



Medicare  
Payment Advisory  
Commission

TESTIMONY

## Long-term care hospitals

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Statement of  
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Before the  
Subcommittee on Health  
Committee on Ways and Means  
U.S. House of Representatives

Chairman Johnson, Ranking Member Stark, distinguished Subcommittee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this afternoon to discuss Medicare payment policy for long-term care hospitals.

Medicare beneficiaries can seek care after a hospitalization in four different post-acute settings: skilled nursing facilities (SNFs), home health agencies (HHAs), long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs). In addition, in three of these settings patients can be referred directly from the community. Use and spending for these services have grown rapidly since the introduction of new prospective payment systems for them. About 3.7 million beneficiaries used post acute care in 2002. In 2004 Medicare spending for these settings was about \$36 billion, accounting for more than 12 percent of total Medicare spending.

The overarching issue in Medicare post-acute care (PAC) is that there are no clear and comprehensive criteria for which of these settings are best for patients with particular characteristics or needs. The recuperation and rehabilitation services provided are important for Medicare beneficiaries. Yet, these settings and their payment systems have developed separately over the years, and it is not clear that together they form an integrated whole that provides the highest quality, most appropriate care for beneficiaries or the best value for the Medicare program and the taxpayers who support it. There is a need for comprehensive payment system reform across all PAC settings. Aligning Medicare payment systems with the patient's needs and characteristics and the quality of the care provided, rather than by type of facility, remains a challenge that will have to be met to get the best value for the Medicare program.

The Commission maintains that in the post-acute care sector, just as for the other sectors of Medicare, the services provided should meet the needs of the beneficiaries, Medicare payments should cover the costs of an efficient provider of those services, and higher quality services should be rewarded. Currently in post-acute care, none of these conditions is fully satisfied.

Long-term care hospitals, the subject of this hearing, illustrate the larger problem in the Medicare post acute care payment systems. Medicare payments to LTCHs have increased rapidly—from \$398 million in 1993 to about \$3.3 billion in 2004—and continue to rise. CMS

estimates LTCH payments will be \$5.2 billion in 2007. As shown in Table 1, along with the increase in Medicare spending there has been an increase in the number of LTCHs, the number of cases, and the payment per case. The average length of stay has fallen. Growth has been particularly rapid since the start of the new LTCH prospective payment system (PPS) in 2003. From 2002 to 2004, 71 new facilities entered the program and Medicare payments increased 38 percent in 2004 alone. Medicare is very important to these hospitals, accounting for 73 percent of discharges, on average, in 2004.

**TABLE  
1**

**Growth in number of LTCHs, volume of cases, and Medicare spending**

	2001	2003	2004	Average annual change 2001–2004
Number of LTCHs	273	319	357	9%
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).

Source: MedPAC analysis of MedPAR data from CMS.

