Post Acute and Long-Term Care

An HSCRC Work Group for Progression of the Total Cost of Care Model

MARYLAND HEALTH CARE COMMISSION

MARCH 16, 2023

Background

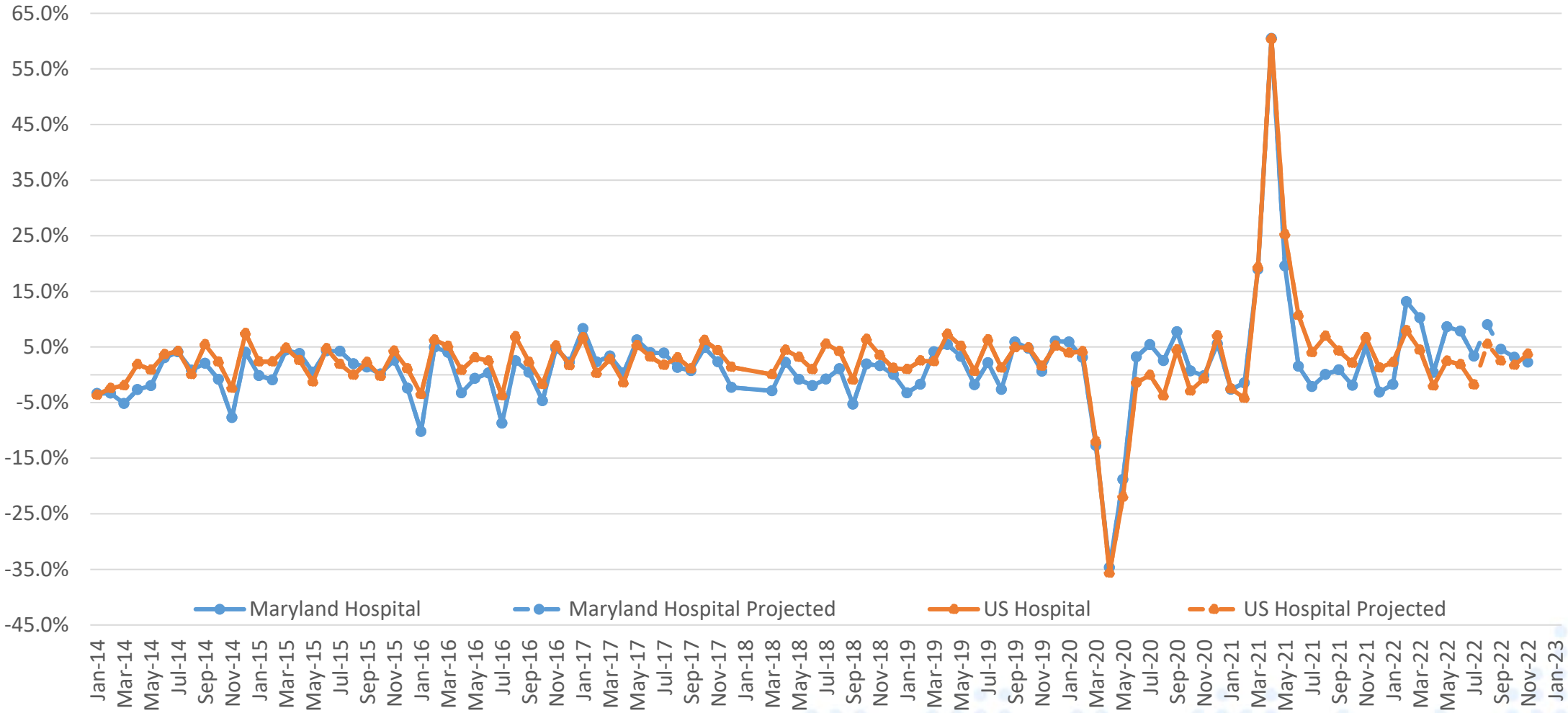
- Post acute care refers to treatment services delivered following discharge of a patient from general hospital acute care. It includes hospital-level rehabilitation (termed “acute rehabilitation” by MHCC), skilled nursing facility (SNF) services, home health agency services, hospice services, and outpatient rehabilitation services
- SNF services are a Medicare benefit for rehabilitation of patients following discharge from a hospital.
- Medicare covers up to 100 days of SNF care per spell of illness after a medically necessary inpatient hospital stay of at least three days. Payment is 100% for the first 20 days of care. Co-payments begin with day 21 through day 100.
- Almost all of Maryland’s comprehensive care facilities (nursing homes) are certified by Medicare to provide SNF rehabilitative therapies to help patients regain skills or functions they've lost because of injury or illness. Among the most common therapies provided are physical therapy, occupational therapy, and speech/language pathology services.

