

CHAPTER

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**Improving Medicare payment  
for post-acute care**

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# Improving Medicare payment for post-acute care

## Chapter summary

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries, about half of whom had a prior hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). In 2018, fee-for-service (FFS) program spending on PAC services totaled \$58.6 billion.

The Commission has two broad goals in making payment recommendations. First, the Commission makes recommendations to update payment rates to ensure that aggregate payments are sufficient to preserve beneficiary access to and quality of care, while protecting taxpayers and the program's long-run sustainability. For more than a decade, Medicare payments for three of the PAC settings (SNFs, HHAs, and IRFs) have been high relative to the cost to treat beneficiaries, and the Commission has, in turn, annually recommended lowering or maintaining the base payment rates.

Second, the Commission makes recommendations to revise payment systems so that program payments are aligned with the costs of treating patients with different care needs. For rate year 2020, CMS overhauled the payment systems Medicare uses to pay HHAs and SNFs, consistent with past Commission recommendations. The dual payment-rate structure used to pay LTCHs, which began implementation in 2016, is having its intended effect

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of reducing the volume of lower acuity stays that could be treated in lower cost settings. These revisions to the setting-specific payment systems are directionally consistent with the changes providers will need to make under an eventual unified payment system for all PAC providers. The Commission will monitor provider responses and consider future recommendations if warranted.

The changes made to the SNF and HHA payment systems will bring much-needed reform, but the systems continue to rely in part on patients' functional status to adjust payments. The Commission has raised questions about the current state of functional assessment data and whether Medicare should rely on the relatively subjective, provider-reported information to establish payments. Because patients of varying functional status have different resource needs and because change in functional status is generally viewed as a key quality metric of PAC, it is important to improve the consistency of reporting this information. ■

## Medicare's payments remain high and need to be aligned with the cost of care

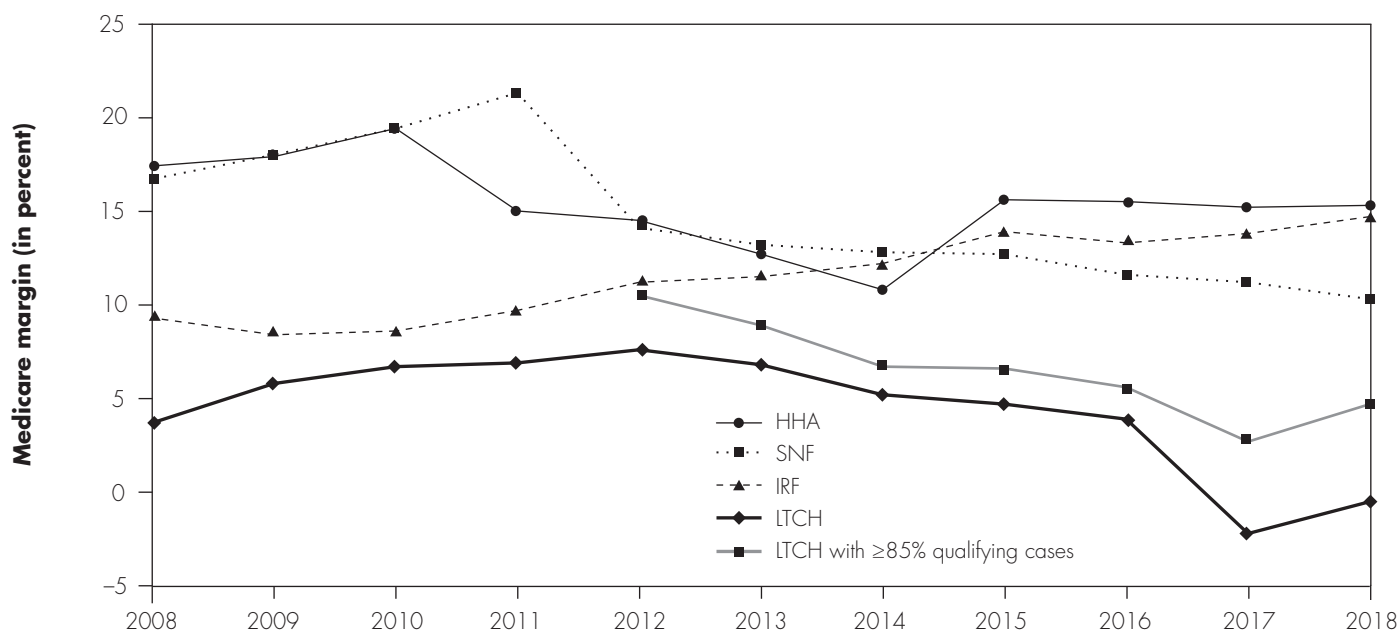
For more than a decade, aggregate Medicare payments for three of the post-acute care (PAC) settings have been high relative to the cost to treat beneficiaries (Figure 7-1). Medicare margins for home health agencies (HHAs) and skilled nursing facilities (SNFs) have been especially high, even after rebasing and productivity and other payment adjustments mandated by the Congress. Over the past 11 years, Medicare margins in HHAs and SNFs averaged over 14 percent. Close behind, inpatient rehabilitation facility (IRF) margins averaged 11.5 percent over the same time period. The aggregate Medicare margin increased substantially soon after each setting's prospective payment system (PPS) was implemented, indicating that the initial base rates for each setting were set too high and that providers rapidly adjusted to the new payment rules. The

