CHAPTER 7

Post-acute care: The Congress and CMS must act to implement recommended changes to PAC payments

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Chapter summary

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries after an acute care hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). In 2015, fee-for-service (FFS) program spending on PAC services totaled $60 billion.

The Commission has previously discussed the challenges to improving the accuracy of Medicare's payments and the shortcomings of the separate FFS payment systems for PAC (Medicare Payment Advisory Commission 2015, Medicare Payment Advisory Commission 2014). Over more than a decade, the Commission has worked extensively on PAC payment reform—pushing for closer alignment of costs and payments, more equitable payments across different types of patients, and outcomes-based quality measures (with payment tied to performance). While there has been some progress on the quality and value-based purchasing fronts, there have been few corrections to the known shortcomings of the SNF and HHA prospective payment systems (PPSs), and payments remain high relative to the costs of treating beneficiaries. As a result, the inequities in payment continue to encourage patient selection and to advantage some providers over others.

In this chapter

The Commission has two goals in making payment recommendations. The *update* recommendations aim to ensure that payments are adequate so that beneficiary access is preserved while taxpayers and the long-run sustainability of the program are protected. The recommendations to *revise the payment systems* are intended to match program payments to the costs of treating patients with different care needs. Such targeting increases the equity of the program's payments so that providers have little financial incentive to treat some beneficiaries over others.

The cost to the program of not implementing the Commission's update recommendations is substantial. Across the four PAC settings, if this year's recommendations were implemented, we estimate that FFS program spending would be reduced by more than $30 billion over 10 years, all else being equal. The cost of past inaction is also considerable. Had the 2008 recommendations to eliminate the updates to payments for HHAs and SNFs been implemented, we estimate that FFS spending between 2009 and 2016 would have been $11 billion lower, without affecting access. The Commission also recommended that the payment systems for SNFs and HHAs be revised (in 2008 and 2011, respectively) to base payments on patient characteristics, not the amount of service furnished. Implementing these recommendations would have narrowed the differences in financial performance across providers within each setting by increasing payments for nonprofit and hospital-based providers and by lowering payments to freestanding and for-profit providers. The industries, on the whole, would still be profitable; they have historically demonstrated resilience in reconfiguring their service mix and costs in response to changes in payment policy.

The overpayments and misalignment of incentives for PAC within traditional FFS also distort the payments made by Medicare Advantage (MA) plans and alternative payment models (APMs) such as accountable care organizations and bundled payment initiatives. Because the costs and service use of FFS form the basis of APM payments and MA benchmarks, reducing FFS payment rates also would reduce the level and distribution of spending outside of traditional Medicare. Allowing these distortions to continue may also compromise the integrity of future APMs because the effects of the current PPSs may be difficult to correct with the APMs' design.

The cost to beneficiaries of not revising the PPSs is harder to quantify. Revising the SNF and HHA PPSs would encourage providers to focus on the care needs of patients rather than the financial advantage of furnishing certain services and treating certain patients over others. Rebalancing spending toward medically complex care would improve access for those patients who now may be less desirable for providers to treat.

The unnecessarily high level of spending and the inequity of payments across different types of patients has led the Commission to recommend changes to both the level of spending and the designs of the payment systems. Further, given the similarity of some of the patients treated in the four PAC settings but substantially different payments made by Medicare, in June 2016 the Commission recommended features of a unified payment system (Medicare Payment Advisory Commission 2016). Like the recommended designs of the HHA and SNF PPSs, the unified PAC PPS would base payments on patient characteristics. Transitioning to a PAC PPS could begin as early as 2021; until then, CMS should move forward with revisions to the SNF and HHA PPSs. With consistent incentives, these revised payment systems will give providers valuable experience in managing care under payment systems that tailor payments to the care needs of patients. ■

Challenges to improving Medicare's payments for post-acute care

Improving Medicare's payments is challenging for a number of reasons. Perhaps most vexing is that, for any given patient, the need for post-acute care (PAC) is not clear, and there is limited evidence on which setting would be best and what mix of services would achieve the best outcomes. The availability and use of PAC services also varies widely by market, demonstrating the considerable overlap of clinical capabilities of some PAC providers. Reflecting this ambiguity and variation in service use, Medicare spending on PAC varies geographically more than any other service. Geographic areas (core-based statistical areas) with the highest and lowest per capita fee-for-service (FFS) spending (comparing the 10th and 90th percentiles) vary 22 percent for acute inpatient services and 24 percent for ambulatory services, but 200 percent (twofold) for post-acute services (Medicare Payment Advisory Commission 2011). Decisions about where to place patients often reflect several factors—the availability within a given market, the proximity to a beneficiary's home, patient and family preferences, and financial relationships between the referring hospital and the PAC provider—but not necessarily where the patient would receive the best care.

