ATI ADVISORY
IDEAS TO ACTION IN HEALTHCARE & AGING

Role of LTAC Hospitals in COVID-19 Pandemic

The ongoing COVID-19 pandemic has significantly disrupted all acute and post-acute care[1] delivery in a manner that may permanently change hospital discharge patterns and provider roles moving forward. As healthcare providers have worked to manage COVID-19 hospitalizations, address personal protective equipment (PPE) requirements, develop geographically separated or "cohorted"[2] care units to minimize opportunities for COVID-19 transmission, and treat patients with unpredictable needs, they have had to reconfigure service delivery to provide uninterrupted care for COVID-19 and non-COVID patients alike.

In this environment, many long-term acute care (LTAC) hospitals have played a critical role in public health efforts, working closely with short-term acute care hospitals (STACHs) to deliver necessary hospital-level services to a more clinically complex population, including non-COVID and COVID-19 positive patients. The Public Health Emergency (PHE) has placed enormous pressure on our nation's general acute care hospitals. STACHs, the front line of immediate/critical patient care, are experiencing patient surges that have exceeded intensive care unit (ICU) capacity. LTAC hospitals, which have comparable staff, capabilities, and overall levels of care, have provided a critical relief valve by admitting patients on a timely basis and serving the most medically complex patients – enabling STACHs to maintain throughput and preserve adequate staffing levels. The CARES Act enabled waivers and some managed care plans provided prior authorization relief, which helped facilitate patient transitions to appropriate sites of care and made it possible for LTAC hospitals to serve this critical role in the care of medically complex patients.

Our research has revealed the public health imperative of maintaining a flexible provider asset class that the healthcare delivery system can activate as an inpatient hospital extender during public health crises, and then repurpose to meet non-emergent delivery system needs at other times. The CARES Act-Section 3711 waivers have served as the switch that allowed for this activation, reasserting fluid patient transitions and clinical collaboration between STACHs and LTAC hospitals. Our research indicates that the clinical capabilities in LTAC hospitals have been particularly well suited to extend STACH capacity and fill COVID-related gaps in the post-acute care continuum.

Since the beginning of the PHE, three critical public health challenges have demanded attention. Although STACHs and post-acute care providers have learned a lot in the past year since the PHE was announced[i] and have changed course accordingly, addressing the following challenges – in a more sustainable way – remains a key priority.

1 Post-acute care includes long-term acute care (LTAC) hospitals which provide hospital-level care for medically complex patients; inpatient rehabilitation facilities (IRFs) which provide hospital-level intense medical rehabilitation focused on restoring functional independence for individuals with disabilities resulting from an injury, illness or medical condition; skilled nursing facilities (SNFs) which provide skilled nursing, medical management and therapy services to individuals who do not require services provided in a hospital; and home health agencies (HHAs) which provide skilled care delivered by health care professionals in the patient's home for the treatment of a medical condition, illness, or disability. Together these settings are typically referred to as the post-acute care continuum.

2 Grouping patients and healthcare workers based on exposure to specified diseases.

Managing Capacity in STACHs. A top challenge has been managing capacity in STACHs. Under siege, ICUs have been running above capacity, with some STACHs converting medical-surgical beds into ICU beds. Physical capacity constraints have been exacerbated by staffing shortages, as physicians, nurses, and other administrative personnel struggled with increasing caseloads while their colleagues were forced to quarantine after exposure to COVID-positive patients or falling sick themselves.

Managing an Increasingly Critical and Complex Patient Mix. Additionally, the overall patient mix at STACHs has become clinically more complex – even outside of COVID-19 diagnoses and complications. This has further exacerbated the challenge above as capacity for intensive care continues to be strained at the staff and resource level.

Ensuring Patient Safety in Skilled Nursing Facilities (SNFs). SNFs entered this pandemic already challenged by low Medicaid reimbursement rates, a brand-new Medicare fee-for-service (FFS) payment system and reimbursement and volume pressure from Medicare Advantage plans and alternative payment models (e.g., bundled payment and accountable care organizations). The SNF business model relies on a reimbursement environment that is at odds with public health. Medicaid-reimbursed long-stay residents receive care and services alongside a revolving door of short-stay patients coming directly from the STACH with the ultimate goal of a discharge home. Over time, this model has contributed to financial weaknesses,[ii] and the PHE has further emphasized SNFs' vulnerabilities in certain operational aspects requiring long-term investment (including infection control protocols, PPE resources, training, cohorted care, around-the-clock staffing, and respiratory equipment).[iii] As COVID-19 cases have surged, SNFs have been challenged to limit infection risk when their facilities accommodate both long-stay nursing home residents and COVID-positive SNF patients who were discharged from a STACH setting. Despite SNFs' efforts, at the end of 2020, more than 92,000 nursing home residents had died nationwide as a result of the pandemic.[iv]

The healthcare system responded to these public health needs in ways that have changed the delivery of post-acute care. Initially, the SNF setting, which had previously accounted for the largest share of post-acute volume[v], was effectively removed, or squeezed out of, the post-acute care continuum. As case mix among hospital discharges increased, fewer SNFs were able to provide clinically appropriate care. Further, as SNFs grappled with COVID-19 outbreaks among long-stay resident populations, many short-term patients who may have previously been appropriate for a short rehabilitation stay shifted to home health.[vi] Importantly, this shift to home health could not have occurred without the support of telehealth waivers for Medicare beneficiaries, which made it possible for hospitals and physician groups to ramp up their respective telehealth capabilities to help meet care needs at home.

On the other end of the patient spectrum, STACHs turned to LTAC hospitals to relieve capacity constraints and admit and support, without disruption, patients with more intensive needs. Many STACHs took to relying on LTAC hospitals and IRFs to help manage the increasingly critical caseload. For example, in the beginning of the PHE, some LTAC hospitals became dedicated COVID-19 overflow hospitals. This model has been replicated on a broader geographic basis, especially in regions where there have been STACH bed shortages.[vii] Because LTAC hospitals are licensed acute hospitals, the clinical capabilities required to handle a range of clinically complex patient needs are already embedded within their settings, such as advanced infection protocols, PPE resources, training, and specialty respiratory care. This level of expertise has enabled LTAC hospitals to flex with the capacity needs of their local partner STACHs. Importantly, the coordination and efficient partnerships that have formed between STACHs and LTAC hospitals were enabled by regulatory and prior authorization waivers, which removed barriers to care and facilitated less complicated transitions of critically ill patients from STACHs to these hospitals.

