

Medicare post-acute care reforms

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Statement of
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Chairman Pitts, Ranking Member Green, distinguished Committee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's work on post-acute care (PAC) in Medicare.

MedPAC is a congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and plans fairly by rewarding efficiency and quality, and spends tax dollars responsibly.

The Commission has done extensive work on issues related to PAC, the way Medicare pays for these services, and the reforms that are needed to encourage a more patient-centered approach to match services and settings with the needs of each patient. We have considered reforms that would promote care coordination (such as readmission policies and bundled payments), gather comparable data across PAC settings, improve the accuracy of fee-for-service (FFS) payment rates, and equalize payments made for similar services. Some changes, such as changes to FFS payments or the adoption of quality measures that allow comparison among PAC sectors, could be implemented relatively quickly. Other changes, such as payment reforms that cut across settings and fundamentally alter the way we pay for PAC, would take longer to design and implement.

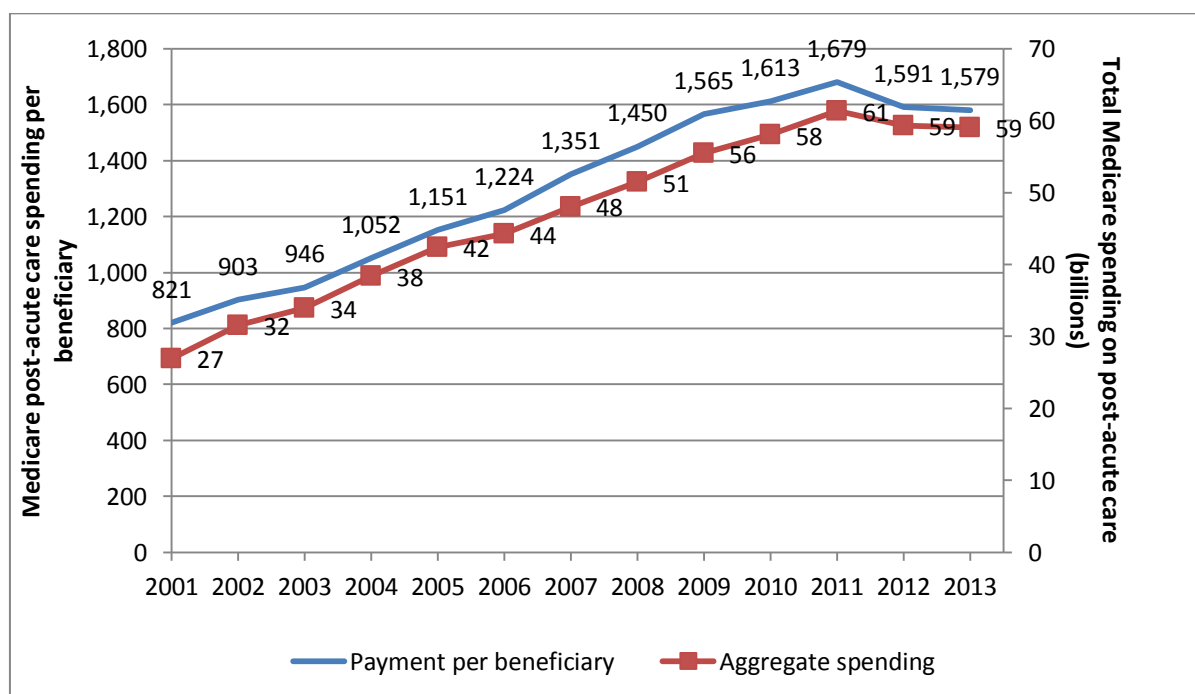
Background

PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). PAC providers offer important recuperation and rehabilitation services to Medicare beneficiaries. In 2013, about 42 percent of Medicare beneficiaries discharged from prospective payment system (PPS) hospitals went to a PAC setting: 20 percent were discharged to a SNF, 17 percent were discharged to an HHA, 4 percent were discharged to an IRF, and 1 percent were discharged to an LTCH. Not all beneficiaries who receive PAC have a preceding hospitalization. Medicare's eligibility rules for IRFs, LTCHs, and HHAs do not require

beneficiaries to have spent time in an acute care hospital prior to receiving these services. While almost all beneficiaries admitted to IRFs and LTCHs have a prior hospital stay, two-thirds of home health episodes are admitted directly from the community. Home health episodes admitted from the community have increased more rapidly than episodes preceded by a hospitalization or PAC stay. Over the 2001–2012 period, the number of episodes not preceded by a hospitalization or PAC stay increased by 116 percent compared with a 23 percent increase in episodes that were preceded by a hospitalization or PAC stay.

