

Intensive Care

BY RONALD WINTERS

LTCHs: Restructuring and Industry Consolidation Ahead

Changes to Medicare reimbursement are expected to result in a reduction of payments to some long-term care hospitals (LTCHs) and/or a redirection of Medicare spending away from LTCHs in favor of hospitals or “acute care hospitals” (ACHs) and other health care providers. LTCHs treat medically complex — but stable — patients.¹ ACHs treat acute needs and seek to discharge patients to other appropriate venues when medically safe and financially prudent. ACHs have historically found it useful to refer certain appropriate patients to LTCHs upon discharge.

This relationship may now begin to change as the reimbursement policy can be expected to create financial pressure on certain LTCHs, particularly those not managed by the large operators or treating high volumes of chronic wound care and other low-acuity patients. This stress, in turn, could lead to or result in continued restructuring and transaction activity. In order to qualify for Medicare reimbursement (2/3rds+ of LTCH patients), LTCHs must meet the same regulatory “conditions of participation”² as ACHs, and their Medicare patients must have an average length of stay (LOS) of greater than 25 days.

Rising Costs, Shrinking Margins, Regulatory Burdens

LTCHs are considered among the most-expensive venues for providing patient care. In 2013, Medicare spent approximately \$5.5 billion to provide LTCH care for just under 138,000 LTCH cases.³ The Centers for Medicare and Medicaid Services (CMS) Fiscal Year 2016 Final Rule Impact Data File lists 419 LTCHs with data for Fiscal Year 2014; 75 percent or more are for-profit, most of the rest are nonprofit and 15 are government-operated. Very few LTCHs are located in the northeastern U.S. (42), and more than half are in the southern U.S. (225). Medicare spending in Fiscal Year 2013 was slightly greater than \$40,000 per LTCH case and varies by acuity and other factors.

LTCHs will face economic headwinds in the coming years, especially the approximately half of all LTCHs that are not managed by larger multi-facility operators. (The larger operators are presumed to have more financial resources to weather a changing environment and more operational resources to more effectively control costs.)⁴ There are three key reasons.

First, the profit (after fully loaded cost) on nearly half of patient volume will be eliminated over time.



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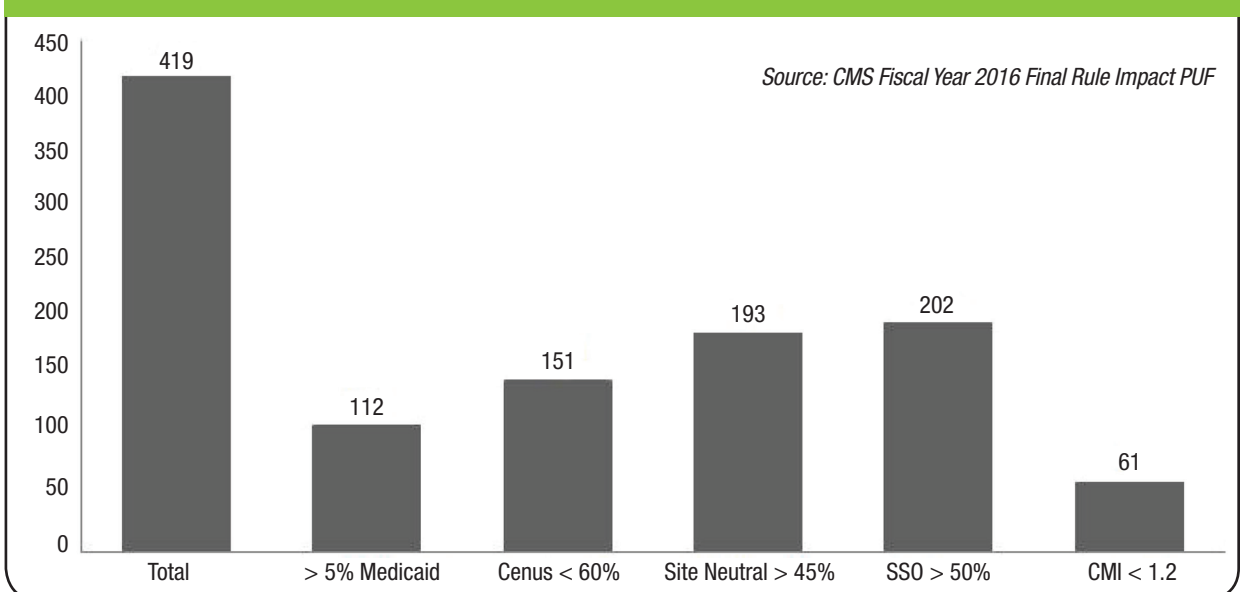
1 “[LTCHs] are certified as [ACHs], but LTCHs focus on patients who, on average, stay more than 25 days.... LTCHs specialize in treating patients who may have more than one serious condition, but who may improve with time and care, and return home. LTCHs typically give services like comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.” “What Are Long-Term Care Hospitals?” CMS Product No. 11347 (Revised August 2014).

