

C H A P T E R

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**Post-Acute Care Providers:  
Moving toward Prospective Payment**

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# R E C O M M E N D A T I O N S

## **The Secretary should:**

- 5A** Collect a core set of patient assessment information across all post-acute settings.
- 5B** Establish quality monitoring systems for post-acute care as prospective payment systems are implemented.
- 5C** Conduct a demonstration to assess the potential of the Functional Independence Measure–Function Related Groups classification system to predict the resource use of intensive rehabilitation patients in skilled nursing facilities.
- 5D** Continue to refine the classification system used in the skilled nursing facility prospective payment system to improve its ability to predict the resources associated with nontherapy ancillary services.
- 5E** Explore the potential for revising the rehabilitation groups of the classification system used in the skilled nursing facility prospective payment system to reduce reliance on measurements of rehabilitation time.
- 5F** Develop a method for updating payment weights in the skilled nursing facility prospective payment system as soon as possible.
- 5G** Identify any distortions in the base payment rates of the skilled nursing facility prospective payment system and explore options for correcting them as better data become available.
- 5H** Develop ways to ensure skilled nursing facilities’ accountability for accurately assessing patient needs and classifying them for payment purposes.
- 5I** Develop a wage index based on skilled nursing facility wage data and use it to adjust payments for those facilities’ services.
- 5J** Develop a discharge-based prospective payment system for rehabilitation facility patients based on the Functional Independence Measure–Function Related Groups classification system. Policies to address transfers and short-stay outliers would be necessary components of such a system.
- 5L** Require home health agencies to use consistent, service-specific codes on all patient bills for services provided during home health visits.
- 5O** Evaluate all relevant case-mix and prospective payment methodologies for their utility in developing a prospective payment system for long-term hospitals.

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## **The Congress should:**

- 5K** Establish in law clear eligibility and coverage guidelines for home health services.
- 5M** Require independent assessments of need for beneficiaries receiving extensive home health services to ensure the appropriateness of such care. Beneficiaries receiving 60 or more home health visits should qualify for assessments. Assessors should confer with prescribing physicians to modify care plans as needed.
- 5N** Require modest beneficiary cost-sharing for home health services, subject to an annual limit. Low-income beneficiaries should be exempt from cost-sharing.

## Post-Acute Care Providers: Moving toward Prospective Payment

**T**he Balanced Budget Act of 1997 initiated substantial changes in payment policy for providers of post-acute care under Medicare. The legislation set forth a timetable for implementing prospective payment for skilled nursing facilities, rehabilitation hospitals and units, and home health agencies. It signaled an intent to pay long-term hospitals prospectively as well. In this chapter, the Commission makes recommendations that pertain collectively to post-acute providers as well as several recommendations that are specific to the prospective payment system in operation for skilled nursing facilities and under development for rehabilitation facilities, home health agencies, and, eventually, long-term hospitals.

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## Issues across post-acute care providers

Although the types of patients treated and the mix of services furnished traditionally have differed across types of post-acute care providers, distinctions are less clear today. Differences between skilled nursing facility (SNF) and rehabilitation facility services diminished partly because until last year Medicare reimbursed SNFs their full costs of furnishing rehabilitation services. Along with technological advances in home care technologies, generous reimbursement policies also encouraged home health agencies to provide some services that used to be furnished mainly in nursing facilities.

Substantial differences in service capabilities and patient mix, however, still exist across post-acute care providers. Medicare coverage policies allow SNFs and home health agencies to treat a wider range of patients compared with rehabilitation facilities. Rehabilitation facilities and long-term hospitals also must meet hospital certification standards (see Chapter 4). Finally, functional abilities, medical needs, and treatment objectives point patients to specific post-acute care settings.

## Collecting common patient assessment information across settings

A lack of readily available data on patient function and health status limits the ability to identify where differences and overlaps in patients occur and to compare costs and payments across provider types. In particular, policymakers are concerned that payment policies may furnish incentives for providers to place patients in settings for financial, rather than for clinical, reasons. A core set of common data about patients in all post-acute care settings will improve considerably the ability to monitor and make policy decisions about post-acute care.

