Rationalizing Medicare's payments for post-acute care

Carol Carter, Evan Christman, and Sara Sadownik

November 7, 2013

MEDPAC

The need for PAC reform

- Medicare has four separate payment systems for post-acute care (SNF, HHA, IRF and LTCH)
- PAC silos frequently provide similar services to similar patients, but payment can vary significantly
- Cross-sector comparisons of quality and efficiency hindered by silos following different approaches to collection of patient functional status
- CMS developed a new cross-sector patient assessment tool
- Reformed PAC systems would be more patient-centered then current approach

Future strategies for PAC reform

- Consolidated prospective payment systems (PPS) for some or all of the current separate PAC PPSs
- Uniform prices for similar services and patients served in multiple PAC settings

Silo-based approach to patient assessment reinforces site-specific payment systems and quality measures

- SNF, IRF and home health have unique patient assessment tools
  - IRF: IRF-PAI
  - SNF: MDS
  - Home health: OASIS
  - LTCH: No required assessment tool
- Three assessment tools define patient attributes (i.e. function, etc.) differently and use different scales for measuring severity
- Separate assessment approaches reinforce the silos, even when settings treat similar patients

CARE tool could serve as a platform for patient-centered PAC reforms

- Medicare developed and tested a cross-sector patient assessment tool
  - Continuity Assessment Record and Evaluation (CARE) tool
  - Assessment items included measures of clinical, functional, and medical complexity
- Pre-demonstration reviews affirmed statistical reliability and clinical validity
- Recruited 140 providers in 11 different geographic areas to test the CARE tool

Analysis of CARE data indicated a combined payment system for PAC settings was feasible

- Examine statistical relationship between patient characteristics and hours of nursing, therapy, aide, etc.
- Common case-mix system could predict significant shares of resource use for the different settings (therapy: 36 percent; routine 70 percent)
- Limited differences in re-hospitalization and functional gain among sites

Illustrative example of a reformed PPS for PAC

- Patient referred to PAC (IRF, LTCH, SNF) and is evaluated with an assessment tool
- Common PAC PPS uses assessment data to set payment based on patient characteristics; payment will not change based on setting of care
- Payment covers PAC services only; other services used post-discharge continue to be paid separately

Future CMS efforts for CARE

- Development of CARE-based quality measures for self-care and mobility
- Assessment of using CARE data in existing PAC PPSs

