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The Future of Post-Acute and Long-Term Care

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Nursing homes are facing an unprecedented crisis. Over 80 percent of nursing homes in the U.S. have reported at least one COVID-19 infection among staff or residents.[1] Over 20 percent of nursing homes reported staff shortages in August. And as of Sept. 1, COVID-19-related deaths in long-term care (LTC) facilities[2] comprise the majority of documented deaths from the disease in 22 states, even though fewer than 1 percent of the U.S. population resides in LTC facilities.[3]

As an example of the disproportionate COVID-19 mortality burden attributable to LTC facilities, consider Idaho. As of Aug. 28, COVID-19 cases associated with long-term care facilities comprised about 7 percent of documented cases in Idaho (confirmed and probable). Deaths associated with these facilities, however, comprised 54 percent of reported COVID-19 deaths.[4]

But the COVID-19 caseloads and mortality rates are not the only crises facing nursing homes. There are myriad downstream complications of the COVID-19 pandemic: decreased revenue, increased expenses, and staffing shortages are all prevalent in facilities across the country.[5] These financial and safety-related issues are dramatically impacting the lives of two of America's most vulnerable populations: Medicare and Medicaid beneficiaries.

Nursing homes[6] serve two broad constituencies: short-term patients who need skilled nursing care following a hospital stay (called "post-acute care"), and long-term patients who need help with activities of daily living in addition to skilled nursing care. The first group of patients is generally funded by Medicare,[7] while the second group of patients is generally funded by Medicaid. Over 60 percent of nursing home residents are covered through Medicaid,[8] though the cost of their care is often subsidized by revenue from patients with private insurance, Medicare, or self-paid.

The spread of SARS-CoV-2 is clearly already impacting the lives of Medicare and Medicaid beneficiaries in nursing homes, as evidenced by the number of facility-related deaths as well as the strict visitation limits and infection prevention and control protocols currently in place in most nursing homes.

But what will be the lasting impact of the COVID-19 pandemic on nursing homes? How will those changes affect the delivery of post-acute and long-term care services? And how will this all affect Medicare and Medicaid beneficiaries who require these services?

Below, I'll investigate these questions in two parts. First, I will focus on the ways in which pandemic-spurred changes to nursing homes might affect Medicare beneficiaries. Second, I will address the ways in which COVID-19's impact on nursing homes might affect Medicaid beneficiaries.

NURSING HOME ISSUES AFFECTING MEDICARE BENEFICIARIES

The nursing home issues predominantly affecting Medicare beneficiaries are payment reform and telemedicine advances. Payment reform will encourage providers to discharge Medicare patients straight home after a hospital stay rather than

to a nursing home. This trend may be further encouraged by enhanced use of telemedicine for post-acute care.

Payment Reform

The COVID-19 pandemic is accelerating hospitals' shift away from traditional fee-for-service (FFS) contracts, with major downstream impacts on nursing home revenue sources.

Hospitals' shift away from FFS and toward alternative payment models (APMs) was already in effect for many years prior to the pandemic. Per the Health Care Payment Learning and Action Network, 62 percent of health care payments in the U.S. were paid under a traditional FFS model in 2015, while in 2018 that proportion was only 39 percent.[9] The movement away from FFS payment has advanced under all payers—commercial, Medicaid, and Medicare. It has been further spurred by the introduction of Accountable Care Organizations through the Affordable Care Act as well as by provisions in the Medicare Access and CHIP Reauthorization Act (MACRA), among many, many other public and private initiatives.