### RECOMMENDATION 5A

**The Secretary should collect a core set of patient assessment information across all post-acute settings.**

A fundamental element of the Health Care Financing Administration's (HCFA) post-acute care payment policy and monitoring efforts has been its recent modification of the Minimum Data Set (MDS), a patient assessment instrument originally designed to monitor the quality of care furnished to nursing facility patients. The new instrument, the Minimum Data Set for Post-Acute Care (MDS-PAC), is intended to be appropriate for patient assessment in any inpatient post-acute setting: SNFs, rehabilitation hospitals and units, and long-term hospitals (see Table 5-1). The MDS-PAC was tested in SNFs that furnish rehabilitation and medically complex care and in rehabilitation and long-term hospitals. The instrument includes more detailed questions than the MDS concerning patient diagnoses, physical and cognitive function, medical service needs, and prognosis. It focuses on diagnoses that are common to patients in rehabilitation and long-term hospitals, such as cardiovascular, musculoskeletal, and neurological conditions.

The Medicare Payment Advisory Commission (MedPAC) commends HCFA's development of the MDS-PAC and encourages its refinement and use. The instrument will facilitate greatly comparisons of patient characteristics and service use across inpatient post-acute care settings. Insights gleaned from these data should inform future prospective payment system (PPS) policies, as well as longer term policy considerations about post-acute care.

Home health agencies also are required to collect information on their patients' needs and function. The data set developed for the home health setting is the Outcomes and Assessment Information Set (OASIS). OASIS includes approximately 100 questions covering 14 categories of care (see Table 5-2). Though less comprehensive than the MDS-PAC, the OASIS includes questions on ambulation, management of medications, psychological and emotional behavior,

### TABLE 5-1

### Sections of the Minimum Data Set-Post Acute Care assessment instrument

- A. Patient identification information
- B. Admission information and payment source
- C. Cognitive patterns
- D. Communication and vision patterns
- E. Mood and behavior pattern
- F. Functional status
- G. Bladder and bowel continence
- H. Diagnoses
- I. Medical complexities
- J. Other health conditions
- K. Oral and nutritional status
- L. Procedures and services
- M. Functional prognosis
- N. Resources for discharge

Source: Hebrew Rehabilitation Center for the Aged, Boston. January 1999.

and living arrangements. The Secretary intends to modify the OASIS to obtain additional data to develop a case-mix classification system for use in a prospective payment system for home health services.

Because standardized patient information for home health users would be otherwise lacking, the Commission supports the collection of OASIS data. In the long run, however, a core set of common patient assessment information should be collected across all post-acute care providers. These core data could be collected by developing common definitions of elements of OASIS and MDS-PAC.

## Ensuring access to quality care

The shift from cost-based payments to prospective rates creates incentives for providers to reduce their costs. Some facilities may respond by reducing the amount of care they furnish. For example, providers may not furnish patients with needed services, or they may avoid admitting certain types of patients entirely. In addition, access to care could be reduced if facilities close. Monitoring

**TABLE  
5-2**

**Sections of the  
Outcomes and  
Assessment  
Information Set**

- A. Clinical record items
- B. Demographics and patient history
- C. Living arrangements
- D. Supportive assistance
- E. Sensory status
- F. Integumentary status
- G. Respiratory status
- H. Elimination status
- I. Neurological, emotional, and behavioral status
- J. Activities of daily living and instrumental activities of daily living
- K. Medications
- L. Equipment management
- M. Emergent care
- N. Agency discharge and inpatient facility admission information

Source: Center for Health Services and Policy Research, Denver. October 1998.

the services to ensure that beneficiaries have access to providers and receive the care patients need will therefore be important.

**RECOMMENDATION 5B**

**The Secretary should establish quality monitoring systems for post-acute care as prospective payment systems are implemented.**

As required in the nursing home reform provisions in the Omnibus Budget Reconciliation Act of 1989, skilled nursing facilities submit patient information using the MDS to the survey and certification agency in their states. MDS data are intended to help improve care in nursing facilities by monitoring residents' health status and outcomes. With such data, providers can measure and improve their care and benchmark that against other facilities. MDS data also help state survey agencies target their activities toward particular facilities.

As required by the Balanced Budget

Act of 1997 (BBA), the Secretary is establishing a medical review process to examine the effects of the PPS recently implemented for SNF services. Because the Congress was concerned about the impact of a PPS on nonroutine care (such as therapies, medications, and physician services), medical review activities will focus on these areas. HCFA is currently developing this process through contracts with some of its peer review organizations. These contractors will analyze MDS data to identify trends suggesting access or quality problems and will develop focused interventions to address deficiencies. A key benefit of this effort is that it will encourage better coordination among the entities responsible for different aspects of quality monitoring and enforcement: Medicare fiscal intermediaries, peer review organizations, state survey and certification organizations, and Medicaid programs.