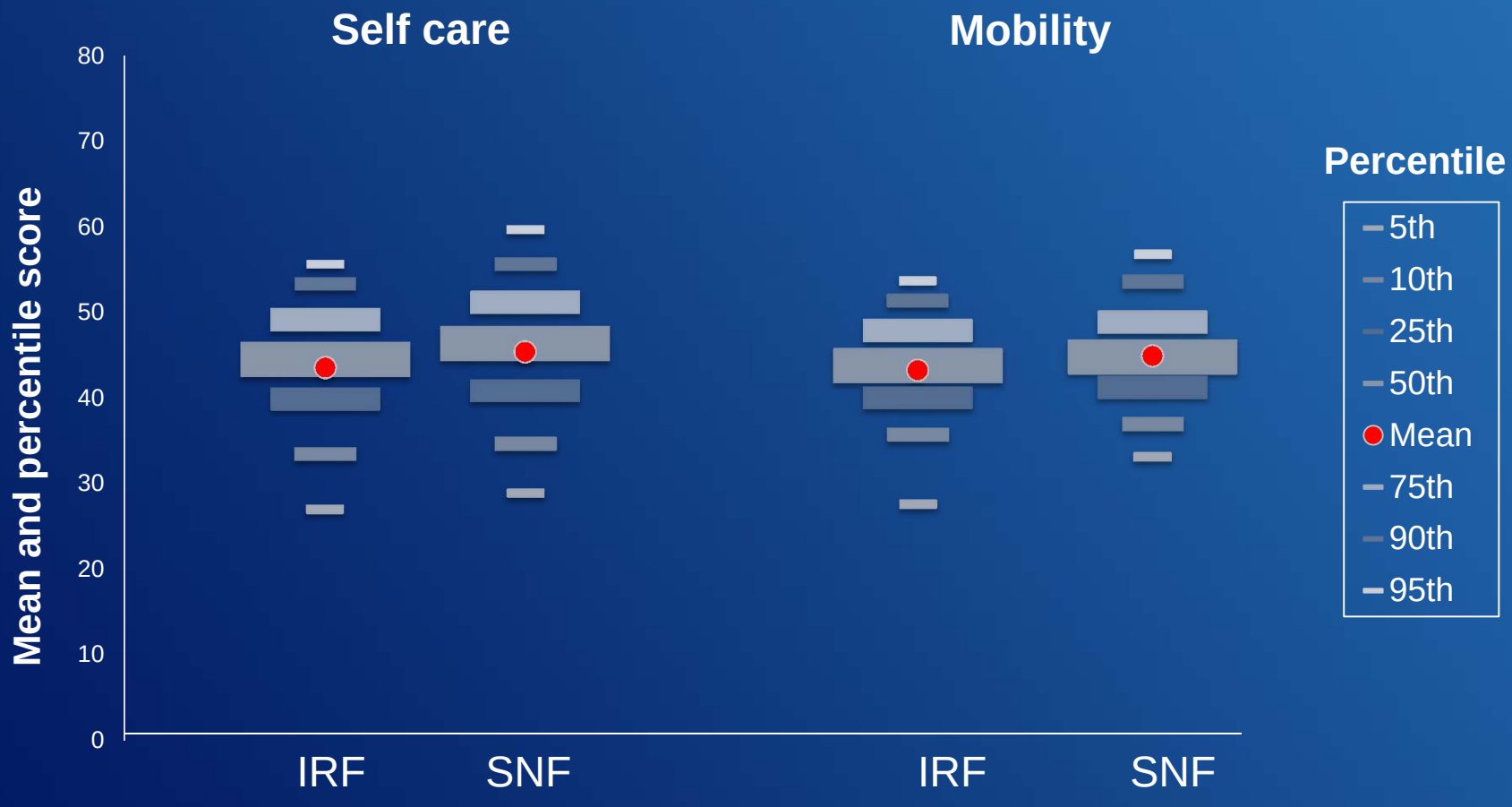
Advancing patient-centric PAC reform call for several new policies

- Current law effectively requires separate payment systems and does not create a mandate for a patient-centric system
- Mandating a unified assessment approach for functional status
- Implementing cross-sector quality measures
- Creating a common payment system that combines some or all of the existing PAC silos

Narrowing prices between IRFs and SNFs

- SNFs and IRFs offer similar services and treat some of the same conditions
- Patients achieve similar outcomes in both settings
- For the same patient, Medicare pays different prices depending on the setting
- Site-neutral payments would base payments on patient characteristics regardless of where they were treated

