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Choosing Wisely: Next Steps
POLICY IN CLINICAL PRACTICE: Choosing Post-Acute Care in the New Decade

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Clinical Scenario: A 70 year-old woman with Medicare and a history of mild dementia and chronic bronchiectasis was hospitalized for acute respiratory failure due to influenza. She was treated in the intensive care unit (ICU) for two days requiring mechanical ventilation, and was subsequently extubated and weaned to high-flow nasal cannula (HFNC) at 8 liters oxygen per minute and noninvasive ventilation at bedtime. She otherwise had stable cognition, and required no other medical or nursing therapies. She was referred to recover in a SNF for respiratory support and rehabilitation, but was declined due to HFNC use, noninvasive ventilation, and mild dementia. Instead, she was transferred to an LTACH for respiratory support. In the context of major post-acute care (PAC) policy changes, where should and could this patient go to recover after hospitalization?

Background and History

In 2018, 44% of hospitalized patients with fee-for-service Medicare (herein referred to as Medicare) were discharged to PAC, accounting for nearly $60 billion in annual Medicare spending.[1] PAC includes four levels of care—home health agencies (HHAs), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term acute care hospitals (LTACHs)—which vary in intensity and complexity of medical, skilled nursing, and rehabilitative services, use separate reimbursement systems, employ different quality metrics and have different regulatory requirements (**see Table 1**). Because hospitalists care for the majority of these patients and commonly serve in leadership roles for transitions of care and PAC use, PAC policy has direct implications on discharge patterns and the quality and nature of care patients receive after discharge.

HHAs, the most commonly used PAC setting, provide skilled nursing or therapy to homebound beneficiaries.[1] HHAs were historically reimbursed a standardized 60-day episode payment based on case-mix, which was highly dependent on the number of therapy visits provided, with extremely little contribution from nontherapy services, such as nursing and home health aide visits.[2]

SNFs, which comprise nearly half of PAC spending, provide short-term skilled nursing and rehabilitative services following hospitalization. SNFs are reimbursed on a per-diem basis by Medicare, which historically was determined by the intensity of the dominant service furnished to the patient—either nursing, ancillary care (which includes medications, supplies/equipment, and diagnostic testing), and rehabilitation.[3] Due to strong financial incentives, over 90% of SNF days were paid solely based on rehabilitation therapy furnished, with 33% of SNF patients receiving ultra-high rehabilitation (>720 minutes/week),[3] even if it was not considered beneficial or within the patient's goals of care.[4]

IRFs provide intensive rehabilitation to patients who are able to participate in at least three hours of multidisciplinary therapy per day.[1] IRF admissions are paid a bundled rate by Medicare based on the patient's primary reason for rehabilitation, age, and level of functioning and cognition.

LTACHs, the most intensive and expensive PAC setting, care for patients with a range of complex hospital-level care needs, including intravenous infusions, complex wound care, and

respiratory support, because the only requirements for LTACHs since 2002 was to meet Medicare's requirements for hospital accreditation and maintain an average length of stay of 25 days for their population.[5] LTACH stays are paid a bundled rate by Medicare based on the diagnosis.

Policies in Clinical Practice

Due to considerable variation in PAC use with concerns that similar patients can be treated in different PAC settings,[6,7] The Centers for Medicare and Medicaid Services (CMS) recently introduced several major policy changes for HHAs, SNFs, and LTACHs (**see Table 1**).[1] No major policy changes were made for IRFs.

For HHAs and SNFs, CMS implemented new payment models to better align payment with patients' care needs rather than the provision of rehabilitation therapy.[1] For SNFs, the Patient-Driven Payment Model (PDPM) was implemented October 1, 2019, and for HHAs, the Patient-Driven Grouping Model (PDGM) was implemented January 1, 2020. These policies increase payment for patients who have nursing or ancillary care needs, such as intravenous medications, wound care, and respiratory support. For example, the per-diem payment to SNFs is projected to increase between 10-30% for patients who require dialysis, intravenous medications, wound care, and respiratory support, such as tracheostomy care.[8] These policies also increase payment for patients with increased severity and complexity, such as patients with severe cognitive impairment and multimorbidity. Importantly, these policies pay HHAs and SNFs based on the clinical needs of patients and not solely based on the amount of rehabilitation therapy delivered, which could increase both the number and complexity of patients that SNFs accept.

