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. In December 2013, Congress passed the *Bipartisan Budget Act*, which, among other changes, implements several important reforms that will more clearly distinguish the LTCH role. These include a new, two-tiered payment system beginning in October 2015, under which LTCHs will be paid an LTCH-level rate for patients with higher severity of illness levels, and a lower, "site-neutral" rate (comparable to general acute care hospitals) for patients with lower medical acuity.

In addition, the new law addresses the "25% Rule", established by the Centers for Medicare & Medicaid Services to limit referrals from one source, by implementing more manageable "25% Rule" thresholds for cost reporting periods beginning Oct. 1, 2013 through Sept. 30, 2017.

AHA POSITION

The AHA has long supported the development of criteria to distinguish LTCHs from general hospitals and other post-acute settings. The new LTCH criteria in the *Bipartisan Budget Act* will appropriately focus Medicare's LTCH resources on sicker patients. We also support the 25% Rule relief provided under this law, which will implement less burdensome levels of the policy to allow the field to focus on transitioning to the new payment system and to prepare for broader delivery system reforms, such as bundled payments. **Overall, the *Bipartisan Budget Act* will bring much-needed regulatory stability that will ensure access for the beneficiaries who need an extended hospital stay. However, some LTCH policies in the *Bipartisan Budget Act* require targeted technical adjustments to ensure the effective and fair implementation of the law.**

WHY?

- **While the AHA is pleased that Congress addressed this issue, some of the LTCH policies in the *Bipartisan Budget Act* require closer review and consideration for limited technical corrections.** One provision in need of refinement is the definition of the cases that remain eligible for payment under the traditional LTCH prospective payment system (PPS). Under this law, LTCH PPS payments will apply to cases that, in the immediately prior inpatient PPS hospital stay, received either 3+ intensive care unit days of service or were discharged with a principle diagnosis based on 96+ hours of ventilator services. **While these LTCH PPS payment criteria are appropriate, a modest expansion should be considered to include high-acuity patients who do not meet the current criteria.**

Continued on reverse

1/13/14

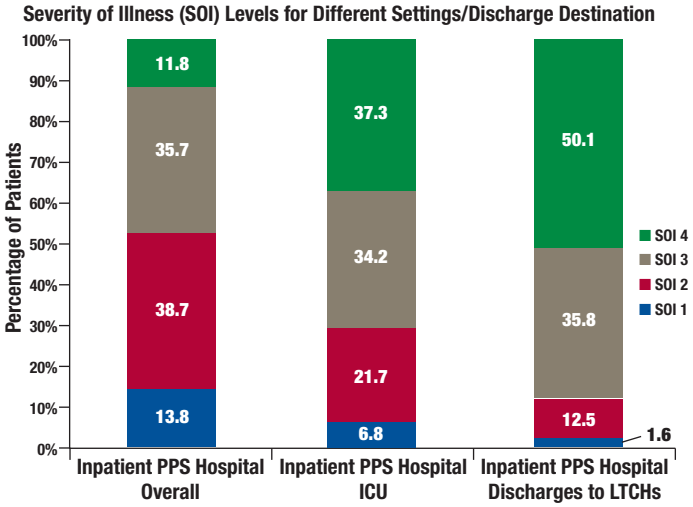
- The *Bipartisan Budget Act* provision placing a cap on the site-neutral cases is also worthy of reconsideration. Under this provision, for cost reporting periods beginning Oct. 1, 2019, any LTCH with 51 percent or greater of its discharges paid a site-neutral rate would be subject to a major penalty – all discharges in future cost reporting periods will be paid the inpatient PPS rate. **However, this could result in an unwarranted penalty for LTCHs serving a low percentage of Medicare beneficiaries. Therefore, the denominator for the formula determining an LTCH's compliance with the discharge cap should be more explicitly defined as "all [fee-for-service] Medicare beneficiaries discharged by the LTCH during the applicable cost reporting period." In addition, Medicare Advantage cases in LTCHs should not be subject to this LTCH requirement since they are typically paid below LTCH PPS rates.**

The AHA will continue to monitor the implementation of the new LTCH PPS criteria and the need for additional technical corrections.

KEY FACTS

LTCHs Treat Severely Ill Patients

The LTCH patient population is more severely ill than patients treated in general acute care hospitals. Data from general acute hospitals show that patients discharged to LTCHs have the highest medical severity when compared to patients in other settings. For example, 50 percent of inpatient PPS patients discharged to an LTCH have a severity of illness (SOI) level 4 (extreme severity) compared to only 37 percent of patients in ICUs. Since LTCH patients are typically far sicker, their average length of stay (ALOS) is much longer: 27.2 days for LTCHs, 5.1 days for general acute hospitals, and 6.7 days for ICUs in general acute hospitals.



Source: Analysis of 2011 MedPAR data.