## What are long-term care hospitals?

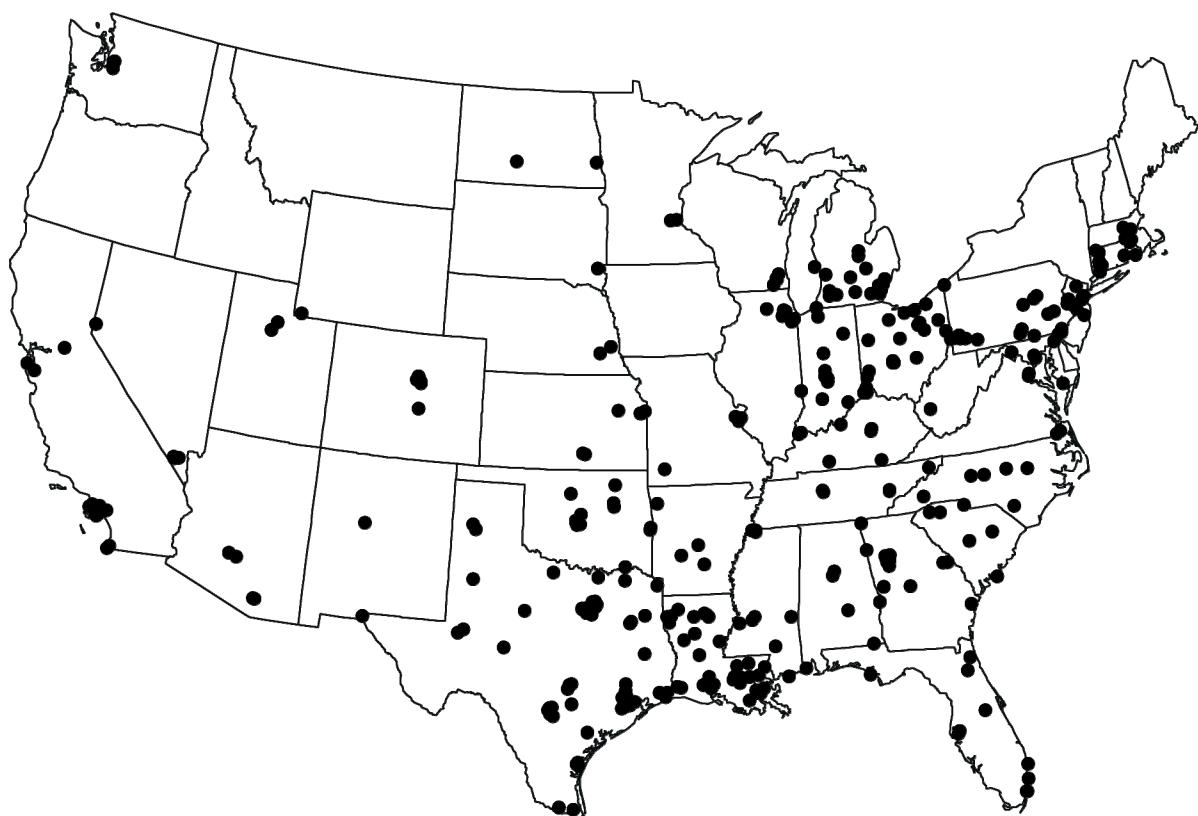
The characteristics of long-term care hospitals vary. Some are converted from former public health hospitals; these tend to be the largest and are concentrated in New England. Others are freestanding but have entered the program more recently. The newest entrants, called “hospitals within hospitals,” are collocated with an acute care hospital but have separate ownership and financial arrangements. Hospitals within hospitals (HWHs) are smaller than the older LTCHs. The numbers of HWHs and freestanding LTCHs both increased following implementation of the LTCH PPS in 2003, but 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. Almost 60 percent of LTCHs are for profit, two-thirds of which are owned by just two chains.

LTCHs are unevenly distributed across the country (Figure 1). Some areas have many LTCHs; other areas have none. As shown in Table 2, the 5 states with the greatest number of LTCH beds per thousand Medicare beneficiaries account for 39 percent of the available beds but only 12 percent of the Medicare beneficiary population. Long-term care hospitals serve a wide mix of patients including ventilator patients, those requiring wound care, and those with respiratory and other infections.

**FIGURE  
1**

**Location of long-term care hospitals**



Source: Online Survey, Certification, and Reporting System from CMS.

The regulatory distinction between long-term care hospitals and acute care inpatient hospitals is the length of stay. Long-term care hospitals are certified as hospitals and are intended to treat medically complex patients with long lengths of stay. Medicare requires that the average Medicare length of stay be more than 25 days (the average length of stay in hospitals under the acute care inpatient PPS is approximately 5 days). Cost sharing and coverage follow the acute care hospital rules.

**TABLE  
2**

**LTCH beds are concentrated in a few states in 2004**

	<b>Share of LTCH beds</b>	<b>Share of beneficiaries</b>	<b>Beds per 10,000 FFS beneficiaries</b>
Rhode Island	2.5%	0.3%	56.1
Massachusetts	14.1	2.3	44.3
Louisiana	7.5	1.5	37.0
Texas	11.7	6.4	14.7
Connecticut	2.8	1.4	14.3
Total	38.6	11.9	27.7
Nationwide	100	100	6.7

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

Source: MedPAC analysis of MedPAR data from CMS.