Momentum was already clearly in favor of APMs before COVID-19 hit. But then the COVID-19 pandemic exposed huge fault lines in the FFS model. FFS payments are a function of volume of services provided, so when procedures were canceled in droves in the spring, hospitals' revenue dried up. On top of that, the COVID-19-driven recession has caused millions to lose their employer-based health insurance coverage.[10] This loss is driving a shift in payer mix from commercial reimbursement to payment from Medicaid, the individual market, and self-pay/uninsured patients. Commercial payers tend to have higher contractual rates with hospitals than any other payer type. As such, a drop in the share of commercial business implies that, even if the volume of services returns to pre-pandemic levels, hospital revenue will fall. For these reasons, industry stakeholders are now calling to accelerate the movement toward APMs.[11]

There is evidence that some hospital-centric APMs may incentivize lower utilization of nursing homes[12] by Medicare beneficiaries. For example, the largest driver of savings in a study of Medicare Shared Savings Program Managed Care Organizations was a reduction in spending in post-acute care facilities.[13] Similar findings emerged from studies of the Centers for Medicare & Medicaid Services' (CMS) original Bundled Payments for Care Improvement initiative, CMS' Comprehensive Care for Joint Replacement (CJR) program, and comparisons of spending for FFS Medicare beneficiaries versus Medicare Advantage (MA) members.[10] All this evidence led one paper to deem nursing homes "the piggy bank for savings" in APMs.[14]

The basic idea underlying each of these studies is that under the APM, the hospital receives a bundled payment (or a case rate) intended to finance all care required for a patient over a defined period. As the cost to provide care to the patient decreases, the hospital's profit margin increases since they receive the same payment regardless of their costs. One of the most effective ways to lower the cost of care is to avoid or reduce the length of a patient's stay in a post-acute care facility.[10] And as lower-acuity patients are routed away from nursing homes, the average acuity level of nursing home patients increases, which puts further strain on the nursing home's finances and staffing needs.

Given the increased motivation to shift away from FFS payment structures due to the COVID-19 pandemic, and the large financial incentive for hospitals under APMs to reduce utilization of institutional post-acute care, Medicare beneficiaries may soon find themselves more often discharged straight home following a hospital stay, rather than discharged to recuperate in a nursing home.

Interestingly, this may be the case regardless of whether the beneficiary has coverage through FFS Medicare or Medicare Advantage (MA). CMS piloted the Comprehensive Care for Joint Replacement (CJR) program, an APM for hip and knee replacements. Providers were randomly assigned to participate in the CJR program or not. The providers who were randomly assigned to participate in the CJR program were paid through the APM for hip and knee replacements, while providers who were randomly assigned as the control were paid under the traditional FFS structure for those procedures. Note that this discrepancy in payment only applied to FFS Medicare patients; there was no impact of the CJR program on payment for hip and knee replacements for MA patients.

A study of the CJR program found that FFS Medicare beneficiaries receiving hip and knee replacements at CJR-participating providers were discharged to post-acute care facilities at lower rates than those receiving treatment at non-participating providers.[16] This is not surprising; as explained above, the APM incentivizes providers to bypass nursing homes. However, Medicare Advantage members receiving hip and knee replacements at CJR-participating providers were **also** less likely to be discharged to a nursing home, even though the provider's payment for the MA patient would not change either way. This "spillover" impact could imply that payment-driven changes to discharges of Medicare beneficiaries could ripple through the senior population relatively quickly.

Telemedicine

CMS has encouraged a shift from in-person care to virtual care for Medicare beneficiaries during the COVID-19 pandemic[17] using a plethora of incentives, including the following:[18]

- Allowing provider payment irrespective of originating site for the telemedicine visit (previously, the beneficiary would have to be in a designated rural area before Medicare would consider paying for a telemedicine service).

- Accepting various types of telemedicine services for payment, including communications between a patient and provider via an online portal, some audio-only visits, and services provided through video- and audio-enabled platforms.
- Paying for telemedicine visits at the same rate as in-person visits.
- Waiving the requirement for the beneficiary to receive the telemedicine service in a medical facility, so that they could instead conduct the visit in their home.
- Allowing providers to treat new patients via telemedicine, rather than established patients only.
- Permitting providers to have the discretion to waive cost-sharing for some telemedicine services.
- Notifying providers that the Office for Civil Rights was exercising enforcement discretion such that they would not be fined for HIPAA violations if they conducted telemedicine visits through non-HIPAA compliant platforms like FaceTime or Skype.