In 2013, PAC FFS spending totaled \$59 billion, with Medicare paying for 9.6 million PAC encounters (IRF and LTCH discharges, home health episodes, and SNF stays). PAC spending has more than doubled since 2001, from \$27 billion in 2001 to \$59 billion in 2013 (Figure 1). The rate of increase in spending has leveled off since 2011, consistent with a general spending slowdown in other parts of Medicare, as well as the private sector, over this time period. Per capita PAC spending has followed a similar pattern.

Figure 1. Total and per capita Medicare spending on post-acute care have grown significantly since 2001

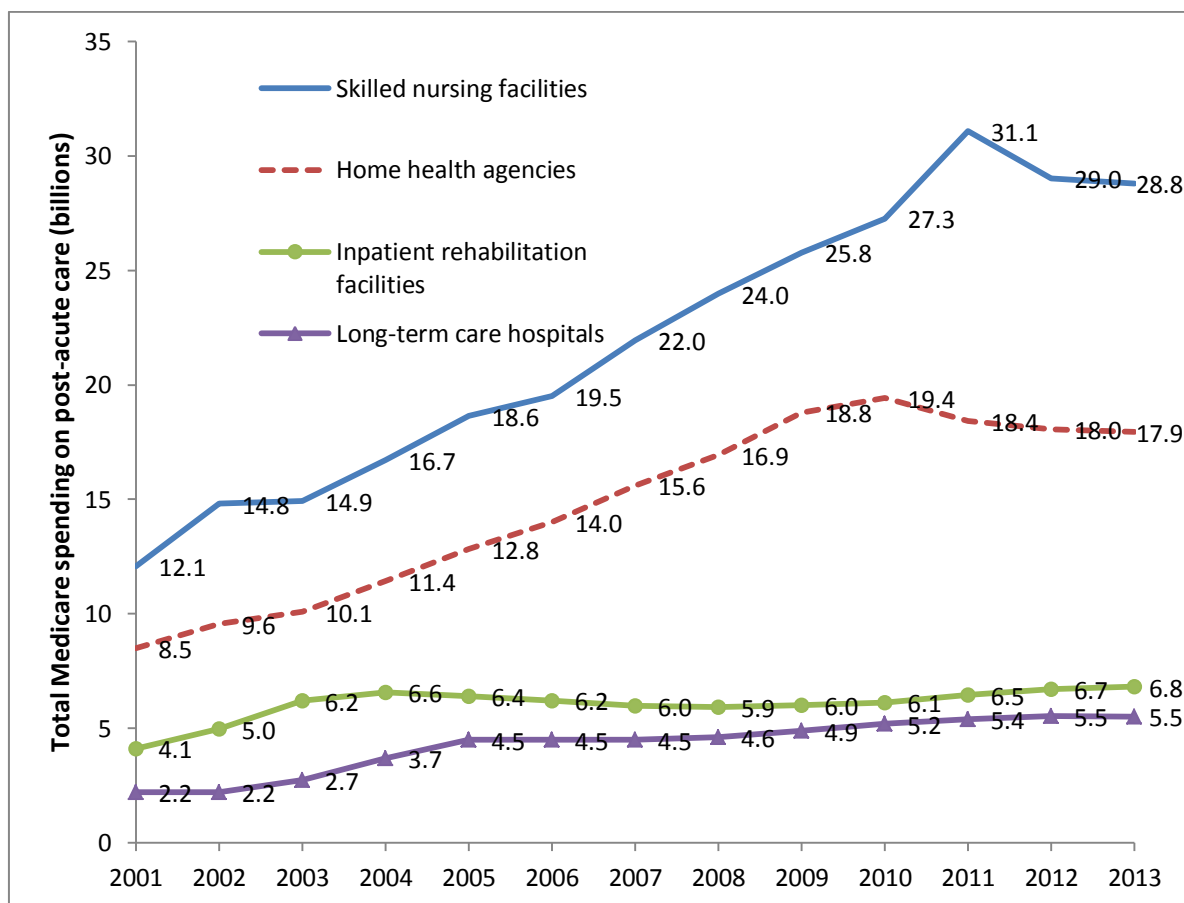


Note: These numbers are program spending only and do not include beneficiary cost sharing.

Source: CMS Office of the Actuary.