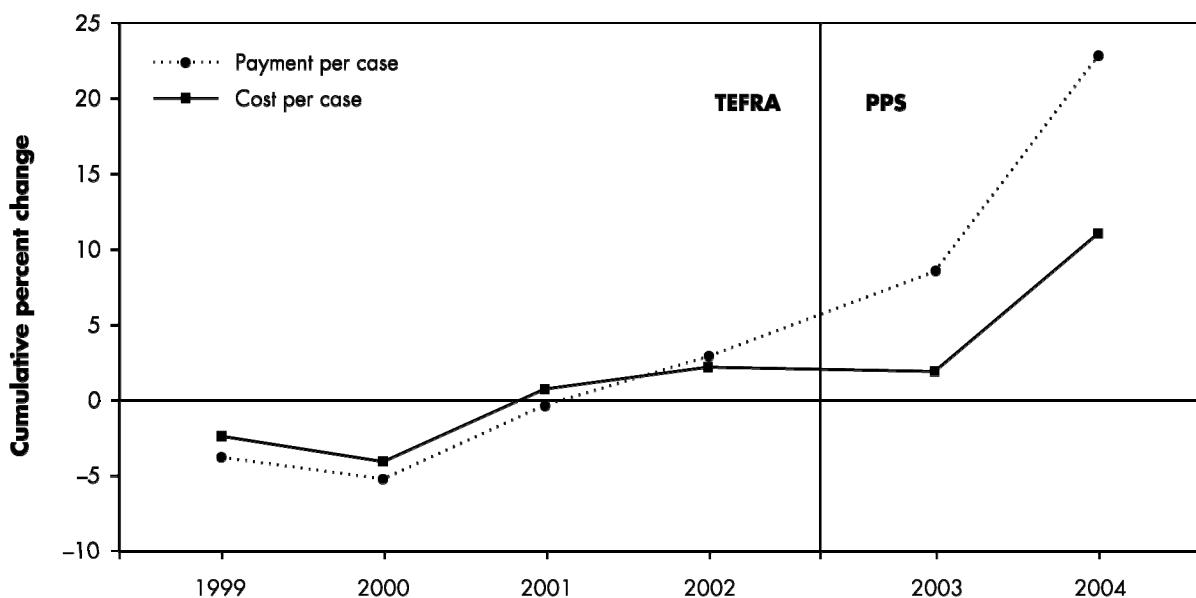
### **Medicare payments to LTCHs**

Before October 2002, long-term care hospitals were paid on the basis of their average costs per discharge, subject to an annually adjusted limit calculated for each facility. Since then, under the new PPS, Medicare has paid LTCHs under a prospective payment system based primarily on the patient's diagnosis. Payment rates range from \$15,665 to \$121,376 for a LTCH in an average wage area. These rates are higher than those hospitals receive under the inpatient PPS and they are also higher than rates for SNFs. In fiscal year 2004, for patients with the most common LTCH diagnoses, Medicare rates for LTCHs ranged from about 3 to almost 12 times as much as estimated rates for SNFs.

Under the previous payment system, the change in payment per case was at or below the change in cost per case (Figure 2). After PPS implementation, payment per case rose rapidly: it increased 5.5 percent in 2003 and 13.2 percent in 2004. 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.

**FIGURE  
2**

**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.

There was little change (less than –0.1 percent) in the reported cost per case from 2001 to 2003, the first year of PPS. It then increased substantially in the second year of the PPS (by 8.9 percent). More complicated LTCH patients could account for at least part of this increase in cost per case. However, the average length of stay decreased in 2004, which generally would decrease costs. 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 the old system.