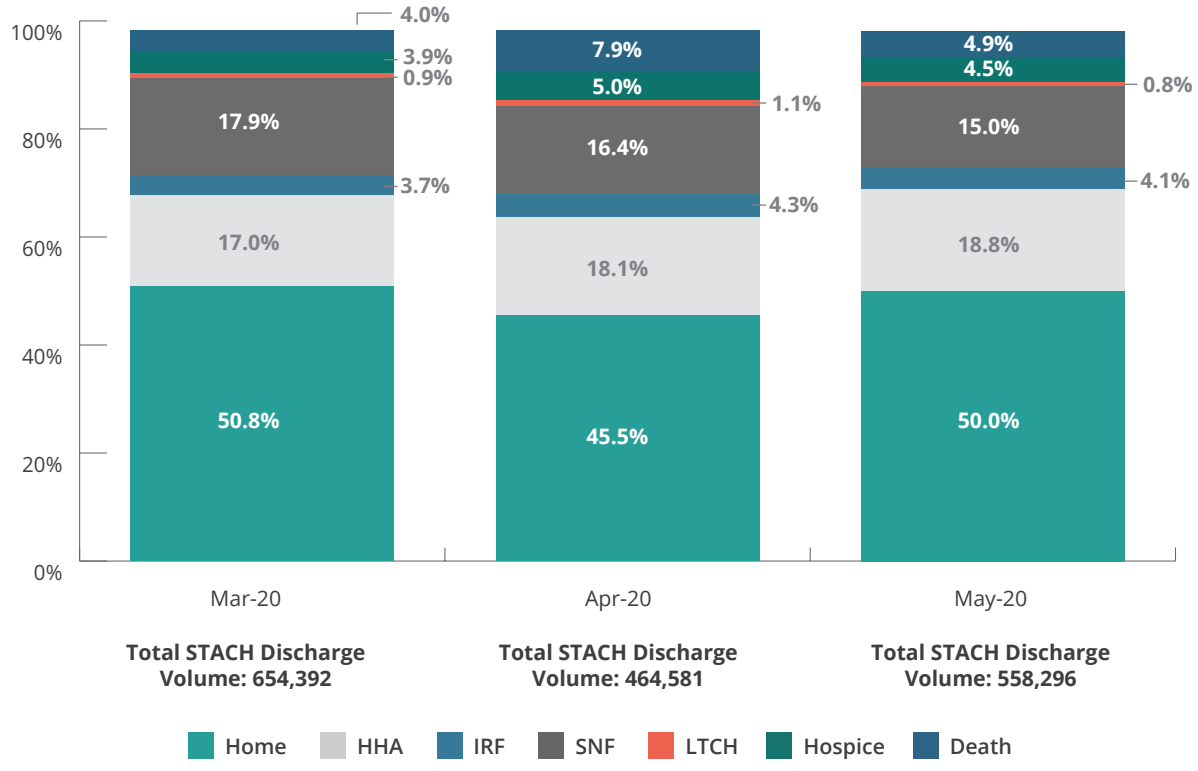
As LTAC hospitals have emerged as critical components of the public health response, ATI Advisory (ATI) performed research to investigate how these hospitals have contributed to meeting public health needs during the PHE. This paper presents the results of this research and offers key lessons and considerations policymakers can integrate into their work supporting continued care delivery innovations as well as public health goals, particularly for the older adult population.

Systemic Shift in Medicare FFS STACH Discharge Patterns to Post-Acute Care

In order to better understand utilization trends during the PHE, ATI spoke with healthcare professionals and clinicians, including Medical Directors, Medical Specialists (Critical Care, Pulmonologists), Case Managers from STACHs, health plan personnel, C-suite/leadership in STACHs/post-acute care hospitals, and experts in reimbursement and post-acute care. These interviewees reported on their experience with patients in both Medicare FFS and Medicare Advantage during the PHE. ATI also performed initial claims data analysis (Medicare FFS claims incurred January 2019 – May 2020 and paid through June 2020) to identify patient trends and support the qualitative feedback we received. This data analysis reflects only the first three months of the pandemic. Although instructive, the analysis is preliminary and will be enhanced significantly as additional months of data become available. ATI will continue to update this work as the pandemic evolves.

As mentioned above, the PHE has markedly changed typical Medicare FFS STACH discharge patterns. This has been driven by significantly lower STACH volume; in May 2020 STACH discharges had decreased 30% year over year. This decline has appeared in post-acute care volume as well, with STACH discharges to LTAC hospitals and SNFs down 34% and 44%, respectively, year over year.[viii]

Figure 1: Monthly STACH Discharges Shifted from SNFs to HHA



Source: ATI Advisory analysis of 100% Medicare FFS National claims incurred March 2020 – May 2020 and paid through June 2020.
Note: LTCH = Long-Term Acute Care Hospital. Does not show Other Inpatient Discharges, which is generally <1.0%.

In the beginning months of the PHE, STACH discharges shifted from Home and SNFs to HHA, with Hospice and Death comprising smaller but still notable volume (see Figure 1). As SNFs' share ticked down, HHAs in turn increased their share of total Medicare FFS STACH discharges, receiving almost 20% of STACH discharge volume in May 2020, suggesting these settings have taken in some share of the patients who would have otherwise gone to SNFs. These patients and their clinicians have expressed concerns about COVID-19 exposure during the course of post-acute recovery and rehabilitation in SNFs due to the prevalence of infections among the long-stay, nursing home resident population also occupying these buildings.

As clinicians and patients shifted preferences away from SNFs in order to prioritize patient and resident safety, changes in share among facility and hospital-based post-acute care were expected. As discussed below and supported by claims data analyses (see Figure 2 and Figure 3), this trend has become especially pertinent as an increasingly more serious and complex patient population (partially indicated by Case Mix Index or CMI, the measure of a patient's anticipated healthcare resource requirements based on their specific diagnoses) has been transitioning out of STACHs, many of whom are in need of rehabilitative care beyond the scope of services that SNFs can offer. Facility-based discharges[3] in April and May 2020 support this development and show that IRFs – even more than LTAC hospitals – have become a more likely site of discharge versus last year as the combination of SNF closures and higher complexity patient populations have become more prevalent. More research on the role IRFs have played is forthcoming.

