Long-Term Acute Care Hospitals: Bracing for Change

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PREPARED BY:

Mandy Asgeirsson and Greg Russo

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Between 2004 and 2013, Medicare spending for care rendered in long-term care hospitals (LTCH) increased from $3.7 billion to $5.5 billion.[1] Medicare beneficiaries constitute the majority of patients being served by these providers. With this increase in spending, Medicare sought to implement a change in the manner in which it pays for care rendered by LTCHs through the Pathway for SGR Reform Act of 2013. This change, implemented in fiscal year 2016, aims to reduce the payment rate for certain discharges and will impact the LTCHs and the industry. We explore this impact in this paper.

LTCHs are acute care hospitals that typically treat chronically, critically ill patients who have a length of stay greater than 25 days. Before the recent changes, Medicare reimbursed these providers under the LTCH prospective payment system (PPS). In this methodology, Medicare prospectively defines reimbursement for groupings of patients with similar characteristics and requiring similar amounts of resources. Under the Pathway for SGR Reform Act of 2013, Medicare is required to pay these providers using a "site-neutral" rate if a patient's characteristics do not meet certain criteria. The site-neutral payment is similar to what Medicare pays in the acute care hospital setting and is calculated as the lesser of two rates: the inpatient PPS (IPPS) comparable per diem amount or the estimated costs of the case.

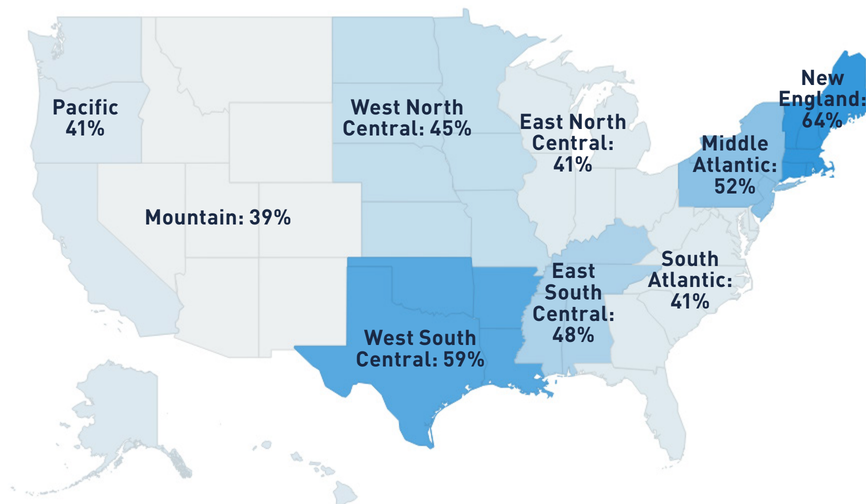
For a Medicare discharge from an LTCH to be paid using the PPS rate, the discharge must meet the following requirements:

- Not having a principal psychiatric (rehabilitation) diagnosis in the LTCH
- Having immediately prior treatment delivered at a hospital paid under the inpatient prospective payment systems
- Having one of the following courses of care:
  - Spent at least three days in an intensive care unit or coronary care unit in the subsection (d) hospital[2] stay immediately preceding the LTCH admission
  - Received at least 96 hours of respiratory ventilation services during the LTCH stay

Additionally, LTCHs will be evaluated as to the percentage of discharges paid at the site-neutral rate. If an LTCH has more than 50 percent of discharges at the site-neutral rate, Medicare will begin paying the LTCH at the IPPS rate. This evaluation will be effective in FY 2021.

Using Medicare claims data from CY 2011 through 2016, we identified LTCH discharges that would have been paid at the site-neutral payment rate per the new requirements listed above. We found the impact of these changes varied by region and year. The census divisions of New England and West South Central are most affected by the changing reimbursement methodology (see Exhibit 1). In these census divisions, in 2011, between 59 percent and 64 percent of LTCH discharges would have been subject to site-neutral payments. This varies significantly from the Pacific, Mountain, East North Central, and South Atlantic census divisions, which would have about 40 percent of discharges at a site-neutral rate.

