decreasing the relative weights. In addition, 45 percent of the 115 LTC–DRGs had an increase in charges that was less than the 16 percent average overall increase in charges. Because the LTC–DRG relative weights are determined by dividing the average charge for each group by the average overall charge (across all groups), the relative weights for these groups also decreased. These changes in relative values were not budget neutral.

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