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

Evan Christman

September 7, 2017

MEDPAC

Overview

- Cost and quality of post-acute care (PAC)
- Patient experience in selecting PAC and Medicare's requirements for discharge planning
- Trends in the quality of PAC provider used by Medicare beneficiaries
- Options for encouraging the use of higher-quality PAC providers

PAC use is frequent and costly after an acute hospital discharge

	Medicare expenditures (billions) - 2015	Number of providers-2015
Skilled nursing facilities (SNF)	**$27.2**	**15,052**
Home health agencies (HHA)	**$18.1**	**12,346**
Inpatient Rehabilitation Facilities (IRF)	**$7.4**	**1,182**
Long-term acute care hospitals (LTCH)	**$5.3**	**426**

Source: MedPAC March 2017 Report to the Congress

- About 40 percent of hospital discharges result in use of at least one of the four formal PAC providers

Local markets often have multiple providers with significant variation in quality

- Availability of providers varies by type and market
  - SNF and HHA – many markets have multiple providers available (i.e., 86 percent of beneficiaries live in an area served by 5 or more HHAs)
  - IRF and LTCH – concentrated in urban areas
- Quality varies widely within a silo – e.g., average SNF re-hospitalization rate was double between the SNFs in the bottom quarter and the top quarter

Quality of PAC provider selected can affect both beneficiaries and hospitals

- Hospitals penalized for some readmissions from PAC
- May affect financial results in reform programs (accountable care organizations, bundling demonstrations)
- Beneficiaries may experience more hospital stays and diminished health status

Beneficiaries often need assistance selecting PAC providers

- Hospital stay can be a disorienting period for beneficiary and caregiver
- Beneficiaries often have limited or no knowledge of PAC functions and capabilities or may not be aware of the need for PAC
- Discharge can occur with limited prior notice
- PAC facility availability and capability may also affect options

Beneficiary choice of PAC provider has not been significantly influenced by quality data

- Medicare provides publicly available provider-level quality data through Nursing Home Compare and Home Health Compare
- Measures cover broad categories of patients and do not report results for specific conditions
- Prior studies of referral patterns indicate that release of Medicare's quality measures did not significantly increase utilization of higher-quality providers

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
  - Provide 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

Experience of beneficiaries selecting PAC during a hospital stay

- Beneficiaries report distance from home and provider reputation as important in selecting PAC
- Patients solicit views on quality from trusted intermediaries such as family, physicians, or associates that have used PAC
- Discharge planners can assist, but may face impediments
  - Prohibition on recommendations
  - Not always aware of quality differences among PAC providers

Hospitals and ACOs rely on voluntary efforts to encourage use of higher-quality PAC providers

- Lowering readmissions from PAC a focus for hospitals in ACOs and inpatient bundling programs
- Most delivery system reform demonstrations do not change Medicare's discharge planning rules
- Common strategies reported by hospitals and health systems
  - Established preferred provider networks of PAC providers to identify better providers
  - Expanded patient education and offers of supplemental services to encourage use of selected PAC provider

Hospitals in the Comprehensive Care for Joint Replacement (CJR) program may recommend PAC providers

- CJR program establishes bundled payment for hospital stay and 90 days of follow-up care (includes any PAC) for patients receiving hip or knee replacements
- Applies to 67 areas (reduced to 34 in 2018)
- Changes discharge planning requirements to permit hospitals to recommend PAC providers
- Beneficiaries still have freedom to select other PAC providers

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

- Utilization patterns will reflect discharge planning practices
- Examined how often beneficiaries that used SNF or HHA in 2015 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, such as capacity, patient clinical needs, and other beneficiaries preferences affect provider selected

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

Percent of beneficiaries with better options nearby:	Number of higher quality providers available within 15-mile radius						
	0/No better options	1	2	3	4	5 or more	Total
SNF patients	14.7%	12.2%	9.8%	8.3%	8.2%	46.8%	100%
HHA patients	5.5%	5.7%	6.0%	5.9%	7.4%	69.5%	100%

Source: MedPAR 2014, Home Health Standard Analytic File 2014, and Medicare Beneficiary Summary File

- Beneficiaries in urban areas generally had more higher-quality options nearby
- Average quality differences between selected and nearby providers were non-trivial (e.g., better SNFs had a re-hospitalization rate that was about 3 percentage points lower then selected provider)

Expanded efforts to encourage higher-quality PAC use could benefit patients and the program

- Medicare does not require the use of quality measures in discharge planning
- Hospitals and health systems are limited in the means they can use to encourage the use of better providers
- Beneficiaries often have a better provider nearby
- Fewer re-admissions from PAC would benefit the patient and Medicare

Options that modify Medicare's discharge planning guidance

- Modify discharge planning rules to allow hospitals to recommend PAC providers
  - Consistent with other efforts to hold hospital accountability for post-discharge care
  - Already permitted in the CJR program
- Require planners to consider PAC facility quality in the development of discharge plans
- Require that hospitals provide quality data to beneficiaries seeking PAC

Options that create financial incentives for hospitals and PAC providers

- Expand the Hospital Readmissions Reduction Program to apply to more conditions (June 2013 MedPAC report)
- Implement PAC value-based purchasing (VBP) programs
  - Currently have VBP for SNF, could expand HHA
  - Establish programs for IRF and LTCH

Conclusion

- Near-term options modify discharge planning requirements
  - Permit hospitals to recommend
  - Require hospitals to use quality data and provide it to beneficiaries
- Longer-term options modify or create incentives
  - Expand HRRP
  - Implement PAC VBP