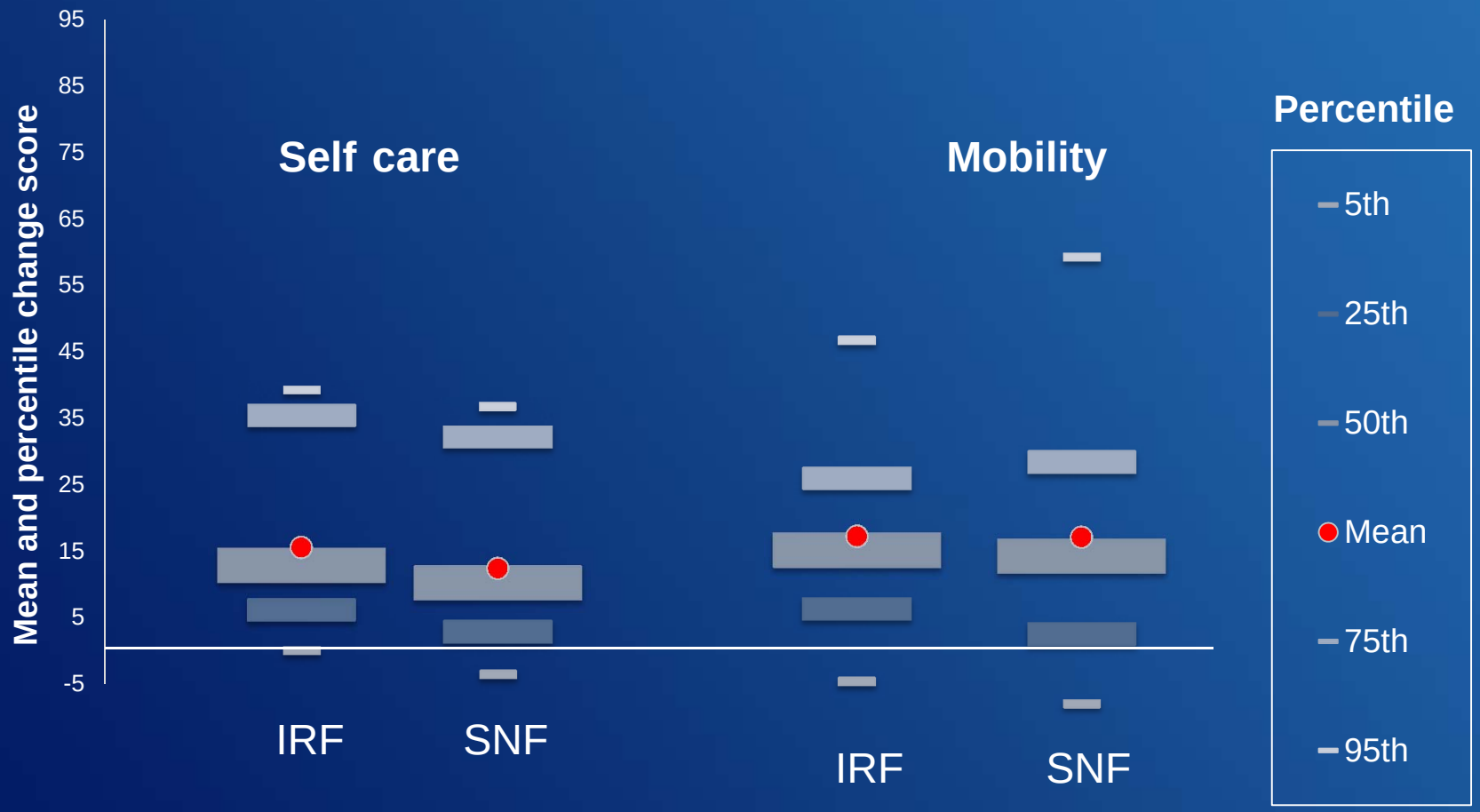
Beneficiaries admitted to IRFs and SNFs are similar in their functional status



Source: A. Deutsche. Change in Functional Status: A Comparison of PAC Settings. AcademyHealth. 2012.

MEDPAC

Changes in function for beneficiaries treated in IRFs and SNFs are similar



Source: A. Deutsche. Change in Functional Status: A Comparison of PAC Settings. AcademyHealth. 2012.

MEDPAC

Average Medicare payments per discharge are considerably higher in IRFs than SNFs

MS-DRG		Ratio of IRF to SNF payments
64	Stroke with MCC	1.9
65	Stroke with CC/ MCC	1.4
66	Stroke without CC/MCC	1.7
462	Bilateral major joint replacement without CC	1.9
469	Major joint replacement with MCC	1.7
470	Major joint replacement without MCC	1.5
481	Hip and femur procedures with CC /MCC	1.1
482	Hip and femur procedures without CC /MCC	1.3

Note: Complications and comorbidities (CC), major complications and comorbidities (MCC). Conditions shown are 7 of the 10 highest volume in IRFs.
Source: MedPAC analysis of IRF, SNF, and hospital claims 2011.
Data are preliminary and subject to change.

Study design to evaluate narrower prices for select conditions

- Focus on select conditions
- Develop common metric to compare SNF and IRF prices
- Examine comparability of patients in SNFs and IRFs
- Model IRF payments under alternative SNF PPS design and current policy

Factors considered in selecting conditions for narrower prices between SNFs and IRFs

- Large share of cases treated in SNFs, even in markets with both IRFs and SNFs
- Account for a sizable share of Medicare business in IRFs
- Included in studies of comparability of sites
- Will focus on patients recovering:
  - Major joint replacement without CC
  - Hip fracture with CC
  - Stroke with CC

Next steps for advancing PAC reform

- Uniform prices for select conditions in IRF and SNF
- Mandating a unified assessment approach for functional status
- Implementing cross-sector quality measures
- Creating a common payment system that combines some or all of the existing PAC silos