Home health agencies also now are required to collect OASIS data and submit them to state survey agencies. Using these data, agencies will be able to compare their patients with those served by other agencies and evaluate progress resulting from quality improvement actions. Like the MDS data collection effort, the OASIS data will allow state survey agencies to compare past and current performance and assess the quality improvement activities of home health agencies (HCFA 1997).

Medicare does not require rehabilitation facilities to submit MDS or other patient assessment data. Since 1990, though, most rehabilitation facilities have monitored patients using an 18-item functional status instrument. Its widespread use has enabled comparisons of rehabilitation patient function over time and across providers. The instrument's questions recently were integrated into the MDS-PAC. That integration will improve quality monitoring efforts after a rehabilitation PPS is implemented by enabling analysis of patient trends both before and after changes in payment policy.

Collecting and analyzing patient assessment information across post-acute care settings should lead to a better understanding of the quality of care and

outcomes of patients across settings. Some recent published studies using detailed patient information have compared, for example, patients in rehabilitation hospitals and SNFs. Most of these focused on the outcomes of stroke and hip fracture patients in the two settings. Stroke patients were found to fare better in rehabilitation facilities than SNFs, while fewer outcome differences by setting were identified among hip fracture patients (Kramer et al. February 1997, Kane et al. 1996, Ottenbacher and Jannell 1993). A core set of data collected and analyzed across post-acute care settings would aid the monitoring and refinement of payment policies and ultimately help ensure fair payments and access to appropriate post-acute care services.

**Applying consistent methods of payment**

The Commission supports the principle of developing consistent payment methods where appropriate, such as when a similar mix of patients and services are found in different settings (see Chapter 1). In the area of post-acute care, policymakers currently face unattractive trade-offs regarding payment consistency. Consistency could be realized most quickly by adapting for rehabilitation hospitals and units (and possibly for long-term hospitals) the per diem classification system used in the PPS recently implemented in nursing facilities.

However, as discussed below, the Commission believes a discharge-based system is more appropriate for rehabilitation facilities because these providers focus on the intensive rehabilitation of patients with the goal of functional improvement and discharge. But MedPAC also is concerned about the potential overlap of patients and services between SNFs that have established intensive rehabilitation services and rehabilitation facilities. In fact, an estimated 69 percent of SNF patients are classified as SNF rehabilitation patients under the current SNF payment system (HCFA 1998). MedPAC believes it is appropriate to work toward a discharge-based system for intensive rehabilitation patients treated in both settings.

## RECOMMENDATION 5C

### The Secretary should conduct a demonstration to assess the potential of the Functional Independence Measure–Function Related Groups classification system to predict the resource use of intensive rehabilitation patients in skilled nursing facilities.

Largely because of the potential overlap of patients and services across post-acute care provider types, the Commission has urged the Secretary to consider more consistent payment policies across these settings. To accomplish this, HCFA plans to pay rehabilitation facilities on a per diem basis and develop a rehabilitation PPS with the same method used in the SNF PPS.

The Commission believes, however, that a discharge-based payment system is more appropriate for intensive rehabilitation patients in SNFs and for rehabilitation facility patients. Past efforts to develop a discharge-based system for SNF patients have failed mainly because of difficulties including all nursing facility patients (SNF patients and longer stay, Medicaid and private-pay patients) into a single classification scheme. But preliminary research has yielded a

discharge-based design that used diagnostic and functional characteristics to successfully classify rehabilitation patients treated in both SNFs and rehabilitation facilities (Kramer et al. June 1997).

That work suggests it may be possible to classify SNF rehabilitation patients by modifying and using a discharge-based classification system for rehabilitation hospital patients. In the mid-1990s, HCFA sponsored the development and evaluation of a system that classifies patients in rehabilitation hospitals, the Functional Independence Measure–Function Related Groups (FIM–FRG) classification system. The system was found to be a robust predictor of per discharge costs of Medicare patients (Carter et al. 1997).

