Mandated report: Long-term care hospitals

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MEDPAC

Presentation roadmap

- September:
  - Background and context for the mandate
- Today:
  - Review the payment changes made under the Pathway for SGR Reform Act of 2013
  - Review of the Commission's mandate
- Initial findings:
  - Operational changes in response to the payment change
  - LTCH supply, use, and financial performance
  - Patterns of post-hospital discharge to other post-acute care (PAC) and hospice providers since 2012
  - An assessment of several quality measures in LTCHs

Long-term care hospitals (LTCHs)

- Meet Medicare's conditions of participation for acute care hospitals (ACH)
- Have an average length of stay for certain Medicare cases greater than 25 days
- In 2016:
  - Mean payment per case: ~$41,000
  - Total Medicare spending: $5.1 billion
  - Cases: ~126,000
- Medicare FFS beneficiaries account for about 2/3 of LTCH discharges

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

- Cases that meet the criteria:
  - Have an immediately preceding acute care hospital (ACH) discharge and either:
    - 3+ days in an intensive care unit of a referring ACH; or
    - Received prolonged mechanical ventilation in the LTCH
  - Are paid the LTCH standard payment rate
- Cases that do not meet criteria:
  - Are paid a lower "site-neutral" rate
    - The "site-neutral" rate is being phased in over four years
    - These cases are currently paid a blended rate, 50 percent the reduced rate and 50 percent the LTCH standard payment

Mandate: Section 1206(a) of the Pathway for SGR Reform Act of 2013

- The Congress requested that MedPAC examine the effect of the dual-payment rate structure on:
  - Different types of long-term care hospitals;
  - The growth in Medicare spending for services in such hospitals;
  - The use of other post-acute care and hospice care settings; and
  - The quality of patient care in long-term care hospitals.
- The final report is due June 2019

Analytic challenges

- Partial policy phase-in
  - 50 percent phase-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 post-acute care (PAC) and hospice use
  - Analysis of high-use LTCH areas compared with low-use LTCH areas
  - Analyze changes in acute care hospital discharge patterns across certain diagnoses

Facility-reported changes in response to the dual-payment rate structure

- LTCHs made several operational changes in response to the dual-payment rate structure
- Facilities reported either:
  - Changing their admission patterns to admit only beneficiaries who meet the criteria
  - Continuing to take beneficiaries who do not meet the criteria

Some LTCHs focus on admitting only cases that meet the criteria

- LTCH staff reported focusing admissions on patients that met the criteria
  - Financial reasons – other cases no longer profitable
  - Practical reasons – consistent messaging to referring ACHs
- Operational changes:
  - Expanded referral regions
  - Educated physicians and case managers at ACH on facility capabilities
  - Expanded the mix of patients and payers

Some LTCHs continue to take cases that do not meet criteria

- LTCH staff reported several reasons for this approach:
  - Maintaining relationships with referral sources
  - Providing a service to the community
  - Cases with short lengths of stay could be profitable under the blended pay rate
    - These cases were typically expected to have a length of stay of 7 days or less