Given these pushes, the telemedicine take-up rate has been astonishing. The weekly number of Medicare beneficiaries receiving services via telemedicine was 13,000 prior to 2020. In the last week of April, the number of beneficiaries receiving services via telemedicine was 1.7 million.[19] Services received through telemedicine included preventative care, mental health care, and evaluation and management (E/M) visits, along with some nursing home visits.14 And proposed changes to Current Procedural Terminology (CPT) coding requirements for E/M visits beginning in 2021 will further encourage the use of telemedicine.[20]

CMS is now proposing to make some of the telemedicine payment changes permanent. If some of the permanent changes will allow providers to be paid to monitor and treat patients in their home following a hospital discharge, providers may be encouraged to discharge patients to their home rather than to a post-acute care facility. This could have a dramatic impact on nursing homes. A decline in Medicare patients would cause a shift in payer mix. This shift could be detrimental for facilities that rely on Medicare revenue to subsidize the care delivered to Medicaid patients. As such, a decrease in the Medicare census could impact facility finances that could have a downstream impact on the quality of care provided to the facility's remaining patients.

CMS also broadened the definition of a hospital campus during the PHE to include home care under certain conditions as being rendered at the hospital and enabled at a higher payment rate than home health care allowances.[22] This initiative further reduces the use of post-acute facilities, thus exacerbating the effects described above.

For Medicare patients who are bypassing a post-acute facility stay and recuperating at home, there could be a concern about the quality of the care they are receiving. This could be assessed using hospital readmission rates; if discharging a patient to their home is just as safe as discharging them to a nursing home for a given procedure, readmission rates shouldn't increase for the home-based patients on a risk-adjusted basis. Avoiding a post-acute facility stay can also mean reduced risk of exposure to COVID-19 and other infectious diseases.

NURSING HOME ISSUES AFFECTING MEDICAID BENEFICIARIES

Situs of care preference and consolidation are the nursing home issues predominantly affecting Medicaid beneficiaries. The mass movement to work from home is allowing family members to care for relatives who otherwise might need to be admitted to a post-acute or long-term care facility. Given the high COVID-19 mortality rates in nursing homes, and the desire of most people to age at home anyway, there are fewer new institutional long-term care admissions relative to pre-pandemic levels. The decline in LTC admissions, combined with the decrease in the Medicare-funded census as discussed above as well as increased PPE- and testing-related expenses, might spur a wave of closures and consolidation in the nursing home industry. This would have a disproportionate impact on Medicaid patients who rely on nursing homes as long-term residents.

Situs of Care Preference

We know that there is a demand for aging in place; the waiting lists for Home- and Community-Based Services (HCBS) for Medicaid beneficiaries needing LTC services have an average wait time of over three years.[23] And the desire for home-based LTC has increased due to the COVID-19 pandemic.[24]

Long-term care facility admissions fell dramatically beginning in March, consistent with utilization changes across the health care landscape. One hypothesis for the drop in new LTC facility admissions is that families are trying to support aging in place for their loved ones as much as possible because they are fearful to place them in a facility. As discussed above, the increased ability of many employees to work from home (and, conversely, high unemployment) has enabled families to support their aging relatives at home more easily than before the COVID-19 pandemic, even though it can still be very difficult to manage the care along with work and other responsibilities.

There have been efforts to deliver more support to families trying to provide LTC at home. For example, the HEROES Act passed by the House of Representatives in May would increase the federal share of Medicaid HCBS spending by 10 percentage points.[25] If the HEROES Act becomes law, an increase in the availability of HCBS could siphon LTC patients away from nursing homes.

But even though there is clearly demand for HBCS, the nature of long-term care will likely prohibit a 100 percent shift from institutional to home-based care. Long-term care facility admissions are generally triggered by an inability to perform some Activities of Daily Living (ADLs), such as continence, feeding, and bathing. And while assistance with ADLs may not require skilled care, it requires a lot of work from family members and friends who often have work and childcare and other responsibilities to tend to as well. As such, the ability of loved ones to care for aging relatives sometimes cannot keep up with the level of care required, and so institutional care needs to be put back on the table.