To discourage LTACH use by patients who are unlikely to benefit from this level of care, CMS fully implemented the site neutral payment policy on October 1, 2020 (although paused during the pandemic), which substantially decreased payment to LTACHs for patients who either did not have an ICU stay of 3 or more days preceding the transfer or did not receive prolonged mechanical ventilation in the LTACH for 96 or more hours.

Commentary and Recommendations

Historically, PAC payment policy has not properly incentivized the appropriate amount of care be delivered in the appropriate setting.[9] The recent HHA, SNF, and LTACH policy changes will not only shift the discharge of patients across PAC settings but also change the amount and type of care that occurs at each PAC site (**see Table 2**). The potential benefit of these new policies is that they will help to align the right level of PAC with patient's needs by discouraging inappropriate use and unnecessary services. Under the new HHA and SNF payment models, initial media reports suggest a decline in therapy services has occurred, which could be beneficial if the therapy was excessive and not indicated.[4,10,11] Similarly, LTACHs are experiencing a large decline in admissions that do not meet the new payment criteria.[1] As with all policy changes, the potential exists for unintended consequences. Because HHAs and SNFs are no longer

incentivized to provide therapy, they might withhold the provision of needed rehabilitation therapy.[10] Furthermore, because payments are based on patient coding by HHA and SNF providers under the new payment models, coding practices may change in order to optimize their payments. Indeed, the PDGM policy for HHAs includes a "behavioral adjustment" to account for anticipated changes in improved documentation by HHAs. Because LTACHs will be less likely to admit patients without prolonged mechanical ventilation or a qualifying ICU stay of 3 or more days, these patients might remain in the hospital for longer periods of time if they are too sick or complex for other PAC settings. Given these possible unintended consequences, the implications for hospital discharge patterns, PAC access, and quality of care will need to be closely monitored as it is unclear as to how these PAC policy changes will impact patient care.

In terms of broader payment reform, the four PAC settings are still fragmented with little effort to unify payment, regulation, and quality across the PAC continuum. As required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, we would encourage the adoption of a unified PAC payment system that spans the four settings, with payments based on patient characteristics and needs rather than site of service.[12] This type of reform would also harmonize regulation, quality measurement and reward payments across the settings. Currently, CMS is standardizing patient assessment data and quality metrics across the four PAC settings. Given the pandemic, the transition to a unified PAC payment system is likely several years away.

What Should I Tell My Patient?

For our patient who was transferred to an LTACH after referrals to SNFs were denied, post-acute care options now differ following major PAC policy reforms and SNF transfer would be an option. This is because SNFs will receive higher payment for providing respiratory support under the PDPM, and LTACHs will receive considerably lower reimbursement since the patient did not have a qualifying ICU stay or require prolonged mechanical ventilation. Furthermore, hospitals participating in accountable care organizations would achieve greater savings given that LTACHs cost at least three times as much as SNFs for comparable diagnoses.

Instead of referring this patient to an LTACH, the care team (hospitalist, discharge navigator, case management) should inform and educate the patient of discharge options to SNFs for weaning from respiratory support. To help patients and caregivers choose a facility, the discharge planning team should provide data about the quality of care of SNFs (i.e. CMS star rating scorecard) instead of simply providing a list of names and locations.[13,14] Discharge planning should start as soon as possible to permit caregivers an opportunity to visit facilities and for the providers to coordinate the transfer as seamlessly as possible.

Conclusions

Recent major PAC policy changes will change where hospitals discharge medically complex patients and the services these patients receive at these PAC settings. Historically, reduction in PAC use has been the source for savings in alternative payment models that encourage value over volume, such as accountable care organizations and episode-based ("bundled") payment

models.[15] We anticipate these PAC policy changes are a step in the right direction to further enable hospitals to achieve value by more closely aligning PAC incentives to match patient's needs.