Figure 2 reports spending growth by sector. The Commission has documented changes in the numbers of providers, the mix of services they furnish, and the patients they treat. The intensification of rehabilitation services furnished by SNFs drove the more than two-fold increase in spending on these services. The explosive growth in the number of HHAs, the increase in the number of beneficiaries receiving home health care, and the amount of care beneficiaries receive explain the more than doubling of Medicare’s spending on home health care services. Medicare payments to IRFs and LTCHs grew rapidly after these sectors adopted prospective payment systems, until other policies were put in place to control the types of cases treated in these high-cost settings. An almost 60 percent increase in the number of LTCHs during this period contributed to Medicare’s increased spending in that sector.

Figure 2. Medicare’s spending on post-acute care by sector



Note: These numbers are program spending only and do not include beneficiary cost sharing.

Source: CMS Office of the Actuary.

Challenges to PAC reform

The Commission has made multiple recommendations regarding Medicare’s FFS payments and quality measures for PAC and the need for a more coordinated and integrated approach to PAC. Ideally, a well-functioning PAC payment system would encourage providers and beneficiaries to develop plans of care that focus on patient needs and coordination of care. The current system of payment based on siloes discourages such patient-centered planning and coordination. However, the FFS and PAC landscapes present many challenges to reform.

First, PAC is not well defined and the need for PAC services is not always clear. Some patients can be discharged from an acute hospital stay without PAC. Others need PAC care, but similar patients receive services in varying amounts and in different settings. Still other patients may do best by staying a few more days in the acute care hospital and avoiding the transition to a PAC setting. Clinical evidence does not clearly delineate the types of patients who belong in each setting and the amount of services needed.

A lack of clear, consistent guidelines for appropriate PAC use has contributed to wide geographic variation in PAC utilization and spending. Variation in PAC service use per beneficiary is larger than for other services: PAC service use varies two-fold between low-use and high-use geographic areas, even when the most extreme low- and high-use areas are excluded. In contrast, inpatient hospital service use varies by about twenty percent (Table 1). At the extremes, the differences are even larger: PAC spending varies about eight-fold, while inpatient hospital services vary roughly 60 percent.

Table 1. Comparison of service use variation across geographic areas

Ratio of high- to low-service-use areas	Inpatient hospital	Ambulatory care	Post-acute care
Areas at the 90th to 10th percentiles	1.22	1.24	2.01
Highest use to lowest use area	1.59	2.01	7.97

Note: Areas are defined as metropolitan statistical areas for urban counties and rest-of-state nonmetropolitan areas for nonurban counties. Service use is measured as risk-adjusted per capita spending (adjusted for wages and special add-on payments) by sector among fee-for-service beneficiaries in each area.

Source: MedPAC analysis of 2006–2008 beneficiary-level Medicare spending from the Beneficiary Annual Summary File and Medicare inpatient claims.

There is also wide variation within a given clinical condition. Even among beneficiaries who use PAC and have similar care needs, Medicare spending on PAC varies more than three-fold between the 25th and 75th percentiles (Table 2). These spending differences reflect both the mix of PAC services (e.g., whether the beneficiary went to a SNF or an IRF) and the amount of PAC used (e.g., the number of SNF days or home health care episodes).

Table 2. Medicare spending on post-acute care varies more than three-fold for conditions that often use these services

Condition	Spending on post-acute care within 30 days of hospital discharge			Ratio of 75th to 25th percentiles
	Mean	25th percentile	75th percentile	
Coronary bypass w cardiac catheterization	\$5,286	\$1,864	\$6,913	3.7
Major small & large bowel procedures	\$6,100	\$2,110	\$8,804	4.2
Major joint replacement	\$8,152	\$3,890	\$11,484	3.0
Stroke	\$13,914	\$5,936	\$19,371	3.3
Simple pneumonia & pleurisy	\$7,039	\$2,351	\$10,785	4.6
Heart failure & shock	\$5,997	\$2,034	\$9,331	4.6
Fractures of hip & pelvis	\$11,688	\$8,213	\$14,427	1.8
Kidney & urinary tract infections	\$8,040	\$3,335	\$11,963	3.6
Hip & knee procedures except major joint replacement	\$13,608	\$10,526	\$16,498	1.6
Septicemia or severe sepsis w/o MV 96+ hours	\$8,282	\$3,344	\$11,744	3.5

Note: Post-acute care includes services furnished by home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. We risk adjusted spending using Medicare severity–diagnosis related groups (MS–DRGs) and standardized payments for differences in wages and special payments (such as teaching, disproportionate share, and outlier payments). Data shown are for patients assigned to MS–DRG acuity level 1 (no complications or comorbidities). Spending is for care furnished within 30 days after discharge from an inpatient hospital stay. MV is mechanical ventilation.

