

# TRENDWATCH

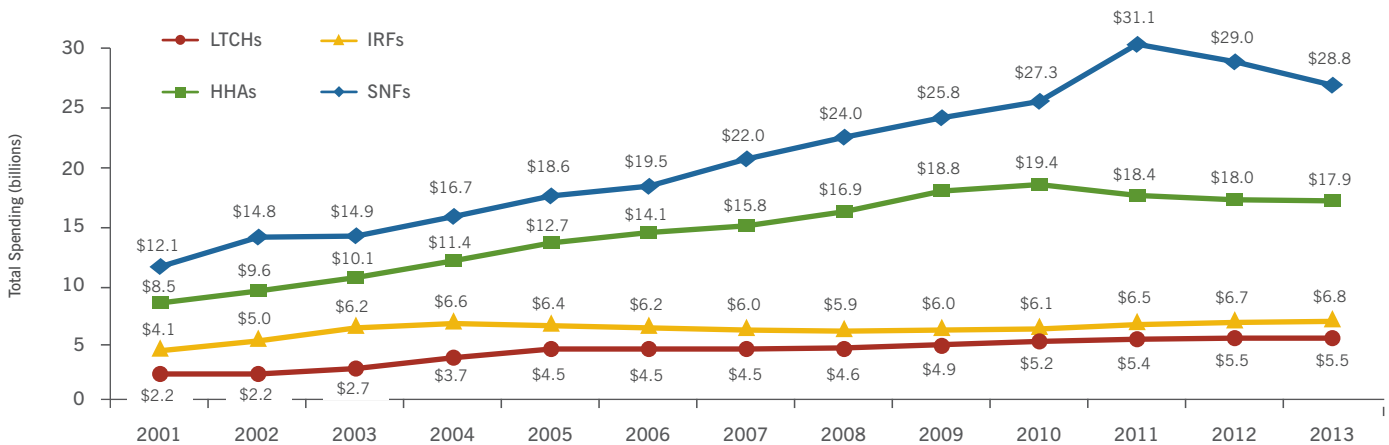
## Addendum: Background On Post-Acute Care

Medicare, Medicaid and most states recognize four types of post-acute care (PAC) settings: long-term acute-care (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs) and home health agencies (HHAs). Between 2001 and 2012, program payments to

PAC providers doubled to \$59 billion. Although Medicare spending on PAC was only 11 percent of total Medicare spending in 2013, the rapid increase in payments to SNFs and HHAs has caused both the Centers for Medicare & Medicaid Services (CMS) and the Medicare Payment

Advisory Commission (MedPAC) to focus on the value of the service and patient outcomes. (Chart A-1). This addendum will describe the types of patients cared for in each venue, the current fee-for-service (FFS) payment system and recent regulatory changes in each venue.

Chart A-1: Medicare Spending on PAC by Sector



Source: Miller, M. Medicare PAC Reforms. *U.S. Congress House Subcommittee on Health: Committee on Energy and Commerce*. 16 April 2015.

## PAC Provider Snapshot and Overlap of Patient Characteristics

Each PAC venue is briefly described in this section of the report.

### Long-term Acute-Care Hospitals (LTCHs)

LTCHs treat a patient population that, on average, is more severely ill than

patients treated in short-term, acute-care hospitals. Most LTCH patients exhibit chronic critical illness, including metabolic, endocrine, physiologic and immunologic abnormalities which result in profound debilitation and often ongoing

respiratory failure. LTCHs may be either freestanding or co-located with short-term acute-care hospitals. Because LTCH patients are far sicker than patients discharged to other post-acute venues, their average length of stay is longer, averaging

26.5 days for Medicare FFS beneficiaries in 2013.<sup>23</sup>

Regulatory differences and levels of patient acuity compared to other settings partially explain the higher average payment to LTCHs. While 47 percent of LTCH admissions were classified in the highest level of severity of illness (SOI) in the short-term acute-care hospital, only 7.5 percent of patients discharged to a HHA were in the top SOI level. (Chart A-2).

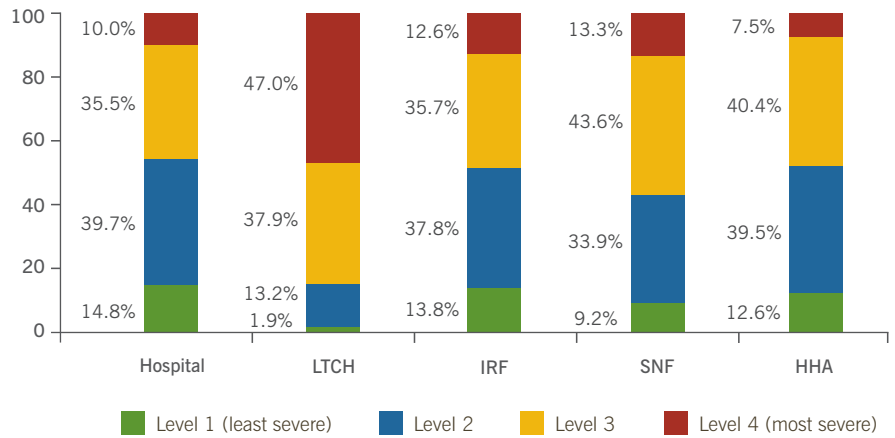
**Inpatient Rehabilitation Facilities (IRFs)**

