Mandated report: Long-term care hospitals

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MEDPAC

Presentation roadmap

- Today:
  - Statutory changes to long-term care hospital (LTCH) payment policy
  - The Commission's mandate
  - LTCH overview and payment policy
  - Regulatory and statutory history
  - Defining LTCH-appropriate patients (including MedPAC's recommendation)
  - Work plan
- Future: Findings

The Pathway for SGR Reform Act of 2013 establishes "site-neutral" payments for LTCHs

- Beginning FY 2016:
  - Higher LTCH payments allowed for qualifying cases with 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
  - All other LTCH cases paid lower "site-neutral" rate
- Full implementation beginning in FY 2020

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 policy on:
  - The quality of patient care in long-term care hospitals;
  - The use of hospice care and post-acute care settings;
  - Different types of long-term care hospitals; and
  - The growth in Medicare spending for services in such hospitals.
- The mandate further requested the Commission to opine on the continued need to apply the 25-percent threshold rule

Long-term care hospitals (LTCHs)

- Requirements for LTCH certification:
  - Meet Medicare's conditions of participation for acute care hospitals (ACH) and
  - 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

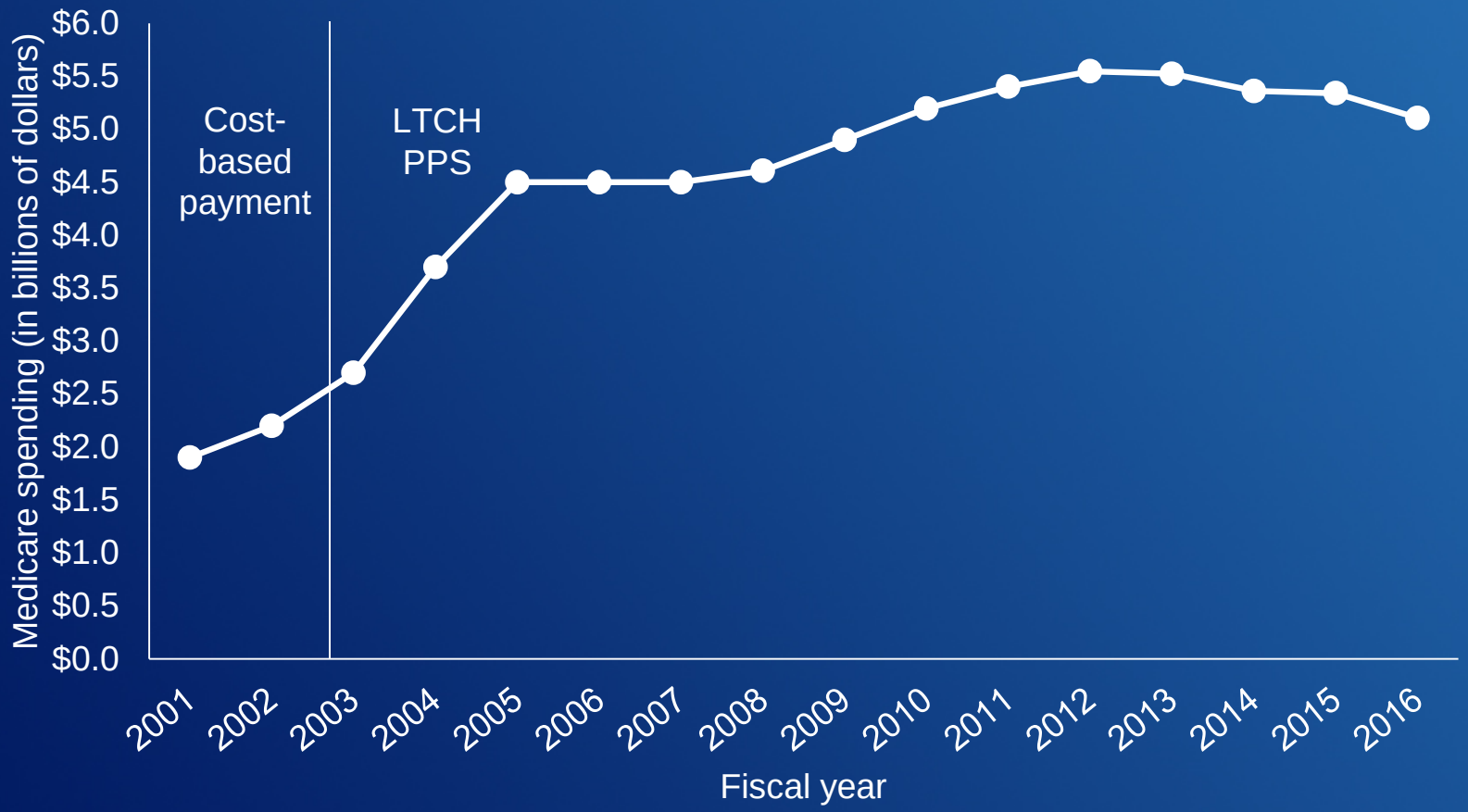
LTCH payment policy

- LTCHs were excluded from the inpatient prospective payment system (PPS) beginning in 1983
- Medicare paid for LTCHs on a cost basis until fiscal year 2003
- The LTCH PPS is similar to the acute care hospital inpatient PPS, paying on a per discharge basis, but with a base rate and relative weights specific to LTCH patients
  - High-cost outlier payments
  - Short-stay outlier payment adjustment

MedPAC's concerns about LTCHs

- LTCHs are often clustered with multiple facilities in a single market
- There is overlap between lower-acuity LTCH patients and patients who receive care in other less expensive post-acute care (PAC) settings
- Research on patient outcomes and episode spending for LTCH users has been both limited and mixed
- Defining the type of patients appropriate to receive LTCH care has been difficult, yet important, given the high cost of LTCH care

After rapid growth, Medicare spending on LTCHs peaked in 2012



Note: PPS (prospective payment system). Results are preliminary and subject to change.
Source: MedPAC analysis of cost report data.

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Regulatory and statutory efforts to reduce growth in LTCH spending

- Limiting share of cases that can be admitted to an LTCH from a single referring ACH
  - "25-percent threshold" rule
  - Eliminated in fiscal year 2019 final payment rule
- Limiting the development and expansion of LTCHs
  - Moratorium 1: 12/29/2007 – 12/28/2012
  - Moratorium 2: 4/1/2014 – 9/30/2017
- Reducing payments for cases with relatively short lengths of stay

Defining the patients most appropriate for LTCH care has been elusive