Source: Analysis of 5 percent 2007 and 2008 claims data prepared for MedPAC by 3M Health Information Systems.

Current use patterns do not necessarily reflect how much care patients should receive or where they would best receive it because there are no financial incentives for providers to refer patients to the most efficient and effective setting. Instead, placement decisions can reflect many factors, including the availability of PAC settings in the local market, geographic proximity to PAC providers, patient and family preferences, and financial relationships between providers (for example, a hospital may prefer to discharge patients to providers that are part of its system). Until recently, hospitals and PAC providers had little incentive to consider the cost to Medicare of a patient’s total episode of care or to coordinate care across settings. As a result, providers focused on their silo of care, which may not have

best served the beneficiary and may have potentially generated unnecessary costs to the program and beneficiaries. The hospital readmission penalty has begun to provide important incentives for providers to coordinate care across settings.

Another complication is that while different PAC settings treat similar patients, Medicare pays them different rates depending on the setting. For example, patients recovering from joint replacement are treated by IRFs, SNFs, and HHAs, but each setting has a different payment rate for this care. Higher payments may be warranted for a provider that produces better outcomes. However, Medicare currently lacks the necessary data to compare outcomes for similar patients treated in different settings. Without uniform information about the patients discharged from the hospital and treated in different PAC settings, it is difficult to make appropriate placement decisions and to compare costs and outcomes across settings.

Broad reforms for post-acute care

The Commission maintains that Medicare needs to move away from FFS payment and toward integrated payment and delivery systems that are focused on the patient's needs, coordinating care, and ensuring positive outcomes. Our work on Medicare Advantage plans, accountable care organizations (ACOs), and bundled payments are examples of reforms that center payments on the beneficiary or episode of care rather than on specific services furnished in particular settings. Under these new approaches, providers are encouraged to coordinate care across settings and to furnish the lowest cost mix of services necessary to achieve the best outcomes.

Over the last several years, Medicare has begun moving toward paying providers differentially for the quality of care they provide and the success of their care coordination efforts. Readmission penalties, which began in the inpatient hospital PPS and have since expanded to SNFs (effective 2018), were an initial effort to use payment policy to encourage better care coordination for beneficiaries. Bundling initiatives, which assign a single entity responsibility for a patient's episode of care, represent a more expansive effort to incentivize care coordination. The Commission is also beginning work on a unified PAC payment system, which would base payments on patient characteristics, rather than site of care.

Expand readmission policies to PAC providers in FFS

Based on analysis of the sources of variation in Medicare spending across episodes of care, in 2008 the Commission recommended that hospitals with relatively high readmission rates be penalized. As of October 2012, a readmission policy now penalizes hospitals with high readmission rates for certain conditions, and readmission rates have started to decline.

In 2011, the Commission began to examine expanding readmission policies to PAC settings to reduce unnecessary rehospitalizations and better align hospital and PAC incentives. If hospitals and PAC providers were similarly at financial risk for rehospitalizations, they would have an incentive to coordinate care between settings. Unnecessary hospital stays pose risks for beneficiaries and raise the cost of episodes. Among 10 conditions that frequently involve PAC, we found Medicare spending for episodes with potentially preventable rehospitalizations was twice as high as for episodes without them: readmissions accounted for one-third of the episode spending. Furthermore, there is large variation in readmission rates, suggesting ample opportunity for improvement. For example, SNF rehospitalization rates for five potentially avoidable conditions vary by more than 60 percent between the best and worst facilities.

Aligned readmission policies would hold PAC providers and hospitals jointly responsible for the care they furnish. In addition, the policies would discourage providers from discharging patients prematurely or without adequate patient and family education. Aligned policies would emphasize the need for providers to manage care during transitions between settings, coordinate care, and partner with providers to improve quality.

To increase the equity of Medicare's policies toward providers who have a role in care coordination, the Commission has recommended payments be reduced to both SNFs and HHAs with relatively high risk-adjusted readmission rates. The proposed readmissions reduction policies would be based on providers' performance relative to a target rate. Providers with rates above the target would be subject to a reduction in their base payment rate, while providers below would not. Such an approach could encourage a significant

number of providers to improve, thereby achieving savings for the Medicare program through fewer hospital readmissions. The proposed policies also seek to establish incentives for all providers to improve, without unduly penalizing providers that serve a significant share of low-income patients. To do so, providers' performance would be compared with other providers that serve a similar share of low-income patients.

