THE POST-ACUTE CARE WORLD

Deborah W. Robin, M.D., MHCM
Corporate Medical Director, naviHealth
DISCLOSURE

Corporate Medical Director at naviHealth
ITS ALL ABOUT MEDICARE

“Ready to walk the Reimbursement Maze?”
POST-ACUTE CARE (PAC)

• What is it?
  • The care that a patient receives following an acute illness or injury in order to maximize functional and medical recovery.
  • Older patients with complex medical needs frequently require care in multiple settings
  • Often associated with a new diagnosis or a change in functional status which is acute and unplanned
  • Prognosis for functional recovery is poor

• Levels of PAC
  • Home Health Care (HH)
  • Skilled Nursing Facility (SNF)
  • Inpatient Rehabilitation Facility (IRF)
  • Long Term Acute Care (LTAC)

• 40% of Medicare hospital admissions are discharged to PAC
  • Largest percentage go to SNF
  • 20% are re-hospitalized
  • Many will use multiple PAC sites of care
LONG TERM ACUTE CARE

• Most intense level of care post hospital
• Regulatory
  • Must maintain at least a 25 day average length of stay
  • Licensed as acute care or specialty hospitals
  • Use acute hospital days
• Certified by Medicare as long-term care hospitals
• Accredited by JCAHO
• Types of patients
  • Technology dependent
    • Ventilator dependent and difficult to wean
    • Special monitoring
    • IVs
    • Dialysis
    • Nutritional support – TPN, tube feeding
    • Complex wound care
  • Medically complex – multi-system failure

Examples of appropriate patients:
  • Prolonged vent dependent with weaning potential
  • Multiple complex wounds that require frequent or complicated dressing changes
  • Enterocutaneous fistulas requiring TPN
  • Multi-organ failure requiring close medical monitoring
INPATIENT REHABILITATION FACILITY

• Regulatory
  • Licensed as acute hospitals
  • Must provide 24-hour, 7 day-a-week availability of physicians and nurses with specialized training or experience in medical rehabilitation.
  • Must have medical, surgical and mental health specialists available to provide consultations.
  • Must have access to hospital services necessary for the diagnosis and treatment of the co-morbidities that can occur during the course of a patients stay.
  • 60% of admissions have to have one or more of 13 medical conditions:
    • stroke, congenital deformity, major multiple trauma, amputation, hip fracture, spinal cord injury, traumatic brain injury, burns and neurologic diseases (Parkinson’s disease, multiple sclerosis, muscular dystrophy).
    • 4 musculoskeletal conditions

• Types of patients
  • Most likely to return to previous function
  • Significant functional deficits
  • Medically complex but stable
  • Capable of participation – stamina and cognition
  • Clear functional goals – realistic and offer practical improvements

Examples of appropriate patients:
  • CVA with reasonable chance for recovery
  • Traumatic brain injury
  • Multiple trauma
SKILLED NURSING FACILITY

- Over 50% of nursing home admissions are hospital discharges most often to skilled level of care - Only accounts for 4% of nursing home care
- Admission criteria are imprecise - Decisions usually made on a case by case basis
- Medicare Part A
  - 100 days
    - Pays 100% of first 20 days
    - 80% of next 80 days
      - 20% covered by Medicare supplement, Medicaid or self pay
- Regulatory - Must meet strict qualifying criteria
  - 3 day inpatient hospital stay – observation status doesn’t count
  - Need for a daily “skilling service”
    - PT/OT/ST
    - New tube feeding
    - Complex wound care
    - IV antibiotics
- Medicare Advantage
  - Requires prior approval – will limit number of days
  - May waive requirement for 3 day inpatient stay
INTERMEDIATE LEVEL OF CARE

• Traditional long term care
  • Nursing Homes are frequently called Skilled Nursing Facilities

• Payer sources
  • Medicaid
    • Over 50% of residents
    • Based on need for care and lack of financial resources
    • May require spend down
  • Private pay
  • Long term care insurance

