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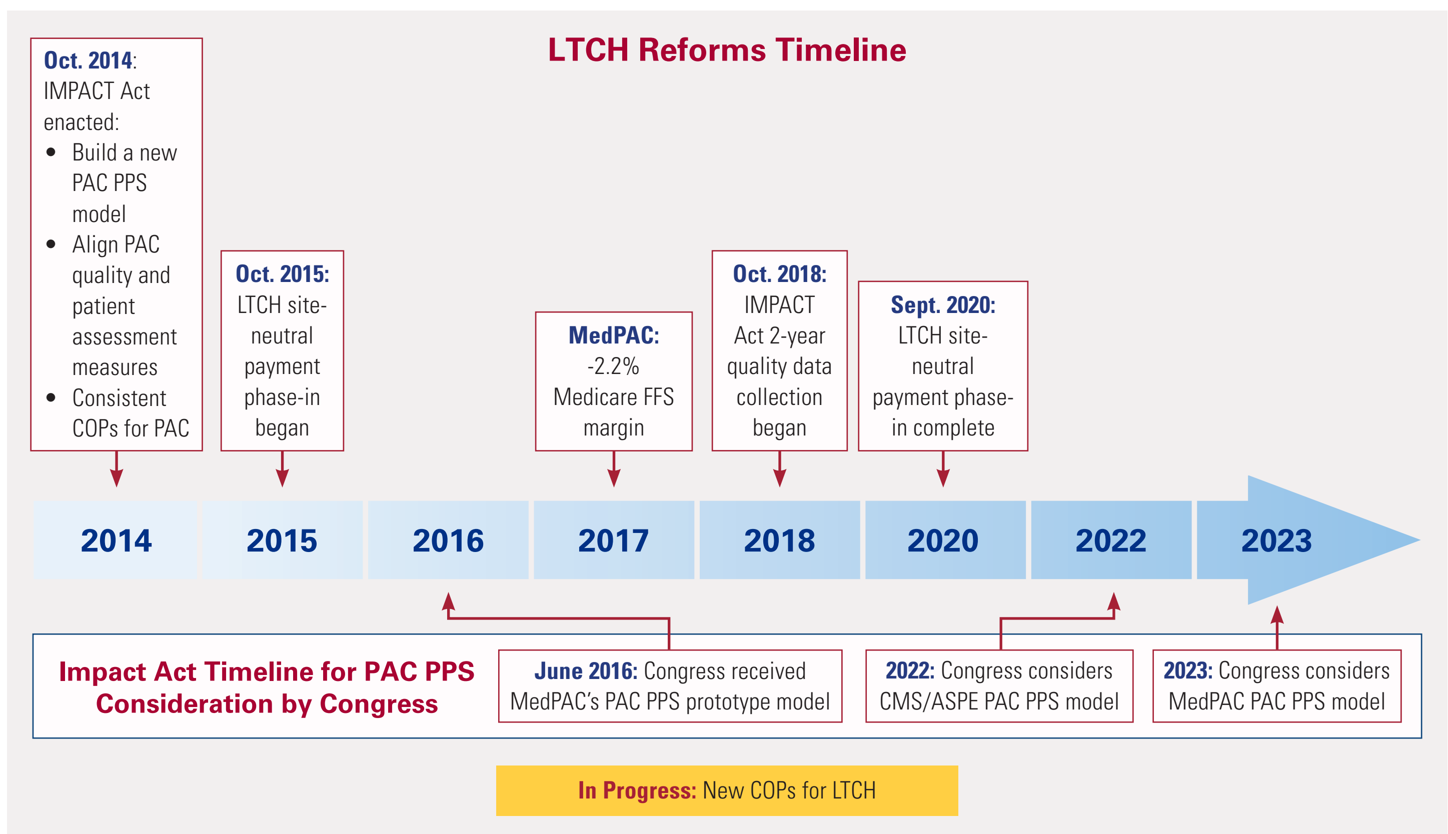
Fact Sheet: Long-term Care Hospitals

The Issue

Long-term care hospitals (LTCHs) serve a critical role within the Medicare program by treating the sickest patients who need extended hospital stays. This important role is under threat as the LTCH field implements the Bipartisan Budget Act of 2013 requirement for "site-neutral" payments for cases with lower acuity. Analyses by the Medicare Payment Advisory Commission (MedPAC) and the AHA highlight the transformative nature of the site-neutral payment policy, which has led to the underpayment of 36 percent of LTCH cases, a more than $1 billion reduction in payments to LTCHs and LTCH closures.