Figure 2: LTAC Hospitals and IRFs Have Been Filling Gap Left by SNFs

(STACH National Discharges to Facility-Based Care)

	April 2019	April 2020	Δ	May 2019	May 2020	Δ
IRF	14.9%	19.7%	4.9%	15.2%	20.5%	5.3%
SNF	81.4%	75.4%	-6.0%	81.0%	75.4%	-5.6%
LTAC hospital	3.8%	4.9%	1.2%	3.7%	4.1%	0.4%

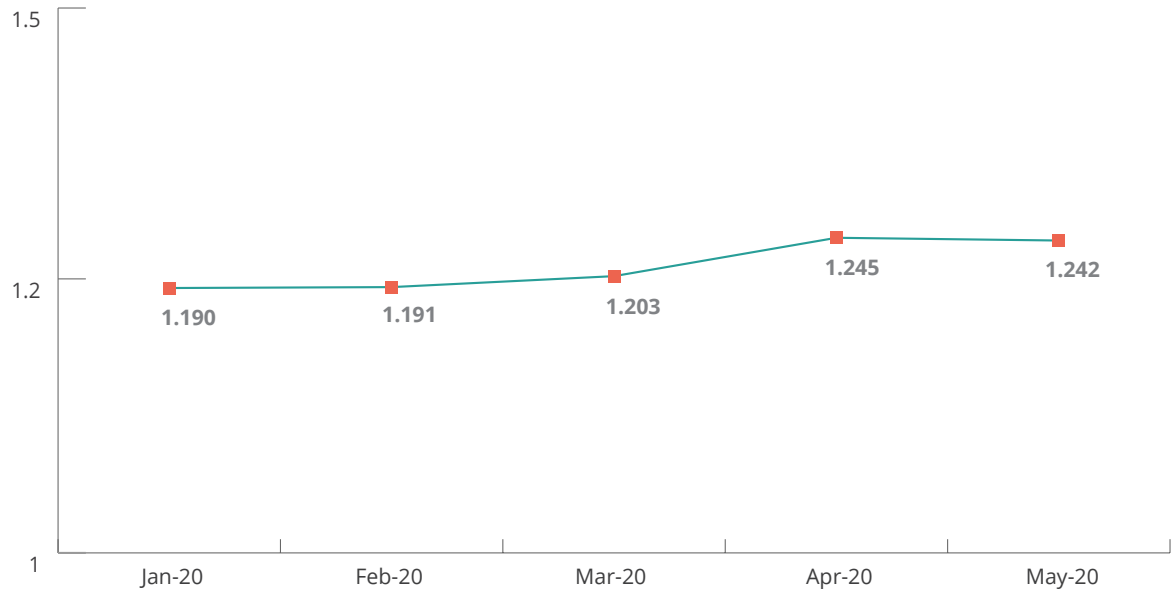
Source: ATI Advisory analysis of 100% Medicare FFS National claims incurred April 2019 – May 2019 and April 2020 – May 2020 and paid through June 2020.

Based on interview feedback and claims data, we believe this increase in share of discharges to LTAC hospitals and IRFs was driven by a sicker patient population being admitted to the STACH (even non-COVID admissions), and that the increase less likely reflects inappropriate patients going to higher levels of care during times when SNFs could not accept new admissions. Regarding the shift in patient mix, a Health System Chief Clinical Officer stated:

> ***"The elderly elective orthopedic population that often seeks a short post-acute stay is not present at this time. Our acuity of medical care is much greater. We have been measuring record CMI in our hospital for weeks given the high acuity of our population."***[ix]

3 Does not include discharges appropriate for home health.

Figure 3: LTAC Hospital CMI Increased Since Start of PHE

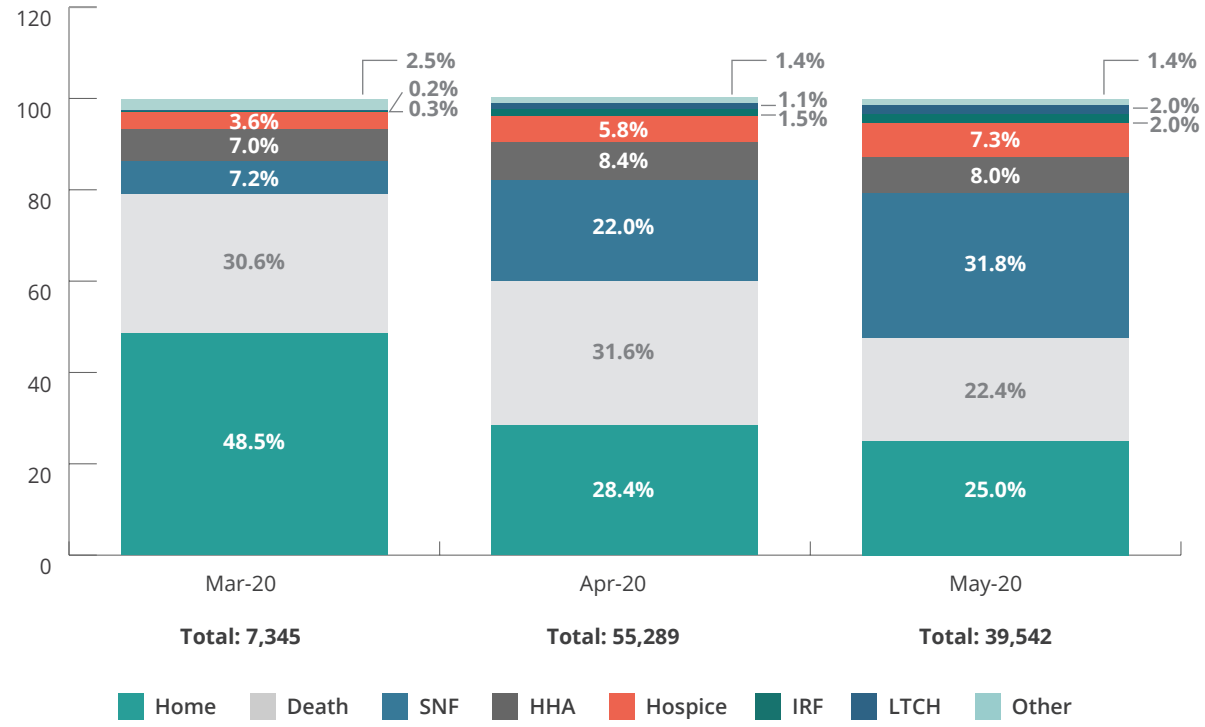


Source: ATI Advisory analysis of 100% Medicare FFS National claims incurred January 2020 – May 2020 and paid through June 2020.
Note: CMI is the DRG weight on the LTAC hospital claim itself.