Even though cost rose after the PPS started, payments outstripped them. Margins rose rapidly as suggested by the increasing difference between payments and costs in Figure 2. Margins reached 9.0 percent in 2004 and we project a margin of 7.8 percent in 2006. The Medicare margin is the difference between Medicare payments and providers' costs, as a percentage of Medicare payments.

In our March 2006 report to the Congress, the Commission assessed the adequacy of payment for long-term care hospitals. We found Medicare payments for LTCH services are more than adequate. The supply of LTCHs, the volume of services, and the number of beneficiaries admitted to LTCHs have all increased rapidly since 2001 and access to capital is good. Moreover, Medicare spending for these facilities increased twice as fast as volume. As mentioned, margins are high.

The Commission concluded that long-term care hospitals should be able to accommodate increases in the cost of care in 2007 and recommended that the Congress eliminate the update to payment rates for LTCH services for 2007.

### **CMS actions**

CMS has reacted to the growth in LTCHs and Medicare spending with several regulatory changes. First, CMS established a new policy, the 25 percent rule, which CMS intended to protect the integrity of the inpatient PPS by attempting to ensure that HWHs do not function as hospital-based units of host hospitals. Second, CMS made other changes to increase the accuracy of payments under the new PPS.

### **LTCHs can substitute for other settings**

The Commission undertook extensive quantitative analysis, interviews, and site visits to understand which beneficiaries use LTCH services, what services they otherwise would have used, and what are the costs to Medicare. We found that LTCHs provide post-acute care to a small number of medically complex patients who are more stable than patients in an intensive care unit (ICU) but may still have unresolved underlying complex medical conditions. Many of these patients require ventilator support for respiratory problems, have failure of two or more major organ systems, neuromuscular damage, contagious infections, or complex wounds needing extended care.

Using quantitative analysis, we found that the tendency to use LTCHs is associated with certain diagnoses, severity levels, and the proximity of the facility. Having a diagnosis of tracheostomy is the single strongest predictor of LTCH use. Diagnoses other than tracheostomy also predict long-term care hospital use—respiratory system diagnosis with ventilator support, acute and subacute endocarditis, amputation, skin graft and wound debridement, and osteomyelitis. When we divided each diagnosis into four levels by how severely ill the patient was, those with the highest severity level, regardless of diagnosis, had almost quadruple the probability of LTCH use. Beneficiaries living near an LTCH were more likely to use them, and being in an acute hospital with a HWH quadrupled a beneficiary's probability of using an LTCH.

LTCHs can substitute for both hospital care and post-acute care. LTCHs can substitute for the end of an acute hospital stay. About 80 percent of LTCH Medicare patients are transferred from acute hospitals and patients who use LTCHs have shorter acute hospital lengths of stay than similar patients who do not use these facilities. Freestanding SNFs are the principal post acute alternative to LTCHs. Patients who would be most likely to use LTCHs often use SNFs and when patients use LTCHs the probability of using SNF care declines—suggesting that SNFs and LTCHs are used as substitutes.

In general, patients who use long-term care hospitals are more costly to Medicare than similar patients using alternative settings when we account for payments over an entire episode—that is, including payments in both the acute and post acute settings. However, the cost differences narrow considerably when LTCH care is targeted to very ill patients who are most likely to need and benefit from this level of care.

To better understand which patients most need and can most benefit from the particular capabilities of LTCHs, we undertook site visits and held discussions with LTCH representatives. According to LTCH clinicians, long-term care hospitals:

- frequently use admission criteria to determine whether patients require an LTCH level of care and have sicker patients who are more likely to improve;
- have active daily physician involvement with patients;

- have licensed nurse staffing of 6 to 10 hours per day per patient (much higher than other post-acute care settings);
- frequently employ specialist registered nurses and employ physical, occupational, speech, and respiratory therapists the latter of whom are available 24 hours per day; and
- have multidisciplinary teams that prepare and carry out treatment plans.

We drew on these observations to help tailor our recommendations.

### **Commission recommendations**

In its June 2004 *Report to the Congress: New Approaches in Medicare*, the Commission recommended that Congress and the Secretary define long-term care hospitals by patient and facility criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement.