REFERENCES:

1. Medicare Payment Advisory Commision. *Report to the Congress: Medicare Payment Policy.* Washington D.C.2020.
2. Department of Health and Human Services; Centers for Medicare & Medicaid Services. *Medicare and Medicaid Programs; CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Heatlh Quality Reporting Requirements; and Home Infusion Therapy Requirements.* 84 Fed. Reg. 60478 (November 8, 2018) (to be codified at 42 C.F.R. Parts 409, 414, 484 & 486).
3. Department of Health and Human Services; Centers for Medicare & Medicaid Services. *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Final Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program.* 83 Fed. Reg. 39162 (August 8, 2018) (to be codified at 42 C.F.R. Parts 411, 413, & 424).
4. Weaver C, Mathews AW, McGinty T. How Medicare Rewards Copious Nursing-Home Therapy. August 16, 2015; https://www.wsj.com/articles/how-medicare-rewards-copious-nursing-home-therapy-1439778701. Accessed October 13, 2020.
5. Eskildsen MA. Long-term acute care: a review of the literature. *Journal of the American Geriatrics Society.* 2007;55(5):775-779.
6. Newhouse JP, Garber AM. Geographic variation in health care spending in the United States: insights from an Institute of Medicine report. *JAMA : the journal of the American Medical Association.* 2013;310(12):1227-1228.
7. Makam AN, Nguyen OK, Xuan L, Miller ME, Goodwin JS, Halm EA. Factors Associated With Variation in Long-term Acute Care Hospital vs Skilled Nursing Facility Use Among Hospitalized Older Adults. *JAMA internal medicine.* 2018;178(3):399-405.
8. Acumen L. *Skilled Nursing Facilities Payment Models Research Technical Report.* Burlingame, CA2017.
9. Ackerly DC, Grabowski DC. Post-acute care reform--beyond the ACA. *The New England journal of medicine.* 2014;370(8):689-691.
10. Span P. A Change in Medicare Has Therapists Alarmed. November 29, 2019; https://www.nytimes.com/2019/11/29/health/new-old-age-medicare-physical-therapy.html. Accessed September 16, 2020.
11. Graham J. Why Home Health Care Is Suddenly Harder To Come By For Medicare Patients. February 3, 2020; https://khn.org/news/why-home-health-care-is-suddenly-harder-to-come-by-for-medicare-patients/. Accessed September 16, 2020.
12. Medicare Payment Advisory Commision. *Report to the Congress: Medicare and the Health Care Delivery System. Implementing a Unified Payment System for Post-Acute Care.* Washington D.C.2017.
13. Nazir AOL, M; Arling, G W. More Than Just Location: Helping Patients and Families Select an Appropriate Skilled Nursing Facility. *Annals of Long Term Care: Clinical Care and Aging.* 2014;22(11).
14. Tyler DA, Gadbois EA, McHugh JP, Shield RR, Winblad U, Mor V. Patients Are Not Given Quality-Of-Care Data About Skilled Nursing Facilities When Discharged From Hospitals. *Health Aff (Millwood).* 2017;36(8):1385-1391.
15. Barnett ML, Mehrotra A, Grabowski DC. Postacute Care - The Piggy Bank for Savings in Alternative Payment Models? *The New England journal of medicine.* 2019;381(4):302-303.

Table 1. Definition of Post-Acute Care Settings and New Major Policies Affecting Medicare Payment		
Setting	**Definition**	**New Medicare Policy**
Home health agency (HHA)	Provides intermittent or part-time (fewer than 8 hours per day) skilled nursing, therapy, aide services, and medical social work to homebound patients who generally do not leave their home except for medical appointments, religious services or other minor outings. HHAs do not provide meal delivery or preparation, nor do they provide personal care (i.e. bathing, toileting) or home services (i.e. cleaning, laundry) if this is the only care provided.	***Patient Driven Grouping Model (PDGM):*** is a new case-mix payment system that eliminated the number of visits for rehabilitation therapy as a determinant of HHA payment, and instead considers clinical diagnosis and other patient factors, including functional impairment, cognitive status, comorbidities, referral source (community versus institution), and timing (first 30-day period vs subsequent 30-day periods).
Skilled nursing facility (SNF)	Provides short-term (up to 100 days) skilled nursing care and rehabilitation therapy to patients recovering after a qualifying hospitalization of typically 3 or more days. SNFs do not provide personal care (i.e. bathing, dressing) if this is the only type of care required. Most SNFs are dually certified as nursing homes, which provide long-term care services (i.e. personal care) that are typically paid by Medicaid, but not by Medicare.	***Patient Driven Payment Model (PDPM):*** makes substantial changes to SNF payment that eliminated tying payment to total minutes of rehabilitation therapy, and instead considers many aspects of a patient's condition and care needs including nursing and ancillary care, such as wound care, intravenous medication infusions, and respiratory support.
Inpatient Rehabilitation Facility (IRF)	Provides intensive rehabilitation to patients needing at least two therapy modalities and are able to participate in at least three hours of multidisciplinary therapy a day at least five days a week. IRFs generally focus on rehabilitation of patients with strokes, spinal cord injury, certain other neurological conditions, major trauma, burns, and selected orthopedic conditions.	No new policy enacted
Long-Term Acute Care Hospital (LTACH)	Provides care to patients who have extended inpatient care needs following a hospitalization, with an average length of stay of 25 or more days. While specializing in the care of patients on prolonged mechanical ventilation, LTACHs provide care for a variety of extended inpatient care needs, including complex wound care, severe infections, and multiorgan failure.	***Site neutral payment:*** stipulates full LTACH payment for patients who either had a preceding intensive care unit stay of 3 or more days or received prolonged mechanical ventilation (≥ 96 hours) in the LTACH, and are not transferred for a rehabilitation or psychiatric primary diagnosis. LTACH stays not meeting these criteria will receive a substantially reduced payment.