The Problem

- Beginning in 2018, HSCRC has regulated hospital charges under a Total Cost of Care (TCOC) Model State Agreement with the federal government.
- As part of that agreement, HSCRC committed itself to achieving $300 million in annual, total Medicare spending by the end of 2023.
- Between early 2021 and early 2022, the trend in non-hospital Medicare spending in Maryland, which includes SNF services, significantly exceeded the national growth trend. Prior to 2021, the Maryland trend more closely aligned with the nation and, in 2022, the gap between the Maryland and U.S. trend moderated. However, growth in non-hospital Medicare spending in Maryland in 2022 continued to exceed growth in national Medicare spending for non-hospital services.
- In the past two years, HSCRC has not met its Agreement objectives of moderating hospital spending growth or achieving specific savings target for total Medicare spending.

Medicare Hospital Spending per Capita

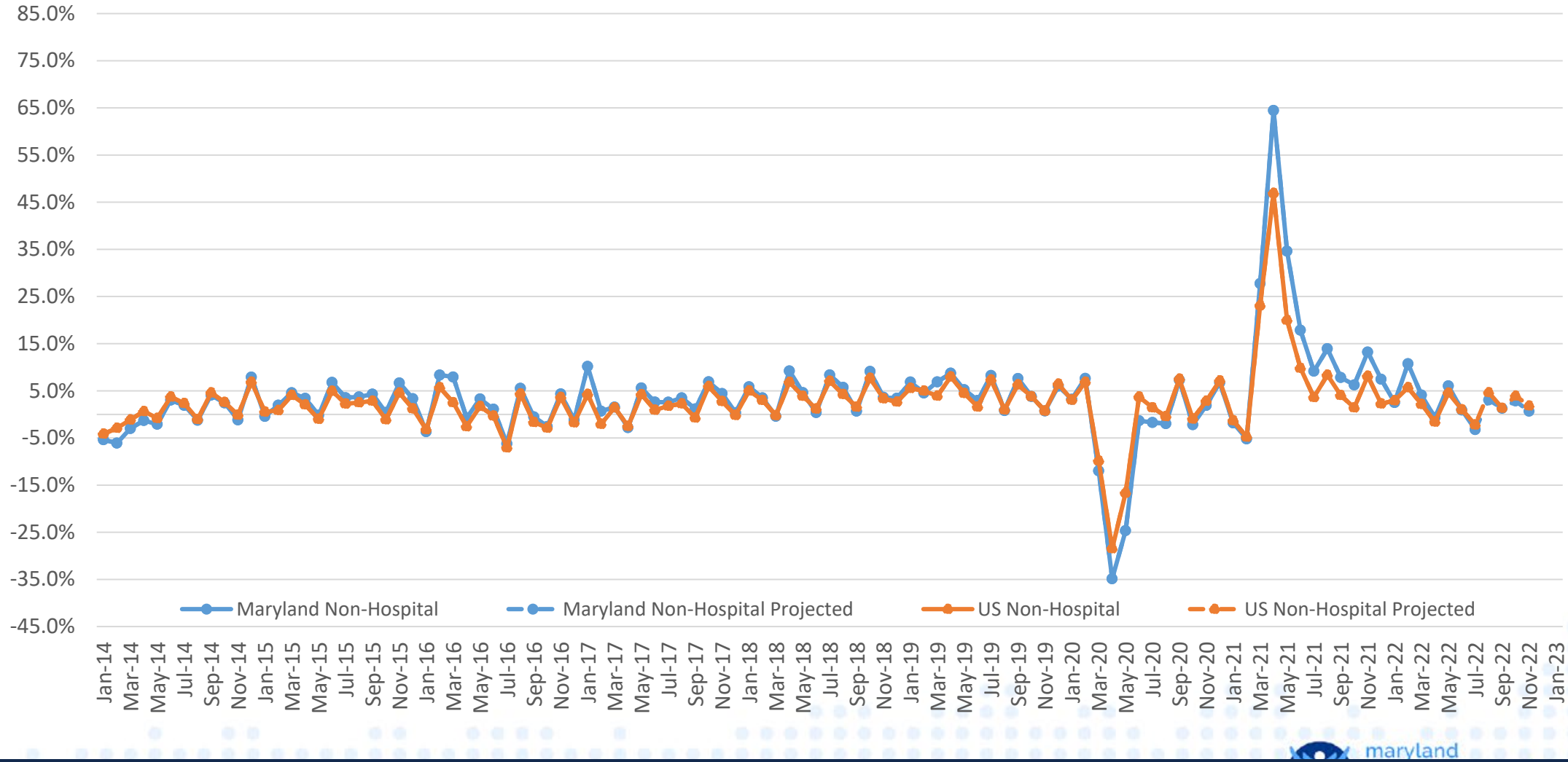
Actual Growth Trend (CY month vs. Prior CY month)