EXHIBIT 1: SITE-NEUTRAL DISCHARGES AS A PERCENTAGE OF TOTAL DISCHARGES (2011)

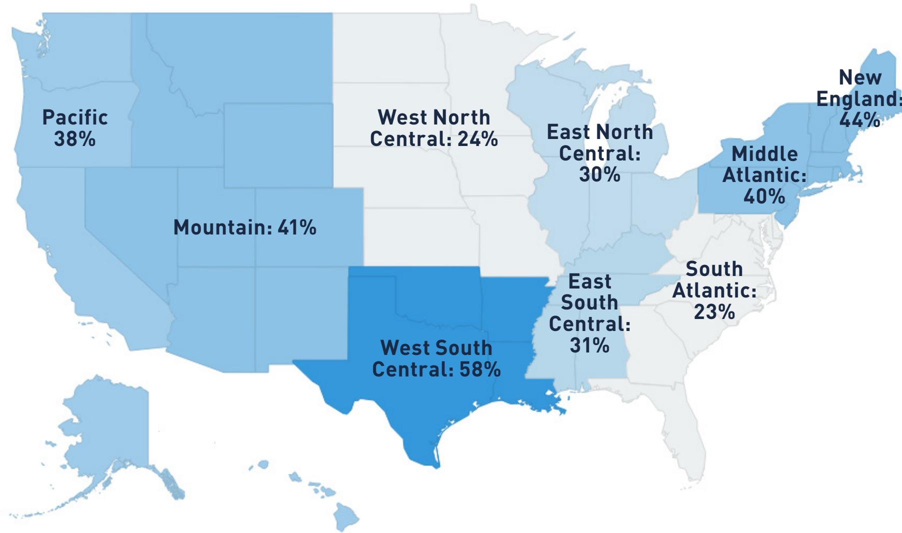


1 Chapter 11 of the Medicare Payment Advisory Commission (MedPAC) March 2015 *Report to the Congress: Medicare Payment Policy*, available at: http://www.medpac.gov/-documents-/reports

2 Subsection (d) hospital is defined in the Social Security Act, Section 1886(d)(1)(B), available at: http://www.ssa.gov/OP_Home/ssact/title18/1886.htm

In 2016, the West South Central division was impacted most, with 58 percent of the LTCH discharges subject to site-neutral payments (Exhibit 2). Of the nine census divisions, eight decreased the percentage of discharges subject to site-neutral payments from 2011 to 2016. The Mountain division actually had an increase in the percentage of site-neutral eligible discharges from 2011 through 2016.

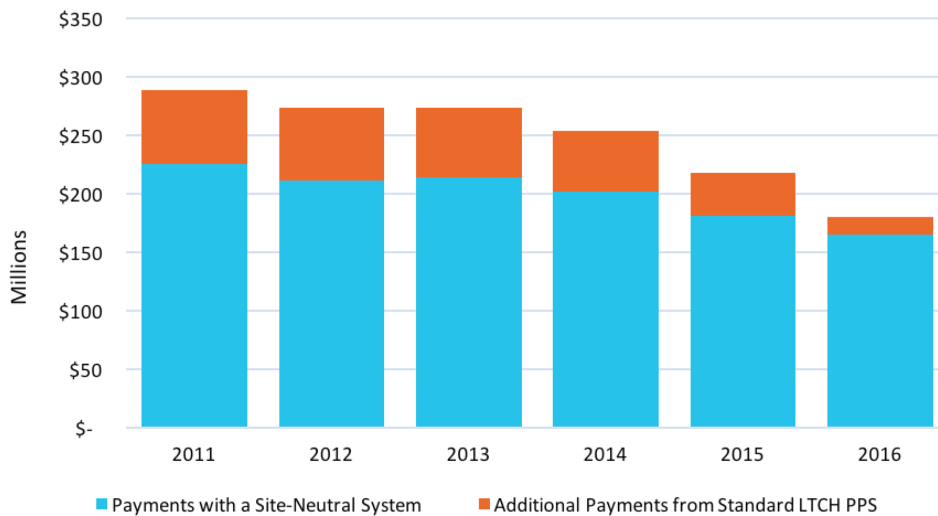
EXHIBIT 2: SITE-NEUTRAL DISCHARGES AS A PERCENTAGE OF TOTAL DISCHARGES (2016)



In addition to identifying which discharges would be paid at the site-neutral rate, we calculated the payment impact that this would have. Similar to the results shown above, the New England and West South Central divisions would be impacted most. To identify the financial impact of the payment system changes, we calculated the payments for the site-neutral system versus additional payments the LTCH would have received under the traditional LTCH payment system.

