Mandated report: Changes in post-acute and hospice care following the implementation of the long-term care hospital dual payment-rate structure

Stephanie Cameron and Emma Achola

March 8, 2019

MEDPAC

Presentation roadmap

- September: Background and context for the mandate
- November: Analysis of data through 2016
- December and January: Analysis of payment adequacy
- Today:
  - Review of payment changes made under the Pathway for SGR Reform Act of 2013
  - Review of the Commission's mandate
  - Analysis of data through 2017
  - Finalize the report for inclusion in the June 2019 report

The Pathway for SGR Reform Act of 2013 establishes a dual payment-rate structure for LTCHs

- Established patient-level criteria that determine payment level
  - Cases that meet these criteria are paid the standard long-term care hospital (LTCH) prospective payment system (PPS) rate
  - Cases that do not meet these criteria are paid a lower “site-neutral” rate
- Criteria for the standard LTCH PPS rate:
  - Have an immediately preceding acute care hospital (ACH) discharge and either a) 3+ days in an intensive care unit of a referring ACH; or b) received prolonged mechanical ventilation in the LTCH

Mandate: Pathway for SGR Reform Act of 2013

- MedPAC should examine the effect of the dual-payment rate structure on:
  - Growth in Medicare spending for LTCH services;
  - Different types of LTCHs;
  - Quality of patient care in LTCHs; and
  - Use of other post-acute care (PAC) and hospice settings.
- The mandate further requested the Commission assess the continued need to apply the 25-percent threshold rule
- The final report is due June 2019

Analytic approach

- Quantitative analysis of administrative data:
  - Claims and cost report data through 2017
  - Provider of services file data through 2018
- Site visits
  - Nine LTCHs, seven ACHs, three skilled nursing facilities (SNFs)
  - Six states
  - Varying market and facility characteristics
- Telephone interviews with facility representatives in three additional markets

Analytic challenges

- Policy only 50 percent phased-in through fiscal year 2019
- LTCH spending, use, and margins began to decrease prior to the implementation of the dual payment-rate structure
- Low volume of LTCH cases relative to other PAC and hospice use
  - Analyze high LTCH-use areas compared with low LTCH-use areas
  - Analyze changes in ACH discharge patterns for certain diagnoses

Facility-reported response to the dual-payment rate structure

- Admitting only beneficiaries who meet the criteria
  - Rationale:
    - Financial – other cases no longer profitable
    - Practical – consistent messaging to referring ACHs
  - Operational changes:
    - Expanded referral regions
    - Educated physicians and case managers at ACH on facility capabilities
- Continuing to take beneficiaries who do not meet the criteria
  - Rationale:
    - Maintaining relationships with referral sources
    - Providing a service to the community
    - Cases with short lengths of stay could be profitable under the blended payment rate