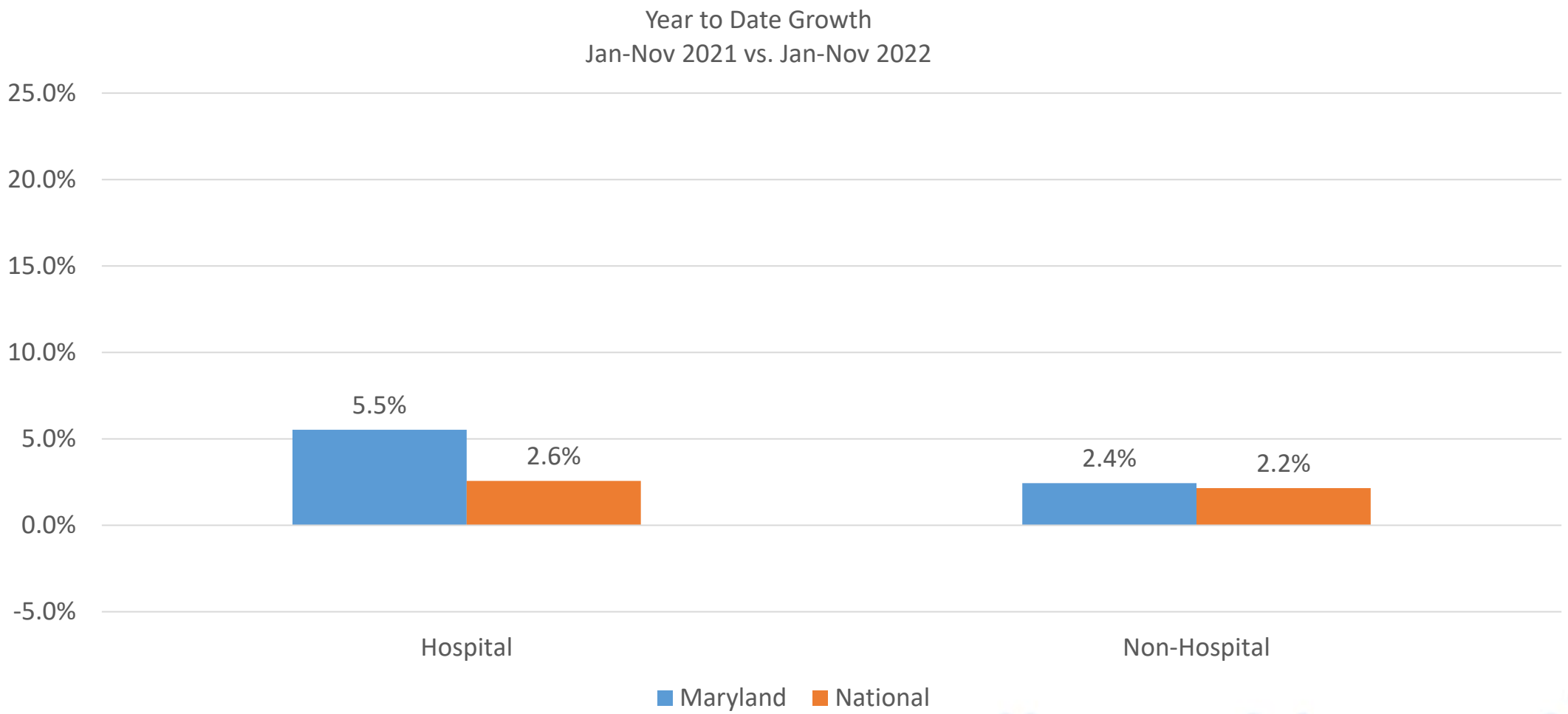
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)

