CHAPTER 10

Long-term care hospital services

RECOMMENDATION

10 For fiscal year 2023, the Secretary should increase the 2022 Medicare base payment rate for long-term care hospitals by the estimate of market basket minus the applicable productivity adjustment.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

CHAPTER 10

Long-term care hospital services

Chapter summary

Long-term care hospitals (LTCHs) provide care to beneficiaries who need hospital-level care for relatively extended periods of time. To qualify as an LTCH, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay of more than 25 days for certain Medicare patients. In 2020, Medicare spent $3.4 billion on care provided in LTCHs; about 71,000 fee-for-service Medicare beneficiaries had about 77,600 LTCH stays.

Medicare pays for care in LTCHs under the LTCH prospective payment system (PPS) for cases that meet the qualifying criteria specified in law (in the Pathway for SGR Reform Act of 2013). LTCH qualifying cases are those with an immediately preceding acute care hospital (ACH) stay who either have 3 or more days in an intensive care unit or coronary care unit or receive mechanical ventilation for at least 96 hours in the LTCH. Under the dual payment-rate system, cases that do not meet Medicare's qualifying criteria may be treated in LTCHs but are paid a lower rate. After a four-year transition period from 2016 through 2019, during which they were paid a blended rate, LTCHs were slated to be paid lower site-neutral rates for cases that did not meet the qualifying criteria starting in 2020. However, site-neutral payments have not yet been fully implemented

In this chapter

because they were temporarily waived during the coronavirus public health emergency (PHE).

In this chapter, we recommend a payment rate update for 2023. While policies in effect during the coronavirus PHE have temporarily delayed the complete transition to site-neutral rates, the extent to which LTCHs shift toward cases that qualify for the standard LTCH PPS rate will ultimately determine the industry's financial performance under Medicare's LTCH PPS. To assess the adequacy of standard payments under the LTCH PPS for cases meeting the LTCH criteria, some analyses in this chapter focus on LTCHs treating a high share (more than 85 percent) of LTCH PPS–qualifying cases, consistent with the goals of the dual payment-rate system.

Because of standard data lags, the most recent complete data we have for most payment adequacy indicators are from 2020. In presenting these data, we discuss the effects of the coronavirus PHE and PHE-related policies on LTCHs and use data from prior years as context for 2020 changes. To the extent that the effects of the PHE are temporary or vary significantly across LTCHs, they are best addressed through targeted temporary funding policies, such as those that have been enacted, rather than a permanent change to all LTCHs' payment rates in 2023 and future years.

Assessment of payment adequacy

Beneficiaries' access to care—We consider the capacity and supply of LTCH providers and changes over time in the volume of services they furnish. We expect and have seen reductions in these metrics since the implementation of the dual payment-rate system that began to be phased in with cost reporting periods starting in fiscal year 2016.

- ***Capacity and supply of providers—***The number of LTCHs began to decrease in 2013, but the decline has been more rapid since the implementation of the dual payment-rate system. Between 2019 and 2020, the decline in the supply of LTCHs slowed compared with the prior three years. Average LTCH occupancy in 2020 was 65 percent, which was similar to the 2019 occupancy rate.
- ***Volume of services—***Before the pandemic, LTCH volume had been falling during the transition to site-neutral rates for nonqualifying cases. From 2016 through 2019, after controlling for the number of Medicare fee-for-service beneficiaries, total LTCH case volume fell about 10 percent annually, compared with a 12.4 percent decline in case volume in 2020.

Cases meeting the LTCH qualifying criteria had also declined prepandemic, but less than cases overall. Between 2016 and 2019, qualifying cases per beneficiary fell about 2 percent annually, compared with an 11 percent decline in 2020.

- ***Medicare marginal profit—***Medicare marginal profit, an indicator of whether LTCHs with excess capacity have an incentive to admit Medicare patients, averaged about 18 percent across LTCHs in 2020. For LTCHs with a high share of qualifying cases, marginal profit was 20 percent in 2020, an increase over 2019 reflecting temporary PHE-related policies that raised Medicare payments.

Quality of care—Aggregate risk-adjusted rates of successful discharge to the community declined, and rates of all-condition hospitalizations within a stay remained unchanged during the dual payment-rate phase-in period (2016 through 2019). In 2020, the risk-adjusted rate of hospitalizations was higher (6.1 percent) than in prior years, as was the rate of successful discharge to the community (23 percent). Given the effects of the pandemic, we do not draw conclusions about whether the changes reflect the adequacy of Medicare's payments.

Providers' access to capital—The pending implementation of site-neutral rates for nonqualifying cases starting in 2020 coupled with payment reductions to annual updates required by statute have limited opportunities for growth and reduced the industry's need for capital to expand. In 2020, temporary payment policies to create additional inpatient capacity during the coronavirus PHE raised payments for nonqualifying LTCH cases. In addition, the Coronavirus Aid, Relief, and Economic Security (CARES) Act, enacted in March 2020, gave LTCHs access to relief funds and temporary suspension of the sequester. In 2020, the all-payer LTCH margin with relief funds included was 4 percent; all else equal, the margin was 2.7 percent excluding relief funds.

Medicare payments and providers' costs—Annual Medicare aggregate margins for all LTCHs have been variable and negative during the phase-in of the dual payment-rate system because providers' costs grew more than Medicare payments between 2016 and 2019. LTCHs with a high share of qualifying cases in 2019 had a Medicare aggregate margin of 2.9 percent. Fueled by the suspension of the 2 percent sequestration reduction and temporary waivers of site-neutral payments and other LTCH payment criteria, Medicare aggregate margins in 2020 increased to 6.9 percent. While the waiver of some site-neutral payment rules has delayed full implementation of the dual payment-

rate system, we expect continued changes in admission patterns when site-neutral rates resume for cases that do not meet the LTCH PPS criteria. We project that LTCHs' Medicare aggregate margin for facilities with more than 85 percent of Medicare discharges meeting the LTCH PPS criteria will be 3 percent in 2022.

How should Medicare payment rates change in 2023?

Based on payment adequacy indicators and in the context of ongoing changes to payment policy, the Commission's recommendation for fiscal year 2023 would increase the 2022 Medicare base payment rate for LTCHs by the market basket minus the applicable productivity adjustment. This update supports LTCHs in their provision of safe and effective care for Medicare beneficiaries meeting the LTCH PPS criteria for payment at the standard LTCH PPS rate. ■

Background

While most chronically critically ill (CCI) patients—those with profound debilitation of multiple systems, frequently with ongoing respiratory failure—are treated in acute care hospitals, some are treated in long-term care hospitals (LTCHs). To qualify as an LTCH for Medicare payment, a facility, which can be freestanding or colocated with another hospital, must meet Medicare's conditions of participation for short-term acute care hospitals (ACHs) and have an average length of stay of more than 25 days for certain Medicare patients.[1] LTCHs are located in primarily urban areas and are not distributed uniformly across the country.

As in 2019, in 2020, less than 1 percent of fee-for-service (FFS) Medicare ACH stays were discharged to LTCHs. About 71,000 FFS Medicare beneficiaries had about 77,600 LTCH stays.[2] FFS Medicare beneficiaries accounted for 51 percent of LTCHs' discharges covered by any payer and had an average Medicare length of stay of 27.6 days, up from 26.8 days in 2019. In 2020, Medicare program payments to LTCHs, exclusive of beneficiary cost sharing, were about $3.4 billion (Office of the Actuary 2021).

Medicare's prospective payment system for LTCHs

Under Medicare's LTCH prospective payment system (PPS), payments for discharges are adjusted for differences in expected resource use due to patient differences using the Medicare severity long-term care diagnosis related group (MS–LTC–DRG) patient classification system.[3] MS–LTC–DRGs classify patients primarily according to diagnoses and procedures using the same groupings used in ACHs paid under the inpatient PPS (IPPS), but the MS–LTC–DRG relative weights are specific to LTCH qualifying cases. The LTCH PPS makes high-cost outlier payments for cases that are extraordinarily costly and makes lower short-stay outlier payments for cases with shorter-than-average lengths of stay.[4]

Site-neutral payments for nonqualifying cases in LTCHs were phased in over four years, but full implementation was temporarily waived due to the public health emergency

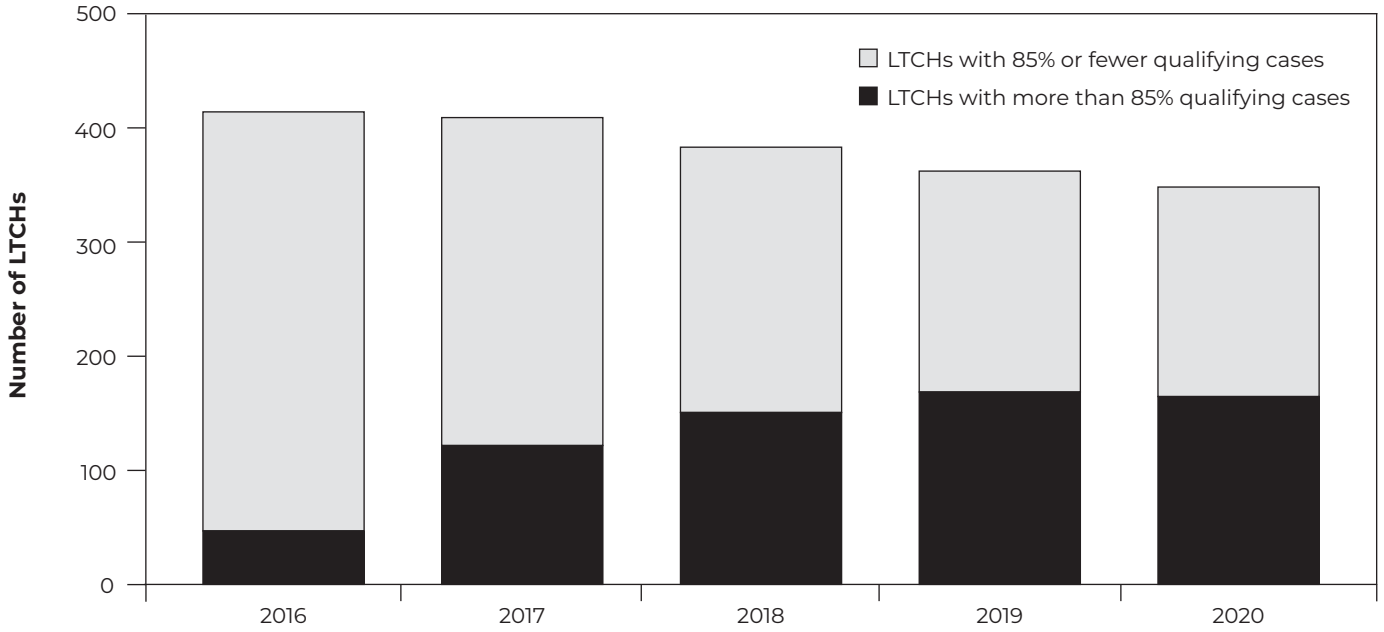
LTCHs were statutorily created as a category of Medicare providers in the early 1980s to exempt 40 chronic disease hospitals from Medicare's IPPS for ACHs (Einav et al. 2021). By 2014, the sector had expanded to more than 400 LTCHs. The Pathway for SGR Reform Act of 2013 established a dual payment-rate system for LTCHs, which mandated that the higher standard LTCH PPS rate be paid only for cases that had an ACH stay immediately preceding LTCH admission and for which either the ACH stay included at least 3 days in an intensive care unit (ICU) or the case received prolonged mechanical ventilation in the LTCH, defined as at least 96 hours. LTCH PPS–qualifying cases are referred to as "cases meeting the LTCH PPS criteria" or "qualifying cases." When an LTCH treats a beneficiary whose case does not meet the LTCH PPS criteria (referred to as a "nonqualifying case"), it is paid a site-neutral rate, which is the lower of an amount based on Medicare's IPPS payments or 100 percent of the costs of the case.[5]