Generally, LTCHs reported operational and staffing changes

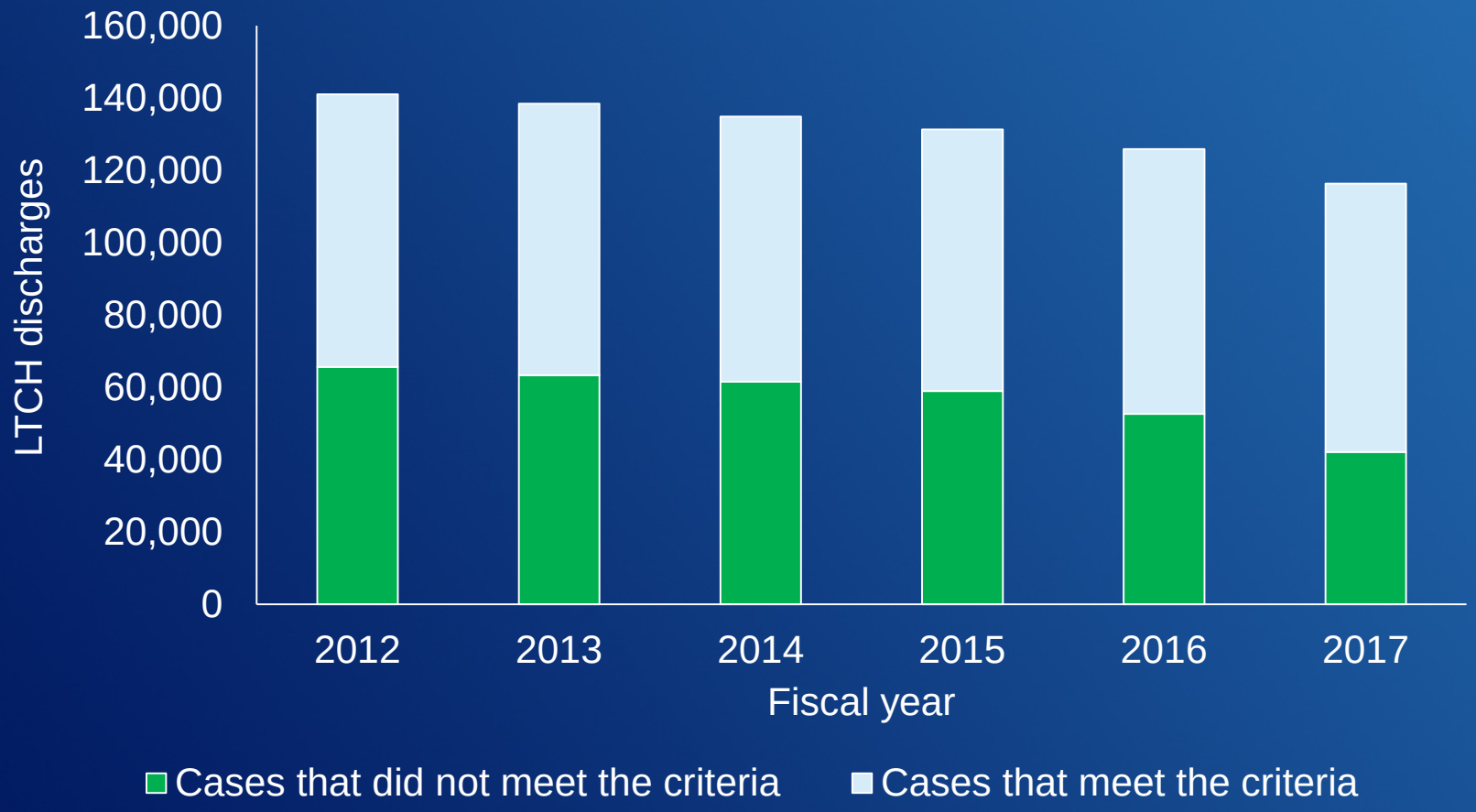
- Increased level of training at all levels
  - Including critical care training
- Increased capabilities
  - Bariatric beds, ICU beds, telemetry services
- Despite these changes, interviewees referenced closures and declining occupancy rates
  - In response to the declining occupancy rates, some facilities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

The rate of LTCH closures has increased since 2016

- Over 40 facilities have closed since 2016, representing about 10 percent of the industry
  - Primarily in areas with multiple LTCHs or within a two-hour drive of another LTCH
- 90 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

Results are preliminary and subject to change.

LTCHs have increased the share of beneficiaries that meet the criteria since 2012



Note: Results are preliminary and subject to change.
Source: MedPAC analysis of Medicare claims data.

Reduction in LTCH volume occurred in high-use areas, but not in low-use areas

- Overall reduction in cases that did not meet the criteria
- Areas with high per beneficiary LTCH use reduced LTCH volume for cases that meet the criteria
- In contrast, areas with the low per beneficiary LTCH use increased volume for cases that meet the criteria
  - LTCH users from low-use areas had higher illness severity, risk of mortality, and longer ICU stays than high-use areas

Results are preliminary and subject to change.

