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Recent Developments in Medicare Affecting Long-Term Care Hospitals

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Summary

Medicare pays about \$36 billion annually for post-acute care in four separate settings: long-term care hospitals (LTCHs), inpatient rehabilitation settings (IRFs), skilled nursing facilities (SNFs), and in the home. Medicare pays for care in each setting under a unique payment system that uses different patient assessment instruments (PAI) to establish a patient's level of care. LTCHs, often considered the most expensive post-acute care setting, are not required to use any PAI. Generally, Medicare requires that LTCHs be licensed as acute care hospitals and have an average length of stay of 25 days. Although there is no prior hospitalization requirement in order for a Medicare beneficiary to qualify for care in an LTCH, approximately 80% of beneficiaries receiving such care are transferred from an acute care hospital. LTCHs provide intensive care to patients who have multiple, coexisting conditions who may need hospital level care for relatively extended periods. However, Medicare's ability to assess whether patients are being treated in the most appropriate setting is undermined because there are no common patient assessment tools or outcome measures across post-acute care settings. This report provides background information on several operational issues affecting LTCHs that are currently attracting attention from Congress, specifically efforts to develop a patient assessment tool, to develop qualification criteria that should be imposed on LTCHs, and to change Medicare's LTCH payment methods.

For all post-acute settings, the overarching policy concern is how to expedite the development of methods that best identify the post-acute care setting that provides the most appropriate, cost-effective care for a specific patient or a particular condition. For LTCHs, the debate centers around (1) the standards that should be imposed in order to qualify as an LTCH; and (2) the criteria that should define the level of care provided by LTCHs. Specific rate setting proposals concerning appropriate adjustments within the new prospective payment system (established in 2002) and the adequacy of Medicare payments have generated animated discussion as well.

Recommendations from the Medicare Payment Advisory Commission (MedPAC) regarding patient and facility criteria for LTCHs or, most recently, supporting a 0% update

to rate year (RY) 2007 Medicare payments have attracted attention. Also, past actions from the Centers for Medicare and Medicaid Services (CMS) regarding requirements imposed on LTCHs that are physically located as part of other providers (also known as hospitals-within-hospitals, or HwHs), as well as RY2007 proposals for payments for short-stay admissions, have elicited concern among providers and their advocates.

Identifying Appropriate Post-Acute Care Settings

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) required the Secretary to submit a report to Congress by January 1, 2005, on the development of standard instruments for the assessment of the health and functional status of Medicare patients who receive hospital, rehabilitation, SNF, home health, therapy, or other specified services. The report has not yet been received. The Subcommittee on Health within the Committee on Ways and Means held a hearing on June 16, 2005 to examine what progress had been made in that area and to discuss the status of and solicit recommendations on Medicare's current post-acute payment systems.

In that hearing, CMS presented an overview of several different agency initiatives that may result in the development of a standard PAI, common health information terminology, and consistent coding practices.¹ MedPAC and industry representatives also testified on different issues affecting LTCHs.² MedPAC discussed the problems with integrating the current post-acute patient assessment tools and indicated that a new PAI is needed.³ As part of its testimony, MedPAC reiterated its recommendation (made in 2004) that LTCHs be defined by facility and patient criteria to ensure the patients admitted to these facilities have medically complex conditions and a good chance for improvement.⁴ MedPAC also recommended that quality improvement organizations (QIOs) review LTCH admissions for medical necessity and monitor facilities' compliance with yet-to-be-determined LTCH criteria.⁵ Testimony from one group representing the LTCH industry spoke to the critical yet distinct roles of each provider in the post acute care sector, generally supported efforts to develop a comprehensive PAI, and supported

¹ See [<http://waysandmeans.house.gov/hearings.asp?formmode=view&id=2790>] for testimony delivered for CMS.

² The Government Accountability Office also testified on its work with respect to the appropriate classification criteria for IRFs.

³ See MedPAC, *Report to the Congress: Issues in a Modernized Medicare Program*, June 2005, pp.114-119, for more information of the existing PAIs.

⁴ MedPAC considered facility-level criteria such as staffing, patient evaluation and review processes, and mix of patients as characteristic of this level of care. Relevant patient-level criteria include specific clinical characteristics (such as open wounds) and treatment modalities (such as need for frequent intravenous fluid or medication). For more information, see MedPAC, *Report to the Congress: New Approaches in Medicare*, June 2004, pp. 121-135.