Medicare's PAC payment systems do not encourage efficient care. The home health agency (HHA) and skilled nursing facility (SNF) prospective payment systems (PPSs) encourage the provision of therapy services regardless of the patient's care needs. By paying per day, the SNF PPS may also encourage SNFs to extend lengths of stays. As a result, current practice patterns may not reflect efficient care. Medicare Advantage (MA) plans and providers participating in alternative payment models have different incentives, and there is some evidence that they have lower PAC use; they refer fewer patients to PAC, use lower cost PAC settings, and, in the case of SNFs, have shorter and less therapy-intensive stays—without appearing to harm patient outcomes (Colla et al. 2016, Dummit et al. 2016, Huckfeldt et al. 2017, Navathe et al. 2017, Winblad et al. 2017). In addition, one study comparing quality measures for short- and long-stay patients in nursing homes found mixed results between MA and FFS enrollees, with MA enrollees having better quality for some measures and worse quality for other measures (Chang et al. 2016). However, the evidence is limited, and differences between traditional FFS and the other payment models are not always statistically significant. More work needs to be done to better understand the mechanisms by which these cost and outcome results are achieved, the degree to which unmeasured differences in patient selection may explain the results, whether volume is induced (in the case of bundled payments), and whether results are scalable.

Across the four settings, Medicare requires providers to use different patient assessment tools, which undermines the program's ability to compare the patients admitted, the cost of care, and the outcomes patients achieve. Providers may appear to have higher costs or achieve worse outcomes when, in fact, they treat more complex patients. Adequate risk adjustment is needed to make fair comparisons across providers and give beneficiaries accurate information so they can make informed choices when selecting a PAC provider.

The Commission has called for a variety of quality initiatives

Since 1999, the Commission has called for a variety of quality initiatives, including the collection of uniform patient assessment information, the reporting of outcomes-based quality measures, and implementation of value-based purchasing (VBP) policies. The Congress and CMS have acted on many of the Commission's recommendations, including the development of a common patient assessment tool, outcomes-based quality measures, and VBP for HHAs and SNFs (Table 7-1, p. 190). CMS has made no progress in developing a VBP program for inpatient rehabilitation facilities (IRFs) or long-term care hospitals (LTCHs).

To meet the requirements in the Improving Medicare Post-Acute Care Transformation Act of 2014, CMS has developed measures of function and cognition, skin integrity, Medicare spending per beneficiary, discharge to community, hospital readmissions, medication reconciliation, and incidence of major falls. However, not all of the measures are outcome based or uniformly defined across the settings, though such refinements may be made in the future. In its design of a unified PAC PPS, the Commission noted that a PAC-wide value-based purchasing policy could be adopted as a companion policy to the PAC PPS.

TABLE 7–1

Post-acute care quality initiatives promoted by the Commission and the progress to date on implementation

Commission action	Congressional or CMS action
Recommended the collection of uniform patient assessment information (1999, 2005, 2010).	The Deficit Reduction Act of 2005 required the development and testing of a uniform assessment instrument. CMS tested and evaluated the tool (2011).
Reported outcomes-based quality measures in its payment adequacy work (including rates of risk-adjusted discharge to community and hospital readmission and changes in patient function). Recommended outcomes-based measures in inpatient rehabilitation facilities and home health agencies (2011, 2012).	The Improving Medicare Post-Acute Care Transformation Act of 2014 required the development of common outcomes-based measures (discharge to community; hospital readmission; Medicare spending per beneficiary; incidence of major falls; medication reconciliation; and changes in function, cognition, skin integrity) in the four settings. To meet these requirements, CMS has developed measures in all post-acute care settings.
Encouraged the expansion of Nursing Home Compare to include measures of key goals of post-acute care (2007).	CMS overhauled Nursing Home Compare and added four short-stay measures (2016).
Recommended a value-based purchasing program for skilled nursing facilities (2008, 2012). Included a value-based purchasing policy in discussion of companion policies to a post-acute care prospective payment system (2016).	The Protecting Access to Medicare Act of 2014 required a skilled nursing facility value-based purchasing program that will affect payments beginning October 2018. CMS implemented a demonstration value-based purchasing program for home health agencies in nine states in January 2016. The Patient Protection and Affordable Care Act of 2010 required value-based purchasing pilots in long-term care hospitals and inpatient rehabilitation facilities; CMS has taken no action.