• Admissions
  • Skilled nursing care
  • Community – usually a waiting list
  • Directly from hospital – “medical necessity”
HOME HEALTH CARE

• 16% of hospitalized Medicare recipients are discharged to Home Health Care
• Must be home-bound
  • **Criteria One:** The patient must either:
    • Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence or
    • Have a condition such that leaving his or her home is medically contraindicated.
  • If the patient meets one of the Criteria-One conditions, then the patient must also meet two additional requirements defined in Criteria-Two below.
    • **Criteria-Two:**
      • There must exist a normal inability to leave home and
      • Leaving home must require a considerable and taxing effort.
• Medicare does not pay for 24 hour-a-day care at home, meals delivered to the home, homemaker services or personal care.
PAC IS GROWING

The New York Times

The Hidden Financial Incentives Behind Your Shorter Hospital Stay
Austin Frakt
THE NEW HEALTH CARE JAN. 4, 2016

Hospital and Post-Acute Utilization Over Time

- SNF Days Per 1000
- Home Health Per 1000
- Hospital Length of Stay
PAC IS EXPENSIVE

Chart 8.2. Home health care and skilled nursing facilities have fueled growth in Medicare’s post-acute care expenditures

Note: These numbers are program spending only and do not include beneficiary copayments.

- Increases in fee-for-service (FFS) spending on post-acute care have slowed in part because of expanded enrollment in managed care under Medicare Advantage; Medicare Advantage spending is not included in this chart.

TABLE 2: Unit of Payment, Average Payment Amount, and Length of Stay in Post-Acute Care Settings, 2010

<table>
<thead>
<tr>
<th>Unit of Payment</th>
<th>Skilled Nursing Facility</th>
<th>Home Health Agency</th>
<th>Inpatient Rehabilitation Facility</th>
<th>Long-Term Care Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average payment per unit</td>
<td>$10,806</td>
<td>$2,839</td>
<td>$17,085</td>
<td>$38,582</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>27 days</td>
<td>2 episodes</td>
<td>13.1 days</td>
<td>26.6 days</td>
</tr>
</tbody>
</table>

PAC spending accounts for 73% of the Medicare spending variation – more so than spending on acute care - suggesting that there are significant market forces and practice variations driving PAC utilization rather than medical necessity or patient outcomes.
PAC IS CHANGING

• LTAC PAYMENT REFORM
• BPCI
• SITE NEUTRAL PAYMENTS
• IMPACT
CURRENT PAYMENT – Prospective Payment System

• **SNF**
  • Variable per diem rate
  • Based on 66 Resource Utilization Group (RUG) categories
    • Each RUG category has two components – rehabilitation and nursing RUG rate is determined retrospectively using the minutes of therapy reported during the look back period for the Minimum Data Set
  • Incentivizes:
    • High RUG categories
    • Long length of stay

**Rehabilitation RUG Categories**

<table>
<thead>
<tr>
<th>RUG Category</th>
<th>Therapy Minutes</th>
<th>Disciplines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultra High</td>
<td>720</td>
<td>1 Discipline – 5xwk, 1 Discipline – 3xwk</td>
</tr>
<tr>
<td>Very High</td>
<td>500</td>
<td>1 Discipline – 5xwk</td>
</tr>
<tr>
<td>High</td>
<td>325</td>
<td>1 Discipline – 5xwk</td>
</tr>
<tr>
<td>Medium</td>
<td>150</td>
<td>Treatment 3xwk by any discipline combination</td>
</tr>
<tr>
<td>Low</td>
<td>45</td>
<td>Treatment 3xwk by any discipline + 2 RNP programs 6xwk</td>
</tr>
</tbody>
</table>

**NURSING INDEX**

Determined by summing up all the individual Activities of Daily Living (ADL) scores for each of the four daily activities: bed mobility, transfer, eating and toilet use - from 0-4. The range of scores is 0-16 with a higher score representing a greater dependency and need for more nursing care.
CURRENT PAYMENT – Prospective Payment System

