

Assessing payment adequacy and updating payments: Long-term care hospital services

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Long-term care hospitals (LTCHs)

- Meet Medicare's conditions of participation for acute care hospitals (ACH) and have an average length of stay (ALOS) for certain Medicare cases greater than 25 days
- Medicare spending: \$5.1 billion in 2016
 - Cases: ~126,000
 - Mean payment per case (all cases): ~\$41,000
 - Mean payment per case (qualifying cases): ~\$47,000
- Per case payments based on MS-LTC-DRGs, adjusted for:
 - High cost outliers
 - Short-stay outliers (SSO)

The Pathway for SGR Reform Act of 2013 establishes “site-neutral” payments for LTCHs

- Beginning FY 2016:
 - Higher LTCH payments allowed for qualifying cases with an immediately preceding ACH discharge and either:
 - 3+ ICU days in referring ACH; or
 - principal LTCH diagnosis that includes prolonged mechanical ventilation
 - All other LTCH cases paid lower of IPPS-based rate or costs
- LTCH required ALOS of 25+ days excludes:
 - Medicare fee-for-service cases paid based on the site-neutral rate
 - Medicare Advantage cases

Payment adequacy framework

- Access
 - Supply of providers
 - Volume of services
- Quality
- Access to capital
- Payments and costs