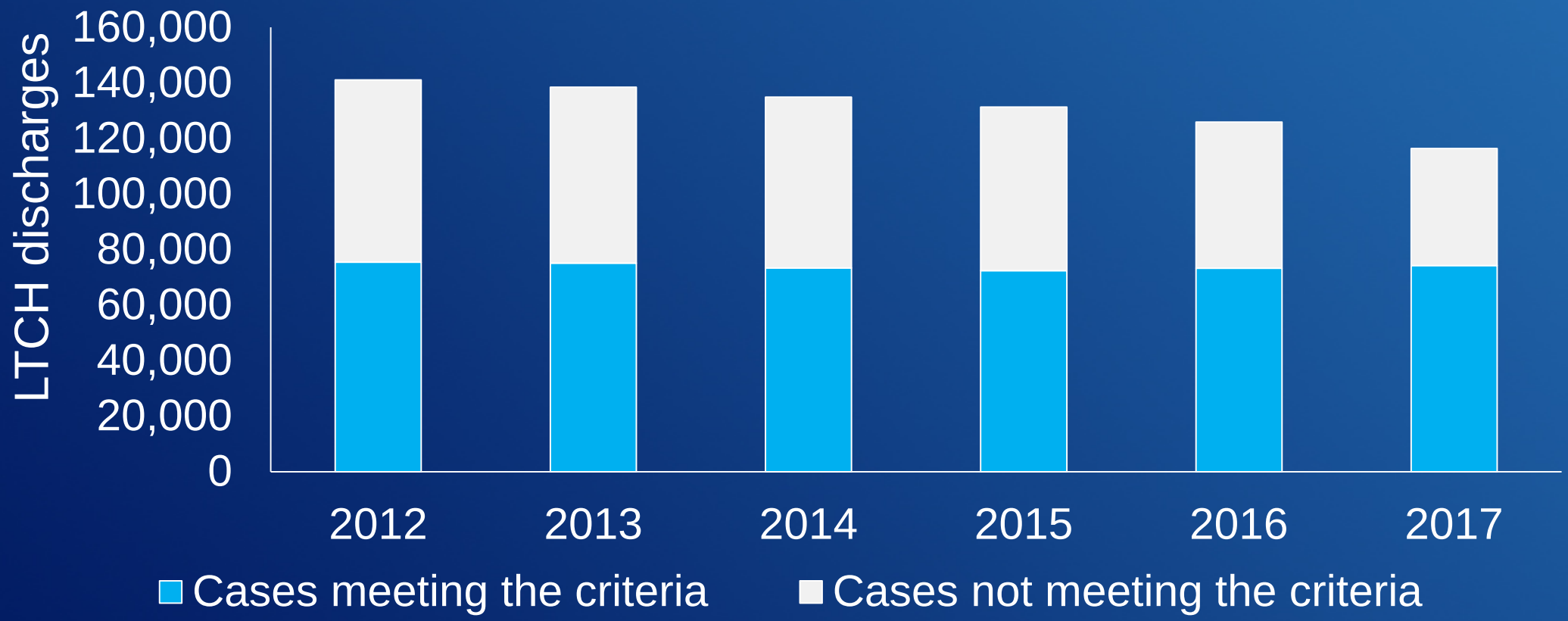
Generally, LTCHs reported operational and staffing changes

- Increased level of training at all levels
  - Including critical care training
- Increased capabilities
  - Bariatric beds, intensive care unit beds, telemetry services
- Despite these changes, interviewees referenced closures and declining occupancy rates
  - In response to the declining occupancy rates, some facilities planned to repurpose beds as inpatient psychiatry, inpatient rehabilitation, or skilled nursing

The rate of LTCH closures has increased since 2016

- Over 50 facilities have closed since 2016, representing more than 10 percent of the industry
  - Primarily in areas with multiple LTCHs or within about a two-hour drive of another LTCH
- 85 percent of closures were for-profit facilities
- Facilities that closed tended to have:
  - A lower share of discharges that met the criteria
  - Lower occupancy
  - Lower Medicare margins
  - Higher standardized costs

LTCHs are admitting fewer cases that do not meet the criteria



Note: LTCH (long-term care hospital). "Cases meeting the criteria" refers to Medicare discharges that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for the standard long-term care hospital prospective payment rate. "Cases not meeting the criteria" refers to Medicare discharges that do not meet the criteria specified in the Pathway for SGR Reform Act of 2013.
Source: MedPAC analysis of Medicare claims data.