- **IRF**
  - Similar to an acute hospital DRG
    - Cases are grouped into Rehabilitation Impairment Categories
    - Further grouping into case-mix groups (CMG)
      - Grouped into Tier 1-4 within each CMG
  - Additional adjustments are made for interrupted stays, stays of less than three days, short stay transfers and high cost outliers
  - Regional adjustments
  - For an IRF to qualify for payment under this system, 60 percent of IRF admissions must

- **LTAC**
  - Payments are determined according to the principle diagnosis or Long-Term Care Diagnosis-Related Groups.
    - Higher than an acute hospital and are, therefore, the highest cost post-acute care setting and should be reserved for the sickest patients.
  - Adjustments for short stays and outliers

- **Home Health Care**
  - Single payment for all services provided in a 60-day episode of care
  - Costs per visit are significantly less than the daily costs of skilled nursing care
  - Case mix methodology adjustment for patient characteristics and resource needs
  - LUPA and outlier payment adjustments
WHERE PAC IS GOING

Figure 1. Transitions in U.S. health care.

*Note.* ACOs = accountable care organizations; FFS = fee for service.

AJOR April 2016
PAYMENT REFORM – REDESIGN OF PAC PPS

• Overlap in types of patients treated across the 4 settings
  • Geographic variation in availability and practice patterns
  • Lack of clear criteria identifying which patients need PAC and how much
  • Lack of evidence-based guidelines
• Medicare pays different rates for similar patients depending on the setting
• Goal: Unified PAC PPS
  • Move away from separate PAC payment systems
  • Common payment system that spans the 4 settings
    • Payment based on patient characteristics not site of service
• Per stay payment adjusted for:
  • Patient’s condition
  • Co-morbidities
  • Functional status
  • Cognitive status
  • Impairments
PAYMENT REFORM – IT'S ALREADY HERE

• In 2015 Medicare, enacted LTAC payment reform
  • LTACs will be paid the full Medicare prospective rate for patients:
    • Prior acute care stay included at least 3 days in ICU or CCU
    • The patient is on a ventilator and spends at least 96 hours on a ventilator following LTAC admission
    • Admitted to the LTAC immediately following discharge from acute care
  • LTAC care for all other patients will be reimbursed on a per diem site neutral rate
  • LTACs that receive more than 25% of their patients from a single referring hospital will receive a reduced payment
  • Excluded from the 25-day average LOS calculation
    • Discharges paid on a site neutral basis
    • Medicare Advantage
  • 50% Rule - At least 50% of all discharges must be reimbursed at LTAC rates to preserve eligibility for LTAC reimbursements
    • If not, all discharges for future cost reporting periods will be paid at the site neutral rate
  • New LTAC quality measure
    • Change in mobility for patients requiring ventilator support
    • Moratorium on new LTAC beds and hospitals
PAYMENT REFORM – IT'S ALREADY HERE - BPCI

Initiative Design
Participants in the BPCI initiative can choose from among four episode-based payment models.

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode</strong></td>
<td>All DRGs; all acute patients</td>
<td>Selected DRGs; hospital plus post-acute period</td>
<td>Selected DRGs; post-acute period only</td>
<td>Selected DRGs; hospital plus readmissions</td>
</tr>
<tr>
<td><strong>Services included in the bundle</strong></td>
<td>All Part A services paid as part of the MS-DRG payment</td>
<td>All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions</td>
<td>All non-hospice Part A and B services during the post-acute period and readmissions</td>
<td>All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
</tr>
</tbody>
</table>

**Current**

- $ Acute
- $ Post-acute
- $ Part-B
- $ Readmit

Limited coordination, promotes fragmentation, patient confusion

**Bundled Reimbursement**

- One $ payment

2% discount to CMS
Remaining savings distributed
Provider reimbursement unchanged

Increased efficiency, communication, and accountability

Acute + 90 days post-acute
BPCI – RESULTS (JAMA Internal Medicine – Feb 2017)

• Observational study in 3942 patients who received lower extremity joint replacement surgery

• Average Medicare episode expenditures declined
  • Without complications - $26785 to $21208 (20.8%)
  • With complications - $38537 to $33216 (13.8%)