A reduction in the number LTCH facilities and beds began in 2012

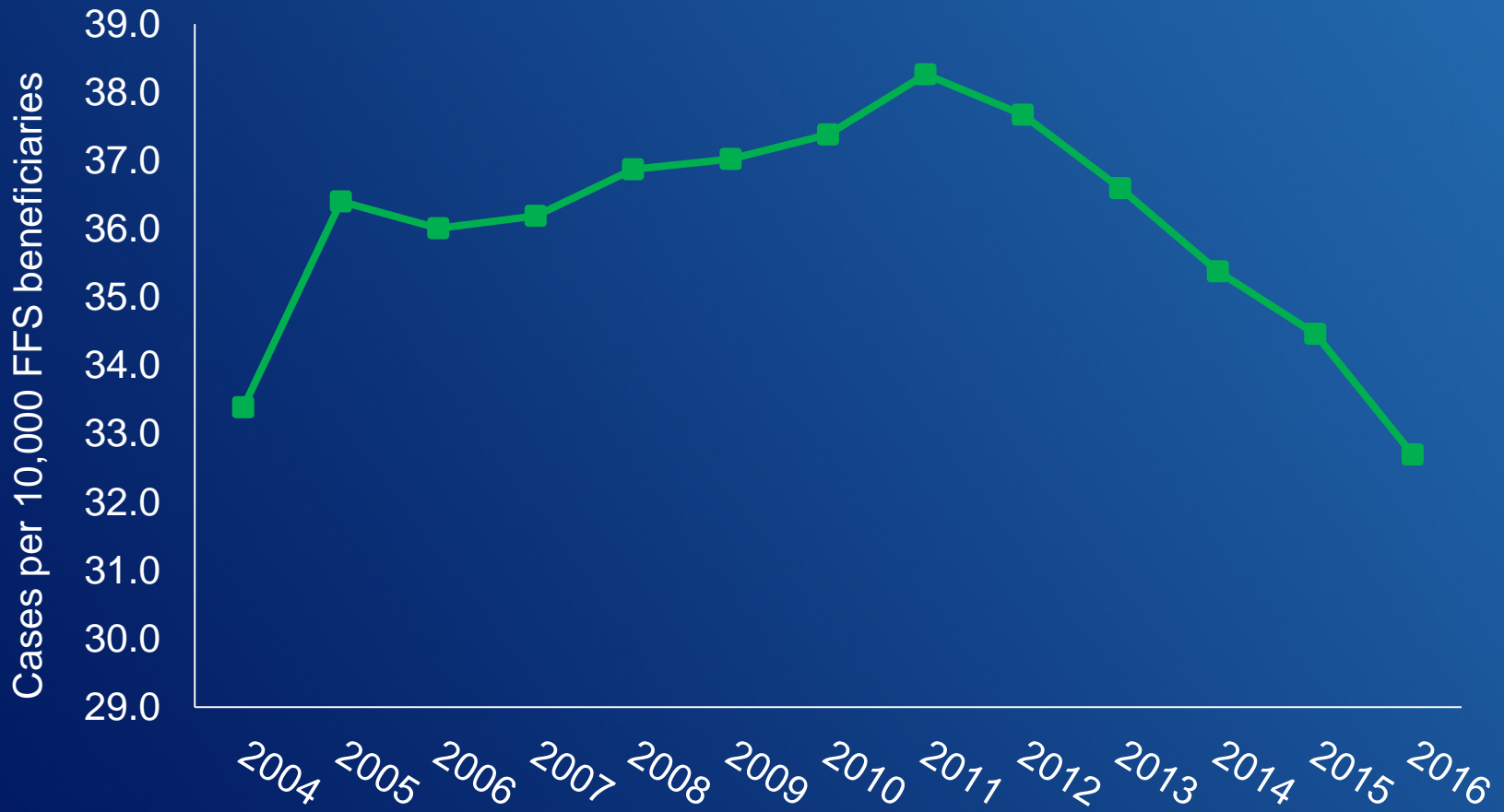


- 2016 occupancy rate: 66 percent

Results are preliminary and subject to change.

Source: MedPAC analysis of cost report data.