The Commission's payment recommendations would lower and redistribute program spending

Since 2008, the Commission has made recommendations to lower the level of program spending in each of the PAC settings, either by lowering payments by a fixed percentage or by eliminating annual updates to payment rates, or both. To redistribute payments more equitably between therapy and medically complex care, the Commission has recommended redesigns of the HHA and SNF payment systems (in 2011 and 2008, respectively), which together pay for almost 80 percent of Medicare PAC stays.

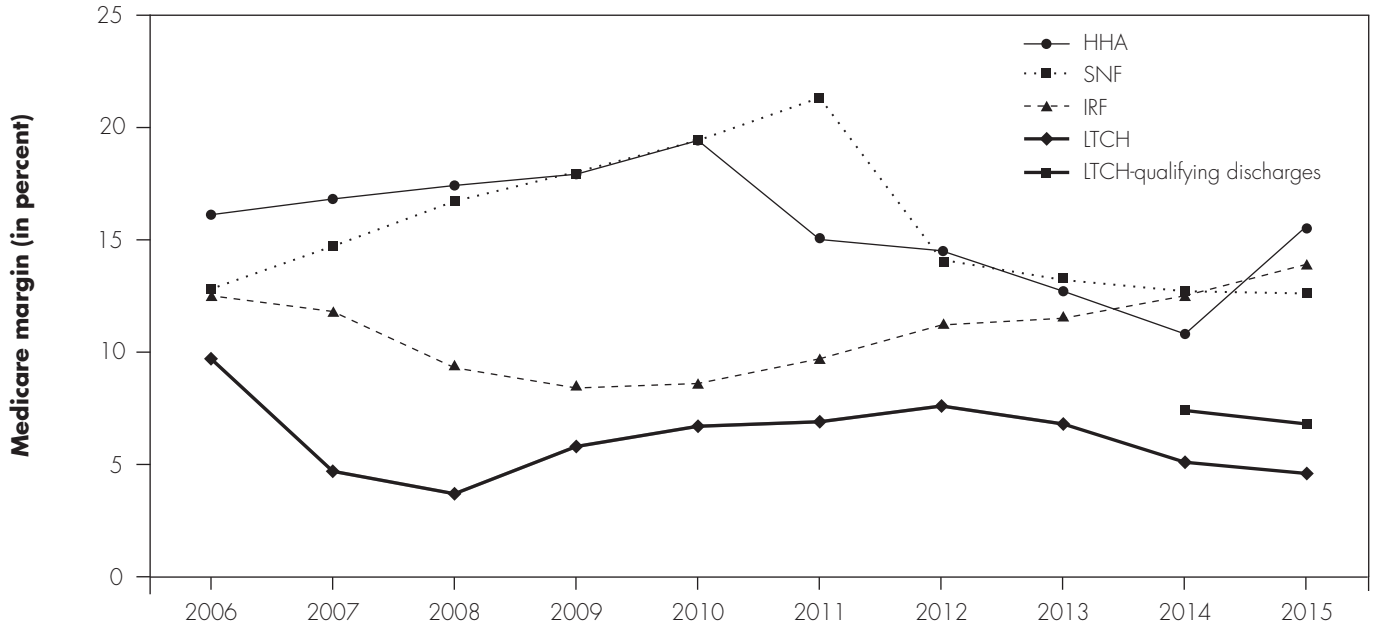
The level of Medicare's payments for post-acute care is too high

Medicare margins for three of the PAC settings (HHA, SNF, and IRF) have been above 10 percent for most of the past 10 years (Figure 7-1). In each setting, Medicare margins increased substantially soon after the PPSs were implemented, indicating that the base rates were set too high, providers adjusted to the new payment rules, or some combination.