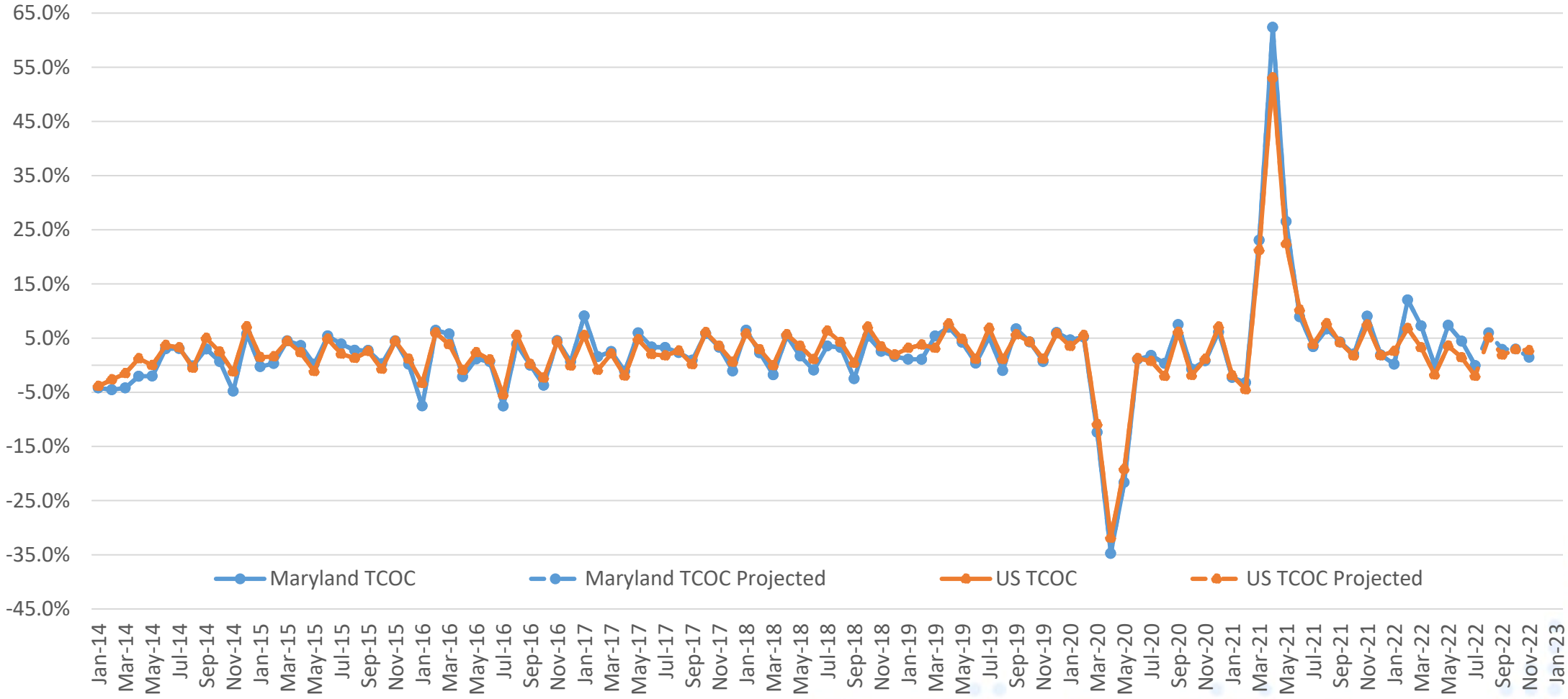


Medicare Hospital and Non-Hospital Payments per Capita



Medicare Total Cost of Care Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)