Site-neutral payments for cases in LTCHs were phased in between 2016 and 2019. During this period, for cases that did not meet the criteria specified above, LTCHs received a transitional blended payment of 50 percent of the standard LTCH PPS rate paid for qualifying cases and 50 percent of the lower site-neutral rate. Full site-neutral rates were to have been paid for nonqualifying cases starting the month a facility's cost reporting year began in fiscal year 2020. However, the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 temporarily waived certain provisions relating to site-neutral payments during the coronavirus public health emergency (PHE) to allow for expansion of inpatient capacity (Centers for Medicare & Medicaid Services 2020a). Effective for claims with an admission date on or after January 27, 2020, and continuing through the duration of the PHE, all cases admitted are paid the LTCH PPS standard federal rate and are counted as discharges paid the LTCH PPS rate for purposes of calculating an LTCH's discharge payment percentage.[6] Under current law, site-neutral rates will resume after the PHE. CMS also waived the 25-day average length-of-stay requirement to participate in the LTCH PPS when an LTCH admits or discharges patients to meet PHE-driven demands. This requirement will resume with a hospital's first cost reporting period that does not include the PHE waiver period.[7]

Because this chapter is concerned with the adequacy of Medicare's payments under the LTCH PPS, we restrict some analyses to LTCHs that had more than 85 percent of their Medicare cases meet the criteria for the LTCH

FIGURE 10–1

Growth in the number and share of LTCHs with more than 85 percent of Medicare cases meeting the LTCH PPS criteria stalled in 2020



Note: LTCH (long-term care hospital), PPS (prospective payment system). "Medicare cases meeting the LTCH PPS criteria" refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH prospective payment system.

Source: MedPAC analysis of the LTCH Final Rule Impact files for fiscal years 2018 through 2022.

PPS rate, which we also refer to as "qualifying cases."[8] Rates for cases that do not meet the LTCH PPS criteria are paid based on IPPS rates. Between 2016 and 2019, the number and share of all LTCHs with more than 85 percent of qualifying cases increased each year (Figure 10-1). In 2016, about 11 percent of LTCHs met this threshold, compared with more than 47 percent in 2019. In 2020, growth in the size of this cohort stalled, remaining at 47 percent of LTCHs. These facilities treated 47 percent of all Medicare FFS cases and 56 percent of qualifying Medicare FFS cases; in aggregate, 92 percent of the FFS Medicare cases in these facilities were qualifying cases.

Each year, based on the most recent year of data, we define the cohort of LTCHs with more than 85 percent of Medicare cases meeting the criteria for the LTCH PPS rate. While LTCHs can move in and out of this group from year to year, we found that LTCHs that achieve a high share of qualifying cases are likely to remain in this cohort the following year. We also found that 44 percent of LTCHs that billed Medicare each year from 2016 through 2020 did not reach the 85 percent proportion of qualifying cases in any year, though collectively their number and share of site-neutral cases declined over the period. Just under half of these LTCHs are in Texas or Louisiana.

Profile of Medicare LTCH users

As in prior years, FFS Medicare beneficiaries who used LTCHs in 2020 were disproportionately dually eligible for Medicare and Medicaid compared with the overall population of FFS Medicare beneficiaries. Dual-eligible beneficiaries accounted for about 17 percent of all beneficiaries but represented about 43 percent of Medicare LTCH users, 44 percent of LTCH cases, and 43 percent of LTCH qualifying cases (Medicare Payment Advisory Commission 2021a).

TABLE 10–1

About 30 percent of qualifying LTCH cases die during their LTCH stay or within 30 days of discharge

		2015	2016	2017	2018	2019	2020
Death in LTCH	Nonqualifying cases	8%	7%	6%	6%	6%	8%
	Qualifying cases	17	16	16	16	16	17
Death within 30 days of discharge	Nonqualifying cases	9	9	9	9	9	10
	Qualifying cases	13	13	13	13	13	14

Note: LTCH (long-term care hospital). "Qualifying cases" refers to Medicare stays that meet the criteria specified in the Pathway for SGR Reform Act of 2013 to qualify for payment under the LTCH prospective payment system. "Nonqualifying cases" refers to Medicare stays that do not meet the criteria specified in the Pathway for SGR Reform Act of 2013. The share of qualifying cases is defined as having that specified share of cases in the reported year (e.g., 2018 rates are for providers with the designated share of cases in 2018); therefore, the providers in those groups can vary from year to year. Mortality rates in this table are unadjusted for patient characteristics, so changes in patient severity can affect rates each year.

Source: MedPAC analysis of Medicare Provider Analysis and Review and enrollment data from CMS.

LTCH users are also disproportionately male, under age 65, diagnosed with end-stage renal disease, and Black compared with the overall population of FFS Medicare beneficiaries. Higher rates of LTCH use by Black beneficiaries could be due to the concentration of LTCHs in areas of the country with larger Black populations (Dalton et al. 2012, Kahn et al. 2010). Another contributing factor may be a greater incidence of critical illness in this population (Mayr et al. 2010) and a greater likelihood to opt for LTCH care, since Black beneficiaries are less likely than White beneficiaries to elect hospice care (Medicare Payment Advisory Commission 2021b).

LTCH users' complex critical illnesses are reflected in their unadjusted mortality rates, as shown in Table 10-1. In 2020, about 17 percent of qualifying cases died during an LTCH stay and 14 percent died within 30 days of discharge. Among qualifying cases, unadjusted mortality rates varied based on which qualifying criteria the case met. Among cases that received mechanical ventilation services in the LTCH for 96 hours, 26 percent died during their LTCH stay in 2020, compared with 14 percent for those qualifying solely because of a stay of 3 or more days in an ICU (data not shown). These differences between the two groups are consistent with data in 2019.

Are Medicare payments adequate in 2022?

To address whether LTCH PPS payments for 2022 are adequate to cover the costs that LTCHs incur in furnishing services to Medicare beneficiaries, we examine metrics of beneficiaries' access to care, including the capacity and supply of LTCH providers, changes over time in the volume of services furnished, and providers' willingness to admit Medicare beneficiaries; quality of care; providers' access to capital; and Medicare payments and providers' costs for LTCH PPS–qualifying cases. During the transition to the dual payment-rate system, our payment adequacy analysis for LTCHs considered the anticipated effects of this policy on our payment adequacy metrics.

Beneficiaries' access to care: Expected reductions in supply and volume continue, without affecting access to care

As Medicare phased in the dual payment-rate system, reductions in the overall supply of LTCHs and the volume of services they furnish were expected as facilities adapted to the new payment incentives to treat higher-acuity cases that qualify for the standard LTCH PPS rate. Total volume and volume per capita

The coronavirus public health emergency, the Commission's payment adequacy framework, and analysis of LTCHs' payment adequacy in 2020

On January 31, 2020, the Secretary of Health and Human Services first declared the coronavirus public health emergency (PHE). In March 2020, the first wave of COVID-19 cases hit the U.S. (For details on the effects of COVID-19 on beneficiaries' health and access to care, see Chapter 1.) Among its many responses to the unfolding national crisis, the Congress created multiple funding streams for health care providers, including suspension of the 2 percent sequestration payment adjustment applied to all Medicare fee-for-service (FFS) claims and creation of the Provider Relief Fund (PRF), which furnished qualified providers with payments for health care expenses or lost revenue due to the pandemic. In addition to funding, the Congress and CMS altered Medicare payments and policies and granted regulatory flexibilities starting in March 2020 (Podulka and Blum 2020).

As a result of the coronavirus pandemic and policy responses to the PHE, changes in our payment adequacy indicators in 2020 reflect temporary changes during the PHE far more than changes in the overall adequacy of Medicare payments to long-term care hospitals (LTCHs). (For a description of how the pandemic has been incorporated into our payment adequacy framework, see Chapter 2.) Because of standard data lags, the most recent complete data we have are from 2020 for most payment adequacy indicators. In brief, the effects of the PHE on indicators of Medicare's payment adequacy to LTCHs include:

- dramatic drops in inpatient hospital volume in spring 2020 that affected the number of referrals to post-acute care providers, including LTCHs;
- increases in all-payer margins driven by federal relief funding;
- increases in Medicare payments for site-neutral cases due to the waiver of certain LTCH payment policies; and
- increases in Medicare payments due to temporary suspension of the 2 percent sequestration payment adjustment.

In this chapter, we use available data and changes in payment policy to project LTCH margins for 2022 and recommend payment rate updates for 2023; however, uncertainty remains about the extent to which the pandemic and related payment flexibilities will last and whether changes to hospital volume, LTCH volume, and financial performance will persist past the PHE. Therefore, while analyzing 2020 data is an important part of understanding what happened to beneficiaries' access to care, quality of care, providers' access to capital, and Medicare's payments and providers' costs, it is more difficult to interpret these indicators than is typically the case. For many of the metrics in this chapter, we present data from 2020 as well as prepandemic historical trends for context.