The margins for HHAs and SNFs have been especially high, even after rebasing and productivity and other payment adjustments mandated by the Congress. Over the last decade, HHA and SNF Medicare margins averaged 15.6 percent, while IRF margins averaged 10.9 percent. The average margin for LTCHs has been considerably lower, though still above 5 percent for most of the past 10 years and higher for stays that meet the criteria to receive LTCH PPS payments. Within each setting, disparities in financial performance across providers reflect differences in costs, admitting practices, coding strategies, and the amount of therapy provided. These margins indicate that many providers can exert control over their costs when there is fiscal pressure to do so and can generate payments that robustly exceed costs.

FIGURE 7–1

Medicare margins have remained high for post-acute care providers



Note: HHA (home health agency), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital). Medicare margin is calculated as (Medicare payments – Medicare costs) / Medicare payments. The Pathway for SGR Reform Act of 2013 established separate payment methodologies for cases that qualify as LTCH discharges and cases that do not. To qualify as an LTCH discharge, the stay must have been immediately preceded by an acute care hospital stay that included at least three days in an intensive care unit or the stay must have an LTCH principal diagnosis indicating prolonged mechanical ventilation. We did not calculate margins for LTCH-qualifying discharges before 2014.

Source: MedPAC analysis of Medicare cost reports 2006–2015.

The Commission has recommended lowering the level of Medicare's payments for post-acute care

Because the level of program payments has been high relative to the cost of treating beneficiaries, the Commission, for many years, has recommended lowering and/or freezing Medicare's payment rates for PAC (Table 7-2).

The Commission recommended no updates to payments (a 0 percent update) or reductions to payments each year since 2008 for HHAs, SNFs, and IRFs and since 2009 for LTCHs. Yet during this period, without Congressional action, SNF, IRF, and LTCH payments were increased. For HHAs, although the Patient Protection and Affordable Care Act of 2010 calls for annual rebasing of payments, the

TABLE 7–2

Commission's payment recommendations since 2008

	Year(s) the Commission made the recommendation			
Recommended action	**SNF**	**HHA**	**IRF**	**LTCH**
No update (0 percent update)	2008–2017	2008–2016	2008–2016	2009–2017
Lower payments	2012–2015	2009–2017	2017	
Revise the payment system design	2008–2017	2011–2017		

Note: SNF (skilled nursing facility), HHA (home health agency), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital). In some years, the Commission's recommendation spans multiple years, with no update to payments in some years and a reduction in payments in others.

mandated reductions were offset by payment updates and, consequently, do not go nearly far enough in realigning payments to costs. Given the continued high level of payments, the Congress and CMS need to correct the considerable overpayments in each of these settings.

The cost to the program of not implementing the update recommendations is substantial. Across the PAC settings, if this year's recommendations were enacted, we estimate that FFS program spending would be reduced by over $30 billion over the next 10 years, all else being equal. Looking back, the statutory and regulatory inaction has also been costly to the program. For example, we estimate that, had the 2008 update recommendations for HHAs and SNFs (for fiscal year 2009) been implemented, FFS program spending would have been $11 billion lower, all else being equal.

The Commission has recommended increasing the equity of program payments for post-acute care

Because disparities in providers' financial performance partly reflect design features of the PPSs, the Commission has also recommended key revisions to the SNF (in 2008) and HHA (in 2011) payment systems that would increase the equity of payments. The Commission's recommended changes would base payments on the clinical, functional, and demographic characteristics of patients, not on the amount of therapy furnished. The revised designs would rebalance payments between therapy cases and medically complex cases, which would shift payments from the relatively more profitable (typically for-profit and freestanding facilities) to the relatively less profitable (typically nonprofit and hospital-based) providers. For example, we estimated that a redesigned SNF PPS would have raised spending to facilities with low shares of therapy days (by 16 percent), facilities with high nontherapy ancillary costs (by 12 percent), facilities with low shares of intensive therapy (by 32 percent), hospital-based facilities (by 21 percent), and nonprofit facilities (by 4 percent). These shifts in payments would have narrowed the differences in financial performance across the industry. Although CMS has extensive research underway on a new SNF PPS design, it has yet to include a revised design in a proposed rule. And while CMS has proposed an alternative design for the HHA PPS, there is no time line for its implementation.