- Some literature has described the chronically critically ill as:
  - Multi-system failure (metabolic, endocrine, physiologic, immunologic, respiratory)
  - Requiring long ACH stays with heavy use of intensive care unit services
  - Being ventilator-dependent with major comorbidities
  - Having septicemia and other complex infections
- LTCH medical staff, administrators, and case managers also have been unable to articulate how to define the most appropriate patient for LTCH care

- But, ICU days are an indicator of case complexity

MedPAC recommendation to the Congress

- Recommendation:
  - Standard LTCH payment rates be paid only for LTCH patients who:
    - Spent 8+ days in an ICU during the preceding IPPS stay or
    - Received mechanical ventilation for 96+ hours during the preceding IPPS stay
- Rationale:
  - ICU days are positively associated with case complexity
  - Ensures appropriate access to specialty weaning services offered by many LTCH for beneficiaries requiring prolonged ventilation
- The Congress adopted a variant of this policy

Mandated report: Analytical 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 SNFs
  - Six states
  - Varying market and facility characteristics
- Telephone interviews with facility representatives in three additional markets

Assessing changes in quality of care provided in LTCHs

- Relatively new quality program
  - Public reported on a limited number of measure began in late 2016
- Commission has historically reported changes in unadjusted mortality and readmissions
  - Mortality is relatively high
  - During-stay readmissions are relatively low
- Plan to assess changes in unadjusted measures for all Medicare discharges from LTCHs and for discharges meeting the criteria

Use of hospice care and other PAC providers

- The relatively low volume of LTCH discharges creates difficulties in detecting changes in use trends across other PAC providers
- Analysis will focus on:
  - Patterns in LTCH use for a select set of ACH diagnoses
  - Patterns in PAC use in markets with the highest and lowest LTCH use on a per beneficiary basis

Assessing changes in use and spending

- Assessment of administrative data to detect changes by LTCH ownership and size including:
  - Facilities and beds
    - Data through 2018
  - Cases and spending
    - Data through 2017

25-percent threshold policy

- Reduced incentive for LTCHs to function as step-down units of a referring ACH
- In context of the dual-payment structure:
  - Continued incentive for ACHs to discharge patients to LTCHs for financial, rather than clinical reasons
  - Twenty percent of ACH patients would qualify to receive the full LTCH payment under statute
- The expiration of the moratorium could result in growth in the number of LTCHs especially in markets with high-occupancy, tertiary and other high acuity hospitals

Discussion

- Questions
- Feedback on:
  - Information presented today
  - Overall approach to fulfilling the mandate
  - Additional areas of interest