2 Code of Federal Regulations, Title 42, part 482.

3 Report to the Congress, Medicare Payment Policy (March 2015); Medicare Payment Advisory Commission (MedPac) (the “March 2015 MedPac Report”).

4 Kindred, Select, Vibra, Cornerstone, Lincare and Promise.

Chart 1: Number of LTCHs



Under new rules going into effect under the Pathway for SGR Reform Act of 2013, for cost-reporting periods beginning as early as October 2015, in order to qualify for standard Medicare LTCH reimbursement,⁵ prior to admission to an LTCH Medicare patients must have met either of the following criterion: (1) the patient had to have been treated in an ACH intensive care unit (ICU) for at least three days, or (2) the patient is expected to receive mechanical ventilation for at least 96 hours during the LTCH stay. All other Medicare discharges will be reimbursed on a “site-neutral” basis at the rate Medicare pays ACHs under the inpatient prospective payment system (IPPS) or 100 percent of the costs, whichever is less.

For context, 45 percent of all Fiscal Year 2014 LTCH discharges would have been paid at the lower site-neutral designation had the revised reimbursement rules been in effect at that time.⁶ The impact of these reductions on LTCHs and their ability to provide service and pay expenses, including long-term debt, could be significant. But commencing for the cost-reporting period⁷ starting Oct. 1, 2019, CMS will add pressure by then limiting site-neutral cases to no more than half of all cases. CMS estimates that LTCH PPS payment rates (non-site neutral) will increase approximately 1.7 percent in Fiscal Year 2016, but actual spending on LTCH PPS cases is estimated to decrease of 4.6 percent or \$250 million because a reduced number of cases will be eligible for a standard LTCH PPS payment.⁸ A portion of this reduction will then be paid to LTCHs (and other providers) under lower-site-neutral payments. This

5 Payment under a Medicare severity diagnosis-related group (MS-LTC-DRG) reimbursement under the LTCH prospective payment system (PPS) which assigns a weighting based on acuity.

6 Calculated from CMS’s “FY 2016 Final Rule LTCH Impact PUF.xlsx.”

7 Medicare-certified institutional providers are required to submit an annual cost report to a Medicare Administrative Contractor (MAC). This report contains provider information such as facility characteristics, utilization data, costs and charges by cost center (in total and for Medicare), Medicare settlement data and financial statement data. CMS maintains the cost-report data in the Healthcare Provider Cost Reporting Information System (HCRIS), available at www.cms.gov.

8 Based on a market basket update of 2.4 percent adjusted by a multi-factor productivity adjustment of -0.5 percentage points and an additional adjustment of -0.2 percentage points in accordance with the Affordable Care Act, available at www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-31-4.html (last visited on Aug. 19, 2015).

reduction is for Fiscal Year 2016, so when fully phased in over two years, the annual reduction to LTCH PPS payments may be greater.

Second, quality reporting requirements may adversely impact LTCHs in two ways:

- Medicare established an LTCH quality-reporting program required under the Patient Protection and Affordable Care Act of 2010 (PPACA) requiring LTCHs to report on certain quality measures. Beginning in Fiscal Year 2014, the “market basket update”⁹ will be reduced by two percentage points for any LTCH that does not report on a specified set of quality measures.

- Under the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), which addresses post-acute care (PAC), a standardized patient-assessment tool was created. The results of required reporting could have a subsequent impact on reimbursement levels and rates in later periods because this standardized data will enable Medicare to compare quality across all four PAC settings,¹⁰ which may then lead to further downward adjustments to LTCH reimbursement.

