FACTSHEET

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 long hospital stays. This important role is undergoing a transformation as the LTCH field implements a congressional mandate, which significantly reduced payments for half of current LTCH cases. Specifically, in December 2013, Congress passed the Bipartisan Budget Act, which, among other changes, implemented a two-tiered system, under which LTCHs are paid an LTCH-level rate for patients with higher severity of illness levels, and a far lower "site-neutral" rate (comparable to general acute care hospitals) for treating patients with lower-medical acuity.

Given the scope of this major change, LTCHs need to focus their energy and resources on the complex transition to providing two lines of clinical services. The magnitude of this conversion requires relief from other pressures, such as the outdated 25% Rule, and any new regulatory burden. For LTCH referrals that exceed a specified threshold, the 25% Rule reduces the Medicare payment from the LTCH rate to a far lower amount that is equivalent to an inpatient prospective payment system (PPS) payment.

AHA POSITION

Under the Bipartisan Budget Act reforms, one out of two LTCH patients has moved into the new site-neutral category. On average, LTCHs face a 73 percent payment reduction when caring for these patients. Given the magnitude of these LTCH cuts, now is not the time to add further payment penalties or administrative burden to LTCHs. Rather, now is the time for policymakers to pass The Sustaining Healthcare Integrity and Fair Treatment Act of 2016 (H.R. 5713), which would allow LTCHs to focus on managing their transition to site-neutral payment by providing temporary 25% Rule relief for LTCH discharges between Oct. 1, 2016 and June 30, 2017.

WHY?

- **The LTCH site-neutral payment policy, unlike the 25% Rule, categorizes LTCH patients based on their medical acuity, and reduces payment for only those with lower-medical acuity.** Given the extensive impact of the new site-neutral policy, the 25% Rule is no longer necessary and should be withdrawn.
- **The 25% Rule was intended to reduce "inappropriate" admissions to LTCHs;** however, its focus on referral source rather than a patient's clinical status means that the Centers for Medicare & Medicaid Services (CMS) would reduce payments for patients who are medically appropriate for the LTCH setting.
- **Applying the 25% Rule payment cut contradicts the clear LTCH payment methodology mandated by Congress in the Bipartisan Budget Act.** CMS should not unilaterally add the substantial 25% Rule payment cut on top of the congressionally mandated site-neutral cuts.

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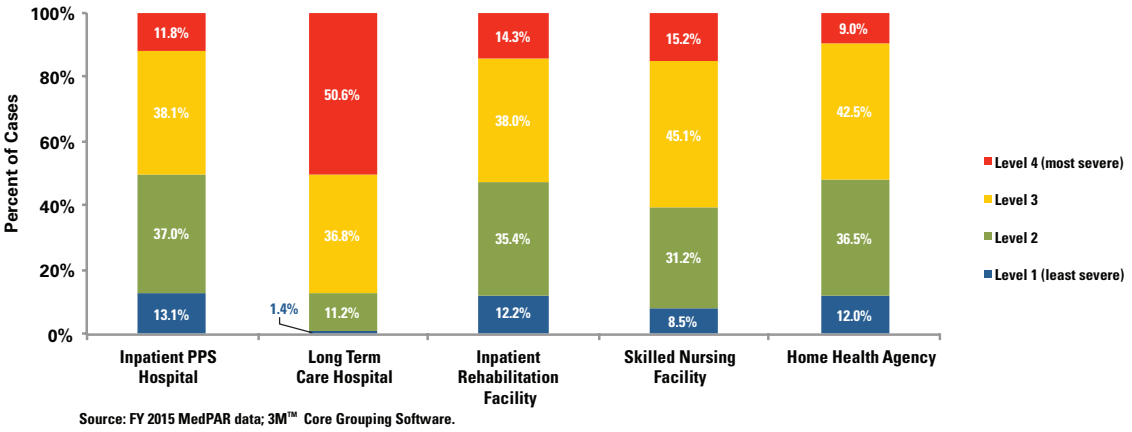
KEY FACTS:

LTCHs treat the most severely Ill patients. The LTCH patient population, overall, is more severely ill than the population treated in general acute care hospitals and other post-acute settings. Data from general acute care hospitals show that LTCHs are far more focused on treating patients with "extreme" medical severity, as indicated in the chart below, with 50.6 percent of their patients having the highest level of severity of illness. Combining the patients in the two highest tiers of severity (levels 3 and 4), shows that almost 9 out of 10 LTCH have "severe" or "major" medical severity. No other hospital or post-acute care setting provides such a concentrated focus on treating the highest acuity patients who, as a result of their medical severity, require long hospital stays. This unique role warrants special consideration from policymakers who want to preserve LTCHs' distinctive role in caring for this severely ill patient population.

Severity of Illness Levels for Different Settings/Discharge Destination



Source: FY 2015 MedPAR data; 3M™ Core Grouping Software.

OTHER LTCH CHALLENGES

LTCHs are undergoing transformational change and challenges. The transition of LTCH operations to a two-tiered payment system for patients treated in LTCHs began in October 2015. The LTCH field is using multiple approaches to adapt to this new and challenging paradigm, including restructuring clinical and staffing protocols and making other operational changes needed to treat two distinct patient populations within one LTCH.

CMS's payment policy underpays site-neutral cases. LTCH site-neutral cases face a significant underpayment due to CMS's current payment methodology. Specifically, CMS is applying duplicative 5.1 percent budget-neutrality adjustments at two points in the process used to calculate site-neutral payments. In a May 2016 letter to CMS, the Medicare Payment Advisory Commission agreed that two such adjustments are redundant and that CMS should eliminate one of the 5.1 percent cuts. In its LTCH fiscal year 2017 final rule, CMS made an appropriate, but modest, improvement to the policy, which recognizes our concern about underpaying these cases. However, the core problem remains and should be fixed by removing the second 5.1 percent payment cut that is being applied to LTCH site-neutral payments.

Quality measurement requirements are growing rapidly. To meet the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, CMS has doubled the number of LTCH quality measures. While we appreciate that these new requirements are intended to foster greater consistency across post-acute care, we are concerned CMS has adopted measures that have not been adequately tested, and do not provide accurate, meaningful data. As a result, many of the measures add administrative burden without adding value.