As the Commission stated last year, temporary effects of the coronavirus pandemic or effects that vary significantly across providers are best addressed through targeted temporary funding policies rather than a permanent change to all providers' payment rates in 2023 and future years.

Timing of 2020 claims, cost reports, and coronavirus public health emergency–related policies

This year we analyzed 2020 claims and provider cost reports that reflect the impact of the pandemic, as well as the complex interactions of PHE-related funding and policy changes.

Claims data from 2020

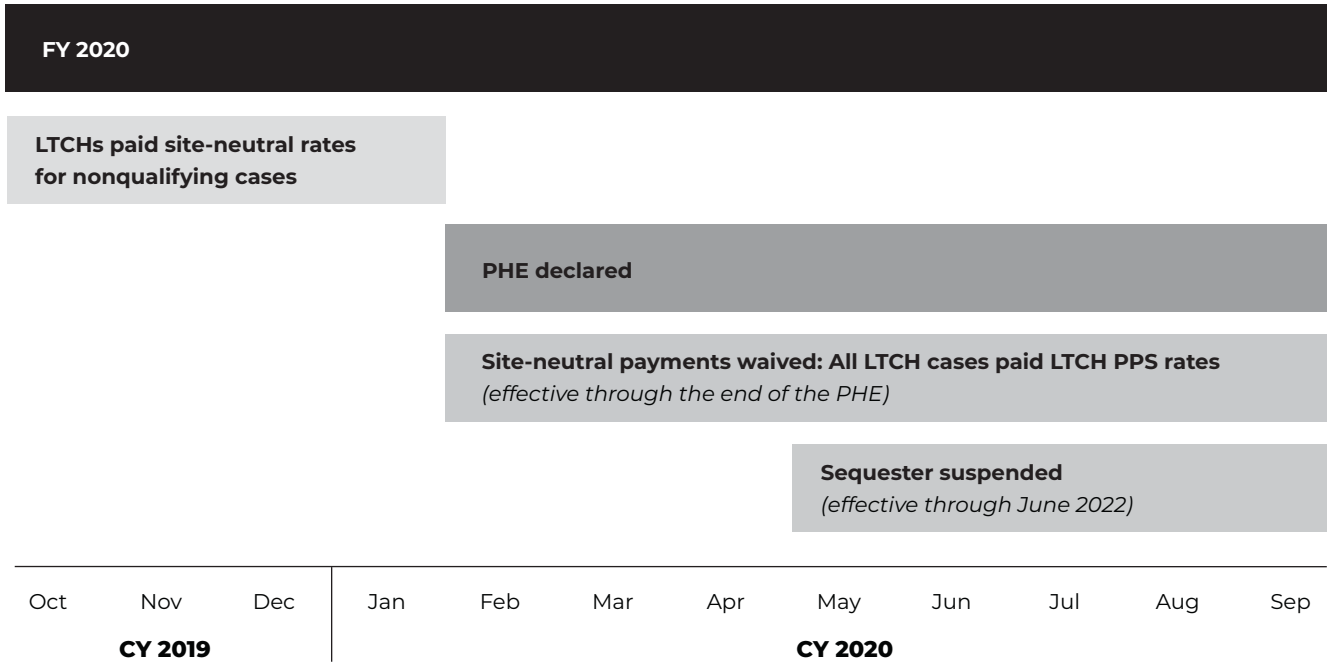
It is instructive to understand the timing of the PHE and PHE-related policy changes that are reflected in fiscal year 2020 claims data (Figure 10-2). For sectors whose payment years begin with the federal fiscal year (which includes LTCHs), the first four months of the 2020 payment year occurred before the PHE

(*continued next page*)

The coronavirus public health emergency, the Commission's payment adequacy framework, and analysis of LTCHs' payment adequacy in 2020 (cont.)

FIGURE 10–2

Fiscal year 2020 time line



Note: FY (fiscal year), LTCH (long-term care hospital), PHE (public health emergency), PPS (prospective payment system), CY (calendar year). The CARES Act suspended the 2 percent sequestration reduction to payments from May 1, 2020, through December 31, 2020. The Consolidated Appropriations Act, 2021, suspended it through December 31, 2021. The Protecting Medicare and American Farmers from Sequester Cuts Act suspended the 2 percent reduction from January through March 2022 and applies a 1 percent reduction from April through June 2022.

was declared, on January 27, 2020. After four years of being paid blended rates, LTCHs were then to be paid full site-neutral rates for nonqualifying LTCH cases in fiscal year 2020, beginning in the first month of their cost reporting year. Because the temporary PHE-related policy to waive site-neutral payments and pay the LTCH standard federal prospective payment system (PPS) rates for all cases went into effect starting January 27, 2020, providers with cost reporting years that started in October through January received site-neutral rates for nonqualifying cases before the waiver. The suspension of the sequester, which is set to expire under current law in June 2022, was in effect starting in May 2020.[9]

Cost report data from 2020

For providers, including LTCHs, that submit cost reports to CMS, we estimate total Medicare-allowable costs and assess the relationship between Medicare's payments and those costs, which we express as a payment margin. Within each sector, 2020 cost reports included in this year's analysis of Medicare margins reflect varying numbers of months overlapping the PHE because providers' cost reports can start on different months of the

(continued next page)

The coronavirus public health emergency, the Commission's payment adequacy framework, and analysis of LTCHs' payment adequacy in 2020 (cont.)

year; the Commission defines 2020 cost reports as those with a midpoint falling in fiscal year 2020. Medicare payments to providers with cost reporting periods overlapping the PHE include temporary add-on payments and suspension of the sequester; providers' reported costs reflect PHE-related costs (e.g., personal protective equipment, supplies, labor). Providers received billions of dollars in additional grants that are not reflected in claims or Medicare payments on cost reports, so they are not reflected in Medicare margins. All providers must report relief fund payments on their cost report's statement of revenues for informational purposes.

Almost 40 percent of LTCHs in this year's analysis of cost reports have cost reporting years that begin on September 1, but the remainder start at different months throughout the year. In aggregate, providers included in the analysis of LTCHs' 2020 cost reports had approximately 60 percent of the months in their cost reporting year in the PHE period—February 2020 through December 2020. Similarly, we estimate that providers included in the analysis of LTCHs' 2020 cost reports had approximately one-third of the months in their cost reporting year in the period following the suspension of the sequester starting in May 2020. These shares of months overlapping the PHE and in the period following the sequester waiver are similar for LTCHs with high shares of qualifying cases in 2020. Given the variation in cost reporting years and the duration of the PHE, we expect data in future years to reflect effects of the PHE and related policies. ■

fell in 2020, but 2020 monthly volume compared with 2019 showed bigger declines before the PHE, likely due to changes in admission patterns in response to rolling implementation of site-neutral payments for nonqualifying cases.

Capacity and supply of providers: Decrease in number of LTCHs began in 2013 and continued through 2020

Before the passage of the dual payment-rate system in the Pathway for SGR Reform Act of 2013, lawmakers implemented policies over time to constrain growth in the supply of LTCHs because of concerns about the growth in and appropriate use of costly LTCH-level care. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and subsequent legislation imposed a limited moratorium on new LTCHs and new beds in existing LTCHs from December 2007 through December 2012. During that time, new LTCHs were able to enter the Medicare program only if they met exceptions to the moratorium.[10] The Pathway for SGR Reform Act of 2013 and subsequent legislation implemented a new moratorium from April 1, 2014, through September 30, 2017.[11]

During the phase-in of the dual payment-rate system between 2016 and 2019, the number of LTCHs paid under the LTCH PPS fell by an average of 4.2 percent per year, as shown in Table 10-2. Between 2019 and 2020, the number of LTCHs paid under the LTCH PPS fell 3.6 percent.

Between fiscal year 2017 and 2021, 83 LTCHs have closed, representing about 19 percent of facilities and 16 percent of beds. The closures occurred primarily in market areas with multiple LTCHs. From October 2015 through 2020, almost 80 percent of the MedPAC areas with an LTCH closure had at least one other LTCH.[12] In the remaining areas, the closest LTCH was within about two driving hours of the LTCH that closed. The geographic distribution of active LTCHs and LTCHs that closed between 2017 and 2021 is shown in Figure 10-3 (p. 344).

TABLE 10–2

The number of LTCHs fell in 2020, but not as much as the decline during the dual payment-rate system transition period (2016–2019)

Type of LTCH	2019	2020	Average annual change 2016–2019	Change 2019–2020
LTCHs paid under the LTCH PPS	361	348	–4.2%	–3.6%
LTCHs with valid cost reports*	351	325	–4.8	–7.4
Nonprofit	61	52	–4.9	–14.8
For profit	271	258	–5.4	–4.8
Government	19	15	5.9	–21.1

Note: LTCH (long-term care hospital), PPS (prospective payment system). The Medicare, Medicaid, and SCHIP Extension Act of 2007 and subsequent legislation imposed a moratorium on new LTCHs and new LTCH beds in existing facilities from December 29, 2007, through December 29, 2012. The Pathway for SGR Reform Act of 2013 and subsequent legislation implemented a new moratorium from April 1, 2014, through September 30, 2017.
*LTCHs with valid cost reports as of August 31, 2021.

Source: Data for LTCHs paid under the LTCH PPS are from the Provider of Services (POS) file, based on the applicable fiscal year. Data for LTCHs with valid cost reports are from the Commission's analysis of cost report data in the applicable fiscal year. The counts in the POS and the counts with valid cost reports differ due to the timing of the files and applicable data trims to the cost report files. In addition, the decline in the number of LTCHs with valid cost reports between 2019 and 2020 reflects delays in reporting. The October 31, 2021, cut of the cost reports contained valid data for 11 additional providers; inclusion of these additional cost reports did not materially affect the calculation of payments, costs, or margins that we report using the August 31, 2021, cost reports.

In 2018 and 2019, average occupancy was 63 percent for all LTCHs. LTCHs that had more than 85 percent of their Medicare cases meet the LTCH PPS criteria ("qualifying cases") had a higher aggregate occupancy rate (67 percent) than all LTCHs. Aggregate occupancy rates for providers included in our 2020 cost report analysis were similar to the rates in 2018 and 2019. Recent occupancy levels, combined with declining volume of cases paid the site-neutral rate, suggest that remaining LTCHs have capacity to treat additional LTCH qualifying cases. Further, many patients treated in LTCHs can be treated in other settings.