Third, there are other factors not yet legislated or under current regulation but being promoted by MedPac that could put further pressure on LTCH revenues. MedPac is an independent congressional agency established by the Balanced Budget Act of 1997 to advise Congress on issues affecting the Medicare program. Although Medicare is implementing a “payment update” that generally increases the LTCH PPS payments described above, all 17 MedPac Commissioners voted to recommend not to update the payment rates at all in each of the last two years. According to the reports, statements and testimony:

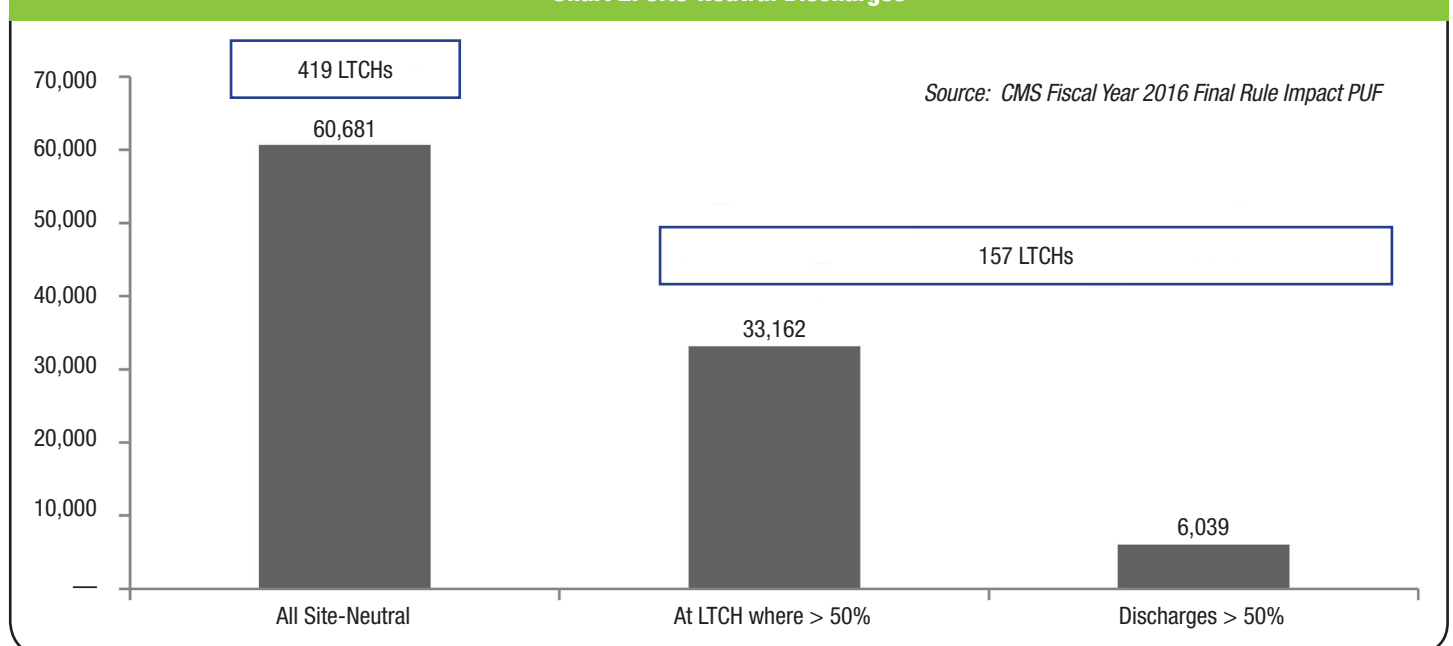
- MedPac has stated that the absence of meaningful criteria for LTCH admission, coupled with comparatively

9 The CMS market baskets are used to update payments and cost limits in the various CMS payment systems. They also reflect input price inflation facing providers in the provision of medical services.

10 LTCHs, in-patient rehabilitation facilities, skilled-nursing facilities and home-health agencies.

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Chart 2: Site-Neutral Discharges



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attractive rates, has resulted in regional oversupply and the treatment of patients who are not critically ill and could be cared for in less-expensive settings.¹¹

- MedPac has stated that LTCHs should only treat “chronically critically ill” (CCI) patients¹² and, relying on various studies, believes that an ICU length of stay is the best proxy for gauging a CCI standard.
- MedPac asserts that other services should be paid comparably irrespective of where the services are provided (MedPac is also scheduled to publish a study in June 2016 examining post-acute payment systems).
- MedPac has recommended that the minimum ICU-day criterion for LTCH PPS payment be made even more stringent and expanded to eight days.¹³ While this may reduce LTCH payments, there is some overlap with the new criteria presently being implemented; nearly 70 percent of LTCH discharges that complied with the criterion for mechanical ventilation were previously in an ICU for more than eight days.
- MedPac has recommended that the savings from its recommended change be directed to increase high-cost outlier payments under the IPPS, which essentially redirects funds from LTACHs to ACHs (at least in part).