Home discharges generally received the highest portion of COVID-specific[4] discharges in the beginning of the pandemic (see Figure 4), as other post-acute care settings were preparing for how best to deal with COVID-positive patients and reduce strain on STACH resources. Although patterns in April and May show SNFs receiving a higher portion of STACH COVID-19 discharges, SNF providers have suggested this is due, at least in part, to SNF long-stay residents who were diagnosed with COVID-19 in the facility, admitted to the STACH, and then readmitted to the SNF.

4 As defined by diagnosis-related group (DRG).

Figure 4: STACH COVID-19 Discharges by Care Setting



Source: ATI Advisory analysis of 100% Medicare FFS National claims incurred March 2020 – May 2020 and paid through June 2020.
Note: LTCH = Long-Term Acute Care Hospital.
Note: Above analysis is not adjusted for potential shifts/changes in coding after March 2020.

By way of reminder, this data analysis reflects only the first three months of the pandemic. ATI intends to update the preliminary analyses herein as CMS releases additional claims data.

The Role of LTAC Hospitals During COVID-19

Although care patterns and the respective capabilities of post-acute care settings will continue to evolve, **our research, which included interviews with healthcare professionals and clinicians, as well as data analysis, strongly suggests that LTAC hospitals have played an important role in meeting the public health needs of clinicians, patients, and patients' families over the course of the pandemic.**

LTAC hospitals appear to have strengthened partnerships with STACHs struggling to manage the surge of both COVID-19 and non-COVID patients in need of care during the PHE. Our interviewees reflected that LTAC hospitals have provided local market leadership in public health efforts (e.g., training SNFs in PPE utilization, loaning ventilators, etc.), and have successfully cohorted patients and/or dedicated full hospitals to COVID-19 patients. Prior to the PHE, and as a result of public policy and other legal restrictions, LTAC hospitals played a relatively narrow role in the healthcare delivery system; serving patients who had previously been in an intensive care unit or required mechanical ventilation. LTAC hospitals operating under pandemic-induced waivers (see below) have expanded their role, and in so doing, perceptions about them have shifted among leaders in the healthcare domain. David Grabowski, PhD, a professor of health care policy in the Department of Health Care Policy at Harvard Medical School, recently spoke out on the importance of LTAC hospitals during the PHE, stating:

> ***"In a pandemic, you really do need that kind of intensive care. For years, we said, 'Why do we need long-term care hospitals?' And all of a sudden with COVID, we're saying 'Why don't we have more long-term care hospitals?'"[x]***

ATI's research revealed four key themes related to LTAC hospitals' role in the PHE: (1) Government action waived payment barriers and provided funding support that enabled faster transitions in care, (2) LTAC hospitals have served an increasingly more complex patient population during the pandemic, (3) LTAC hospitals ramped up strategies in order to serve COVID-positive patients, and (4) perspectives regarding LTAC hospitals and their capabilities have shifted since the start of the PHE.

Government Action

The CARES Act-Section 3711 waivers have enabled LTAC hospitals to serve in an important public health capacity. Together these waivers ("LTAC hospital waivers") changed three important aspects related to LTAC hospital prospective payment criteria:

1 | **Site-Neutral Payments:** CMS waived the LTAC hospital site neutral payment policy, so all LTAC hospital admissions during the PHE are now paid the standard prospective payment rate instead of the site neutral rate. Outside of the waivers, the site neutral payment rate applies when the patient either: (1) has not been admitted directly from an acute care hospital which included at least three days in the ICU or (2) the patient does not require more than 96 hours of mechanical ventilation in the LTAC hospital.

2 | **50% Rule:** CMS waived the LTAC hospital 50% Rule, so there is no limit to the number of site-neutral patients the LTAC hospital can admit. All LTAC hospital admissions during the PHE are now counted as discharges paid the standard prospective payment rate.

3 | **Average Length of Stay (ALOS):** Patients admitted to and discharged from an LTAC hospital in order to meet the demands of the PHE are now excluded from the LTAC hospital's ALOS calculations. Typically, Medicare FFS reimbursement regulations require LTAC hospitals to maintain an average inpatient length of stay greater than 25 days in order to be paid as an LTAC hospital. *(Blanket Waiver)*