Reduced LTCH payments result in lower Medicare margins

- From 2015 to 2016, facilities with a high share of cases (>15 percent) that do not meet the criteria had:
  - 13 percent reduction in payment per case
  - 7 percent reduction in cost per case
- Facilities with a low share of these cases can remain profitable under the dual-payment rate structure
- We will continue to monitor as cost report data reflects the policy phase in across all LTCHs

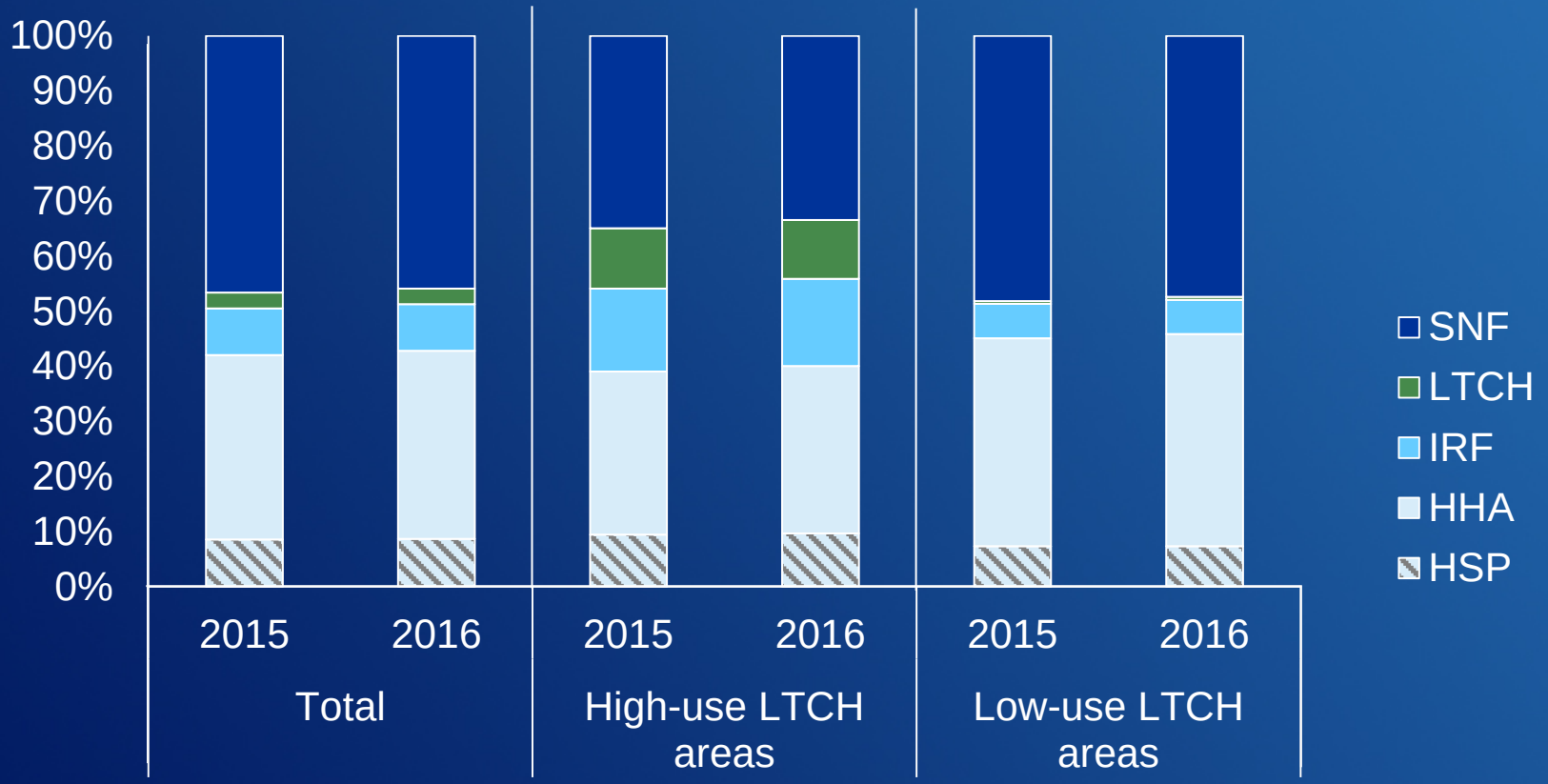
Results are preliminary and subject to change.