According to a Bank of America report,¹⁴ MedPac’s more-restrictive criteria would reduce LTCH PPS payments by \$0.7 billion annually when fully implemented. In addition to the MedPac pressures, CMS itself is

implementing pilot programs exploring opportunities to bundle a single payment for services provided in PAC and ACH settings.

LTCHs will need the phase-in periods to re-engineer themselves to deal with the lost profit on 50,000+ annual discharges that will ultimately be reimbursed at no more than cost, plus some case and volume that may shift back to ACHs. Pressure from these future events could occur sooner than upon full implementation of the new rules if alert creditors, landlords (including real estate investment trusts) and investors lack confidence in an LTCH’s ability to execute required changes to adjust costs or attract appropriate patients. These changes in reimbursement rates and constructs may be expected to impact future restructuring and transaction activity in the following areas.

About half of all LTCHs are not operated by major LTCH operators.¹⁵ These “independent” or smaller-chain LTCHs are concentrated in certain census regions: West South Central (83), East North Central (29), South Atlantic (29) and East South Central (20). In 2014, they accounted for about 40 percent of 2014 discharges,¹⁶ and under the new rules, it appears that a slightly greater percentage of discharges will now be reimbursed at the lower site-neutral payment. Some of these LTCHs may lack the capability to reduce costs or seek alternative revenue sources. At the same time, LTCHs controlled by major operators with significant capital backing could see the weaker operators as an opportunity for local market consolidation.

Operating at low utilization presents challenges to covering fixed costs. As shown in Chart 1 on p. 34, approxi-

11 “Hospital Policy Issues,” Statement of Mark E. Miller, Ph.D., executive director, Medicare Payment Advisory Commission (July 22, 2015).

12 CCI patients include “those who exhibit metabolic, endocrine, physiologic, and immunologic abnormalities that result in profound debilitation and often ongoing respiratory failure.” See Long-Term Hospital Payment System Payment Basics, revised October 2014.

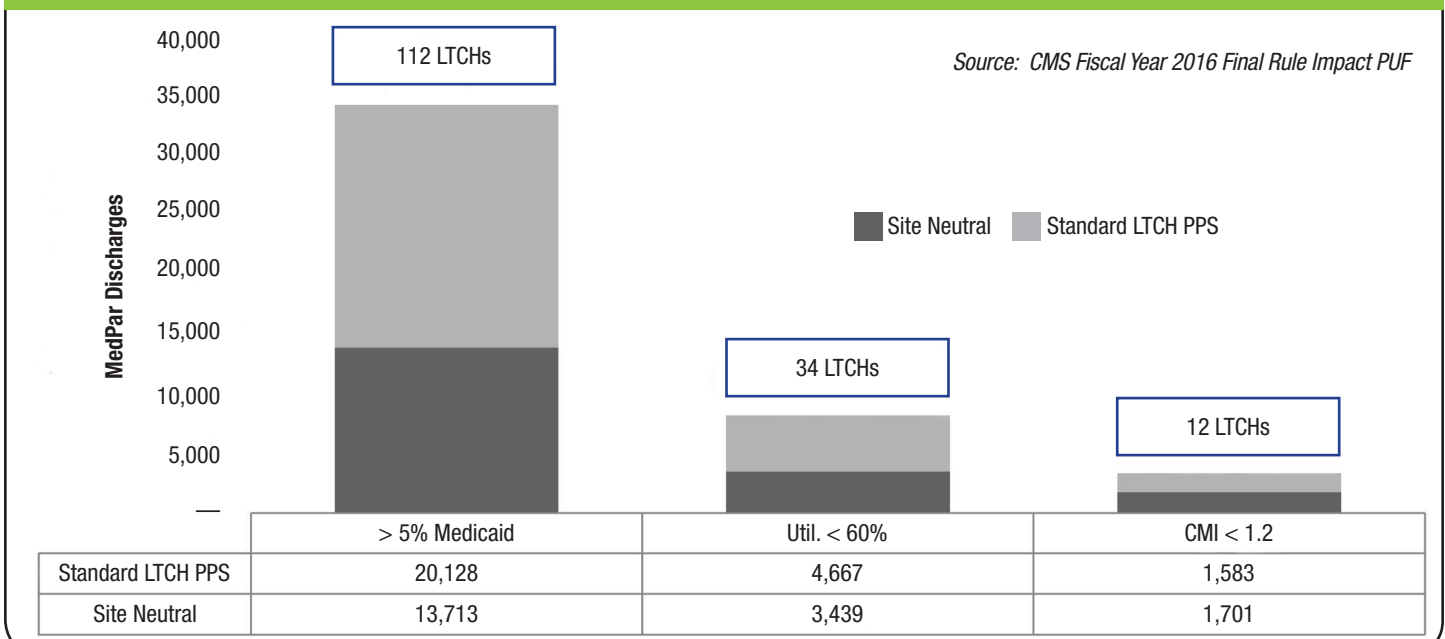
13 Per the March 2015 MedPac Report, the eight-day standard would account for 6 percent of all Medicare ACH discharges.