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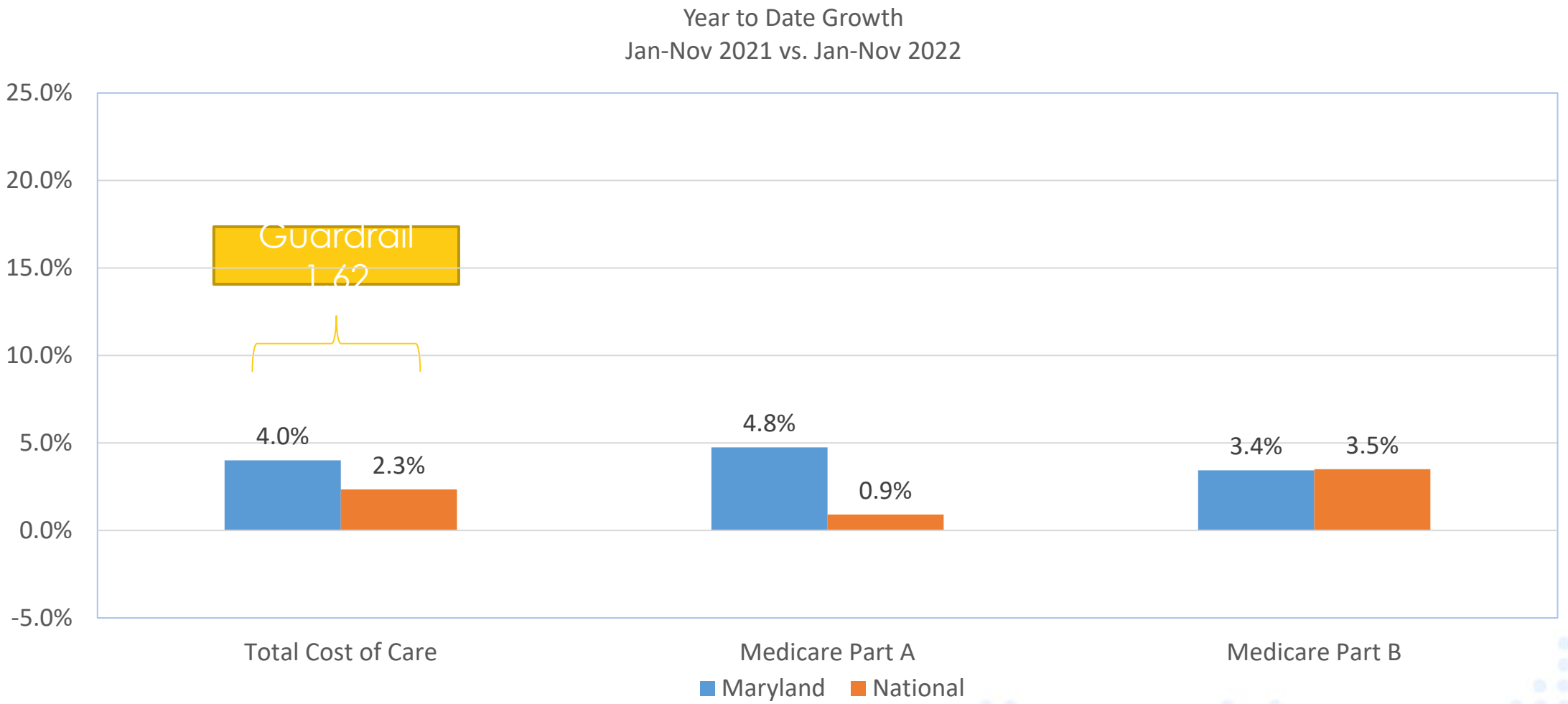