Changes in post-acute care and hospice services, 2012-2016

- Post-acute care (PAC):
  - Spending has grown slightly from $58 billion in 2012 to about $60 billion in 2016
  - Supply has remained stable
  - PAC use on a per beneficiary basis has decreased
- Hospice:
  - Spending on hospice services increased from about $15 billion in 2012 to almost $17 billion in 2016
  - The number of hospice providers increased
  - Hospice use per beneficiary remained stable

Results are preliminary and subject to change.

Discharge patterns to PAC and hospice have remained fairly stable, 2015-2016



Note: Results are preliminary and subject to change.
Source: MedPAC analysis of Medicare claims data.

ACH discharge patterns for beneficiaries in high-use areas changed slightly from 2015-2016

- For beneficiaries with < 3 day ICU stay in a referring ACH stay
  - Minimal change in low-use LTCH areas across LTCH, other PAC, and hospice use
  - Slight decrease in LTCH use in high-use LTCH areas
- For beneficiaries with > 3 day ICU stay
  - Increases in the share of beneficiaries discharged to LTCH in both low-use and high-use LTCH areas
  - Slight decrease in the share of beneficiaries discharged to SNF in high-use areas

Note: Results are preliminary and subject to change.
Source: MedPAC analysis of Medicare claims data.

In areas with high-LTCH use, ACH discharge patterns changed for certain conditions, 2015-2016

MS-DRG	MS-DRG name	Percentage point change in discharges to: LTCH 2015-2016	Percentage point change in discharges to: SNF 2015-2016
003	ECMO or tracheostomy with MV support > 96 hours or primary diagnosis except face, mouth, & neck with major OR procedure	3%	-1%
570	Skin debridement with MCC	-6%	2%
853	Infectious & parasitic diseases with OR procedure with MCC	-7%	1%

Note: MS-DRG (Medicare severity-adjusted diagnosis related group), LTCH (long-term care hospital) SNF (skilled nursing facility), MCC (major complications or comorbidities, OR (operating room). Results are preliminary and subject to change.
Source: MedPAC analysis of Medicare claims data.

Unadjusted measures of LTCH quality remained stable from 2015 to 2016

- In 2016 (and consistent with 2015):
  - Direct ACH readmissions: 9%
  - In-LTCH mortality: 12%
  - 30-day post LTCH mortality: 12%
- For cases that met the criteria:
  - Similar levels of direct ACH readmissions and 30-day post LTCH mortality
  - In-LTCH mortality is higher, 16% in 2016

Results are preliminary and subject to change.

Risk-adjusted quality measures, 2015-2017

Measure	July 1, 2015 through June 30, 2016	July 1, 2016 through June 30, 2017
Pressure ulcer (rate)	1.8%	1.5%
Catheter-associated urinary tract infection (standardized infection ratio)	0.88	0.99
Central-line associated bloodstream infection (standardized infection ratio)	0.89	0.91
30-day unplanned readmission	24.6%	25.0%

Note: The 30-day unplanned readmission measure is based on data collected from claims data over a two-year period. The most recently published unique time periods include discharges occurring January 1, 2013 through December 31, 2014 and January 1, 2014 through December 31, 2015. Standardized infection ratios (SIR) a SIR greater than 1.0 indicates that more infections were observed than predicted; an SIR less than 1.0 indicates that fewer infections were observed than predicted. Results are preliminary and subject to change.

Source: CMS LTCH Compare website.

Summary of changes since the start of the dual-payment rate structure

- The share of LTCH cases that meet the criteria has increased
- The volume of cases that do not meet the criteria has decreased
- Over 40 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
- Changes in the supply or use of other PAC or hospice providers have been minimal
- Negligible change in LTCH quality measures
- 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
  - Additional areas of interest