14 Bank of America Annual Outlook Report (long-term care hospital reimbursement), Jan. 27, 2015 (pp. 194-209).

15 See fn.4.

16 From the Medicare Provider Analysis and Review (MEDPAR) file, which contains data from claims for services provided to beneficiaries admitted to Medicare-certified in-patient hospitals and skilled-nursing facilities.

Chart 3: Medicare Discharges Where Medicaid Was > 5 Percent



mately 150 LTCH's are operating below 60 percent census, and nearly one-fifth of these are also operating at CMI of < 1.2 (below median of just under 1.4).

LTCHs may seek high-acuity patients for greater revenue¹⁷ and to support the overall minimum average LOS gauging requirement. The risk to seeking the CCI (high-acuity) patients, which CMS and MedPac indicate are LTCH-appropriate (and for which LTCHs receive the highest payments), however, is that some CCI patients may prove to be too ill for LTCH care. Approximately 30 percent of 2014 cases designated as non-site-neutral resulted in being discharged early principally for ACH re-admission or because they died¹⁸ (such patients have a "short stay outlier" (SSO) designation). Unlike LTCH PPS discharges, LTCH's receive lower SSO payments, (the lowest of four factors, but not exceeding cost).¹⁹

17 Although the standard payment is approximately \$40,000, the payment for MS-LTC-DRG 207 is nearly twice that amount.

18 The March 2015 MedPac Report noted that 27 percent and 14 percent of VSSO and SSO cases were readmitted to an ACH and that 42 percent and 20 percent, respectively, died in an LTCH. Twenty-six percent of VSSO patients discharged alive were still living one year following discharge.

LTCHs can also suffer losses from extremely costly cases ("high-cost outliers" (HCOs)). Where LTCH costs exceed cost plus a fixed loss of approximately \$15,000, the LTCH receives an HCO payment of 80 percent of the costs above this threshold (the threshold is greater for site-neutral cases). CMS targets HCO payments at about 8 percent of all Medicare LTCH payments. In Fiscal Year 2013, 78 LTCHs received HCO payments exceeding 12 percent of their total LTCH Medicare payments.

The "25 percent rule" uses payment adjustments to create disincentives for LTCHs to admit a large share of their patients from a single ACH. The rule commences in cost-reporting years starting July 1, 2016, for free-standing LTCHs, and Oct. 1, 2016, for hospitals within hospitals. This rule could also require additional expenditures to attract patients.

One hundred and fifty-seven LTCHs had 2014 site-neutral discharges exceeding the 50 percent maximum, which

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Chart 4: Top 25 MS-LTC-DRG's Cases Ranked by 2014 Volume*