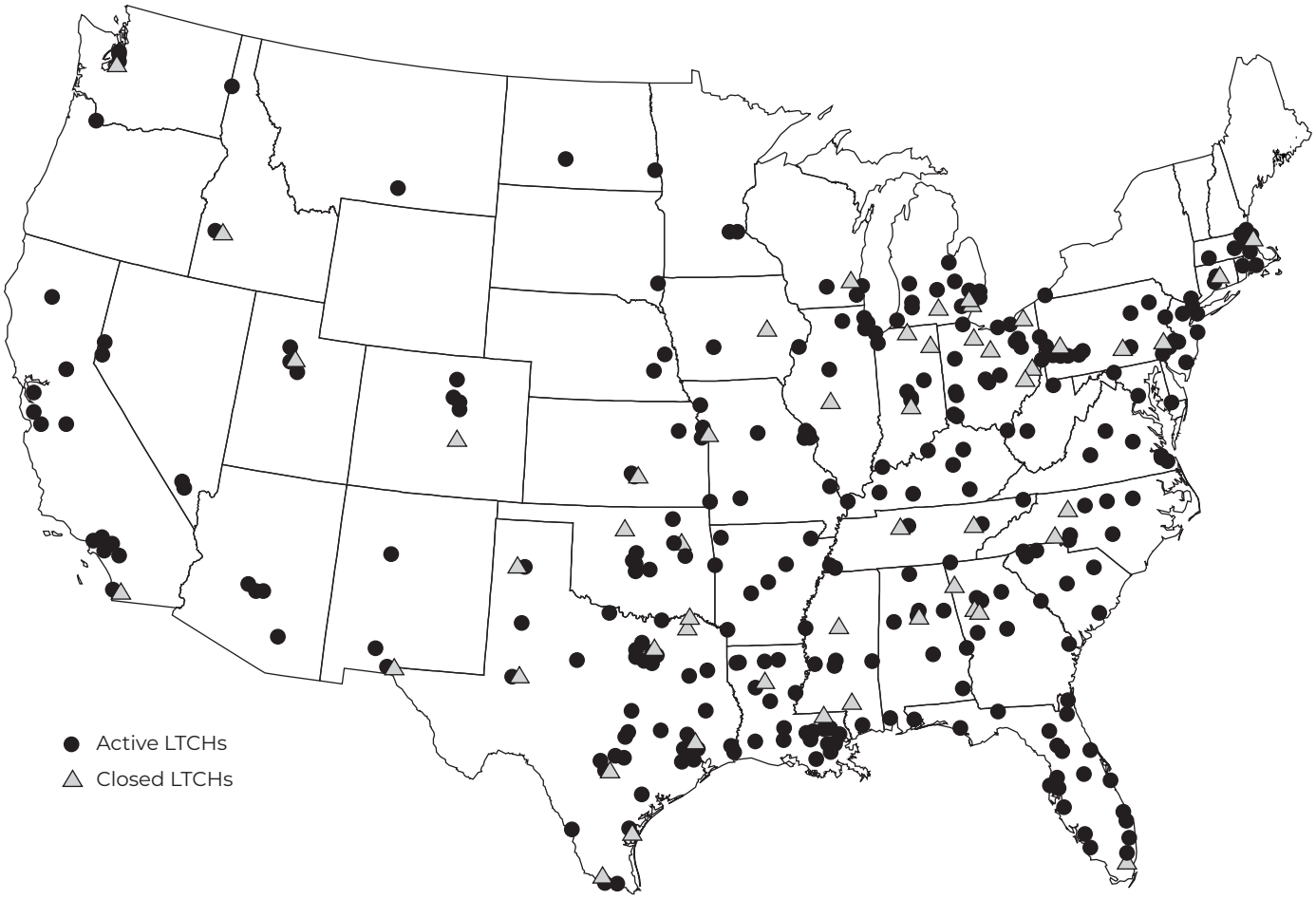
Volume of services: LTCH volume had been falling before the PHE during the dual payment-rate system transition period

In 2020, the volume of all LTCH cases fell nearly 15 percent, while the volume of LTCH-qualifying cases fell 13.4 percent. This reduction is due, in part, to the overall reduction in upstream acute care volume during the pandemic, but the volume of LTCH cases has been falling steadily since the start of the dual payment-rate system, before the PHE (Table 10-3, p. 345). From 2016 to 2019, total LTCH cases per 10,000 beneficiaries dropped by about 10 percent annually, largely due to the decline in nonqualifying cases. Controlling for the number of FFS beneficiaries, qualifying cases fell by an average of just 2 percent per year over the same period.

In 2020, the share of qualifying LTCH cases was about 76 percent, similar to the share in 2019 (Table 10-3, p. 345).[13] Before 2020, LTCH qualifying cases as a share of total cases had been increasing each year of the transition to the dual payment-rate system because the reduction in the number of site-neutral cases was greater than the reduction in the number of LTCH qualifying cases. Between 2019 and 2020, the decline in site-neutral ("nonqualifying") cases per beneficiary was smaller than in the pre-PHE dual payment-rate system transition period, while the decline in qualifying cases per beneficiary was larger. Due to temporary PHE-related payment changes to allow for greater flexibility and expanded hospital capacity, the average payment per case for nonqualifying cases between 2019 and 2020 increased 26 percent.

FIGURE 10–3

Active and closed long-term care hospitals, 2017–2021



Note: LTCH (long-term care hospital). Map does not show Alaska and Hawaii, which each had one active LTCH and no closed LTCHs. "Active LTCHs" were continuously open between 2017 and 2021; "closed LTCHs" closed between 2017 and 2021.

Source: MedPAC analysis of cost report data from CMS.

In fiscal year 2020, before the implementation of temporary PHE-related policy changes for LTCHs, providers began receiving site-neutral rates (rather than the transitional blended rates) for nonqualifying cases starting the month that a facility's cost reporting year began. While the PHE likely contributed to volume reductions in 2020, the biggest monthly LTCH case volume differences between 2019 and 2020 occurred in December, January, and February, *before* the first major wave of COVID-19 cases in March 2020 (Figure 10-4, p. 346). Although the PHE-related LTCH payment waivers were in effect for claims with an admission date on or after January 27, 2020, they were not passed until March 2020 and were then applied retroactively. Before the passage of these temporary waivers, providers had incentives to reduce the number and share of site-neutral cases. The PHE-related temporary waiver of the site-neutral payments, together with the waivers of requirements for length of stay and discharge payment percentage (the ratio of FFS discharges that qualify for the LTCH PPS rate to the LTCH's total number of Medicare discharges requirements), may

TABLE 10–3

LTCH volume had been falling during the dual payment-rate system transition period largely due to declining volume of nonqualifying cases

	2019	Average annual change 2016–2019	2020	Percent change 2019–2020
Cases				
All	91,147	–10.1%	77,603	–14.9%
Nonqualifying cases	23.160	–24.2	18,702	–19.2
Qualifying cases	67,987	–2.0	58,901	–13.4
Share of qualifying cases	75%	8.6	76%	1.8
Cases per 10,000 FFS beneficiaries				
All	23.8	–10.1	20.9	–12.4
Nonqualifying cases	6.1	–24.2	5.0	–16.9
Qualifying cases	17.8	–2.0	15.8	–10.9
Payment per case				
All	$41,448	0.6	$45,634	10.1
Nonqualifying cases	$25,738	–8.0	$32,401	25.9
Qualifying cases	$46,800	0.4	$49,835	6.5
Average length of stay (in days)				
All	26.8	–0.1	27.6	3.0
Nonqualifying cases	23.3	–2.9	23.8	2.4
Qualifying cases	28.0	0.1	28.8	2.8

Note: LTCH (long-term care hospital), FFS (fee-for-service). "Qualifying cases" refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 to qualify for payment under the LTCH prospective payment system. All counts are for stays covered by FFS Medicare and do not include those in private plans.

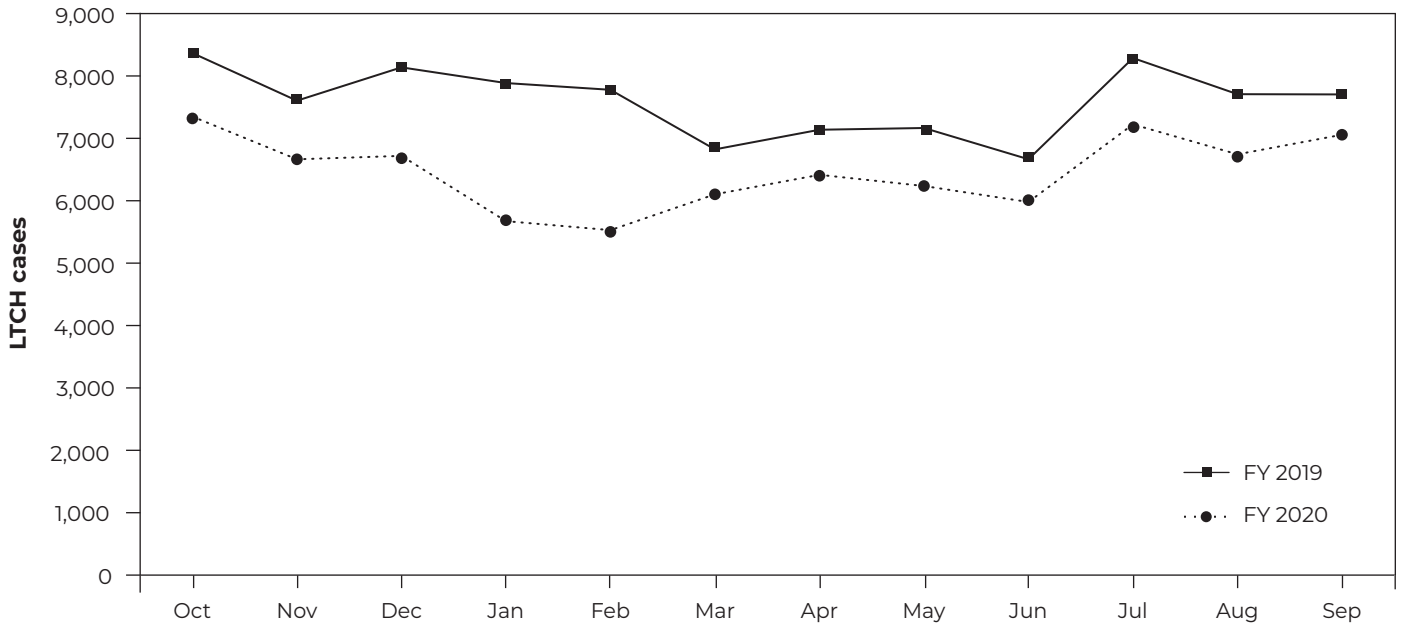
Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS and the 2021 annual report of the Boards of Trustees of the Medicare trust funds.

have contributed to increases in case volume compared with the fiscal year's beginning months, when site-neutral payments started to go into effect. Increased LTCH volume starting in March may reflect LTCHs treating the first wave of COVID-19 cases and providing expanded inpatient capacity in areas where hospitals experienced shortages of staff, space, or supplies during COVID-19 surges. Once additional flexibility is no longer needed and the temporary PHE-related policies expire, we expect that the volume of site-neutral cases will continue to decline, in response to the incentives of the dual payment-rate system.