For IRFs, the Commission's 2016 recommended changes to the outlier policy would redistribute FFS payments within the IRF PPS, ameliorating the financial burden for providers that have a relatively high share of costly cases whose acuity may not be well captured by the case-mix system. That same year, the Commission also recommended that the Secretary conduct focused medical record review of IRFs with unusual patterns of case mix and coding as an initial step in discerning whether observed differences reflect real differences in patient acuity. Other Commission efforts have focused on ensuring that program payments for the service-intensive, high-cost PAC settings are made only for patients who require this level of care. As early as 2007, the Commission identified the need to limit IRF payments to patients appropriate for this intensive level of care and since has supported CMS's efforts to do so.

Seeking to increase the equity in payments across PAC settings, the Commission recommended three payment reforms. First, in 2015, the Commission undertook extensive comparison of the patient characteristics and outcomes for 22 conditions frequently treated in both IRFs and SNFs. The Commission concluded there were no substantial differences in the patients treated and the outcomes in the two settings and recommended that the payment differences between IRFs and SNFs for these conditions be eliminated. By paying IRFs the lower SNF payment rates for the select conditions, we estimated that spending would be lower by between $1 billion and $5 billion over five years. Second, the Commission, in its March 2014 report, recommended changes to LTCH payments that would restrict LTCH payments to patients who are chronically critically ill (CCI). Payments for non-CCI patients would be aligned with those paid for similar patients under the acute care hospital PPS (the hospital PPS rates are much lower).

Last, in 2016, as required by the Congress, the Commission outlined the key design features of a unified payment system to span the four PAC settings (Medicare Payment Advisory Commission 2016). Underpinning this work is the recognition that many similar patients are treated across the four settings. Like the recommended designs for SNF and HHA PPSs, the unified PAC payment system bases payments on patient characteristics, not services furnished, and would redirect program payments toward medically complex patients and away from patients who receive therapy services unrelated to their care needs.

The research on the redesigns for the HHA and SNF PPSs is complete, and the Commission urges CMS to revise them without delay. The revised SNF and HHA payment systems and the unified PAC PPS encourage similar

provider behavior, so SNFs and HHAs will gain valuable experience managing care under the revised PPSs that will ease their transition to a unified payment system. Continuing its alignment of payments to patients' care needs, CMS could begin to implement a uniform PAC PPS as soon as 2021, using a transition that blends setting-specific and PAC PPS rates.

Conclusion

The Commission has pushed for better quality measurement—developing and tracking risk-adjusted outcomes-based measures—and recommended tying payment to performance for PAC providers. In response, the Congress has required the Secretary to develop common quality measures, collect patient assessment information, and implement or test VBP for three of the PAC settings. Although the Commission has urged more uniformity in the measure definitions and risk adjustment that CMS developed, CMS is on track to meet its deadlines for quality reporting and assessment data collection. However, CMS has been less successful in implementing VBP in each of the four settings. With the advent of a uniform PPS, a uniform VBP program will be imperative.

Unfortunately, similar progress has not been made regarding PAC payment policy. CMS and the Congress have not substantially lowered PAC payments or revised the HHA and SNF PPSs. The cost of inaction is high along many dimensions. The program is paying more for services than it needs to, and its payment systems unfairly advantage some providers over others. By sending the wrong price signals, current payments encourage providers to furnish unnecessary care and to prefer to treat some patients over others. Given that FFS payment rates form the basis of Medicare Advantage benchmarks and a variety of current and future alternative payment models, the overpayments also affect non-FFS payments. From the taxpayers' perspective, unnecessarily high payments contribute to the projected insolvency of the Hospital Insurance Trust Fund, estimated to occur in 2028 (see Chapter 1). The Commission urges the Congress and CMS to implement its recommendations this year. By tying payments to the care needs of patients, the revised payment systems will begin to transition providers to a unified PPS to span the four PAC settings that the Commission believes could begin as early as 2021. ■

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