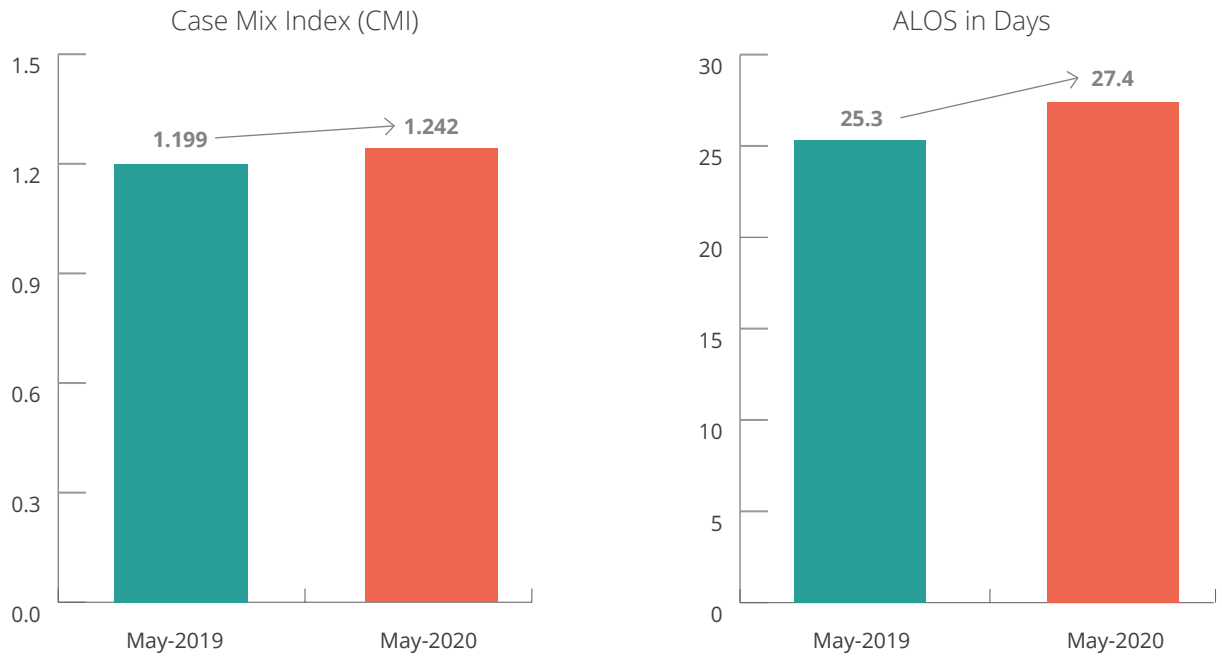
Given where LTAC hospitals sit in the care continuum, their ability to timely admit patients affected care settings both upstream (i.e., STACHs) and downstream (i.e., post-acute care) during the PHE. For example, during patient surges, demands on regional ICUs often exceeded capacity. The waivers enabled STACHs to send patients directly to LTAC hospitals without the customary ICU stay required for the standard prospective payment. Importantly, as licensed hospitals, LTAC hospitals (and perhaps IRFs) have been the only appropriate care setting for these patients due to their critical nature. LTAC hospitals opened capacity for high-risk COVID-19 populations (e.g., trached patients on dialysis) who were (a) not on a ventilator and/or (b) not stable enough to move out of acute care.

In addition to the waivers, the CARES Act provided hospital relief funds that supported those who have been on the front lines during the pandemic. It has been an extremely difficult time to attract, employ, and retain skilled employees in healthcare. The incremental funding helped ensure LTAC hospitals have been able to cover costs in operational areas, especially related to meeting increased workforce costs and having adequate supplies of PPE and testing.

Patient Types/Acuity

Initial claims data analysis from the beginning of the pandemic suggests that LTAC hospitals have remained a specialty setting appropriate for specific patients. This is partly demonstrated in national LTAC hospital CMI data, which show that CMI increased year over year nationally for LTAC hospitals (1.199 in May 2019 to 1.242 in May 2020).[xi] Additional market-level research and analysis is required to understand varying patterns of discharge, case mix, and clinical decision-making, but Figure 5 implies that LTAC hospitals overall did not misuse the waivers by taking low-acuity patients inappropriate for their hospitals.

Figure 5: Increase in LTAC Hospital Case Mix and ALOS Suggest More Complex Admissions



Source: ATI Advisory analysis of 100% Medicare FFS National claims incurred May 2019 and May 2020 and paid through June 2020.
Note: Changes are more significant on a regional basis.

Services & Care Delivery

The providers and physicians we interviewed indicated that LTAC hospital service capabilities not only extend STACH capacity but also deliver clinical expertise specific to a COVID-19 population. The COVID-19 patient needs align with LTAC hospitals' expertise in managing serious, unpredictable, high-need patient populations, with an eye towards recovery. A Hospitalist Specialist in Pulmonology who is the Medical Director of a Risk-Based Physician Group stated:

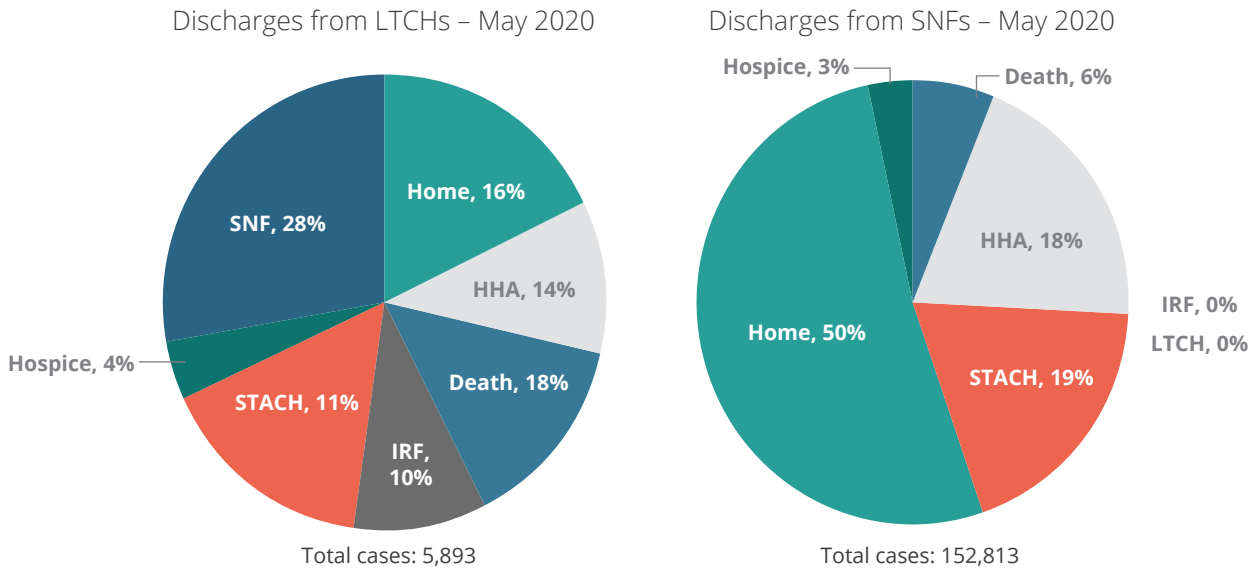
> ***"It was so hard because COVID patients are so unpredictable, it was hard to know what they needed and we didn't have a clear definition of what they needed…LTAC hospitals differentiate themselves because they have a laser focus on patients who are ventilator dependent, have respiratory failure, require dialysis, and have complex [post] surgical needs, etc. – all of that requires a multi-disciplinary approach [in which] LTAC hospitals specialize."***[xii]