Technological advances and the firm desire of some families to avoid a nursing home admission may result in more use of HBCS by high-acuity patients, but the resources required to accommodate a high-acuity patient in a home setting may not be available to Medicaid beneficiaries and their families. Unless more resources are specifically directed to Medicaid HCBS initiatives, there may not be a lasting shift from institutional to HBCS among Medicaid LTC patients, despite the huge demand for home-based care.

CONSOLIDATION

As discussed above, LTC facility admissions in 2020 have been suppressed relative to pre-pandemic levels.[26] Nursing homes experienced significant declines in patient census, which have been attributable to a decline in admissions as well as COVID-19-related fatalities.[27]

The decline in LTC facility admissions beginning in the spring of 2020 coincided with a pandemic-induced drop in utilization across the entire health care industry. Some have theorized that this drop in utilization in traditional health settings might portend a permanent utilization shift. The theory goes: Bob experiences back pain but was unable to see his provider about it. One day he realizes the pain has gone away on its own. This is a striking realization and causes Bob to seek medical care less often in the future. And the fewer surgeries Bob gets, the less likely it is that he will require institutional post-acute care. If there are enough Bobs and their resolve to "wait it out" doesn't fade over time, the more lucrative post-acute care reimbursement that nursing homes depend on could decline.[28] Post-acute admissions and corresponding revenue could also decline due to the APM and telehealth trends discussed above. Declining revenue could portend nursing home industry closures, mergers, or acquisitions.

Even before the COVID-19 pandemic, M&A transactions involving nursing homes were common.[29,30] The interest in nursing homes is in part due to the expected need for them in the future. We have an aging population. The U.S. Census Bureau projects that 21 percent of the population will be of retirement age by 2030, with older adults outnumbering children for the first time in U.S. history by 2034.[31] Per data collected by HHS, 70 percent of retirement-age adults will need LTC at some point, and almost half of all retirement-age adults will receive some paid care, including home health, assisted living, or nursing home services.[32] Medicaid is the largest payer of these services; Medicare generally does not pay for long-term care, and the high cost of nursing home care can cause self-pay patients to spend down their retirement assets quickly (thus potentially making them eligible for Medicaid).

So, how will consolidation and M&A activity affect long-term nursing home residents? The answer might depend on who the buyer is. With respect to COVID-19, there is evidence from nursing homes in New Jersey that private equity ownership was associated with higher COVID-19 infection and fatality rates. [33]

Similarly, a report on skilled nursing facilities in California found that for-profit ownership was associated with higher case and fatality counts than non-profit or government ownership.[34]

Outside of COVID-19, studies show that private equity ownership of nursing homes is associated with declines in patient health.[35] Older studies, however, show that low-quality facilities owned by for-profit entities were low-quality before they were acquired.[23,36] This could indicate that low-quality facilities were not low-quality because of the acquisition; rather, one of the reasons they were targeted for acquisition was because they were low-quality. From an ownership perspective low quality may equate to higher profits and a more attractive investment. Investors may not be morally influenced or personally judgmental about such an investment as long as the facility can check off that it complied with applicable government regulations. As nursing homes evolve to serve patients in a post-COVID-19 world, more research should be done on the impact of M&A activity and ownership status to the facilities' patients and long-term residents.

CONCLUSION

Payment reform, increased use of telemedicine, preference for home-based care, and consolidation are all issues affecting Medicare and Medicaid nursing home patients. These trends were all in place prior to the COVID-19 pandemic but have since been accelerated.

We know that the need for post-acute and long-term care will continue to grow as the population ages. However, for both Medicare and Medicaid beneficiaries, the role of nursing homes in serving those needs may be beginning to shrink. ■

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ENDNOTES

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