⁵ MedPAC discussed interim measures that could be adopted until a common PAI is developed, such as admission criteria for LTCHs, front-end assessments of acute care patients prior to post-acute care admissions, or care coordination by a case manager. See [<http://waysandmeans.house.gov/hearings.asp?formmode=view&id=2788>].

the principle that patients be cared and paid for in the appropriate setting.⁶ Although generally supportive, another group representing LTCH providers focused on the challenges inherent in creating appropriate patient assessment tools and using program safeguard methods, including QIOs, to ensure cost-effective, appropriate care in safe settings.⁷

A post-acute care demonstration project mandated by the Deficit Reduction Act of 2005 (DRA) may eventually help address some of the broader changes necessary to encourage the cost-effective provision of post-acute care in the most appropriate setting. As mandated by DRA, the Secretary of Health and Human Services (HHS) is required to establish a three-year demonstration program to better understand costs and outcomes across different post-acute care sites. Under the program, individuals receiving treatment for specified diagnoses will receive a comprehensive assessment on the date of discharge from an acute care hospital (paid under Medicare's inpatient prospective payment system, or IPPS). The assessment will evaluate clinical characteristics and patients' needs in order to determine appropriate placement of the patient in a post-acute care site. The same standardized patient assessment instrument will be used across all post-acute care sites to measure functional status and other factors. The Secretary is required to submit a report to Congress on results and recommendations no later than six months after the end of the program. DRA authorized the transfer of \$6 million from Medicare's Hospital Insurance Trust Fund to carry out the demonstration.

Defining Entities as LTCHs

In the meantime, certain operational issues have come to the forefront. A long-simmering issue concerns the establishment of an LTCH operating as part of another provider.⁸ Although the Medicare statute does explicitly address the exclusion of distinct-part psychiatric and rehabilitation units of other hospitals from the inpatient prospective payment system (IPPS) used to pay acute care hospitals, no comparable provision excludes long-term care units in those hospitals from IPPS. Until recently, HwHs have accounted for much of the growth in long-term care hospitals.⁹ In 2004, CMS acted to tighten the requirements by which HwHs can be established to function as independent LTCHs.¹⁰ As established in the final rule, Medicare will continue to provide LTCH payments for patients referred from other than the host hospital. With certain exceptions,

⁶ See [<http://waysandmeans.house.gov/hearings.asp?formmode=view&id=2795>] for testimony delivered on behalf of the Acute Long Term Hospital Association (ALTHA).

⁷ A medical record review performed by QIOs found that 29% of 1,400 randomly selected LTCH Medicare admissions in 2004 did not need LTCH hospital-level care. See [<http://waysandmeans.house.gov/hearings.asp?formmode=view&id=2794>] for testimony delivered on behalf of the National Association of Long Term Hospitals (NALTH).

⁸ The Prospective Payment Assessment Commission (ProPAC, a precursor to MedPAC) recommended that growth in the number of HwHs should be monitored in order to evaluate whether Medicare's certification requirements should be changed. ProPAC, *Report and Recommendations to the Congress*, March 1, 1997, p. 59.

⁹ As of October 2005, 175 of the 376 LTCs were HwHs. However, according to CMS, since October 1, 2004, 22 of the 25 newly-established LTCHs are freestanding.

¹⁰ This policy applies to satellite LTCHs established on the same campus of other providers.

as long as the percentage of referrals from the host hospital is less than or equal to 25% (or the otherwise applicable threshold), the LTCH will be paid under the LTCH-PPS for the referrals from the host hospital.¹¹ If the host hospital referrals exceed the applicable transition threshold, LTCH will be paid the lower of the LTCH-PPS payment or the IPPS payment for those cases that exceed that threshold. The policy would be phased in over a four-year transition period for existing LTCHs and those LTCHs under formation.