aggregate margin for long-term care hospitals (LTCHs) has been considerably lower, though higher for a cohort of providers with at least 85 percent of stays in 2017 and 2018 that met the criteria implemented in 2016 to qualify to receive payment under the LTCH PPS.

Because the level of program payments for PAC has been high relative to the cost of treating beneficiaries, the Commission has recommended lowering or eliminating the update to the base rate payments for many years. For HHAs, SNFs, and IRFs, the Commission has recommended reductions or no updates (a 0 percent update) to the base rates each year since 2008. In some years, the Commission made a multiyear recommendation that included no update to payment rates in one year and reductions in subsequent years. Yet during this period, without congressional action, SNF, IRF, and LTCH payments were increased due to statutory updates. For HHAs, the Affordable Care Act of 2010 mandated a four-year rebasing of payments but the reductions were offset

**FIGURE 7-1**

**Aggregate Medicare margins have remained high for most 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 to SGR Reform Act of 2013 established separate payment methodologies in cases that qualify as LTCH discharges and cases that do not. “LTCHs with ≥85% qualifying cases” refers to a cohort of LTCHs defined by their share of Medicare stays that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH prospective payment system (PPS) in 2018. The hospitals in this cohort may or may not have had more than 85 percent of Medicare fee-for-service cases meeting the criteria in prior years. We did not separately calculate margins for LTCHs with a high share of cases meeting the criteria for payment under the LTCH PPS before 2012.

Source: MedPAC analysis of Medicare cost reports from CMS, 2008–2018.

by updates to payment rates. Consequently, payments to HHAs were not realigned with providers' costs.

This year, the Commission continues its focus on aligning payments with the cost of care while protecting the long-run sustainability of the program. In the Commission's judgment, the recommended updates to SNFs, HHAs, and IRFs—no update to base payments for SNFs and reductions to base payments to HHAs and IRFs—would lower program payments without impairing access for beneficiaries.

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## **Revisions to setting-specific post-acute care payment systems aim to increase the equity of Medicare's payments**

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The HHA and SNF PPSs have resulted in relatively high payments for rehabilitation care and relatively low payments for medically complex care, which, in turn, has favored the admission of beneficiaries with therapy care needs over other beneficiaries. To redistribute payments more equitably between therapy and medically complex care, the Commission recommended redesigns of the SNF and HHA payment systems (in 2008 and 2011, respectively), which together dictate payments for 79 percent of Medicare PAC. In October 2019, CMS implemented major revisions to the SNF PPS and began implementing substantial changes to the HHA PPS in January 2020. Both overhauls will bring much-needed reforms to the PPSs. Payments will be based on patients' clinical and other characteristics, not on the amount of therapy they receive. Both redesigns are consistent with the Commission's recommended changes and seek to rebalance payments between therapy cases and medically complex cases. For example, under the revised SNF PPS, CMS estimated that payments in 2017 would have decreased over 8 percent for high-cost therapy cases and would have increased over 20 percent for patients who had high drug costs or require ventilator or tracheostomy care, bringing payments more in line with the resource costs of caring for these patients (Centers for Medicare & Medicaid Services 2018). By increasing the equity of program payments, providers will have less financial incentive to favor admitting beneficiaries with certain care needs over other beneficiaries.

The changes to the payment systems will affect some providers more than others based on the mix of patients

they admit and their current practice patterns. CMS estimates that had the revised SNF PPS been in place in 2017, payments to nonprofit SNFs and hospital-based SNFs would have increased 2.9 percent and 16.7 percent, respectively (Centers for Medicare & Medicaid Services 2018). Similarly, CMS estimated that the changes to the HHA PPS will increase 2020 payments to facility-based providers and nonprofit providers by 3.7 percent and 2.8 percent, respectively (Centers for Medicare & Medicaid Services 2019). All else being equal, these changes will narrow the substantial differences in Medicare margins between nonprofit and for-profit providers and between hospital-based and freestanding providers. However, differences in Medicare margins between providers are likely to remain due to differences in economies of scale, cost growth, level of costs, and coding practices.