COVID-19 highlighted that an LTAC hospital's capabilities are closer to that of a STACH than a SNF, forcing SNF operators to re-assess their own competencies and what an appropriate admission looks like. For example, as of early May 2020, nearly half of all the COVID-related deaths (252 fatalities) in Boston occurred within the city's nursing homes and assisted living facilities, while an LTAC hospital in a large system serving the greater Boston area treated 286 COVID-19 patients, with few readmissions to the STACH, the majority discharged to home health, and two deaths.[xiii] As licensed hospitals, LTAC hospitals are able to accept critical patients, collaborate and apply new learnings with STACHs, and discharge a majority of their patients to a lower level of care.[xiv]

Patient discharge patterns are an important aspect of the care experience, and these trends can help uncover areas of clinical proficiency within respective post-acute care settings. ATI compared LTAC hospital discharges and SNF discharges and found that although LTAC hospitals discharge to death at a higher rate than SNFs, SNFs discharge

to STACHs two times as frequently as LTAC hospitals (see Figure 6 below, in May 2020, on a national basis, SNFs discharged to STACHs 19% of the time, LTAC hospitals discharged to STACHs 11% of the time). Notably, this trend was similar in May 2019 as well, suggesting these numbers are not just reflecting activity specific to COVID-19 regulations.[xv]

Figure 6: SNFs Twice as Likely to Discharge to STACHs



Source: ATI Advisory analysis of 100% Medicare FFS National claims incurred May 2020 and paid through June 2020.
Note: "Home" discharges from SNF will include private family homes as well as the nursing home as a resident. Claims data does not contain information to allow differentiation between the two settings.
Note: LTCH = Long-Term Acute Care Hospital.

This analysis is further supported by 30-day All-Cause Readmission data. Performance on readmissions has remained strong for LTAC hospitals, as rates were generally ~500 basis points below SNFs from January – May 2020.[xvi]

COVID-Specific Initiatives

The ability to cohort and separate care for non-COVID and COVID-positive patients has been a critical tool for STACHs, and a key contribution of LTAC hospitals during the pandemic. In certain markets LTAC hospitals continue to be the only post-acute care facilities admitting COVID-positive patients, due to specialized COVID-19 units, the ability to safely separate patients, and robust inpatient/intensive care practices.[xvii] LTAC hospitals have also worked locally with STACHs to identify ICU-throughput patterns in order to best address the needs of the STACHs. For example, a President of an Integrated Post-Acute Care System noted:

> ***"We have a significant oncology population and the waivers enabled us to take in the oncology population again – we were doing active chemo in our LTAC hospital so it's meaningful to have the freedom the pandemic offered us to do this work again."***[xviii]

In some instances, the patient surges required LTAC hospitals to reconfigure their physical settings. Kindred Hospital Chicago Central designated itself as a dedicated COVID-19 hospital, expressly for the care of ventilator-dependent COVID-19 patients. In this 45-bed hospital, Kindred has offered solutions to the long-term hospitalization needs of patients with COVID-19 in what they describe as a tightly controlled, protected hospital environment, overseen by clinicians with expertise in infection control.[xix]

New Perspectives

The contributions LTAC hospitals have made during the pandemic have shifted outdated perspectives from clinicians and perhaps even some managed care plans. LTAC hospitals that appropriately redesigned processes during the pandemic were able to (a) deliver better COVID-specific care and (b) highlight the LTAC hospital model's unique capabilities.

Case Study: A New Perspective

A Medical Director that heads a physician-led organization describes how her perception of LTAC hospitals changed, which led to an important breakthrough in how they managed their population:

> ***"We used to [have a negative perception of them] – even up until five years ago. There was no vision, patients were in a holding pattern. COVID has proved this is not the case, we have repurposed our patients at a lower cost, not lower level of care."***

The doctor worked with regional LTAC hospitals to credential her specialists so they could visit patients at the LTAC hospital and maintain better continuity of care. She also developed a specific format for the discharge summary which facilitated a standardized transition of care and made mutually transparent the type of patient being transferred.

Importantly, this doctor is managing an at-risk population and has not been pressured to shift her population downstream to contain costs. In fact, the at-risk arrangement has enabled her to be more agile in her decisions, using LTAC hospitals when appropriate.

The presence of LTAC hospitals has implications for national healthcare. A Medical Director of a physician-led organization commented:

> ***"U.S. health systems are so big we cannot carry our own weight…LTAC hospitals can deliver a breadth of services and continuum of care for steady state acute patients in a way that decompresses the overburdened acute care system."***[xx]

Similarly, clinicians noted LTAC hospitals are "extenders of acute care" and a "necessary part of the landscape…we can control costs in the acute care setting by partnering with them."[xxi]

The contributions of LTAC hospitals have extended beyond acute physical recovery. Some LTAC hospitals have also elevated the availability of inpatient behavioral health. This has become increasingly important as anxiety and social isolation continue to impact the broader population. Together, these insights suggest that LTAC hospitals are a resource that other clinicians value, from both a cost and patient-centered care perspective. These clinicians emphasize LTAC hospitals will need to continue to demonstrate that the benefit of the flexibility they received during the pandemic serves patients, not operators. This is especially important with regards to the prior authorization relief LTAC hospitals received from managed care plans.

Managed Care During COVID-19

The paradigm-breaking nature of the pandemic accelerated decision-making and also (temporarily) changed typical behavior at managed care plans, which had significant bearing on how providers managed the influx of patients. Prior authorization relief was mentioned repeatedly during our conversations with the industry as one of the most important changes, as it enabled providers to access needed resources during the PHE without hitting payment barriers. Clinicians referred to prior authorization (a utilization management process used by health insurance companies to determine if they will cover a prescribed procedure, service, or medication) as not only a significant administrative burden, but also something that has historically disrupted (or at least delayed) care pathways by taking skilled resources away from responding to patients. Under prior authorization requirements, in some instances STACHs need to delay discharging patients because they are unable to get authorization for an LTAC hospital discharge.

