



*Advising the Congress on Medicare issues*

# Post-acute care: Trends in Medicare's payments across sectors and ways to rationalize payments

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# Post-acute care overview

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- Post-acute care (PAC) includes services furnished in skilled nursing facilities, home health agencies, inpatient rehabilitation hospitals, and long-term care hospitals
- 42% of beneficiaries are discharged from hospitals to PAC
- 29,000 providers
- 9.6 million encounters
- Substantial geographic variation

# Trends in use, quality and spending for post-acute care

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- Spending doubled to \$59 billion from 2001 to 2012
- Medicare margins have been high for 10 years
- Wide variation in providers' Medicare margins
- Rapid growth in payments related to therapy services
- New providers are predominantly for-profit
- Quality measures have indicated little improvement for most sectors

## Commission's work to rationalize Medicare payments for post-acute care across settings

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- Assess payment adequacy and accuracy
- Recommended readmission policy for home health and SNF to improve care and promote coordination
- Commission seeks a more unified PAC payment system
- Continue to improve incentives in current systems while reform is developed

## Possible future Medicare strategies to better manage post-acute care

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- Partnerships between hospitals and PAC providers to help beneficiaries choose high-value post-acute settings
- Expand beneficiary incentives to select high-value providers

# Near-term approach to more rational PAC payments: Site-neutral payments

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- Different PAC settings can treat patients recovering from the same acute conditions
- Patients can appear to be similar yet Medicare's payments differ considerably between settings
- Site-neutral policy would align payments between IRFs and SNFs for select conditions frequently treated in both settings

# Deliberative approach to identify conditions for site-neutral payments

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- Consistent with Commission's other site-neutral work
- The majority of cases with the conditions are treated in SNFs, even in markets with IRFs
- Patients in SNFs and IRFs have similar risk profiles. SNF patients tend to be older and sicker.
- Patients treated in IRFs do not consistently have better outcomes than patients treated in SNFs

# Conditions considered for a site-neutral policy

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- 5 orthopedic conditions included in June 2014 report
- 17 additional conditions are a mix of orthopedic, pulmonary, cardiac, and infections
- Together, the 22 conditions comprise 30% of IRF cases and spending
- Under the site-neutral policy, IRF payments would be lowered by about 7%



# Site-neutral policy for qualifying conditions has several components

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- IRF base rate would be the average SNF payment per discharge
- IRFs will continue to receive add-on payments
- IRFs would get relief from regulations regarding how care is furnished
- The 60% rule would be adjusted as needed
- CMS should gather stakeholder input on criteria and conditions

# How will IRFs respond to site-neutral payment for IRFs?

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- IRFs are likely to continue to treat these patients
  - Policy reduces IRF's regulatory requirements for site-neutral conditions
  - IRFs can lower their costs by changing the intensity and mix of services
    - IRFs have excess capacity (63% occupancy rate)
    - SNF PPS is highly profitable
- Some IRFs may choose to no longer treat these patients
  - IRFs may contract or shifts their mix of patients