Results preliminary; subject to change

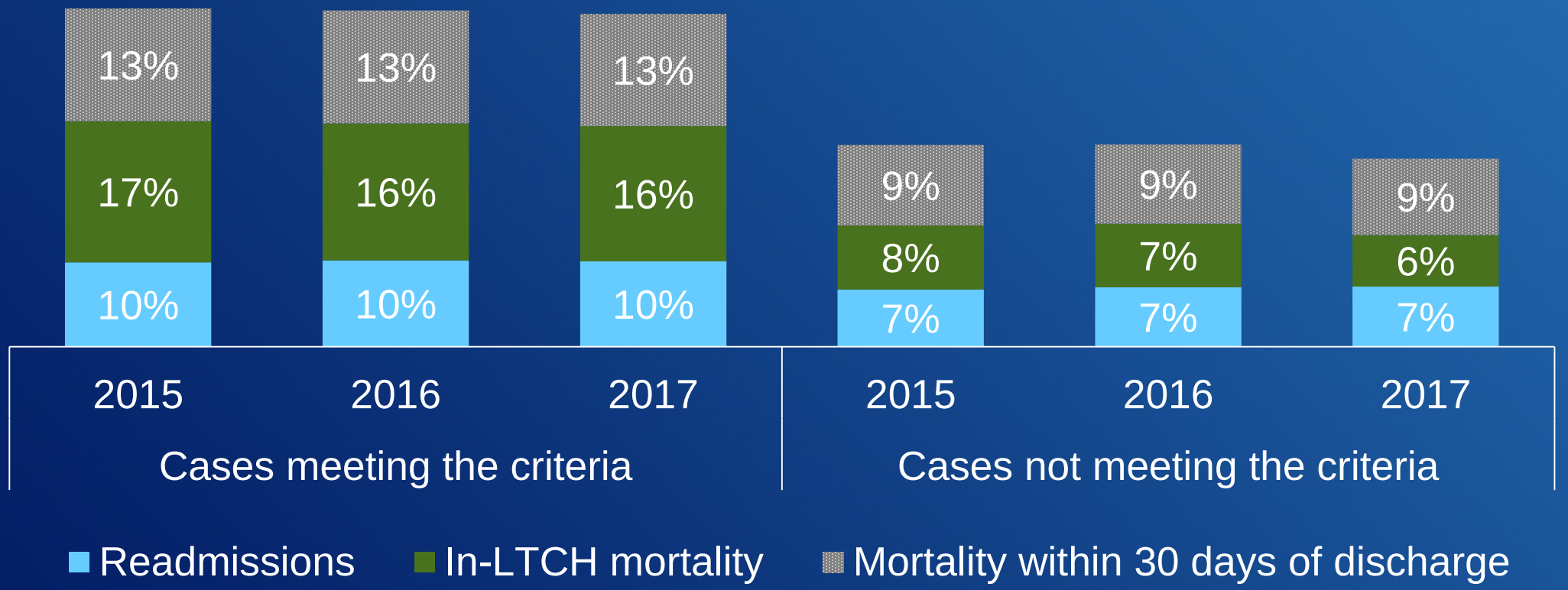
LTCH financial performance under Medicare, 2017

	% of cases	Medicare margin
All LTCHs	100%	-2.2%
For profit	87	-0.3
Nonprofit	12	-13.0
LTCHs with >85% of cases meeting the criteria	23%	4.6%
For profit	87	6.5
Nonprofit	13	-6.9

Note: LTCH (long-term care hospital). "Cases meeting the criteria" refers to Medicare discharges that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for the standard long-term care hospital prospective payment rate.
Source: MedPAC analysis of cost report data from CMS.

Results preliminary; subject to change

Rates of unadjusted quality measures remained stable since 2015



Note: LTCH (long-term care hospital). "Cases meeting the criteria" refers to Medicare discharges that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for the standard long-term care hospital prospective payment rate. "Cases not meeting the criteria" refers to Medicare discharges that do not meet the criteria specified in the Pathway for SGR Reform Act of 2013.
Source: MedPAC analysis of Medicare Provider Analysis and Review and enrollment data from CMS.