In 2020, among all LTCHs, the top 20 LTCH diagnoses remained unchanged from 2019 and made up 68 percent of LTCH stays, up from 66 percent of stays in 2019 (data not shown). The most frequently occurring diagnosis was pulmonary edema and respiratory failure (MS–LTC–DRG 189), accounting for 19 percent of stays, compared with 20 percent in 2019. Though still the most common LTCH diagnosis in 2020, the absolute number of MS–LTC–DRG 189 cases was down 19 percent. Diagnoses that included respiratory conditions were 46 percent of LTCH cases, up 3 percentage points from the previous year.[14] Only

FIGURE 10–4

The largest monthly differences in LTCH case volume between fiscal years 2019 and 2020 preceded the first wave of COVID-19 cases and temporary PHE-related LTCH payment policy changes in March 2020



Note: LTCH (long-term care hospital), PHE (public health emergency), FY (fiscal year). Data include stays covered by FFS Medicare only, not stays covered by private plans.

Source: MedPAC analysis of Medicare Provider Analysis and Review data for fiscal years 2019 and 2020.

one DRG in the top 20—respiratory infections and inflammations with MCC (MS–LTC–DRG 177)—rose in number of cases from 2019.

Among LTCHs with high shares of qualifying cases in 2020, stays were even more concentrated among a small number of diagnosis groups, as they had been in prior years.[15] The top 20 diagnoses made up nearly 77 percent of stays for these LTCHs (Table 10-4); 55 percent of cases (less than 1 percentage point higher than in 2019) in these LTCHs involved diagnoses that were respiratory conditions or involved prolonged mechanical ventilation. The absolute number of respiratory cases in LTCHs fell in 2020.

Financial incentives to serve Medicare beneficiaries across LTCHs

Another measure of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are greater than the marginal costs of treating an additional beneficiary, a provider with capacity has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider could have a disincentive to care for Medicare beneficiaries.[16]

In 2020, the average LTCH marginal profit on Medicare cases was about 18 percent, up from 15 percent in 2019. This value is a positive indicator of access because it suggests that LTCHs with available beds continue to have a financial incentive to admit FFS Medicare beneficiaries, provided they are not capacity

TABLE 10–4

The top 20 MS–LTC–DRGs made up nearly 77 percent of FFS Medicare stays at LTCHs with a high share of qualifying cases in 2020

MS–LTC–DRG	Description	Stays	Share of stays
189	Pulmonary edema and respiratory failure	7,847	21.9%
207	Respiratory system diagnosis with ventilator support 96+ hours	7,073	19.8
871	Septicemia without ventilator support 96+ hours with MCC	1,917	5.4
208	Respiratory system diagnosis with ventilator support ≤ 96 hours	1,450	4.1
177	Respiratory infections and inflammations with MCC	1,047	2.9
166	Other respiratory system OR procedures with MCC	886	2.5
4	Tracheostomy with ventilator support 96+ hours or primary diagnosis except face, mouth, and neck without major OR procedure	849	2.4
981	Extensive OR procedure unrelated to principal diagnosis with MCC	800	2.2
949	Aftercare with CC/MCC	731	2.0
682	Renal failure with MCC	693	1.9
291	Heart failure and shock with MCC	492	1.4
592	Skin ulcers with MCC	453	1.3
314	Other circulatory system diagnoses with MCC	440	1.2
862	Postoperative and post-traumatic infections with MCC	435	1.2
870	Septicemia with ventilator support 96+ hours with MCC	433	1.2
919	Complications of treatment with MCC	431	1.2
539	Osteomyelitis with MCC	400	1.1
559	Aftercare, musculoskeletal system and connective tissue with MCC	389	1.1
853	Infectious and parasitic disease with OR procedure with MCC	322	0.9
637	Diabetes with MCC	319	0.9
	Top 20 MS–LTC–DRGs	27,407	76.6

Note: MS–LTC–DRG (Medicare severity long-term care diagnosis related group), FFS (fee-for-service), LTCH (long-term care hospital), MCC (major complication or comorbidity), OR (operating room), CC (complication or comorbidity). MS–LTC–DRGs are the case-mix system for LTCH facilities. Counts are for stays covered by FFS Medicare and do not include those in private plans. "Qualifying stays" refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH prospective payment system.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

constrained. For LTCHs with a high share of Medicare qualifying cases, marginal profit was even higher, at 20 percent, about 3 percentage points higher than in 2019. The higher Medicare marginal profit among these providers suggests that LTCHs with available beds continue to have a financial incentive to increase their occupancy with FFS Medicare beneficiaries who meet the LTCH qualifying criteria.

Prepandemic, risk-adjusted measures show slight decline in quality; quality of care in 2020 is difficult to assess

While we report 2020 results for our quality measures (average risk-adjusted rates of successful discharge to the community and all-condition hospitalizations within a stay), they reflect conditions unique to the PHE that confound our measurement and assessment

TABLE 10–5

Between 2016 and 2019, mean risk-adjusted rates of discharge to the community declined and hospitalizations for LTCHs were flat

	2016	2017	2018	2019	2020
Hospitalization	5.4%	5.3%	5.2%	5.3%	6.1%
Successful discharge to the community	25.4	24.4	22.9	22.1	23.0

Note: LTCH (long-term care hospital). The hospitalization measure captures all unplanned hospital admissions and readmissions and outpatient observation stays that occur during the stay. "Successful discharge to the community" comprises beneficiaries discharged to the community (including those discharged to the same nursing home) who did not have an unplanned hospitalization or die in the 30 days after discharge. Both measures are uniformly defined and risk adjusted across the four post-acute care settings. Providers with least 60 stays in the year (the minimum count to meet a reliability of 0.7) were included in calculating the average facility rate.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

of trends in 2020. Increased mortality related to COVID-19 and capacity constraints at acute care hospitals could affect both measures. In addition, the Commission's quality metrics rely on risk-adjustment models that use performance from previous years to predict beneficiary risk. COVID-19 is a new diagnosis and is not included in the current risk adjustment models, though many associated conditions are. As a result, our models may not adequately adjust for the acuity of patients receiving LTCH care in 2020. Therefore, we report the changes we observed in the quality measures but do not draw conclusions about whether quality improved, worsened, or stayed the same in 2020.

We evaluate quality of care using average risk-adjusted rates of successful discharge to the community and all-condition hospitalizations within a stay. "Successful discharge to the community" comprises beneficiaries discharged to the community (including those discharged to the same nursing home where the beneficiary was before the hospitalization) who did not have an unplanned hospitalization and did not die in the succeeding 30 days. The hospitalization measure captures all unplanned hospitalizations (admissions and readmissions) and outpatient observation stays that occur during the stay (beneficiaries who died during the LTCH stay are excluded from the measure). Discharges to hospice or beneficiaries with the hospice benefit are excluded from the calculation of both measures. Both measures are uniformly defined and risk adjusted across home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and LTCHs—thus taking another step toward achieving a unified payment system and evaluation of outcomes across post-acute care (PAC) settings.[17]

Between 2016 and 2019—before the PHE—average rates of hospitalization were steady (lower rates are better) and average rates of successful discharge to the community from LTCHs fell each year (higher rates are better) (Table 10-5). During the 2016 to 2019 period, patient acuity increased as a greater share of cases met the LTCH qualifying criteria and more facilities treated a greater share of qualifying cases. In 2020, the risk-adjusted rate of hospitalizations was higher (6.1 percent) than in prior years, yet the rate of successful discharge to the community was also higher (23 percent). These cross-PAC measures are risk adjusted, but to the extent that the adjustment does not account for certain patient characteristics, changes in LTCHs' patients could affect the sector's rate of successful discharge. Notwithstanding the PHE, because the risk-adjustment model for these measures pools cases in all four PAC settings, the model may not work as well for evaluating LTCH cases, given their small contribution to the overall combined-PAC case count.

Providers' access to capital: Implementation of LTCH dual payment-rate system slowed investment

Access to capital allows LTCHs to maintain, modernize, and expand their facilities. If LTCHs were unable to access capital, it might reflect problems with the adequacy of Medicare payments. During the transition to the dual payment-rate system, we expected disruption and contraction in the sector as the industry adapted to Medicare's payment rules. During the transition, the industry diversified service lines and shifted portfolios through closures and sales (Kindred Healthcare 2017, Kindred Healthcare 2015, Select Medical 2017, Select Medical 2015).

The LTCH sector is largely for profit and consists of two large chains (Select Medical and Kindred Healthcare), multiple regional chain operators, and independent providers. Because the sector is small, market analysis of the industry is scant. Evidence from the two largest companies providing LTCH services suggests they have had access to capital during the PHE period. Select Medical, the largest LTCH operator, is a publicly traded company. The adjusted EBITDA (earnings before interest, taxes, depreciation, and amortization) margin for the Select Medical's LTCH segment was 16.5 percent for the year ended December 31, 2020, compared with 13.9 percent for the prior year (Select Medical 2021a). For its LTCH business segment in 2020, Select Medical reported increased revenue, patient days, and revenue per patient day compared with 2019. Through the second quarter of 2021, revenue and revenue per patient day were up compared with 2020. The company reported revenue from relief funds and other temporary payments and noted that Medicare's "relaxation of certain admissions restrictions have contributed to volume increases in certain of its hospitals" in 2020 (Select Medical 2021b). Select Medical also acquired multiple LTCHs in 2021 and announced new joint ventures (Muoio 2021b).