MS-LTC-DRG	MS-LTC-DRG Title	LTCH Cases		
		FY 2013	FY 2014	2014 Relative Weight
207	Respiratory system diagnosis w/ ventilator support for 96+ hours	15,769	14,094	1.8567
189	Pulmonary edema and respiratory failure	13,638	10,461	0.9148
871	Septicemia or severe sepsis w/o MV 96+ hours w/ MCC	7,658	4,603	0.8827
177	Respiratory infections and inflammation w/ MCC	4,044	2,066	0.8517
208	Respiratory system diagnosis w/ ventilator support <96 hours	2,222	1,852	1.0804
870	Septicemia or severe sepsis w/ MV 96+ hours	1,727	1,806	1.9865
4	Trach w/ MV 96+ hrs or PDX exc. face, mouth and neck w/o maj. O.R.	1,909	1,735	2.7765
949	Aftercare w/ CC/MCC	2,779	1,586	0.7394
166	Other resp. system O.R. procedures w/ MCC	1,904	1,564	2.4015
682	Renal failure w/ MCC	2,116	1,437	0.9538
919	Complications of treatment w/ MCC	2,104	1,125	1.1763
314	Other circulatory system diagnoses w/ MCC	1,937	1,029	1.0204
862	Postoperative and post-traumatic infections w/ MCC	1,934	1,028	1.0580
981	Extensive O.R. procedure unrelated to principal diagnosis w/ MCC	1,545	1,023	2.2923
853	Infectious and parasitic diseases w/ O.R. procedure w/ MCC	1,549	962	1.8828
291	Heart failure and shock w/ MCC	1,517	873	0.8482
190	Chronic obstructive pulmonary disease w/ MCC	2,270	850	0.7730
592	Skin ulcers w/ MCC	3,432	826	0.9496
193	Simple pneumonia and pleurisy w/ MCC	1,801	811	0.7652
539	Osteomyelitis w/ MCC	2,776	701	1.1003
371	Major gastrointestinal disorders and peritoneal infections w/ MCC	1,113	667	0.9564
559	Aftercare, musculoskeletal system and connective tissue w/ MCC	2,035	649	0.9533
393	Other digestive system diagnoses w/ MCC	1,279	509	1.0717
288	Acute and subacute endocarditis w/ MCC	670	438	1.1630
56	Degenerative nervous system disorders w/ MCC	1,000	433	0.8688
Total — common MS-LTC-DRGs		80,728	53,128	

* Reflects cases in 2014 that would qualify LTCH PPS payment (non-site neutral); 2013 reflects all volume for the MS-LTC-DRG.

Source: Fiscal Year 2016 Table 11 (CMS-1632-F).xlsx

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will go into effect in 2019. As shown in Chart 2 on p. 35, *pro forma* for the full reimbursement roll-out, those LTCHs would not qualify for payment on more than 6,000 discharges at either standard or site-neutral reimbursement rates.

Medicaid often pays less favorably than Medicare or commercial payors, so many LTCHs shy away from Medicaid patients (nearly 60 percent receive Medicaid on less than 1 percent of their discharge volume²⁰). As indicated in the Chart 3 on p. 76, more than 100 LTCHs, however, receive Medicaid payments on 5 percent or more of their discharges, and about one-third of these are operating at less than 60 percent capacity. Approximately 10 percent also have fairly low acuity.

Growth in LTCH usage and number since 2001 was likely driven by the unsurprising interest of ACHs to safely discharge high-cost patients where potential ACH incremental reimbursement was exhausted or minimal. As such, LTCHs had important utility to ACHs. The coming reim-

bursement changes may not only reduce reimbursement to some LTCHs, but they may also make it financially attractive for ACHs to retain certain patients because of outlier payments re-channeled to them. As shown in Chart 4 on p. 77, *pro forma* for the new rules, there is a significant reduction in LTCH PPS case volume, particularly among lower-acuity discharges. Fiscal Year 2014 reflects volume *pro forma* for the new rules; Fiscal Year 2013 reflects actual volume.

Conclusion

Cost-reduction and “bundling” initiatives or other arrangements with ACHs and other providers may prove helpful, but a meaningful reduction in reimbursement dollars to LTCHs may present significant challenges, particularly for those that are highly leveraged. Industry and/or regional consolidation is a reasonable expectation. LTCHs that have a proven ability to attract and treat the highest-acuity patients will be best advantaged to successfully navigate as buyers and/or survivors. **abi**

¹⁹ SSOs are discharged at or less than five-sixths of the average LOS of the relevant MS-LTC-DRG. SSO cases where the covered LOS is equal to or less than one standard deviation from the geometric average LOS for the same MS-DRG under the IPPS (very short stay outliers (VSSOs)) have another, more-limiting restriction to the payment formula.

²⁰ See fn.6.

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