• Readmissions and ER visits declined

• Stable patient illness severity

• Savings due to:
  • Declining implant costs
  • Decreased use of PAC

• Medicare launching new mandatory bundles
  • Heart Attack
  • Cardiac bypass surgery
  • Hip and Femur fracture treatment

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PAYMENT REFORM - PROPOSED

• Site-Neutral Payments for IRF - MEDPAC report – June 2014
• Comparison of PAC Facilities – IRF and SNF
• 3 conditions frequently treated in both settings
  • Other hip and femur procedures (Hip fracture)
  • Major joint replacement
  • CVA
• The services in the 2 settings differ – should MCR pay for these differences when the patients admitted and the outcomes they achieve are similar?
• What is the Most cost effective site of care?
  • Payments to IRFs were usually higher than to SNFs
  • Larger percentage of these patients are treated in SNFs
• Recommendations:
  • the patients and outcomes for the orthopedic conditions were similar and represent a strong starting point for a site-neutral policy.
  • Patients receiving rehabilitation care after a stroke were more variable, and additional work needs to be done to more narrowly define those cases that could be subject to a site-neutral policy and those that could be excluded from it.
PAC REFORM – IMPACT ACT 2014

Improving Medicare Post-Acute Care Transformation Act of 2014

• Authorizes a uniform method of patient assessment in postacute care
• Requires the submission of standardized data by all PAC settings – the CARE Tool
  • Current:
    o Home Health Care – OASIS
    o SNF – MDS
    o IRF – IRF-PAI
    o LTAC – none
• Standardized measure domains (Quality reporting):
  • Skin integrity and changes in skin integrity;
  • Functional status, cognitive function, and changes in function and cognitive function;
  • Medication reconciliation;
  • Incidence of major falls;
  • Transfer of health information and care preferences when an individual transitions;
  • Resource use measures, including total estimated Medicare spending per beneficiary;
  • Discharge to community; and
  • All-condition risk-adjusted potentially preventable hospital readmissions rates.
• Sets a timetable for developing, implementing, and reporting quality measures
• Lays the groundwork for future payment reform in postacute care (Resource utilization).
PAC REFORM – UNIFORMED PAYMENT SYSTEM

REPORT TO CONGRESS:

• It is feasible to develop a common unit of service
• Patient and stay characteristics can form the basis of risk adjustment
• Separate payment methodology for non-therapy ancillary services
• Special adjustments for Home Health Care
• Patient assessment data using a common assessment tool can be used to predict costs
• Short stay and high cost outlier policy
• Regulatory changes will be needed
• Goal – reward appropriate high quality care
• Expected outcome
  • Redistribution of payments
    • From physical rehabilitation to medically complex care
    • Higher cost settings to lower cost settings
  • Decreased financial incentives for:
    • Cherry picking
    • Provision of unnecessary care
PAC REFORM – UNIFORMED PAYMENT SYSTEM

COMPANION POLICIES

• To decrease incentives to stint on care or generate serial PAC stays
  • Readmission policy to prevent unnecessary hospital admissions
    • Incentivize providers to furnish adequate quality of care to keep patients out of the hospital
  • Value based purchasing to tie payments to outcomes
    • Tie a portion of payments to measures of quality and resource use
  • Providers at full financial risk
    • Decrease unnecessary PAC stays
    • Encouraging care coordination
THE FUTURE OF PAC

Push toward less expensive, “lower” levels of care

LTAC
- Some will close and already have
- May reach out to hospitals for site-neutral patients

IRF
- Some will close
- Need to refocus on area of specialization – eg TBI, spinal cord injury

SNFs
- Lower cost alternative so need to step up their game
- Need to improve level of medical oversight
  - Medically complex patients
  - Decrease acute care utilization
  - Network opportunity

Home Health Care
- Least costly alternative
- Need to improve level of medical oversight
  - Medically complex patients
  - Decrease acute care utilization
  - Network opportunity
QUESTIONS AND COMMENTS