The Commission recommended a SNF readmissions reduction program in its March 2012 report to the Congress. In March 2014, as part of the Protecting Access to Medicare Act of 2014, the Congress enacted a SNF value-based purchasing program beginning in fiscal year (FY) 2019, which includes readmissions and resource use measures. The home health readmissions reduction program recommendation was published in the Commission's March 2014 report to the Congress.

Bundled payments

Under bundled payments, Medicare would pay an entity for providing an array of services to a beneficiary over a defined period of time. In the case of PAC, the bundle could cover all PAC services following a hospitalization. This bundle design would give all the PAC settings involved in providing care an incentive to provide high quality care in the most efficient setting and to tailor the services provided to the patient's needs.

Given the wide variation in PAC use, such an approach could yield considerable savings over time by replacing inefficient and unneeded care with a more effective mix of services. Bundled payments could also give providers that are not ready or that are unable to participate in more global payment like ACOs a way to gain experience coordinating care spanning a spectrum of providers and settings, thus facilitating progress toward larger delivery system reforms.

The Commission recommended testing bundled payments for PAC services in 2008 and since then has examined a variety of bundle designs. In its June 2013 report to the Congress, the Commission described the pros and cons of key design choices in bundling PAC services:

which services to include in the bundle, the duration of the bundle, how entities would be paid, and incentives to encourage more efficient provision of care. Each decision involves tradeoffs between increasing the opportunities for care coordination and requiring providers to be more accountable for care beyond what they themselves furnish.

We also laid out possible approaches to paying providers, comparing an all-inclusive payment made to one entity with continuing to pay providers FFS (like the ACO concept). Though a single payment to one entity would create stronger incentives to furnish an efficient mix of services, many providers are not ready to accept payment on behalf of others and, in turn, pay them. Alternatively, providers could continue to receive payments based on FFS. To encourage providers to keep their spending low, a risk-adjusted episode benchmark could be set for each bundle, and providers could be at risk for keeping their collective spending below it. In establishing the spending benchmarks, current FFS spending levels may not serve as reasonable benchmarks given the FFS incentives to furnish services of marginal value. The return of any difference between actual spending and the benchmark could be tied to providers meeting certain quality metrics to counter the incentive to stint on services. For beneficiaries, bundled payments should improve care coordination and reduce potentially avoidable rehospitalizations.

A unified PAC payment system

Because PAC can be appropriately provided in a variety of settings, Medicare ideally would pay for PAC using one payment system with payments based on patient characteristics, not on fee-for-service. A unified PAC payment system would encourage providers to focus on developing a PAC plan of care based on a patient's clinical needs, rather than identifying the most profitable setting to provide care. A critical requirement for developing a single PAC payment system is comparable assessment data across the four PAC settings.

The Commission has been discussing the need for a common assessment tool to compare PAC patients, their service use, and outcomes since 2005, and recommended the collection of common assessment items across the four PAC settings in 2014. Under the Improving

Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, PAC providers will begin collecting uniform assessment data in 2018. After the Secretary of Health and Human Services has collected two years of data, she is required to submit a report to the Congress recommending a uniform payment system for PAC. The IMPACT Act also requires the Commission to develop a prototype prospective payment system spanning the PAC settings and submit a report in 2016 presenting an approach for a cross-setting PAC payment system. Under a unified PAC payment system, common assessment data would be used to set a single payment rate based on a patient's conditions and characteristics. That payment would follow a patient regardless of which setting provided his or her PAC care.

Need to maintain accurate Medicare fee-for-service payments

While broad payment reforms are needed, FFS methods remain important because they are likely to remain the dominant option for the near term. Therefore, CMS needs to continue to improve the accuracy of program payments for PAC and ensure the comparability of payments across settings when providers treat similar patients.

As required by law, each year the Commission makes recommendations regarding how payments should change for the coming year for services furnished under FFS Medicare. In making its determination, the Commission considers beneficiary access to services, the quality of care, providers' access to capital, and Medicare payments in relation to providers' costs to treat Medicare beneficiaries (referred to as the Medicare margin).