Table 2. Incentives for Medicare Beneficiaries Before and After Policy Changes by Post-Acute Care Setting			
PAC Setting[1]	**Incentives Pre-Policy Change**	**Incentives Post-Policy Change**	**Potential unintended consequences under new policy**
HHA	***Patient Selection***: Patients who have greater rehabilitation needs than nursing or ancillary care needs[2] ***Duration of Services:*** 60 days since HHAs received standardized payment for all covered services, adjusted for case-mix. ***Referral***: Emphasized patients' functional impairments and rehabilitation needs since number of rehabilitation therapy visits dictated HHA payment	***Patient Selection***: greater incentive to accept patients with multimorbidity with greater nursing and ancillary care needs; Less incentive for patients with minimal comorbidity burden and those who only require rehabilitation therapy. Greater incentive to enroll hospitalized patients than community-dwelling patients. ***Duration of Services***: Either 30 or 60 days. New policy has split the 60-day episode into two 30-day episodes, with more payment for the first 30 days since more services used during this time period. ***Referral***: More holistic focus of post-discharge needs, including non-rehabilitation therapy	Patients may receive less rehabilitation therapy since payment to HHAs is no longer tied to the number of therapy visits May experience more requests to refer to HHA after hospitalization rather than from outpatient setting given increased payment if referral originates from a hospital.
SNF	***Patient Selection***: Patients who have greater rehabilitation needs than nursing or ancillary care needs ***Duration of Services:*** For SNFs, patients with a qualifying hospital stay and remaining days in the benefit period are covered for the first 20 days, with co-insurance of $176 per day for days 21-100. ***Referral***: Emphasized patients' functional impairments and rehabilitation needs since the amount of rehabilitation therapy dictated SNF payment	***Patient Selection***: greater incentive to accept patients with multimorbidity with greater nursing and ancillary care needs. The per-diem reimbursement is projected to increase between 10-30% for patients who require dialysis, intravenous medications, wound care, and respiratory support, such as tracheostomy care. There will be less financial incentive to accept patients with minimal comorbidity burden and those who only require rehabilitation therapy. ***Duration of services***: no change ***Referral***: More holistic focus of post-discharge needs, including non-rehabilitation therapy	Patients may receive less rehabilitation therapy since payment to SNFs is no longer tied to number of therapy minutes
LTACH	***Patient selection***: "Sick-but-stable" patients needing 3-4 weeks of care, but not too medically complex or costly.	***Patient selection***: Increased focus on patients needing mechanical ventilation or who have survived a critical care stay of 3 or more days and require 3-4 weeks of hospital-level care	Mistriage patients to other PAC settings who have LTACH-level care needs but do not meet the new payment criteria
Abbreviations: PAC, post-acute care; HHA, home healthcare agency; SNF, skilled nursing facility; LTACH, long-term acute care hospital [1] No policy changes were made to inpatient rehabilitation facilities [2] Includes medications, supplies, equipment, and diagnostic testing			