Exhibit 3 shows the impact that the payment system would have had on LTCHs in New England from 2011 through 2016. The light blue bar represents payments for discharges from the LTCH—some under the LTCH PPS and some under the site-neutral system. The orange bar represents additional payments that the LTCH would have received if discharges were paid on the LTCH PPS. From 2011 to 2016, New England payments would have decreased by 38 percent and West South Central payments by 19 percent. Comparatively, South Atlantic and West North Central payments would have decreased by less than 1 percent.

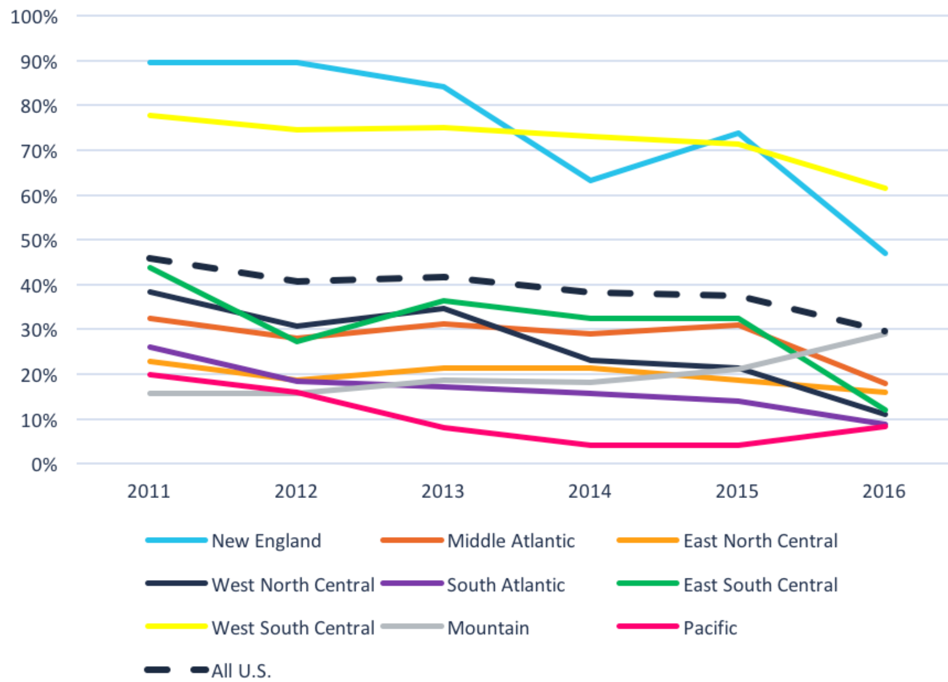
EXHIBIT 3: PAYMENTS WITH A SITE-NEUTRAL PAYMENT SYSTEM COMPARED TO THE LTCH PPS IN NEW ENGLAND



As LTCHs prepared for the payment system changes and the changes were implemented in 2015 and 2016, the impact of the site-neutral payment system also began to change. The decrease in the orange bar in Exhibit 3 is in part due to the implementation of the site-neutral payments in fiscal year 2016.

Finally, we calculated the impact of the new 50 percent rule from 2011 to 2016 for each census division. Exhibit 4 shows the percentage of LTCHs that would be reclassified as a short-term acute care hospital if this regulation had been in effect from 2011 to 2016.

EXHIBIT 4: TOTAL LTCHS PROJECTED TO BE PAID UNDER IPPS BY CENSUS DIVISION



Similar to the discharge analysis and the LTCH payment amount analysis, LTCHs in New England and West South Central were impacted most by the site-neutral payment system.

Regardless of the geographic location of an LTCH, the shifting reimbursement methodology will have an impact. Proactive analysis and review of the LTCH's discharges is necessary before full implementation of the payment system. Each LTCH should assess the impact on its business and revenues to identify strategies that can be implemented to appropriately plan for this new reimbursement methodology.

About the Authors

Mandy Asgeirsson is a senior managing consultant in BRG's Washington, DC, office who provides consulting services to healthcare clients and their counsel related to damages calculations, government investigations, and buy-side private equity deals. She can be reached at AAsgeirsson@thinkbrg.com.

Greg Russo is a managing director in BRG's Washington, DC, office who specializes in providing strategic advice and offering expert witness testimony to healthcare organizations through his use of complex data analyses, financial modeling, and understanding of the healthcare marketplace. He can be reached at GRusso@thinkbrg.com.

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