The Commission has frequently observed that Medicare's payments for PAC are too high and that its payment systems have shortcomings. The high level of payments results both from base rates that were set too high relative to the cost of a service and from weaknesses in the payment systems that encourage providers to increase payments by strategically conducting patient assessments, increasing the amount of therapy they provide to raise payments, and selecting certain types of patients over others. There is also significant variation in financial performance within categories of providers (e.g., for-profit vs. not-for-

profit, freestanding vs. hospital-based facilities). Biases in the HHA and SNF prospective payment systems make certain patients, and the services provided to them, more profitable than others. Medicare's payment incentives can therefore influence providers' decisions about which beneficiaries to admit and the care they furnish, potentially disadvantaging certain patients. For example, the home health care and SNF PPSs favor rehabilitation care over medically complex care because therapy payments are based on the amount of service furnished, and increases in therapy payments outpace increases in therapy costs.

Providers can also increase their payments by delivering more services. The SNF payment system pays on a per-day basis, which may encourage longer than necessary stays because providers can earn additional payments by keeping patients longer. The home health payment system pays per episode, rather than per day, which may create an incentive to generate additional episodes of care. Between 2002 and 2013, the total number of home health episodes increased by almost 64 percent.

The Commission believes that Medicare must concurrently refine its FFS policies while exerting pressure on providers to control their costs and be receptive to new payment methods and delivery reforms. This year, we recommended no payment updates for IRFs and LTCHs in fiscal year 2016, concluding that providers in those sectors will be able to continue to provide appropriate access to care under current payment rates. For payments to SNFs and HHAs, we reiterated our previous recommendations to lower the level of payments. In making these recommendations, the Commission considered the double-digit Medicare margins the SNF and HHA sectors have experienced for many years (Medicare margins in 2013 were 12.7 percent for HHAs and 13.1 percent for SNFs) coupled with wide spread access to and use of these services.

In addition to lowering the payment rates for HHAs and SNFs, the Commission has recommended restructuring the HHA and SNF PPSs to base Medicare's payments on patient characteristics, not the amount of services furnished. In 2008 we recommended revising the SNF payment system to eliminate a payment bias favoring rehabilitation therapy services, and in 2011 we made a similar recommendation for the home health payment system. These

recommendations, which are budget neutral, are intended to accompany the aforementioned payment rate reductions to ensure that both the level of payment and the incentives within the system are accurate and fair, and that no patients are disadvantaged by the payment system.

The Commission also assesses whether additional policies are needed to influence provider and beneficiary behavior. Given the poor definitions of PAC products and a lack of clarity regarding who needs PAC services and how much is appropriate, the sector is open to the delivery of unnecessary or low-value care. When providers tailor the amount of service they furnish to take advantage of the designs of the payment systems, they may deliver services that beneficiaries do not need. To engage beneficiaries in evaluating their use of home health care, the Commission recommended a modest copayment for home health services. The copayment would not apply to episodes preceded by a hospital stay.

Highly questionable patterns of home health care use have also led the Commission to recommend expanded medical review activities and the suspension of enrollment of new providers and payments in areas with high levels of suspected fraud and abuse. The Commission annually publishes a list of the 25 counties with the highest rates of home health utilization to draw attention to the aberrant and potentially fraudulent patterns of home health use in certain areas of the country. For example, in the county with the highest rates of home health use in 2013, 36 percent of FFS beneficiaries used home health services, 4.4 episodes were provided per home health user, and nearly 160 episodes were provided per 100 FFS beneficiaries. In contrast, nationwide in 2013, 9.3 percent of FFS beneficiaries used home health care, 1.9 episodes were provided per home health user, and 18 episodes were provided per 100 FFS beneficiaries. These high rates for select counties underscore the need for further review, as many of the high-utilization areas have appeared in our report for several years. The Commission has encouraged the Secretary to use her authority to place a moratorium on new providers and suspend payments in areas with excessively high rates of home health use.

Home health rebasing

Medicare implemented the first of four years of base-payment reductions in its home health PPS in 2014, as required by the Patient Protection and Affordable Care Act (PPACA). The Commission was required by law to assess the impact of these rebasing cuts on quality of care and beneficiary access. After comparing the legislated rebasing cuts with past home health rate cuts, the Commission determined that they will not harm quality of care or beneficiary access, and in fact deeper cuts are still needed to better align home health payments with costs.

To implement rebasing, CMS set an annual reduction to the home health per episode base rate for four years. However, these reductions are partially offset by annual payment updates that home health agencies will continue to receive. When both rebasing cuts and payment updates are accounted for, the annual net payment reduction is quite small—between 0.4 percent and 0.6 percent per year. Across all four years, the cumulative net reduction equals about 2 percent.