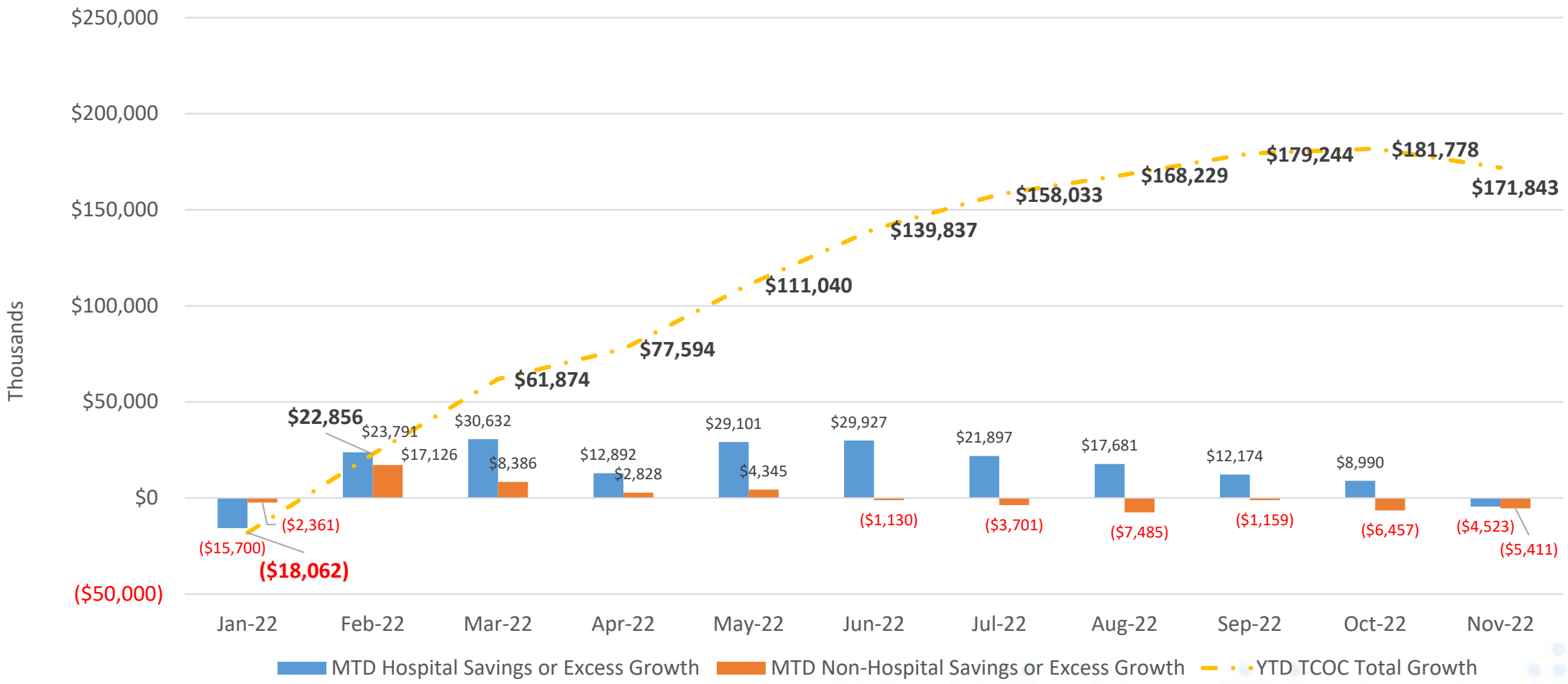
Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through November 2022