> ***"Most patients we discharge are still too complex for SNFs and they stay in the hospital – every metric we see says the longer patients are in the hospital, the riskier it is for the patient."***[xxii]

Prior authorization relief promoted flexible care pathways between STACHs and post-acute care and allowed STACHs to significantly improve throughput and decrease patient length-of-stay, which minimized unnecessary disease exposure (COVID-19 and otherwise) and improved care for LTAC hospital-appropriate patients.

Although prior authorization has been reinstated in many instances, claims data during the PHE will perhaps provide more clarity to health plans regarding how their discharge requirements can influence patient outcomes. For example, a VP of Population Health Management at a Managed Care Plan stated:

> ***"ALOS is very important. If a patient is going to a SNF but staying 45 days and would have only stayed 20 in the LTAC hospital and then gets discharged home, that's probably a better outcome."***[xxiii]

This is not to undermine the importance of the safeguards provided by prior authorization – on the contrary, LTAC hospitals can leverage their meaningful role during COVID-19 in order to foster new conversations with plans and policymakers to share metrics, increase transparency, and collaboratively develop new patient pathways that reduce friction during patient transitions.

Key Lessons and Considerations

The COVID-19 pandemic has laid bare areas in need of review and assessment within our healthcare system. These include public health preparedness, STACH capacity, and the limitations of SNFs. LTAC hospitals have helped address these areas during the PHE by functioning as a flexible acute care venue. However, over the last several years, payment policy has effectively reduced the number of LTAC hospitals through an ongoing narrowing of the types of people deemed appropriate for this setting and the commensurate payment associated. There are far fewer LTAC hospitals today than in 2015,[xxiv] implying future healthcare policy must consider not only payment efficiency in post-acute care but also the future public health need for LTAC hospitals, and how to deliver the best patient outcomes for our population.

Together, providers and policymakers can play an important role in driving change across the healthcare system, and use their collective experience during the PHE to inform future decision-making. To that end, we believe the pandemic has highlighted several opportunities for all stakeholders to contribute to a stronger public health strategy going forward, including a focus on (1) improved transitions of care and communications across settings, (2) fully educated partners who understand capacities across the care continuum, (3) payment policy that can support satisfactory patient outcomes at a lower cost, and (4) care options that address physical as well as behavioral health conditions.

1 | **STACHs Can Take the Lead in Institutionalizing Effective Communication Patterns Used During PHE.** The critical nature of the pandemic required health systems to reconfigure their respective communication and decision-making structures. Clinicians and care managers reported seeing less complacency as they were forced to make decisions that in the past may have been delayed or inefficiently delegated. Physicians were staying more involved with patients at the point of discharge, which, in addition to prior authorization relief and use of telehealth capabilities, enhanced coordination of and access to care for patients. Per a President of an Integrated Post-Acute Care System:

> ***"Time was of the essence, people needed to work effectively, and we don't always work so well together. We have our silos that prevail, so within our system it was a good example of how we COULD work."***[xxv]

Through this enhanced internal communication, proactive organizations introduced new practices and protocols that brought together STACH and post-acute care settings across the care continuum. Cross-institution/physician discipline collaboration became necessary and drove greater transparency between STACHs and LTAC hospitals (especially for freestanding LTAC hospitals). This dynamic can be preserved in a non-PHE environment through implementing more opportunities for centralized communication. For example, stakeholder convenings that include inpatient hospitals, physicians, post-acute care providers, payers, beneficiaries and their advocates can foster discussions that will inform how best to serve the frailest beneficiaries with the most complex care needs now and in the future.

Another way of maintaining clear lines of communication is through the creation of formalized partnerships that recognize the capabilities of post-acute care constituents and promote a more seamless patient transition from each setting. From the LTAC hospital's perspective, this could be achieved via upstream and downstream agreements. The upstream arrangement would require STACHs to have a formalized relationship, or affiliation, with LTAC hospitals. LTAC hospitals have already been working closely with STACHs during the pandemic to manage capacity issues (e.g., admitting critical patients that skipped the ICU) – ideally this relationship would minimize delays in discharging patients from the general hospital. There would also be transfer agreements on the downstream side. For example, if an HHA was going to admit a patient, they would need to have an agreement with an LTAC hospital so that, in the interest of patient care, there is an assurance of safety (e.g., a dependable telehealth connection, assuming a more permanent waiver of Medicare's telehealth restrictions). This type of planning would facilitate public health at a local level to support the interlocking relationships among post-acute care constituents.

Local care delivery systems should take the lead in building these effective communication mechanisms. Federal policy must be supported by an organized, local public health response that enables efficient utilization of the assets in a specific region. This has been incredibly important in areas where LTAC hospitals are part of the delivery continuum as they have played critical roles in the public health response.

2 | **LTAC Hospitals Can Further Promote Education About Their Capabilities.** LTAC hospital care delivery during the pandemic has reminded clinicians, patients, patients' families, and perhaps even payers of the special capabilities within these hospitals. The critical services LTAC hospitals are providing have been documented through higher recorded CMI in 2020, a reflection of LTAC hospitals pivoting their focus as needed to provide ongoing care for both COVID-19 and non-COVID patients. This has been vital in markets where ICUs have been running at surge capacity and SNFs have been unable to admit patients.

Many hospital case managers were already aware of the unique capabilities of LTAC hospitals but required education on a local basis to ensure they were discharging the appropriate patients. Clear communication between STACHs and LTAC hospitals – meaning LTAC hospitals shared specific metrics, services, and outcomes for their services – was a crucial step toward LTAC hospitals developing COVID-dedicated units that helped relieve pressure on ICUs in acute care hospitals.

LTAC hospitals can promote education through improving how and when they share patient information with both providers and managed care plans. Precise documentation from LTAC hospitals demonstrating "you are fiscally responsible" and "can be trusted" sounds like an obvious task but remains a key focus area for managed care plans and will better position LTAC hospitals for future risk-based relationships that rely on data sharing.[xxvi]

Similarly, during several of our discussions, interviewees requested LTAC hospitals improve the way they share the capabilities of their hospitals. Clinicians and plans suggested this could be achieved through understanding more about the detailed clinical capabilities of their local LTAC hospital partners for specific patient types. For example, a pulmonary edema patient would have a specified expected length of stay and targeted outcomes, supported by a specific number of physician visits/types (attending and consulting specialists), clinical hours of care, nursing, respiratory therapy, and rehabilitation. These metrics are especially meaningful vis a vis SNFs.