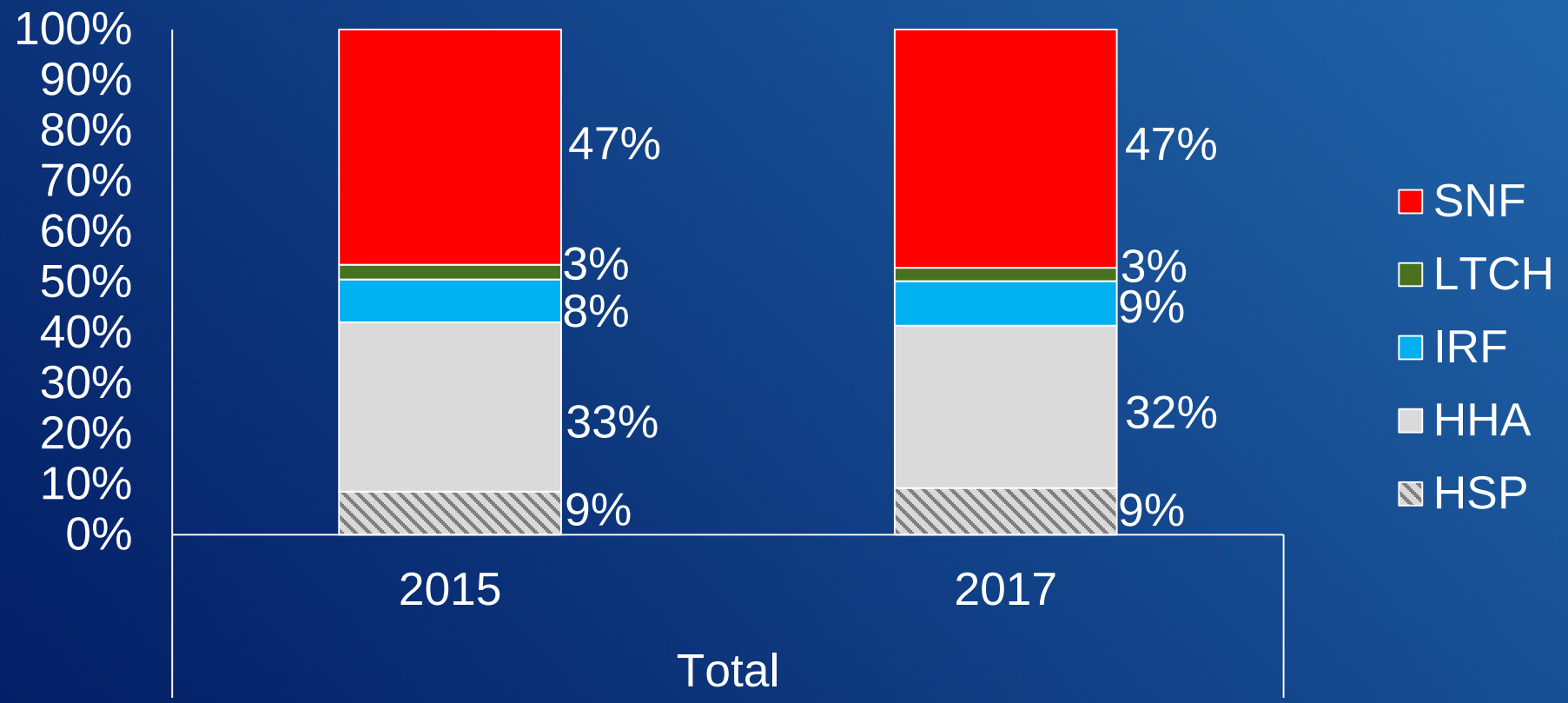
Results preliminary; subject to change

Changes in PAC and hospice services, 2012-2017

- PAC:
  - Aggregate spending has grown slightly from $58 billion in 2012 to about $60 billion in 2017
  - Supply has remained stable
- Hospice:
  - Spending on hospice services increased from about $15 billion in 2012 to almost $18 billion in 2017
  - The number of hospice providers increased