This reduction is small by historical standards; in the past, the home health base rate has been reduced by 3 percent in a given year without a measurable effect on beneficiary access and quality of care, or on HHAs' financial performance under Medicare. Historical data demonstrate that the home health industry has responded to prior payment changes in ways (e.g. reducing visit costs and altering coding practices) that sustained double-digit Medicare profit margins, averaging 17 percent over the period from 2001 and 2012. Additionally, there has been sustained entry into the Medicare program by new home health agencies over the last 13 years, despite payment changes.

The industry has projected widespread negative margins as a result of the legislated rebasing. However, these projections assume that HHAs' costs are fixed, that agencies will not make adjustments to their costs in response to changes in Medicare payments, and that future annual cost growth will equal the market basket. In contrast, we have found that the home health industry is remarkably responsive to changes in Medicare payment policy and has historically managed to keep annual cost growth around 1 percent, which is well below the

average market basket. Home health agencies' rates of visits per episode provide an example of how agencies have reacted to financial incentives in the PPS. When the original payment for home health episodes was established in 2000, it assumed that agencies would provide 32 visits per episode. Because the episode payment does not vary based on how many visits a beneficiary receives, agencies have an incentive to reduce their visits per episode in order to lower costs. Since 2000, when the initial episode rate was established, the intensity of a visit has increased, but visits per episode have declined dramatically—first to 21 in 2001 and, by 2013, to about 18 visits per episode. The episode payment was never adjusted to reflect this decline.

The Commission will continue to review access to care and quality data as rebasing is implemented. However, experience suggests that the small PPACA rebasing reductions will not change average episode payments significantly. Home health agency margins are likely to remain high under the current rebasing policy, and current quality of care and beneficiary access to care are unlikely to be hurt.

Reforms to eliminate price differences across sites of care

Over the longer term, the Commission believes that FFS Medicare should move toward a unified payment system for PAC. In the near term, the Commission maintains that Medicare should move in the direction of uniform payments by aligning payments across settings for select conditions. Relating to PAC, the Commission has focused on payment differences between SNFs and IRFs on the one hand, and LTCHs and acute care hospitals on the other. In each case, the Commission has developed a set of criteria to identify patients with similar care needs to guide the establishment of payment policy.

Patients with similar care needs in SNFs and IRFs

Two PAC settings in which certain groups of patients with similar care needs are treated are SNFs and IRFs. In its most recent March 2015 report to the Congress, the Commission recommends eliminating the differences in payment rates for select conditions frequently treated in both settings. The Commission is not alone in its interest in aligning payments between IRFs and SNFs. Since 2007, administrations' proposed budgets under presidents

from both parties have included proposals to narrow payment rates between IRFs and SNFs for select conditions commonly treated in both settings.

The services typically offered in IRFs and SNFs differ in important ways. IRFs are required to meet the conditions of participation for acute care hospitals, including having more nursing resources available and having care supervised by a rehabilitation physician, among other requirements. Stays in IRFs are shorter on average, and patients in IRFs receive more intensive services, in part because patients admitted must be able to tolerate and benefit from an intensive therapy program. The Commission recognizes that the services in the two settings differ; however, it questions whether the program should pay for these differences when similar patients are admitted.

The site-neutral policy doesn't apply to all patients in the SNF and IRF settings. To identify possible conditions and services for a site-neutral policy, the Commission used a consistent set of criteria. We examined conditions for which the majority of patients were treated in SNFs in markets (defined as hospital service areas) with both types of providers. In addition, we compared the risk profiles of patients treated in both settings to assess whether SNFs and IRFs treat patients of similar complexity. We also examined differences in outcomes. Ideally, we would compare risk-adjusted outcomes, but this information is not consistently available.

Using these criteria, we identified 22 conditions frequently treated in IRFs and SNFs and assessed the feasibility of paying IRFs the same rates as SNFs for these conditions. We examined the characteristics of patients admitted to SNFs and IRFs and did not find large differences: Patients' average functional status at admission, their risk scores, and their comorbidities overall did not differ substantially for these 22 conditions, and the two settings admitted similar shares of minority beneficiaries, while SNFs treated considerably higher shares of beneficiaries dually eligible for Medicare and Medicaid.

The Commission also examined differences in outcomes for patients treated in both settings. Because PAC providers do not yet collect uniform patient assessment information, it is difficult to compare risk-adjusted outcomes. Key measures (such as changes in patients'

function) are not uniformly collected and cannot be adequately risk adjusted. However, neither CMS's PAC demonstration, which could compare patients across settings with the data it collected, nor other research has found consistent differences in outcomes between the two settings. Where differences in outcomes have been detected, researchers concede that the comparisons cannot fully control for selection differences between the settings.