Although LTCHs were intended to serve very sick patients, until 2016, the lack of meaningful criteria for admission resulted in admissions of less-complex patients who could be cared for appropriately in other, lower cost settings. The Commission and CMS had long been concerned that caring for lower acuity patients in LTCHs increased spending without demonstrable improvements in quality or outcomes. Beginning in 2016, under a "dual payment-rate structure," certain LTCH cases continue to qualify for the higher LTCH PPS rate ("cases meeting the LTCH PPS criteria"), while cases that do not are paid lower rates. Even the partially phased-in dual payment-rate structure (through 2019) had its intended effect. From 2015 through 2018, the number of LTCH cases dropped by 22 percent, due largely to a decline in cases that did not meet the criteria. Over the same period, the aggregate share of cases that met the LTCH PPS criteria rose from about 55 percent to 70 percent.

As SNFs, HHAs, and LTCHs make changes to their practices, the Commission will continue to monitor beneficiary access, quality of care, and provider financial performance and will consider future recommendations if warranted. If patient mixes, service provision, and cost structures change, payments for case-mix groups will need to be recalibrated and the level of payments will need to be changed to keep payments aligned with the cost of care.

Currently, no major revisions to the payment system for IRFs are anticipated. However, differences in financial performance across IRFs suggest that patient selection contributes to provider profitability. Our prior work found that IRFs with the highest margins had higher shares of

nonstroke neurologic conditions (including neuromuscular disorders such as amyotrophic lateral sclerosis or muscular dystrophy), lower shares of stroke patients, and fewer stroke patients with paralysis. The Commission intends to explore the differences in relative profitability across types of cases treated in IRFs and, if warranted, consider refinements to the IRF PPS.

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## **Revised setting-specific post-acute care payment systems align with an eventual unified payment system**

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The recent revisions to the setting-specific payment systems align with the changes that providers would need to make to be successful under a unified PAC payment system. As a result, when a PAC PPS is implemented, its effects on payments are likely to be smaller than had it been implemented before these setting-specific overhauls because much of the redistribution of payments from rehabilitation care to care for medically complex conditions, and the concurrent changes in provider practice patterns, will have already occurred under the revised SNF and HHA PPSs. In addition, LTCHs will have decreased their share of lower acuity patients so that the average payments established for these patients under a unified payment system will have a smaller impact on these providers. The Commission views these shifts as necessary and desirable for two reasons. First, beneficiaries with differing care needs will have equal access to PAC. Second, the program will more closely align its payments with the cost of care both within and across PAC settings.

The Commission has discussed the need for aligned regulatory requirements under a PAC PPS so that PAC providers face the same set of requirements and the costs associated with meeting them. Under the two-tiered regulatory structure discussed by the Commission, all PAC providers would be required to meet one set of conditions to establish basic competencies to treat the typical PAC patient. Providers opting to treat patients with specialized or very high care needs (such as treating patients who require ventilator support) would be required to meet a second tier of requirements that would vary by specialized care need. This approach may encourage providers to specialize in the mix of services they furnish and effectively create regional referral centers for select services, which could increase the quality of care beneficiaries receive.

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## **Post-acute care payment system designs rely on functional assessment data that can be influenced by providers' financial considerations**

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The changes made to the SNF and HHA payment systems will bring much needed reform, but the payment systems continue to rely on provider-reported patients' functional status to adjust payments, as does the IRF payment system. In June 2019, the Commission raised questions about the providers' self-reported functional assessment data. Because this information affects payments and the calculation of certain quality metrics, providers have an incentive to report the information in ways that raise payments and appear to improve performance. The Commission has found that the same beneficiary discharged from one PAC setting and admitted directly to another PAC setting received substantially different functional assessment scores in each setting and that the differences consistently were biased toward higher payments and higher quality improvement. There were also large differences between assessment items (such as the ability to walk) used for payment and those used for quality improvement. The large differences and apparent bias in the reporting suggested these data must be improved to reliably capture meaningful differences among patients.

Past experience with PAC providers responding to payment incentives raises questions about the reliability of functional assessment data for establishing payments. Although other administrative data (such as diagnoses) used to adjust payments are provider reported and therefore vulnerable to misreporting, the patient assessment information is particularly subjective and more difficult to audit. Further, even if the data were to appear consistent, Medicare may not want to base its payments on the reporting of a factor of care that is so firmly in a provider's control yet so difficult to verify or audit. But because patients of varying functional status require different resources and the change in functional status is an important health outcome, improving the quality of functional status data is key to paying appropriately for this care and gauging health outcomes. ■

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