Both industry advocates and members of Congress have expressed reservations with respect to the wisdom of this policy. Generally, their concerns are framed in terms of its effect on beneficiaries' access to needed LTCH care. MedPAC (among others) has expressed concern that the HwH policy could lead to an inequitable situation for co-located LTCHs. Freestanding LTCHs also have strong relationships with acute care hospitals. Although, on average, LTCH HwHs receive 61% of their patients from their host hospitals, on average, freestanding LTCHs receive 42% of their patients from their primary referring acute care hospital. Yet the 25% threshold applies only to LTCH HwHs. As mentioned in the proposed LTCH rule concerning rate year (RY) 2007 changes, CMS remains concerned about monitoring the "functional separateness" between LTCHs and referring acute care hospitals. According to CMS, analyses of recent LTCH claims appear to confirm concerns (attributed to MedPAC) that the industry may be circumventing the intent of the 25% payment threshold by creating freestanding instead of colocated LTCHs.¹² CMS is considering, but has not proposed, appropriate payment adjustments to address this issue. Moreover, CMS warned of potentially fraudulent referral arrangements between acute care hospitals and LTCHs (HwH, satellite, and freestanding entities) that could warrant an investigation by the Office of the Inspector General (OIG).

Changing Rate-Setting Methods

Other issues have been raised about changes that have been proposed for the RY2007 Medicare LTCH payment methodology.¹³ As part of the prospective payment system for LTCHs (LTCH-PPS), CMS has established a special payment policy for short-stay outlier cases (SSO cases). These are cases that have a length of stay less than or equal to five-sixths of the geometric average length of stay (ALOS) of the patient category to which the case is assigned.¹⁴ Under the existing SSO policy, the per-discharge payment

¹¹ The alternative payment methodology would apply to HwHs within rural acute care hospitals that have a majority (51%) of host hospital referrals. The threshold for single urban or dominant urban HwHs (those with one-quarter or more of all acute care cases) would be set between 25% and 50%, depending upon the host's percentage of total Medicare discharges for like hospitals in the metropolitan statistical area (MSA). Patients transferred from the host hospital who have already qualified as IPPS outliers would not be considered as host hospital referrals.

¹² FY2004 and FY2005 Medicare data indicate that the 63.7% of the 201 freestanding LTCHs receive at least 25% of their Medicare discharges from a single IPPS hospital; 23.9% of those freestanding LTCHs receive at least 50% of their admissions from one IPPS hospital; 6.7% of the freestanding LTCHs receive 75% or more of their Medicare discharges from one IPPS hospital — 71 *Federal Register* 4698, January 27, 2006.

¹³ 71 *Federal Register* 4647, January 27, 2006.

¹⁴ The LTCH-PPS uses long-term care diagnosis-related groups (LTC-DRGs) as its patient (continued...)

under the LTCH PPS is the lesser of 120% of the estimated cost of the case, 120% of the LTC-DRG specific per diem amount multiplied by the LOS of that discharge, or the full LTC-DRG payment.¹⁵ CMS is proposing two changes to the current policy: (1) to reduce the current adjustment from 120% of the costs of the case to 100% of the costs of the case for discharges occurring on or after July 1, 2006, and (2) to add a fourth payment method whereby an LTCH would receive a payment comparable to that in IPPS. A key fact is that CMS projects a decline of 11.4% for all LTCH payments (or a savings of approximately \$440 million in RY2007) as a result of the SSO change.

CMS believes that many of the SSO cases could have been treated more appropriately in an acute care or IPPS hospital. In FY2003, 80% of all LTCH FY2003 admissions came from acute care hospitals. CMS analysis of FY2004 LTCH claims data indicates that approximately 37% of LTCH discharges are paid as SSOs. Although this represents a decline from 48.4% found at the outset of the LTCH PPS, the current percentage is seen as inappropriately high. Also, the current payment adjustment for SSO cases is seen as providing a financial incentive to inappropriately admit short-stay patients. Because many of these cases are paid as SSOs, CMS believes that the LTCH patients who still need acute-level care may indicate a premature and inappropriate discharge from the acute care hospital, an inappropriate admission to the LTCH, and a second, unnecessary Medicare payment to the LTCH.¹⁶

Among other changes, in the proposed rule, CMS discussed the use of a different market basket (MB) as part of deciding the rate increase for the following year. This MB is based on FY2002 cost reports from IRFs, psychiatric hospitals, and LTCHs (RPL-MB), and is now used as part of the IRF payment system. Rather than proposing the 3.6% increase in payments currently indicated by the RPL-MB, CMS has recommended a 0% update to the LTCH base rate for RY2007. This recommendation is attributed to certain trends such as recent growth in the number of LTCHs,¹⁷ growth in Medicare payments per discharge relative to costs per discharge,¹⁸ and changes in coding and reported case-mix.¹⁹

¹⁴ (...continued)
classification system.

