Encouraging Medicare beneficiaries to use higher-quality post-acute care providers

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MEDPAC

Overview

- Review of Medicare's discharge planning policies
- Factors affecting beneficiary choice of post-acute care (PAC) provider
- Options for encouraging beneficiaries to use higher-quality PAC providers

About 40 percent of hospital discharges resulted in the use of PAC in 2016

	Medicare expenditures (in billions)	Number of providers
Skilled nursing facilities (SNF)	$29.1	15,307
Home health agencies (HHA)	$18.1	12,204
Inpatient rehabilitation facilities (IRF)	$7.7	1,188
Long-term acute care hospitals (LTCH)	$5.1	407

Source: MedPAC analysis of Medicare data
Results are preliminary and subject to change

Discharge planning process is a hospital responsibility

- Hospitals are responsible for:
  - Assessing patient post-hospital care needs
  - Educating beneficiaries about their post-hospital needs and options for care
  - Facilitating transfers to PAC when necessary
  - Providing a list of SNFs and HHAs for patients that require this care – quality measures not required to be included
- Hospital discharge planners may not recommend specific providers – beneficiaries have freedom to choose PAC providers
- IMPACT Act requires the use of quality as a factor in discharge planning; regulation implementing requirement has not been finalized

Quality of PAC provider selected affects beneficiaries, hospitals and Medicare

- Quality varies broadly among PAC providers
  - SNF: Rate of hospitalization ranged from 12.8% for the SNF at the 25th percentile to 19.5% at the 75th percentile
  - HHA: Rate of readmission for ranged from 17.5 % for the HHA at the 25th percentile to 30.1% at the 75th percentile
- Beneficiaries served by lower quality providers may experience more hospitalizations and worse outcomes
- Hospitals whose patients are readmitted or experience other bad outcomes may see payment reductions
- Medicare gets less value and incurs higher program costs

Factors influencing beneficiaries' choice of PAC provider

- Studies of referral patterns indicate that Medicare's publicly available quality measures do not significantly increase use of higher-quality PAC providers
- Patients solicit views on quality from trusted intermediaries such as family, physicians, or associates that have used PAC
- Beneficiaries report distance from home and provider reputation as important in selecting PAC

How often do beneficiaries have a better quality PAC provider nearby?

- Utilization patterns reflect discharge planning practices
- Examined how often beneficiaries that used SNF or HHA in 2014 had another provider nearby (<15 miles) with higher quality
- Measured quality with a composite measure that included readmissions/hospitalizations and changes in mobility
- Other factors affecting provider selection, such as occupancy and patient clinical, not considered

Most SNF and HHA users had a nearby provider of higher quality

- SNF: 84.3% of beneficiaries had at least one higher-quality SNF nearby; 46.8% had 5 or more
- HHA: 94.5% of beneficiaries had at least one higher-quality HHA nearby; 69.5% had 5 or more
- Beneficiaries in urban areas generally had more higher-quality options nearby
- Higher-quality providers had meaningful differences compared to selected provider (e.g., better SNFs had a re-hospitalization rate that was about 3 percentage points lower than selected provider)

Leveraging discharge planning to encourage the use of better PAC providers

- Helping beneficiaries select better quality providers should be a goal of the discharge planning process
- Providing hospital discharge planners with tools and authority to recommend higher-quality providers would advance this goal
- Identifying higher-quality PAC providers necessary to achieve this objective

Flexible approach to encourage use of higher-quality PAC providers

- Hospitals define:
  - Quality measures
  - Levels of performance
  - Other information (compliance history, medical staff review)
- Hospitals would be required to collect and review data on PAC provider performance; maintain formal record of process

Advantages and disadvantages of flexible approach

- Advantage:
  - Provides hospitals with freedom to develop quality standards that best fit patient needs and PAC capabilities in local market
- Disadvantages:
  - Multiple quality standards
  - Designation of PAC provider as higher-quality may be inconsistent across hospitals
  - Confusing for beneficiary to understand why designation varies across hospitals
  - Administrative burden for hospitals and CMS

Prescriptive approach for identifying higher-quality PAC providers

- Medicare-defined criteria:
  - Quality measures
  - Levels of performance
- CMS notifies hospitals and beneficiaries of qualifying PAC providers

Advantages and disadvantages of prescriptive approaches

- Advantages:
  - Establishes single standard that applies to all areas and providers uniformly
  - Easier for beneficiaries and PAC providers to understand
  - PAC providers would be evaluated consistently
  - Lower administrative burden for hospitals
- Disadvantage:
  - Availability of higher-quality PAC providers varies across markets; not evenly distributed across country

Prescriptive approach could be revised to account for variations in PAC quality across markets

- Medicare would implement standards to identify higher-performing PAC providers
- Quality measures could include both national benchmarks and market level benchmarks, such as:
  - Highest quartile on quality measures nationwide, or
  - Highest quartile on quality measures within a market

Advantages of revised prescriptive approach

- Maintains consistency in designation of higher-quality PAC provider
- Would “even-out” supply of providers classified as higher-performing
- Provides beneficiaries and PAC providers with clear definition of quality
- Lower administrative burden on hospitals; designations produced by Medicare

Discussion

- Design of options
- Chapter in June 2018 report