Results preliminary; subject to change

Aggregate ACH discharge patterns to PAC and hospice were stable, 2015-2017

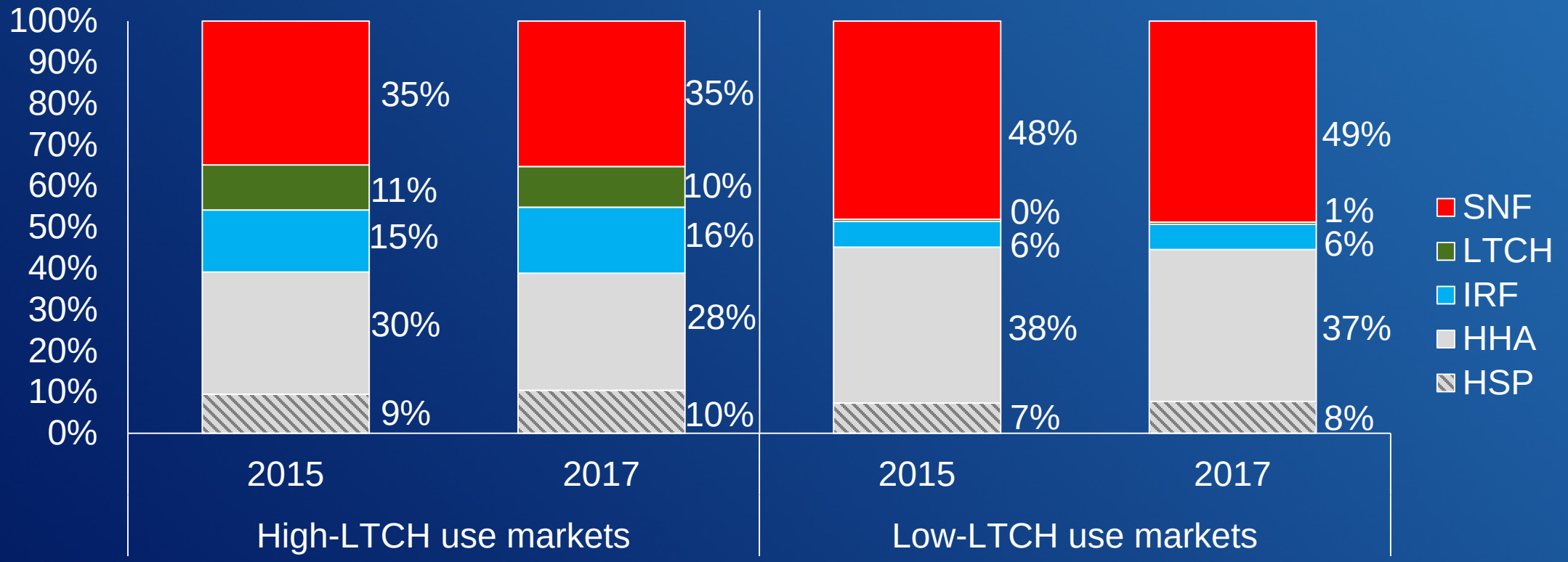


Note: PAC (post-acute care), LTCH (long-term care hospital), HSP (hospice), HHA (home health agency), IRF (inpatient rehabilitation facility). High-use areas were identified as the top 20 MedPAC markets with the highest per beneficiary LTCH use in 2015. Low-use areas were identified as the 20 MedPAC markets with the lowest per beneficiary LTCH use requiring a minimum threshold of 25 Medicare FFS LTCH cases.
Source: MedPAC analysis of Medicare claims data.

MEDPAC

Results preliminary; subject to change

ACH discharge patterns to PAC and hospice also were stable across market types, 2015-2017



Note: PAC (post-acute care), LTCH (long-term care hospital), HSP (hospice), HHA (home health agency), IRF (inpatient rehabilitation facility). High-use areas were identified as the top 20 MedPAC markets with the highest per beneficiary LTCH use in 2015. Low-use areas were identified as the 20 MedPAC markets with the lowest per beneficiary LTCH use requiring a minimum threshold of 25 Medicare FFS LTCH cases.
Source: MedPAC analysis of Medicare claims data.

MEDPAC

Results preliminary; subject to change

In areas with high-LTCH use, ACH discharge patterns changed modestly for certain conditions, 2015-2017

MS-DRG	MS-DRG name	2015-2017 percentage point change in share of discharges to:	
		LTCH	SNF
004	Tracheostomy with MV support >96 hrs or primary diagnosis except face, mouth & neck without major OR procedure	4	1
463	Wound debridement and skin graft except hand, for musculo-connective tissue disorders with MCC	-3	4
853	Infectious & parasitic diseases with OR procedure with MCC	-5	3

Note: ACH (acute care hospital), LTCH (long-term care hospital), MS-DRG (Medicare severity-adjusted diagnosis related group), SNF (skilled nursing facility), ECMO (extracorporeal membrane oxygenation), MV (mechanical ventilation), MCC (major complications or comorbidities, OR (operating room).
Source: MedPAC analysis of Medicare claims data.

Results preliminary; subject to change

Since the start of the dual-payment rate structure:

- Roughly 50 facilities have closed: most in markets with multiple LTCHs and with low occupancy, low share of cases that met the criteria, higher costs than facilities that remained open
- The volume of cases that do not meet the criteria has decreased
- The share of LTCH cases that meet the criteria has increased
- LTCH margins have decreased, but cases that meet the criteria remain profitable
- Negligible change in LTCH unadjusted quality measures
- Changes in the supply or use of other PAC or hospice providers have been minimal

Changes in the LTCH setting are consistent with the policy objectives

- The trends observed in the LTCH setting:
  - were expected,
  - align with the Commission's goals in its March 2014 recommendation to the Congress, and
  - are expected to continue as the policy is fully phased-in
- We will continue to monitor trends in use across PAC and hospice, facility closures, and quality as data become available

Discussion

- Questions
- Feedback on:
  - Information presented today