AHA Position

Given the magnitude of these payment changes and other reforms, LTCHs need to focus their resources on adapting their operations and patient services. They also need relief from other pressures, such as any new regulatory requirements or payment reductions. Once these reforms are fully implemented, policymakers can evaluate their impact to help guide whether subsequent changes are necessary.



LTCH Value

LTCH value. The LTCH patient population has the highest rate of patients with extreme severity of illness (SOI). Specifically, Table 1 highlights that patients discharged to LTCHs have a far higher proportion of patients with extreme SOI (shown in light blue) than the levels found in general acute-care hospitals and

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those discharged to skilled nursing facilities. LTCHs' concentration on serving the highest-acuity patients is executed by specialized clinical teams and programs for respiratory, infectious disease, and other patients with major comorbidities and complications.

Given patient complexity, in 2017, the LTCH average length of stay was 26.2 days compared to 5.0 days for general acute-care hospitals.

LTCH Challenges

Medicare is underpaying LTCH site-neutral cases (36 percent of all LTCH cases) for two reasons:

1. As MedPAC has pointed out, the Centers for Medicare & Medicaid Services (CMS) is applying an unwarranted and redundant 5.1 percent budget-neutrality cut to all site-neutral cases; and

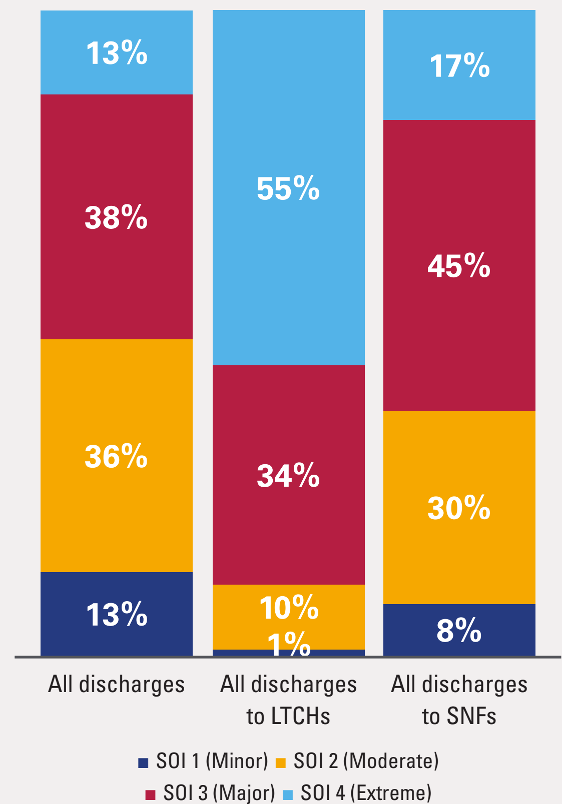
2. CMS incorrectly assumes that LTCH site-neutral cases have acuity and costs that are comparable to inpatient prospective payment system (PPS) cases.

When the site-neutral policy is fully phased in after September 2020, AHA estimates that, on average, only 45 percent of the cost of treating LTCH site-neutral cases will be covered.

In addition, AHA estimates that the systematic underpayment of LTCH site-neutral cases is reducing Medicare payments to LTCHs by more than $1 billion from fiscal years (FY) 2016 through 2019.

Medicare margins for LTCHs are decreasing. During its January 2019 meeting, MedPAC projected a continued decrease in Medicare fee-for-service (FFS) margins for LTCHs, with a *negative* 2.2 percent margin for FY 2017. In addition, the Commission expects additional future LTCH payment reductions should its post-acute care PPS prototype be implemented.

Table 1: Severity of Illness Levels for Patients Discharged from General Acute-care Hospitals, by Percentage



Source: FY 2017 National MedPAR data, CMS; 3M™ APR DRG Software, 3M Health Information Systems, Inc.

Reporting requirements are rapidly growing. In addition to payment pressures, LTCHs face ever growing reporting requirements. Specifically, CMS has quadrupled the number of LTCH quality measures in recent years and it is poised to add many new patient assessment items. While we appreciate that these new requirements are intended to foster greater consistency across post-acute care, we are concerned that they have not been adequately tested, and do not yield accurate, meaningful data.

Source

AHA's January 2019 letter to MedPAC *https://www.aha.org/system/files/2019-01/aha-medpac-letter-payment-recommendations-for-2020-1-14-2019.pdf*.

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