The Commission has recommended that the Congress direct the Secretary to establish site-neutral payments between IRFs and SNFs for select conditions, using criteria such as those the Commission examined. For the selected conditions, the Commission recommends that the IRF base payment rate be set equal to the average SNF payment per discharge for each condition. The additional payments many IRFs receive for teaching programs and for treating low-income patients and high-cost outliers would not be changed by this policy. The Commission recommended that the policy be implemented over three years to give IRFs time to adjust their cost structures and to give policymakers time to monitor the effects of the change on beneficiaries and providers. As part of the policy, IRFs should be relieved from the regulations governing the intensity and mix of services for the site-neutral conditions. CMS should use its rule-making process to first propose criteria to select conditions appropriate for a site-neutral payment policy and then to identify conditions that would be subject to the site-neutral policy. In this way, the Secretary can gather input from key stakeholders.

Care for chronically critically ill patients in LTCHs

The Commission has also observed that LTCH patients have care needs that are similar to those of patients in acute care hospitals (many of whom go on to use lower cost PAC services). LTCHs have positioned themselves as providers of hospital-level care for long-stay chronically critically ill (CCI) patients—patients who typically have long, resource-intensive hospital stays often followed by post-acute care. However, nationwide most CCI patients are cared for in acute care hospitals and SNFs, and most LTCH patients are not CCI.

Medicare pays LTCHs under a separate PPS, with higher payment rates than those made for similar patients in the acute care hospital (approximately three to four times higher on

average). There are few criteria defining LTCHs, the level of care they provide, or the patients they treat. The Commission and others have repeatedly raised concerns that the lack of meaningful criteria for admission to LTCHs means that these providers can admit less-complex patients who could be cared for in less-expensive settings, such as SNFs. Comparatively attractive payment rates for LTCH care have resulted in an oversupply of LTCHs in some areas and may generate unwarranted use of LTCH services by patients who are not CCI.

The Commission has raised questions about what Medicare is purchasing with its higher LTCH payments. Studies comparing episodes of care for beneficiaries who used LTCHs with similar patients who did not failed to find a clear advantage in outcomes for LTCH users. At the same time, some studies have found that, on average, episode payments are higher for beneficiaries who use LTCHs. Other studies have found that per episode spending may be the same or lower for the most medically complex patients who use LTCHs but not for those who are less severely ill.

To reduce incentives for LTCHs to admit lower acuity patients—who could be appropriately cared for in other settings at a lower cost to Medicare—the Commission recommended in its March 2014 and March 2015 reports to the Congress that standard LTCH payment rates be paid only for LTCH patients who meet the CCI profile at the point of transfer from an acute care hospital. LTCH cases that are not CCI would be paid acute care hospital rates approximately the same as MS–DRG payment rates that would have been paid if the patient had been treated in an acute care hospital in the same local market. Funds that would have been used to make payments under the LTCH payment system instead should be allocated to the IPPS outlier pool to help alleviate the cost of caring for extraordinarily costly CCI cases in acute care hospitals.

The Commission recommended that—in the absence of data on the metabolic, endocrine, physiologic, and immunological abnormalities that characterize the CCI condition—Medicare should define LTCH CCI cases as those who spent eight or more days in an intensive care unit (ICU) during an immediately preceding acute care hospital stay. The

Commission also recommended that an exception to the eight-day ICU threshold be made for LTCH cases who received mechanical ventilation for 96 hours or more during an immediately preceding acute care hospital stay. These types of cases are generally considered appropriate for admission to LTCHs and generally viewed as warranting higher LTCH-level payment rates.

The Congress enacted a similar, but less restrictive, policy through the Pathway for SGR Reform Act of 2013, which defined patients appropriate for the LTCH-level payment as those with a three-day ICU stay. The phase-in period for the implementation of this policy will begin in 2016.

Conclusion

Medicare needs a range of policies to ensure the appropriate and efficient use of PAC services. In the near term, the Commission is recommending policies that ensure that program payments under PPS are commensurate with costs – a particularly important policy given the high payments for several PAC settings. In addition, Medicare can begin to move toward site-neutral payments where there is clear overlap in the services provided, such as for certain patients served by SNFs and IRFs. In the longer run, Medicare is beginning efforts to develop a common payment system that will eliminate the adverse incentives and inefficiencies resulting from multiple uncoordinated systems and focus the system on the patient's needs.