IRFs provide intensive rehabilitation services to patients after an injury, illness or surgery. Rehabilitation programs at IRFs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing and speech–language pathology, as well as provision of prosthetic and orthotic devices. IRFs can be freestanding facilities or specialized units within acute-care hospitals. Patients admitted to IRFs must be able to benefit from three hours per day (fifteen hours per week) of skilled therapy services, including at least two modalities, one of which must be physical or occupational therapy. Additionally, 60 percent of IRF patient admissions (Medicare and non-Medicare) must have a primary diagnosis or comorbidity of at least one of 13 conditions specified by CMS.

**Skilled Nursing Facilities (SNFs)**

The greatest volume of patients discharged from hospitals to post-acute settings go to SNFs. SNFs furnish short-term, skilled nursing care and rehabilitation services. To be eligible for the skilled nursing benefit, Medicare beneficiaries in the traditional FFS Medicare payment program must have had a three-day hospital stay within 30 days of admission to the SNF. Post-acute SNF patients include those recovering from surgical procedures, such as hip and knee replacements, or from medical conditions, such as

Chart A-2: Hospital and PAC Severity of Illness (SOI) in Prior Hospital Stay



Source: Analysis of 2013 FY data from Medicare Provider Analysis and Review. Note: SOI is measured by the 3M Core Grouping Software.

stroke and pneumonia. The vast majority of post-acute patients in SNFs receive between nine and 12 hours per week of physical and occupational therapy and speech–language pathology services. Most freestanding SNFs offer both post-acute and long-term care. In order to manage the differences in the level of nursing staff required to meet the needs of post-acute patients, relative to long-term care residents, many SNFs have created separate units for the post-acute patient population.

**Home Health Agencies (HHAs)**

HHAs furnish post-acute services to persons who are homebound and need skilled nursing or therapy. Medicare home health care consists of skilled nursing, physical therapy, occupational therapy, speech therapy, aide services and medical social work. Medicare patients must be under the care of a physician and must have a face-to-face visit with their physician within a period extending from 90 days prior through 30 days after the start of home health care. The face-to-face encounter must be related to the primary reason that the patient needs home health services. Medicare

does not require a preceding hospital stay to qualify for home health care. In fact, 66 percent of home health episodes are not preceded by a hospital or post-acute stay.<sup>24</sup> As shown in Charts 1 and 2, home health care is the second most frequent initial post-acute discharge venue and the most frequent second post-acute discharge venue.

Although these four PAC settings have distinct regulatory and payment parameters, there is overlap in patients cared for in these settings, and providers lack sufficient understanding of which PAC setting will benefit which types of patients.<sup>25</sup> An analysis by MedPAC suggested there is evidence that similar patients are treated in different settings at widely varying costs to the Medicare program.<sup>26</sup>

Hospitals, PAC providers and payers are in the process of developing the tools and the evidence base to make placement decisions based upon patient needs and characteristics. In addition, MedPAC, CMS and Congress are considering ways to assure that Medicare payment is consistent with patient characteristics and resource needs, rather than type of PAC venue.

## Current Fee-For-Service System

Each PAC setting is required to meet certain federal and state regulations for licensure and for receiving third-party payment. Medicare requirements, payment methodologies and average per-patient payment are unique to each of the four PAC settings (Chart A-3).

### Recent Medicare PAC Changes

Over the years, CMS has both modified and added requirements to each PAC setting in an effort to control Medicare spending and improve quality of care.

CMS has imposed regulations in an attempt to control admissions to

the highest cost PAC providers—LTCHs and IRFs. In addition, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 will place additional patient assessment and quality reporting requirements on PAC providers.