- Patient-level criteria should identify specific clinical characteristics and treatment modalities.
- Facility-level criteria should characterize this level of care by features such as staffing, patient evaluation and review processes, and mix of patients.

Medicare should use more precise criteria to ensure that LTCHs treat only appropriate patients. Criteria should describe the level of care required by LTCH patients so that their needs are clearly distinguishable from those of less resource-intensive patients who should be treated in other less costly settings. LTCH criteria should focus, to the extent possible, on patients and their care needs, rather than on facility characteristics.

**Patient-level criteria** would identify specific clinical characteristics and treatments required by patients cared for in LTCHs. All of these criteria would be intended to ensure that the patients admitted to LTCHs require an intensive level of resources and have a good chance of improvement.

National criteria could be required for both admission and discharge for each of the major categories of patients treated in LTCHs, including respiratory, infectious disease, other medically complex, wound care, ventilator-weaning, and cardiovascular or peripheral vascular patients. Because these criteria would be specific to each of the most common case

types, they would need to be as detailed and clinically relevant as possible. Discharge criteria would ensure that patients are medically ready for discharge to less intensive and medically appropriate alternative care settings.

Patient mix and severity criteria are directed toward ensuring that LTCHs treat only medically complex cases. For example, one requirement could be that a high share (e.g., 85 percent) of a facility's patients must be classified into broad diagnosis categories—such as complex medical, complex respiratory, cardiovascular, ventilator-dependent, or extensive wound care—and that a large share (e.g., 85 percent) of an LTCH's patients demonstrate a high level of severity of illness at admission.

***Facility-level criteria*** should delineate features of the care provided in LTCHs. Some examples include a patient evaluation and review process, a patient assessment tool, and the availability of physicians. A standard patient assessment tool would ensure consistency in the assessment process. Though most LTCHs already use assessment tools all facilities should use the same tool that emphasizes clinical and functional assessments of patients. The level of physician availability should be specified. Physicians' presence and their active involvement with patients are key aspects of the care that differentiates long-term care hospitals from SNFs. Also, requiring multidisciplinary teams of professionals, including physicians, to prepare and carry out treatment plans would encourage a team-based focus on patient care.

The 25 day length of stay criterion, the only criterion currently in place for LTCHs, is intended to ensure that patients require a high level of resources. Without other criteria, however, the length of stay criterion does not prevent SNF-level patients from being treated in LTCHs at much higher costs to Medicare. Over time, as patient criteria clearly delineate the types of patients appropriate for treatment in LTCHs, CMS could reevaluate use of this criterion.

A minimum staffing requirement would ensure that LTCHs provide an intensive level of care that is comparable to a step-down unit (from ICU-level care) in a hospital and would be consistent with long-term care hospitals treating medically complex patients who cannot be treated in SNFs.

The Secretary will need to monitor the compliance of LTCHs with facility- and patient-level criteria. Therefore, the Commission also recommended that the Secretary should require the Quality Improvement Organizations (QIOs) to review long-term care hospital admissions for medical necessity and monitor that these facilities are in compliance with defining criteria. A recent QIO medical record review found that 29 percent of 1,400 randomly selected LTCH Medicare admissions in 2004 did not need hospital-level care.

The Commission's recommendation to better target the patients treated in long-term care hospitals should not be taken as a blanket endorsement of LTCHs and their role in the post-acute care continuum. The rapid growth in long-term care hospitals, the opportunities for excess profit, and the fact that patients get care in other settings in markets where LTCHs do not exist all raise concerns for the Commission. The growth and incentives of the HWHs are of particular concern.

## **Quality**

Refinements to the LTCH payment policies should be consistent with Medicare's longer-term goals for payment policy. These goals include improving quality and promoting patient care in the most appropriate and cost-effective setting. 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. It is a positive step that the industry is starting to develop new quality indicators. However, the next steps that should be taken are CMS involvement, greater validation of the measures, and decisions on a data collection strategy.