Finally, this transparency is important not only for clinical and reimbursement purposes, but will also improve healthcare literacy for patient families. LTAC hospitals can help families navigate these waters and will continue to differentiate themselves through creating a system of metrics that can be shared with STACHs and health plans, and is easily understood by the family.

3 | **Federal Policymakers Can Develop and Refine Payment Policy That Supports Physician-driven Site of Care Decisions.** We have learned that reimbursement models impact public health both during and in between PHEs. For example, the financing model for short and long-stay nursing home care contributed to the environment that left so many older adults vulnerable to COVID-19. Rate setting and payment methodologies must support safe and high-quality care in all living and rehabilitative environments. Reimbursement policy should consider the role institutional providers will play in future PHEs. The healthcare delivery system cannot afford to maintain massive amounts of fixed capacity in anticipation of a future PHE, so it must consider modes of delivery and settings that can support capacity that is adaptable to the current healthcare environment. LTAC hospitals have demonstrated they can play a critical role in ensuring this capacity is met.

As risk-based models proliferate, collaborative patient-centered care – not just cost containment – needs to be rewarded. Historically, uneven healthcare funding has sent the message that healthcare providers should be able to do more with less, and unfortunately, this has incentivized short-term decision-making as a way to cope (e.g., providers not stocking up on supplies necessary to support an emergency situation such as COVID-19). It is important that new payment policies align with the various contributions and costs associated with each post-acute care provider, as not all post-acute settings can deliver the same level and range of services. Policy must balance holding providers accountable for spending and ensuring appropriate public health preparedness. According to the American Hospital Association:

> ***"The pandemic highlights the uneven patient care abilities across the four post-acute care settings, with regards to physician leadership and oversight, the contributions of other specialists and clinicians, infection control reliability, and patient outcomes. These disparities are of greatest consequence for medically-complex patients with and recovering from COVID-19."***[xxvii]

As mentioned above, the important work LTAC hospitals performed – and continue to perform – has been greatly supported by the CARES Act-Section 3711 waivers and by prior authorization relief. A Pulmonologist stated in early autumn 2020:

> ***"During the height of COVID we had ICUs at 200% capacity – this has created an incredible public health crisis. We can't afford not to transfer patients to the LTAC hospital. ICUs can't manage the incoming load of patients, once we get the third wave, we are going to be facing issues."***[xxviii]

Fortunately, we have seen rapid shifts in behavior due to the waivers, a Health System Critical Care Case Manager illustrates this dynamic:

> ***"Once the waivers came out it became obvious that we could use capabilities of LTAC hospitals who have the same level of ICU capabilities."***[xxix]

Given providers' timely response – and assuming continued appropriate use of these resources – we believe these waivers should be part of the emergency response going forward.

4 | **LTAC Hospitals Can Invest in Improved Access to Behavioral Health (BH).** The COVID-19 pandemic has exacerbated issues such as depression, suicidal thoughts, drug dependence, and in some cases, severe psychotic symptoms. These conditions have become more acute and severe – even in patients with no history of mental illness[xxx] – as they have been magnified by social isolation and fear. Public health specialists have stated that "the mental health impact of the pandemic is likely to last much longer than the physical health impact."[xxxi] Both clinicians and payers seem to agree the need for behavioral health services will continue to increase, with one Inpatient Utilization Management Supervisor at a Managed Care Plan stating:

> ***"A really strong point for me is when I know an LTAC hospital has a strong BH component at the facility."***[xxxii]

The representative further commented that even if the patient did not have behavioral health needs previously, there is a high chance they do now. Comorbid physical health and behavioral health issues – with the latter exacerbating the physical health ailments – is becoming more prevalent. Unfortunately, access to behavioral health services can be difficult to obtain on a timely basis, due to both lack of available supply and payment barriers. As one Regional CMO of a Health System commented:

> ***"Inpatient sites for behavioral health are almost impossible to get. Trying to get a patient accepted [into a hospital] is impossible. It could work if more LTAC hospitals had capacity or capabilities to admit this population."***[xxxiii]

Some LTAC hospitals are investing more in behavioral health capabilities in order to address this gap in care. Importantly, increasing supply of inpatient beds is not the only solution; it may be ensuring a full-time social worker or equivalent professional is on staff to help manage patient transitions and provide supplementary care. Although the best way to address this growing demand is still unclear, this is a top area of focus for health plans, and therefore an opportune time to bring together plans and providers to discuss different models of care that can treat physical and behavioral health needs in one setting.

Conclusion

The COVID-19 pandemic has highlighted the importance of post-acute care, and reinforced the roles of LTAC hospitals within the healthcare ecosystem, because they have significantly contributed to the treatment and recovery of COVID-19 patients. Moving forward, LTAC hospitals have a responsibility and vested interest in promoting greater transparency, improving documentation, and stepping up collaboration with payers and providers – especially on an at-risk basis. The distinct capabilities these hospitals possess will continue to be highly relevant and required as the nation manages an increasingly medically complex population with both physical and behavioral health needs.

> *"Until we change the perspective of care, it's hard to wrestle through what we consider to be quality of care to provide every intervention you can to provide more life. That's a perfect example of what we do in LTAC hospitals, but if we want to say that this is a waste of resources, then we have to change our perspective in healthcare ethics."*
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> **Health System Chief Clinical Officer**

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xiii Per interview with President of Massachusetts-based post-acute care health system, performed by ATI Advisory.

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xv ATI Advisory analysis of 100% Medicare FFS claims incurred May 2019 – May 2020 and paid through June 2020.

xvi For example, in April 2020, the for LTAC hospital 30-day All-Cause Readmissions was 12.8%, the same metric for SNFs was 18.7%.ATI Advisory analysis of 100% Medicare FFS claims incurred January 2020 – May 2020 and paid through June 2020.

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xviii Per interview with President of Massachusetts-based post-acute care health system, performed by ATI Advisory.

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