Kindred Healthcare, the second largest operator of LTCHs, has attracted investment from private equity since 2018, when it was acquired by Humana and two private equity firms and ceased being publicly traded (Kindred Healthcare 2018). In October 2021, LifePoint Health, which was taken private in 2018 when it was purchased by Apollo Global Management and merged with the private equity firm's RCCH HealthCare Partners, announced its acquisition of Kindred Healthcare (Muoio 2021a). The new 79-hospital company, Scion Health, will include 61 of Kindred's long-term acute care hospitals and 18 of LifePoint's community hospitals (Muoio 2021a).

LTCHs' access to capital largely depends on these hospitals' total (all-payer) profitability, which has been variable but positive in the dual payment-rate phase-in period. During that period (2016 to 2019), the share of Medicare revenue fell from almost 50 percent to about 37 percent of total LTCH revenue, largely due to a reduction in the number of Medicare cases, particularly site-neutral cases. In 2020, Medicare payments constituted 36 percent of total LTCH revenue.

Temporary payment policies related to the coronavirus pandemic have delayed the implementation of fully site-neutral payments and provided LTCHs with higher LTCH PPS payments for nonqualifying LTCH cases. In addition, the CARES Act, passed in March 2020, gave LTCHs access to funds through several mechanisms, including the Provider Relief Fund, Medicare Accelerated and Advance Payments Program, employer payroll tax deferral, Paycheck Protection Program, and elimination of the sequester. (These funding sources were in addition to temporary pandemic-related LTCH payment policy changes.) In 2020, the aggregate all-payer margin was 4 percent with Provider Relief Fund revenue included and 2.7 percent excluding relief funds reported on cost reports, all else equal, indicating that relief funds and PHE-related increases in payment buoyed all-payer LTCH margins to rates above prepandemic levels. In 2018 and 2019, the aggregate all-payer margin was about 2 percent.

Although PHE-related waivers of site-neutral payments have deferred the complete phase-in of such payments, the Commission expects that the industry will continue to contract until after the LTCH dual payment-rate system becomes fully implemented and that LTCHs will adjust their admission patterns and cost structures accordingly. We anticipate that, after the PHE, LTCHs with a higher share of qualifying cases will continue to have stronger financial performance when the dual payment-rate system is fully implemented. In 2020, LTCHs with more than 85 percent of their Medicare cases meeting the LTCH PPS criteria had an aggregate all-payer margin of 6 percent, up from 3.2 percent in 2019.

TABLE 10–6

Pandemic-related payment increases drove growth in LTCH Medicare PPS payments per case between 2019 and 2020

	Average change 2016–2018	Change 2018–2019	Change 2019–2020
Payments per case			
All LTCHs	–1.5%	3.0	9.1%
LTCHs with >85% qualifying cases in 2020	1.7	2.3	8.7
Cost per case			
All LTCHs	1.1	4.5	4.2
LTCHs with >85% qualifying cases in 2020	2.7	3.6	4.9

Note: LTCH (long-term care hospital), PPS (prospective payment system). "LTCHs with >85% qualifying cases" refers to facilities for which more than 85 percent of their Medicare cases qualify for the full LTCH PPS rate. Payments do not include relief funds.

Source: MedPAC analysis of cost report data from CMS.

Medicare's payments for LTCH services exceeded providers' costs in 2020

Driven by temporary PHE-related payment rate increases for site-neutral cases and temporary suspension of the 2 percent sequestration reduction, the aggregate Medicare margin for all LTCHs rose to 3.6 percent in 2020, a 5 percentage point increase from 2019. LTCHs with more than 85 percent of their cases qualifying for the LTCH PPS rate in 2020 had Medicare margins of 6.9 percent (excluding relief funds), compared with 2.9 percent in 2019. These LTCHs were just under half of all facilities and cases in 2020.

Payments per LTCH stay grew faster than costs in 2020

Based on data from 2020 cost reports, payments per stay in all LTCHs increased 9 percent in aggregate to about $46,000 per case (Table 10-6). For LTCHs with high shares (more than 85 percent) of qualifying cases, payments per stay increased almost 9 percent to more than $51,000 per case. The 2020 increase in payments per case reflects the higher payments for LTCH rate–qualifying cases, a net 2.5 percent annual update to the LTCH PPS, and increased case mix. It also reflects temporary payment increases related to the PHE, including suspension of the 2 percent sequestration and increased payments for site-neutral cases in 2020. Retroactive to January 27, 2020, LTCHs were paid LTCH PPS rates for all cases. This waiver of site-neutral payments is in effect until the end of the PHE. Due to varying months that are captured in 2020 cost reports, the number of "waiver months" reflected on providers' cost reports varies, as discussed in the text box (pp. 340–342).

In 2020, reduced case volume, increased acuity, longer stays, and coronavirus pandemic–related costs likely contributed to aggregate growth in costs per case. According to cost report data, between 2019 and 2020, aggregate cost per case for all LTCHs rose 4.2 percent. Before 2020, LTCH cost growth had been variable from year to year. The 2020 increase was higher than average growth between 2016 and 2018 but consistent with growth from 2018 to 2019. While LTCHs experienced pandemic-related cost pressures, they were also uniquely prepared to care for complex, fragile patients with multiple system failures in need of care for respiratory conditions. For LTCHs with high shares (more than 85 percent) of qualifying cases in 2020, cost per case increased 4.9 percent, which was higher than in previous years, during the dual payment-rate system phase-in. For all LTCHs, including those with high shares of qualifying cases, the increase

TABLE 10–7

LTCHs' Medicare aggregate margin had been negative during the phase-in of site-neutral rates for nonqualifying cases but increased in 2020 due to higher Medicare payments

Type of LTCH	Share of LTCHs 2020	Medicare margin 2017	2018	2019	2020
All	100%	–2.2%	–0.5%	–1.6%	3.6%
Nonprofit	16	–13.0	–11.7	–12.2	–12.7
For profit	79	–0.3	1.3	0.4	6.3

Note: LTCH (long-term care hospital). Nonprofit and for-profit rows sum to 95 percent of facilities because margins for government-owned facilities, which account for 5 percent of providers, are not shown. The Medicare margin does not include relief funds.

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

in payments per case because of temporary PHE-related payment increases more than offset the 2020 cost growth (Table 10-6).

Medicare aggregate margins were higher in 2020 than in previous years, fueled by temporary PHE-related payment increases

From 2017 through 2019, Medicare aggregate margins for LTCHs were negative. Overall volume declined as providers transitioned to the dual payment-rate system and received blended site-neutral and LTCH PPS rates for nonqualifying cases. In 2020, Medicare aggregate margins (excluding relief funds) for all LTCHs increased to 3.6 percent (Table 10-7). With reported Provider Relief Fund revenue allocated to Medicare payments, margins were 5 percent (data not shown).[18] Between 2019 and 2020, the difference between nonprofit and for-profit LTCHs' margins widened, owing to higher growth in payments per case among for-profit LTCHs—10.6 percent—compared with just 1.6 percent for nonprofit LTCHs. At least some of this difference was likely an artifact of the differences in cost reporting years among nonprofit and for-profit LTCHs. For-profit LTCHs, in aggregate, had a greater portion of their cost reporting year overlap with the period of temporary PHE-related waiver of site-neutral (rather than full LTCH PPS) payments.

The LTCH Medicare aggregate margins in 2020 reflect LTCH PPS payments for qualifying cases and various payment rates in effect during the year for nonqualifying cases (Table 10-7). However, because this chapter is concerned with how payments for qualifying cases paid under the standard LTCH PPS rate compare with the cost of these cases, we examine margins for LTCHs with a high share (greater than 85 percent) of qualifying cases in the most recent year. Each year, these providers have had consistently higher aggregate margins than the other providers (Table 10-8, p. 352). In 2020, LTCHs with a high share of qualifying cases had Medicare aggregate margins, excluding relief funds, of 6.9 percent, compared with 2.9 percent in 2019. As with the full sample of LTCHs, nonprofit providers had lower margins than for-profit providers among LTCHs with a high share of qualifying cases. As noted in the text box (pp. 340–342), variations in providers' cost reporting years and their overlap with the PHE and related policies affected payments and costs in 2020. Because of the start dates of their cost reporting year, nonprofit LTCHs' margins reflect slightly less overlap with sequester-relief months than do for-profit LTCHs' margins. In addition, for-profit LTCHs had a larger portion of their cost reporting period overlap with the period of temporary PHE-related waiver of site-neutral payments.

TABLE 10–8

Medicare aggregate margins for LTCHs with a high share of LTCH PPS–qualifying cases, 2017–2020

	Medicare margin			
	2017 (N = 117)	2018 (N = 141)	2019 (N = 168)	2020 (N = 152)
All high-share LTCHs	4.6%	4.7%	2.9%	6.9%
Nonprofit	–6.9	–5.6	–6.9	2.3
For profit	6.5	6.2	4.2	7.4

Note: LTCH (long-term care hospital), PPS (prospective payment system). "High-share LTCHs" refers to a cohort of LTCHs defined by their share (over 85 percent) of Medicare stays that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH PPS each year. The Medicare margin does not include relief funds.

Source: MedPAC analysis of Medicare Provider Analysis and Review and cost report data from CMS.

LTCHs with high Medicare margins in 2020 had higher Medicare patient shares, higher occupancy, lower costs per case, and higher payments per case

In prior years, higher costs per stay and lower payments per stay drove differences in financial performance between LTCHs with the lowest (bottom quartile) and highest (top quartile) Medicare margins.[19] High-margin LTCHs had a higher average case mix than low-margin LTCHs, a higher share of Medicare cases meeting the LTCH PPS criteria, and higher occupancy rates. After accounting for differences in case mix and local market input price levels, low-margin LTCHs had higher standardized costs and lower standardized payments per discharge. Outlier payments constituted a larger share of total payments to low-margin LTCHs compared with high-margin LTCHs. When these outlier payments were removed from total payments, the standardized payment per discharge for low-margin LTCHs was lower than for high-margin LTCHs. Differences between the low-margin and high-margin quartile groups in 2020 (Table 10-9) were generally consistent with differences in prior years. However, in 2020, the mean shares of qualifying cases were similar between the two groups. These results are likely confounded by variations in cost reporting years and higher payment rates for site-neutral cases during the PHE.