Since peaking in 2011, the volume of LTCH services declined annually



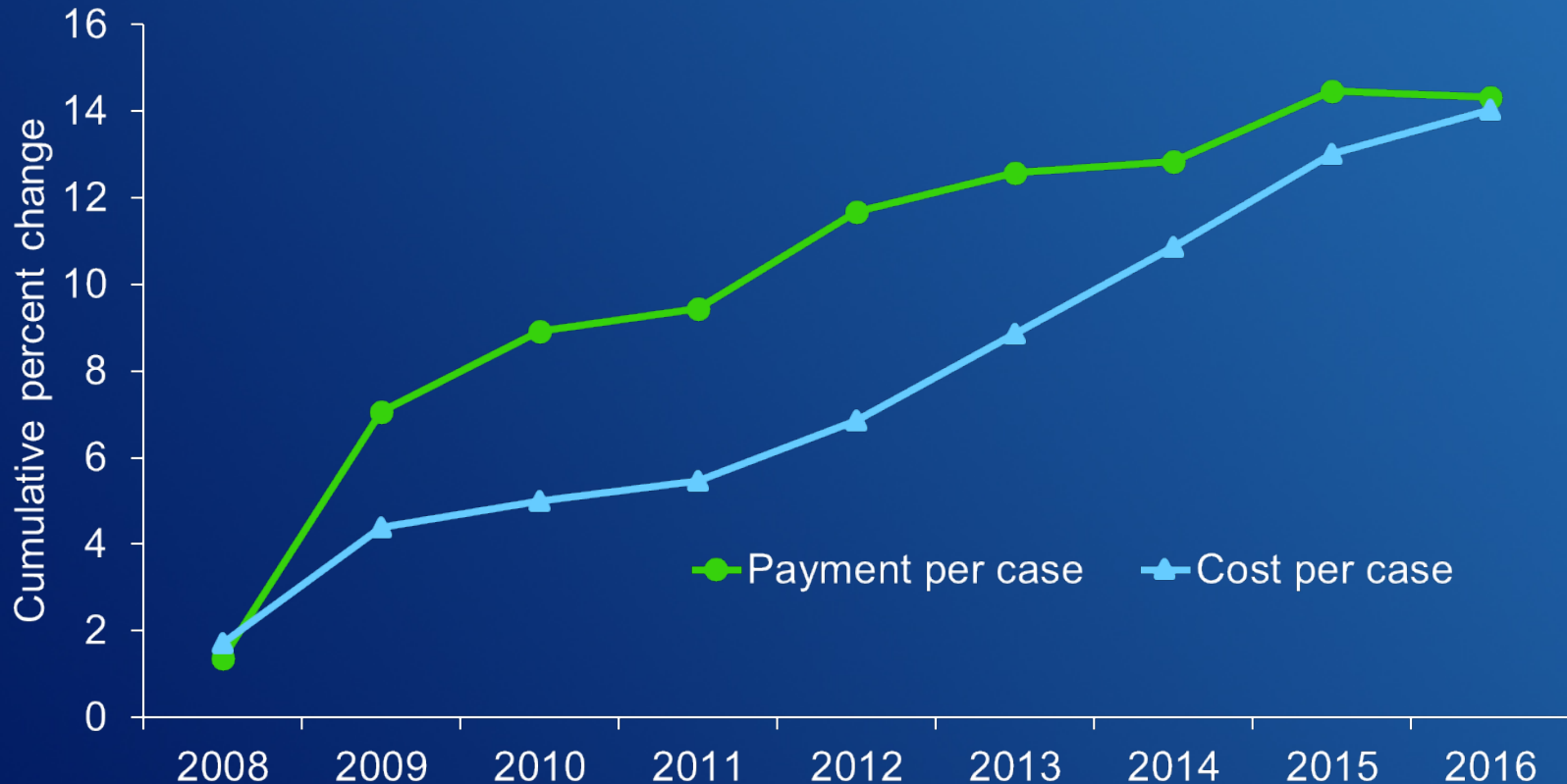
Quality: Limited available measures

- Readmission rates and mortality rates stable or declining for most of the top diagnoses between 2012 and 2016
- LTCH mortality (unadjusted)
 - 24% die in LTCH or within 30 days of discharge and varies by case type
- LTCH readmissions (unadjusted)
 - 9% of discharges are readmitted within 30-days of discharge

Access to capital: Continued near-term uncertainty

- Short-run uncertainties regarding the industry's ability to comply with patient criteria have resulted in low levels of capital investment
 - We expect LTCHs to continue to adapt their admission patterns, cost, and case mix until the policy is fully phased-in
- Long-run industry-wide shift in focus to lower-cost sites of care could affect LTCH use in the future

Lowest level of cost growth since 2011



LTCH Medicare margins, 2016

	% of LTCHs	% of cases	Margin (all cases)	Margin (qualifying cases)
All LTCHs	100%	100%	4.1%	6.3%
Bottom 25 th	25	18	-17.5	N/A
Top 25 th	25	26	17.7	N/A
Urban	95	96	4.3	6.4
Rural	5	4	-0.5	1.4
For-profit	79	87	5.7	7.6
Nonprofit	17	12	-4.7	-0.3

- 2016 Medicare marginal profit: 19.5 percent

N/A (not available). Government-owned LTCHs are not shown. Percentages may not sum to 100% due to rounding. Results are preliminary and subject to change. The margins reflect current law policies.

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

High- and low-margin LTCHs, 2016

	High-margin LTCHs	Low-margin LTCHs
Mean total discharges (all payer)	520	426
Occupancy rate	73%	56%
Standardized cost per discharge	\$27,501	\$35,770
Medicare payment per discharge	\$37,019	\$33,467
High-cost outlier payment per discharge	\$2,607	\$5,947
Short-stay cases	27%	34%
Mean case mix index (non-SSOs)	1.17	1.12
For-profit	88%	63%

SSOs (short-stay outliers). Includes LTCHs that filed valid cost reports in both 2015 and 2016. Government-owned facilities are excluded from this analysis. Results are preliminary and subject to change.

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

Summary

- Access: Occupancy stable (66 percent) but LTCH supply and volume of services decreased
- Quality: Stable or improving for limited available measures
- Access to capital: Limited need given the implementation of the patient-level criteria

- 2016 margin: 4.1%
- 2016 marginal profit: 19.5%
- 2016 margin for qualifying cases: 6.3%

The margins reflect current law policies. Results are preliminary and subject to change.
Source: MedPAC analysis of Medicare cost report and MedPAR data from CMS.