Note: A positive number represents dissavings/excess growth.

The Workgroup

- At the beginning of this year, HSCRC convened several workgroups charged with generating ideas and policy recommendations to improve quality of care, increase care coordination, and reduce costs.

- The specific initial charge for the Post Acute and Long-Term Care Workgroup is to make recommendations for moderating the trend in Medicare expenditures for inpatient episodes of care that include a general hospital stay followed by a stay in a SNF for Medicare post-acute care rehabilitation by the Spring of 2023.

- The Workgroup includes hospital and nursing home representatives and staff from HSCRC, the Medicaid program, and MHCC.

- After an informal group discussion in October 2022, the Workgroup has met officially in January and February 2023 and has a third meeting scheduled for March 20.

Ideas

- Improving the quality of SNF care while reducing costs can be achieved by reducing the length of stay by patients in a SNF and by reducing readmissions to the hospital by SNF patients. Reducing readmissions to the hospital appears to be the bigger opportunity for both quality of care improvement and cost reduction. Maryland has a higher readmission rate to the hospital among SNF patients (ranging above 20% in recent years) than the U.S. (reported as 14.2% in 2020 by MedPAC).

- Cost reductions can also be achieved by reducing admissions to general hospitals that are likely to result in discharge to a SNF and by substituting other forms of post acute care (e.g., home health care) for SNF care.

- Most of the Workgroup discussion has focused on reducing readmission of SNF patients to the hospital. This will require improvements in case management of SNF patients so that the illness conditions and injuries that tend to result in transfer of a SNF patient to the hospital are prevented or receive the correct early intervention by the SNF care team so that admission to the hospital is not necessary.

Incentives for Improved Case Management

- Hospitals, under the current global budget revenue (GBR) model, are strongly incentivized to reduce admissions and readmissions. When they are successful in reducing admissions below the projected level reflected in their GBR, they retain the revenues while reducing expenditures.

- In general, SNFs operate under a fee for service payment model. Unlike hospitals, reducing readmissions to the hospital do not automatically improve the bottom line and can reduce potential Medicare revenue streams generated by SNF patients returning after a medically necessary hospital stay of three or more days.

- This misalignment of financial incentives has resulted in a proposal by a Workgroup member to bring Maryland SNFs under the Maryland TCOC model, with rates controlled by HSCRC. Under this proposal, SNFs achieving reductions in readmissions and improvements in other specified quality metrics would be rewarded through receiving some of the savings achieved. Hospitals participating in collaborative models with SNFs would still retain most of the savings generated.

Financial Incentives for Improved Case Management

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- This misalignment of financial incentives is cited as the chief reason for a proposal by a Workgroup member to bring Maryland SNFs under the Maryland TCOC model, with rates controlled by HSCRC. Under this proposal, SNFs achieving reductions in readmissions and improvements in other specified quality metrics would be rewarded through receiving some of the savings achieved. Hospitals participating in collaborative models with SNFs would still retain most of the savings generated.

Other Approaches to Improved Case Management

- The Workgroup has also heard about and discussed existing hospital/health system collaborations with SNFs to improve care and reduce readmissions These examples appear to primarily rely on the opportunity to increase SNF admissions by collaborating with hospitals to implement case management practices (a “preferred provider network” model).

- The TCOC Model includes a Care Redesign Program, enabling HSCRC to create alignment with providers to provide more coordinated care to Medicare beneficiaries. Under this program, the State of Maryland can share savings created from care improvement activities performed on Medicare beneficiaries and incentivize improved quality of care. Maryland modeled its Episode Quality Improvement Program on bundled payment programs available through CMS and other private payer bundled payment programs.

- The dominant view expressed by the HSCRC staff member on the Workgroup is that expanding the scope of health care facility charge regulation in Maryland is not a favored approach by CMS and that using and improving the programs for voluntary collaboration between hospitals and SNFs is the preferred framework for new ideas and policies.

Going Forward

- Some Workgroup members representing the nursing home industry have expressed a believe that more definitive financial incentives for SNFs are necessary to achieve improvements in quality of care that also produce substantive savings, a view that lends itself to the more direct alternative of bringing SNFs within the TCOC model.

- Maryland may be disadvantaged in some ways by the relatively lower uptake of Medicare Advantage plans by its Medicare beneficiary population. Some research has indicated that MA is associated with improved outcomes and reduced costs post SNF discharge, after adjustment for the lower average age and higher income of MA participants, suggesting some efficiencies in care for SNF patients with MA. Other studies suggest that MA patients experience reduced SNF LOS but were not strongly correlated with reduced readmission rates or improved quality of care.

- The COVID-19 pandemic appears to have created or contributed to a significant current problem in the availability of SNF beds, creating a backup of hospital patients ready for discharge. It may also be a factor in the higher turnover in ownership of SNFs in recent years, creating an unstable environment for effective hospital/SNF collaboration.