How should Medicare payments change in 2023?

To determine how Medicare payments to LTCHs should change in 2023, we first project Medicare payments, LTCHs' costs, and Medicare margins for 2022, considering the experience of LTCHs with a high share of cases qualifying for the standard LTCH PPS rates in 2020. Starting with payment and cost information, we consider (1) expected changes to costs of caring for FFS Medicare beneficiaries between 2020 and 2022 and (2) Medicare payment changes in current law in 2021 and 2022 at the time of this writing. Cost growth for LTCHs is estimated to be 2.7 percent in 2021 and 3.0 percent in 2022.[20] The payment changes that affect our projection of the 2022 margin include:

- market basket increase of 2.3 percent for fiscal year 2021, with no productivity adjustment, for a net update of 2.3 percent;
- market basket increase of 2.6 percent for fiscal year 2022, with a productivity adjustment of −0.7 percent, for a net update of 1.9 percent;
- budget-neutrality adjustments for the elimination of the 25 percent rule in 2021;[21]
- budget-neutrality adjustments for changes to the area wage index in 2021 and 2022;[22]

TABLE 10–9

LTCHs in the top quartile of Medicare margins in 2020 had higher occupancy, higher case mix, lower costs, and higher payments per case

Characteristics	High-margin quartile	Low-margin quartile
Mean Medicare margin	19.9%	–21.1%
Mean total stays per facility (all payers)	486	475
Medicare patient share	58%	45%
Occupancy rate	72%	57%
Mean CMI	1.23	1.18
Mean per discharge:		
Standardized costs	$27,430	$39,840
Standard Medicare payment*	$40,835	$38,787
High-cost outlier payments	$3,991	$5,888
Share of:		
Cases meeting the LTCH PPS criteria	70%	69%
LTCHs that are for profit	88	68

Note: LTCH (long-term care hospital), CMI (case-mix index), PPS (prospective payment system). Figures presented include only established LTCHs—those that filed valid cost reports in both 2019 and 2020. High-margin-quartile LTCHs were in the top 25 percent of the distribution of Medicare margins. Low-margin-quartile LTCHs were in the bottom 25 percent of the distribution of Medicare margins. The Medicare margin does not include relief funds. Standardized costs have been adjusted for differences in case mix and area wages. Case-mix indexes have been adjusted for differences in short-stay outliers across facilities. "Cases meeting the LTCH PPS criteria" refers to Medicare stays that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH PPS. Government providers were excluded.
*Excludes outlier payments.

Source: MedPAC analysis of LTCH cost reports and Medicare Provider Analysis and Review data from CMS.

- CARES Act suspension of the 2 percent sequestration reduction to payments from May 1, 2020, through December 31, 2020; extension of the suspension by the Consolidated Appropriations Act, 2021, through December 31, 2021; and further extension in the Protecting Medicare and American Farmers from Sequester Cuts Act (relief from 2 percent reduction from January through March 2022 and 1 percent relief from April through June 2022).

We estimate that, for cases meeting the LTCH PPS criteria, the net result of these changes will be a payment rate increase of about 3.5 percent from 2020 to 2022.

Assuming the payment changes in current law for facilities that achieved this high share of qualifying cases in 2020, we project that the aggregate margin among these providers will decrease to about 3 percent in 2022. Though the full transition to site-neutral payments for nonqualifying cases does not affect payments for cases paid under the LTCH PPS, it does affect the Medicare margins of LTCHs with high shares of qualifying cases because these providers care for a small share of site-neutral cases (about 8 percent of all their cases in aggregate in 2020). Absent coronavirus PHE–related payment policy changes, the phase-in of the dual payment-rate system would have been complete, and all LTCHs would have been paid the site-neutral rate for cases not meeting the

LTCH PPS criteria by 2021. However, as noted above, LTCHs received full LTCH standard federal payments for nonqualifying cases for all fiscal year 2021 and will for at least part of 2022.[23] In our projections for 2022, we assumed that site-neutral payments (set under the IPPS) resumed in January 2022 because, at the time of the analysis, this was when the PHE was set to expire. If the PHE is extended, margins in 2022 will be higher because of temporarily increased payments for nonqualifying cases. To the extent that LTCHs have a greater share of qualifying cases after the PHE ends, we expect their margins to be higher. LTCHs that maintain a low share of qualifying cases will see their payments, set under the IPPS, reduced once site-neutral payments are implemented.

In 2023, the payment update for cases meeting the LTCH PPS criteria is expected to equal the projected LTCH market basket of 2.6 percent, less an adjustment for productivity of 0.6 percent, but that may change by the time CMS determines the final 2023 update. The final update will include August 2022 estimates of 2023 growth in wages and other inputs and thus could be lower or higher than the current projected update, given future projections of input price inflation and productivity.

Based on these indicators, the Commission concludes that a positive payment update is necessary to support LTCHs focused on cases meeting the LTCH PPS criteria and to ensure that Medicare beneficiaries maintain access to safe and effective LTCH care.

RECOMMENDATION 10

For fiscal year 2023, the Secretary should increase the 2022 Medicare base payment rate for long-term care hospitals by the estimate of market basket minus the applicable productivity adjustment.

RATIONALE 10

Our payment adequacy measures for LTCHs are positive, reflect expected changes under the dual payment-rate system, or are consistent with the effects of the coronavirus PHE and related policies. The aggregate Medicare margin for LTCHs with a high share of cases that meet the LTCH PPS criteria for 2020 was positive, indicating that LTCHs can operate under current payment rates. We estimate that the Medicare margin will decline to 3 percent for these facilities in 2022. Projections of LTCHs' margins are sensitive to assumptions about the continuation of PHE-related waivers. PHE policies that extended beyond January 2022 (our assumption based on the PHE expiration at the time of our analysis) could cause margins to be higher because of temporary policies that increased payment for site-neutral cases. Though waived during the PHE, site-neutral payments (set under the IPPS) will resume when the PHE ends, absent any policy changes. In the post-PHE period, we assume market-basket-level cost growth, which is the best estimate available. Because of these factors, a market basket update is appropriate, given the shift in the industry toward higher-acuity patients and the Commission's desire to support LTCHs that have a high share of cases meeting the LTCH PPS criteria while maintaining financial pressure on an industry that historically has been highly responsive to changes in payment policy.

IMPLICATIONS 10

Spending

- In 2023, the payment update for cases meeting the LTCH PPS criteria is expected to equal the projected LTCH market basket less an adjustment for productivity. This recommendation would therefore have no impact on program spending.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on beneficiaries' access to care or providers' willingness or ability to care for Medicare beneficiaries meeting the LTCH PPS criteria for payment at the standard LTCH PPS rate. ■

Endnotes

1 The Medicare, Medicaid, and SCHIP Extension Act of 2007 also requires LTCHs to have a patient review process that screens patients to ensure appropriateness of admission and continued stay, daily physician on-site availability, and interdisciplinary treatment teams of health care professionals. The Pathway for SGR Reform Act of 2013 specifies that, beginning in fiscal year 2020, LTCHs are also required to maintain a discharge payment percentage (DPP)—the ratio of FFS discharges that qualify for the LTCH PPS rate to the LTCH's total number of Medicare discharges—of 50 percent or higher.

2 Throughout this chapter, we use the term "FFS Medicare" to mean traditional Medicare or what CMS calls "Original Medicare."

3 More information on the prospective payment system for LTCHs is available at https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_ltch_final_sec.pdf.

4 High-cost outlier cases are identified by comparing their costs with a threshold that is the MS–LTC–DRG payment for the case plus a fixed loss amount ($26,778 in 2020). Medicare pays 80 percent of the LTCH's costs above the threshold. In fiscal year 2020, high-cost outlier payments were made for about 13 percent of LTCH cases. The prevalence of high-cost outlier cases varied by LTCH ownership. About 13 percent of cases in for-profit LTCHs were high-cost outliers compared with 18 percent of cases in nonprofit LTCHs. LTCHs are paid adjusted PPS rates for patients who have short stays. Short-stay outliers (SSOs) are cases with a length of stay less than or equal to five-sixths of the geometric average length of stay for the MS–LTC–DRG. For SSOs, LTCHs are paid a rate equal to an amount that is a blend of the IPPS-comparable amount for the MS–DRG and 120 percent of the LTCH per diem payment amount up to the full LTCH PPS standard federal payment rate. As the length of stay for the SSO increases, the portion of payment attributable to the LTCH per diem increases.

5 The Bipartisan Budget Act of 2018 specified that the IPPS-comparable amount would be reduced by 4.6 percent per year for fiscal years 2018 through 2026.

6 Section 3711(b)(2) of the CARES Act provides a waiver of the application of the site-neutral payment rate under Section 1886(m)(6)(A)(i) of the Act for those LTCH admissions that are in response to the PHE and occur during the coronavirus PHE period. Under this provision, all LTCH cases admitted during the PHE period will be paid the relatively higher LTCH PPS standard federal rate (Centers for Medicare & Medicaid Services 2020a). For cost-reporting periods beginning on or after October 1, 2019, an LTCH that has not maintained the required discharge payment percentage (DPP) is paid the full IPPS comparable amount for all discharges until its DPP reaches 50 percent or higher; however, Section 3711(b)(1) of the CARES Act waives the payment adjustment under Section 1886(m)(6)(C)(ii) of the Act for LTCHs that do not have a DPP that is at least 50 percent during the PHE period. (An LTCH's DPP is its ratio of FFS discharges that qualify for the LTCH PPS rate to the LTCH's total number of Medicare discharges.)

7 The Secretary of Health and Human Services first determined the existence of a coronavirus PHE on the basis of confirmed cases of COVID-19 in the U.S. on January 31, 2020. At the time of publication, the coronavirus PHE had been renewed multiple times, most recently on January 14, 2022.

8 The 85 percent threshold originated from conversations with industry representatives and stakeholders as a reasonable goal for financial stability under Medicare.

9 The CARES Act suspended the 2 percent sequestration reduction to payments from May 1, 2020, through December 31, 2020. The Consolidated Appropriations Act, 2021, suspended it through December 31, 2021. The Protecting Medicare and American Farmers from Sequester Cuts Act suspended the 2 percent reduction from January through March 2022 and applied a 1 percent reduction from April through June 2022.