Chart A-3: Payment by PAC Venue Type in 2013

| Provider Type                           | Facilities/<br>Agencies | Beneficiaries<br>Treated | Medicare<br>Payment<br>Type | Medicare Payment Methodology  | Average<br>Medicare<br>Payment per<br>Discharge/<br>Episode |
|---|-------------------------|--------------------------|-----------------------------|---|---|
| Long-term<br>Care Hospital              | 408                     | 122,000                  | Per<br>discharge            | Long-term care diagnosis-related groups (MS-LTC-DRGs) are based on inpatient MS-DRGs, but are weighted to reflect the resources needed to treat the medically complex patients that are typically served by a LTCH. Site-neutral payment will phase in over a two-year period starting in FY 2016.  | \$40,070  |
| Inpatient<br>Rehabilitation<br>Facility | 1,161                   | 338,000                  | Per<br>discharge            | Patients are classified into case-mix groups based on primary reason for inpatient rehabilitation, age, and functional and cognitive impairment levels, with additional classification in each group based on patient comorbidities. IRF payments are adjusted for patient characteristics, resource needs and geographic differences in wages. | \$18,258  |
| Skilled<br>Nursing<br>Facility          | 14,978                  | 1.7 million              | Per diem<br>(day)           | Patients are classified into case-mix categories, which differ by patient services (e.g. level of therapy, specialized feeding), clinical condition and patient's need for assistance in performing activities of daily living.   | \$15,790–<br>\$22,391                                       |
| Home Health<br>Agency                   | 12,613                  | 3.5 million              | Per 60-day<br>episode       | Patients are classified into one of 153 case-mix categories; the base rate is adjusted for patient characteristics, resource needs and geographic differences in wages.   | \$2,662*  |

Source: Medicare Payment Advisory Commission. (2015). *March Report to the Congress: Medicare Payment Policy*. Washington, DC.

\*Average Medicare payment per episode reflects 2012 data.

## Important Medicare Payment Changes and Requirements for PAC Providers

### Quality data reporting:

- In FY 2012, CMS began requiring that LTCHs and IRFs submit data on selected quality measures. Beginning in FY 2014 and thereafter, LTCHs and IRFs that fail to submit quality data are penalized by a reduction of 2 percent to the annual increase factor for payments made for discharges. Each year, CMS adds quality measures for reporting.
- As a result of the IMPACT Act, beginning in FY 2018 and each subsequent year, payment rates for PAC providers that fail to submit data relating to quality measures in five domains will be penalized by withholding 2 percent of Medicare payments for the respective fiscal year.

### LTCHs—Site-neutral payment, beginning FY 2016:

- LTCHs will be paid under a two-tiered system:
  - LTC-MS-DRG if a patient, preceding admission to the LTCH, was in an acute-care hospital’s ICU for at least three days and/ or if a patient was on a ventilator continuously for more than 96 hours in an acute-care hospital.
  - MS-DRG or costs, whichever is lower, for all other admissions.
- Site-neutral payment will be phased in during FYs 2016 and 2017.

### IRFs—New and clarified rules for Medicare payment in 2010:

- Required new and specific documentation (in the IRF medical record) for IRF admissions to be considered reasonable and necessary:

- Preadmission screening
- Post-admission physician evaluation
- Individualized overall plan of care
- Physician orders
- Patient assessment data included in medical record
- Clarified criteria for IRF admissions to be considered reasonable and necessary:
  - Multiple therapy disciplines
  - Intensive level of rehabilitation services
  - Ability to participate in intensive therapy program
  - Physician supervision
  - Interdisciplinary team approach to care

### PAC Payment in Transition

At the same time that PAC providers are experimenting with value-based payment models, they also are anticipating significant changes in the existing payment models. MedPAC and CMS continue to evaluate and propose refinements to the current PPS models for IRF, SNF and HHA providers that move payment away from the amount of service provided and the site of service provision. (Chart A-4).

These changes in the underlying FFS create additional financial uncertainty that is compounded with the unknowns of value-based payments and increasing pressure to reduce utilization. Despite the challenges of multiple operating models with conflicting incentives, PAC providers recognize the importance of making a definitive shift to value-based payment.

Chart A-4: Medicare fee-for-service PAC Payment in Transition<sup>27</sup>

| PAC Setting | Policy Revisions Under Consideration   |
|-------------|--|
| IRF         | Create site-neutral payment by paying IRF at the SNF rate for select conditions treated in both SNF and IRF  |
| SNF         | <ol style="list-style-type: none"> <li>(1) Base payment for therapy on patient characteristics and not the amount of rehabilitation therapy</li> <li>(2) Remove payment for non-therapy ancillary (NTA) from the nursing component</li> <li>(3) Add outlier policy to PPS</li> <li>(4) Rebase payments and start with a 4 percent reduction in payments</li> </ol> |
| HHA         | <ol style="list-style-type: none"> <li>(1) Base payments on patient characteristics to set therapy and non-therapy services and no longer use the number of therapy visits as a payment factor</li> <li>(2) Establish co-pay for episodes not preceded by hospitalization</li> </ol>   |

## ENDNOTES

23. Medicare Payment Advisory Commission. (2015). *March Report to the Congress: Medicare Payment Policy* (268). Washington, DC.
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25. Ackerly, D. C., M.D., & Grabowski, D. C., PhD. (February 2014). *Post-Acute Reform—Beyond the ACA*. *New England Journal of Medicine*, 370:8.
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27. Medicare Payment Advisory Commission. (2015). *March Report to the Congress: Medicare Payment Policy* (164–172, 182–183, 214–215). Washington, DC.



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