¹⁵ The regulation affecting the majority of LTCHs is included at 42 Code of Federal Regulation (CFR) 412.529. Generally, most LTCHs are defined by statute as having an ALOS of greater than 25 days as specified by Section 1886(d)(1)(B)(iv)(I) of the Social Security Act (the Act). There is one subclause (II) LTCH, authorized by Section 1886(d)(1)(B)(iv)(II) of the Act, which is subject to different qualification criteria in that it must have first been excluded as an LTCH in calendar year (CY) 1986, have an average inpatient LOS of greater than 20 days, and demonstrate that 80% or more of its annual Medicare inpatient discharges in the 12-month cost-reporting period ending in FY1997 had a principal diagnosis that reflects a finding of neoplastic disease. The subclause II LTCH is treated differently, and receives higher payments for SSO cases during the transition period.

¹⁶ Estimated outlier payments are limited to 8% of total projected LTCH spending. Since the SSO proposal will lower total payments, CMS proposed to increase the outlier threshold from \$10,501 in FY2005 to \$18,489 in RY2006 to limit outlier payments to 8% of total spending.

¹⁷ The number of LTCHs has almost doubled over the past three years, from 200 in FY2003 to 378 in FY2005.

¹⁸ According to CMS, payments to LTCHs increased more than two times as much as the costs
(continued...)

Moreover, according to CMS, Medicare margins were at 8.8% in 2003 (the first year of LTCH-PPS), and increased to a preliminary estimate of 11.7% in FY2004. In the period prior to the implementation of LTCH PPS (from FY1996 through FY2002), Medicare margins ranged from between a minimum of -2.2% in FY2002 to a maximum of 2.9% in FY1997.

In March 2006, for the first time, MedPAC examined the adequacy of LTCH payment rates in order to recommend an update for the upcoming year. MedPAC found that Medicare payments for LTCH services are more than adequate, and recommended that the update to LTCH payment rates be eliminated for 2007.²⁰ The MedPAC conclusion was based on the following factors:

- **Increased access to care** as indirectly established by the 13% annual increase in Medicare beneficiaries who use an LTCH each year from 2001 to 2004;
- **Increased number of LTCHs** as measured by the 9% annual increase in LTCHs from 2001 to 2004²¹;
- **Increased provision of Medicare services** as measured by the 12% annual increase in services from 2001 to 2004 while Medicare spending increased at more than double that rate (25% per year);
- **Mixed evidence on the current quality of LTCH care** as indicated by the decrease in LTCH deaths and acute care hospital readmissions from 2001 to 2004 countered by a worsening of patient safety measures over the same period²²;
- **Adequate access to capital**, as demonstrated by for-profit LTCHs' ability to borrow, and the rapid entry of both for-profit and nonprofit LTCHs into Medicare;
- **Adequate Medicare margins** as indicated by the 9% Medicare margin in 2004 and the projected 7.8% margin for 2006 (which does not include proposed changes in the RY2007 payments).

¹⁸ (...continued)

increased from FY2002 to FY2003. Medicare payments per discharge increased about 17%, while costs increased by only 8% from FY2002 to FY2003, the first year of LTCH PPS.

¹⁹ Using certain assumptions, CMS estimates that 4% of the LTCH payments received from FY2001 to FY2003 could be attributed to improvements to documentation and coding rather than to the increase in patients' severity of illness.

²⁰ MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2006, p. 207.

²¹ During the same years the LTCH HwH increased more than twice as fast (14% per year) as freestanding LTCHs (6% per year).

²² MedPAC looks at certain Agency for Healthcare Research and Quality (AHRQ) patient safety indicators for acute care hospitals, such as the incidence of decubitus ulcers, infection due to medical care, postoperative pulmonary embolism or deep vein thrombosis, and postoperative sepsis to identify potential preventable adverse events that might suggest compromised quality of care. Incidence of three of the four measures increased significantly from 2003 to 2004.