10 MMSEA and subsequent legislation allowed exceptions to the moratorium for (1) LTCHs that began their qualifying period (demonstrating an average Medicare length of stay greater than 25 days) on or before December 29, 2007; (2) entities that had a binding or written agreement with an unrelated party for the construction, renovation, lease, or demolition of an LTCH, with at least 10 percent of the estimated cost of the project already expended on or before December 29, 2007; (3) entities that had obtained a state certificate of need on or before December 29, 2007; (4) existing LTCHs that had obtained a certificate of need for an increase in beds issued on or after April 1, 2005, and before December 29, 2007; and (5) LTCHs that were in a state with only one other LTCH and that sought to increase beds after the closure or decrease in the number of beds of the state's other LTCH.

11 The Pathway for SGR Reform Act of 2013, as amended by the Protecting Access to Medicare Act of 2014, allowed exceptions to the moratorium for (1) LTCHs that began their qualifying period (demonstrating an average Medicare length of stay greater than 25 days) on or before April 1, 2014; (2) entities that had a binding or written agreement with an unrelated party for the construction, renovation,

lease, or demolition of an LTCH, with at least 10 percent of the estimated cost of the project already expended on or before April 1, 2014; and (3) entities that had obtained a state certificate of need on or before April 1, 2014.

12 We define MedPAC areas as metropolitan statistical areas within a state or rest-of-state nonmetropolitan areas, depending on where beneficiaries reside (Medicare Payment Advisory Commission 2017).

13 Although nonqualifying cases were paid qualifying-case rates during the PHE, they are identifiable as nonqualifying cases in claims data.

14 The following MS–LTC–DRGs are considered related to respiratory illness or prolonged use of mechanical ventilation: MS–LTC–DRG 4, tracheostomy with ventilator support 96+ hours or primary diagnosis except face, mouth, and neck without major operating room (OR) procedure; MS–LTC–DRG 166, other respiratory system OR procedures with major complication or comorbidity (MCC); MS–LTC–DRG 177, respiratory infections and inflammations with MCC; MS–LTC–DRG 189, pulmonary edema and respiratory failure; MS–LTC–DRG 207, respiratory system diagnosis with ventilator support 96+ hours; MS–LTC–DRG 208, respiratory system diagnosis with ventilator support ≤ 96 hours; MS–LTC–DRG 870, septicemia with prolonged ventilator support with MCC.

15 "High share of qualifying cases" refers to a cohort of LTCHs defined by their share (over 85 percent) of Medicare stays that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH PPS each year.

16 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows:

(Payments for Medicare services – (total Medicare costs – fixed building and equipment costs)) / Medicare payments

This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.

17 The risk adjustment for the successful discharge to the community measure includes age and sex of the beneficiary, end-stage renal disease (ESRD) and disability status for entitlement, principal diagnosis, comorbidities, the length of stay of the preceding hospital stay (if there was one), and a count of the hospitalizations during the preceding year. Risk adjusters for the hospitalization measure include primary diagnosis, comorbidities and severity of illness, special conditions (severe wounds, difficulty swallowing, and bowel incontinence), age and sex, disability and ESRD status, hospitalization in the previous month, days in the intensive care unit during a preceding hospitalization (if there was one), a count of the hospitalizations during the preceding year, and the provision of ventilator care during the PAC stay. Providers with least 60 stays in the year, the minimum count to meet a reliability of 0.7, were included in calculating the average facility rate.

18 Federal relief funds were intended to help cover lost revenue and payroll costs, including lost revenue from Medicare patients and the cost of staff that help treat these patients. We allocated a portion of these relief funds (based on FFS Medicare's share of 2019 all-payer operating revenue) to determine the Medicare margin inclusive of those funds.

19 Many new LTCHs operate at a loss for a period after opening. For this analysis of high-margin and low-margin LTCHs, we examined only LTCHs that submitted valid cost reports in both 2019 and 2020. We excluded government-owned LTCHs because they operate in a different financial context than other LTCHs, making their financial performance not comparable.

20 Market basket estimates for 2021 and 2022 are from the third quarter of 2021. Because they were revised upward, the most recent estimates are higher than estimates CMS used to update the LTCH PPS payments for fiscal years 2021 and 2022.

21 CMS established the "25 percent threshold rule" to set a limit on the share of cases that can be admitted to an LTCH from certain referring ACHs and reduce payment for some LTCHs with cases that exceed the threshold. Although the policy was intended to create disincentives for LTCHs to admit a large share of their patients from a single ACH, it was never fully implemented. In its final 2019 payment rule, CMS eliminated the 25 percent threshold rule (Centers for Medicare & Medicaid Services 2018). The 2020 standard federal rate included a temporary, one-time budget-neutrality adjustment of 0.990737 in connection with the elimination of the 25 percent rule (Centers for Medicare & Medicaid Services 2020b). The 2021 standard federal rate included a permanent, one-time budget-neutrality adjustment of 0.991294 for the elimination of the 25 percent threshold rule (Centers for Medicare & Medicaid Services 2020b).

22 The 2021 standard federal rate included an area wage budget-neutrality factor of 1.0016837 (Centers for Medicare & Medicaid Services 2020b). The 2022 standard federal rate included an area wage budget-neutrality factor of 1.002848 (Centers for Medicare & Medicaid Services 2021).

23 The CARES Act also temporarily waived the requirement that, on or after October 1, 2019, to be paid the LTCH PPS rate, a facility must have maintained a discharge payment percentage (DPP) of at least 50 percent. An LTCH's DPP is its ratio of FFS discharges that qualify for the LTCH standard federal PPS rate to the LTCH's total number of Medicare discharges.

References

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2021. Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system and policy changes and fiscal year 2022 rates; quality programs and Medicare Promoting Interoperability Programs requirements for eligible hospitals and critical access hospitals; changes to Medicaid provider enrollment; and changes to the Medicare Shared Savings Program. Final rule. *Federal Register* 86, no. 154 (August 13): 44774–45615.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2020a. COVID-19 emergency declaration blanket waivers for health care providers. https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2020b. Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system and final policy changes and fiscal year 2021 rates; quality reporting and Medicare and Medicaid Promoting Interoperability Programs requirements for eligible hospitals and critical access hospitals. Final rule. *Federal Register* 85, no. 182 (September 18): 58432–59107.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2018. Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long term care hospital prospective payment system and policy changes and fiscal year 2019 rates; quality reporting requirements for specific providers; Medicare and Medicaid electronic health record (EHR) incentive programs (promoting interoperability programs) requirements for eligible hospitals, critical access hospitals, and eligible professionals; Medicare cost reporting requirements; and physician certification and recertification of claims. Final rule. *Federal Register* 83, no. 160 (August 17): 41144–41784.

Dalton, K., D. Kennell, S. Bernard, et al. 2012. *Determining medical necessity and appropriateness of care for Medicare long-term care hospitals (LTCHs): Report on site visits to IPPS critical care services and LTCHs.* Prepared under contract by Kennell and Associates Inc., and Research Triangle International for the Centers for Medicare & Medicaid Services. Baltimore, MD: CMS.

Einav, L., A. Finkelstein, and N. Mahoney. 2021. Long-term care hospitals: A case study in waste. http://web.stanford.edu/~leinav/wp/LTCH2.pdf.

Kahn, J. M., N. M. Benson, D. Appleby, et al. 2010. Long-term acute care hospital utilization after critical illness. *Journal of the American Medical Association* 303, no. 22 (June 9): 2253–2259.

Kindred Healthcare. 2018. Humana, together with TPG Capital and Welsh, Carson, Anderson & Stowe, announce completion of the acquisition of Kindred Healthcare, Inc. News release. July 2. https://www.kindredhealthcare.com/news/2018/07/02/humana-together-tpg-capital-and-welsh-carson-anderson-stowe.

Kindred Healthcare. 2017. Kindred Healthcare reports third quarter 2017 results. News release. November 6. http://investors.kindredhealthcare.com/news-releases/news-release-details/kindred-healthcare-reports-third-quarter-2017-results.

Kindred Healthcare. 2015. Kindred Healthcare reports third quarter 2015 results. News release. November 4. http://investors.kindredhealthcare.com/news-releases/news-release-details/kindred-healthcare-reports-third-quarter-2015-results.

Mayr, F. B., S. Yende, W. T. Linde-Zwirble, et al. 2010. Infection rate and acute organ dysfunction risk as explanations for racial differences in severe sepsis. *Journal of the American Medical Association* 303, no. 24 (June 23): 2495–2503.

Medicare Payment Advisory Commission. 2021a *A data book: Health care spending and the Medicare program*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2021b. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2017. *Report to the Congress: Regional variation in Medicare Part A, Part B, and Part D spending and service use*. Washington, DC: MedPAC.

Muoio, D. 2021a. LifePoint Health to create new 79-hospital company upon close of Kindred Healthcare acquisition. *Fierce Healthcare*, October 27. https://www.fiercehealthcare.com/hospitals/scionhealth-lifepoint-health-to-create-new-79-hospital-company-upon-close-kindred.

Muoio, D. 2021b. Select Medical's latest deals amp up operations in long-term acute care, outpatient clinics. *Fierce Healthcare*, June 23. https://www.fiercehealthcare.com/hospitals/select-medical-s-latest-acquisition-partnerships-will-add-7-long-term-acute-care.

Office of the Actuary, Centers for Medicare & Medicaid Services, Department of Health and Human Servivces. 2021. Personal communication of author with Elliot Weinstein. April 21.

Podulka, J., and J. Blum. 2020. *Regulatory changes to Medicare in response to COVID-19.* Issue brief. Washington, DC: Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/regulatory-changes-medicare-response-covid-19.

Select Medical. 2021a. Select Medical Holdings Corporation announces results for its fourth quarter and year ended December 31, 2020. Press release. February 25. https://www.prnewswire.com/news-releases/select-medical-holdings-corporation-announces-results-for-its-fourth-quarter-and-year-ended-december-31-2020-301236010.html.

Select Medical. 2021b. Select Medical Holdings Corporation announces results for its second quarter ended June 30, 2021 and cash dividend. Press release. August 5.

Select Medical. 2017. Select Medical Holdings Corporation announces results for its third quarter ended September 30, 2017. https://www.selectmedical.com/-/media/project/selectmedical/dotcom/usa/page-assets/ir/earnings-news-releases/07-select-medical-holdings-corporation-announces--2017-third-quarter-results-november-2-2017.pdf?t=20200926032118.

Select Medical. 2015. Q3 2015 Select Medical Holdings Corporation earnings conference call, October 30.