Because this system already has been developed for rehabilitation hospital patients, the Commission urges the Secretary to assess the ability of the FIM–FRG system to predict resource use for intensive rehabilitation patients in SNFs and explore modifications that could result in a discharge-based classification system compatible for patients in both settings. Such a demonstration would have two potential benefits. First, a modified FIM–FRG system might describe the rehabilitation patients in SNFs more accurately than does the RUG–III system

(the classification system used for SNF prospective payment). Second, if this is the case, HCFA could pursue the use of a per discharge payment system based on the FIM–FRG system for all inpatient rehabilitation patients, regardless of the setting where they are treated. This would help accomplish policymakers' goal of consistent payment policies for like services and would use the unit of payment that many consider more appropriate for intensive rehabilitation patients, regardless of where they receive care.

### Improving the payment system for skilled nursing facilities

Skilled nursing facility payments have been among the fastest growing components of Medicare spending, increasing 36 percent annually since 1987. Part A SNF expenditures reached an estimated \$13.2 billion in 1997. Although the pace of this growth has slowed in the last few years, it continues to exceed that of payments for most other services.

To slow this growth, the Congress required implementation of a prospective

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## Elements of the skilled nursing facility prospective payment system

The skilled nursing facility (SNF) prospective payment system uses a classification system called the Resource Utilization Group system, version III (RUG–III).<sup>1</sup> RUG–III is a 44-group hierarchical patient classification system. The first level comprises seven major categories (rehabilitation, extensive services, special care, clinically complex, impaired cognition, behavior only, and physical function reduced) representing groups of patients with certain clinical

conditions (see Table 5-3). Within each category, patients are classified based on functional status (measured by an index of activities of daily living or ADL), and the number and types of services used. The 26 RUG–III groups in the first four major categories are consistent with Medicare coverage criteria for special rehabilitation and skilled nursing services. Patients classified into these groups are presumed to meet SNF level of care criteria, at least initially. Many patients in the remaining

three categories (18 RUG–III groups) would not meet Medicare coverage criteria (these categories more often are used to describe Medicaid patients).

Patients are assigned to a RUG–III classification group based on required, periodic assessments of patients using the Minimum Data Set (MDS).<sup>2</sup> After each MDS

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- 1 The RUG–III system was designed using information on the characteristics of nursing facility patients (long-term Medicaid and private residents as well as Medicare patients) and wage-weighted staff time. Patient characteristics were derived from the Minimum Data Set patient assessment instrument. Wage-weighted staff time measured the staff resources used to care for groups of patients over a 24-hour period for nursing staff and over the span of a week for therapy services (physical, occupational, and speech). Patient characteristics and wage-weighted staff time for the initial version of RUG–III were collected from March to December 1990 for 7,648 patients in 202 nursing homes in seven states. Two additional staff time data collections were performed on 154 Medicare-certified units of hospitals and free-standing facilities in 12 states (including six of the original seven).
- 2 The assessment required on the fifth day covers days 0 through 14; that on the fourteenth day covers days 15 through 30; that on the thirtieth day covers days 31 through 60; that on the sixtieth day covers days 61 through 90; and that on the ninetieth day covers days 91 through 100.



## Elements of the skilled nursing facility prospective payment system

**TABLE 5-3** Components of the Resource Utilization Group-III patient classification system

Patient categories	Number of RUG-III groups	Variables
Rehabilitation <sup>a</sup>	12	therapy intensity and type, nurse rehabilitation, ADL
Extensive services <sup>b</sup>	3	therapy type
Special care <sup>c</sup>	3	ADL
Clinically complex <sup>d</sup>	6	ADL, depression
Impaired cognition	4	ADL, nurse rehabilitation
Behavior only <sup>e</sup>	4	ADL, nurse rehabilitation
Physical function reduced	10	ADL, nurse rehabilitation
Total	44	

Note: Variables are the patient characteristics and service needs used to divide categories into RUG-III groups. ADL (activities of daily living).

<sup>a</sup> Patients requiring any combination of physical, occupational, or speech therapy.

<sup>b</sup> Patients with an ADL score of at least 7 and who meet at least one of the following criteria: parenteral feeding, suctioning, tracheostomy, ventilator/respirator.

<sup>c</sup> Patients with an ADL score of at least 7 and who require special care (such as burns, coma, quadriplegia, septicemia, radiation therapy).

<sup>d</sup> For example, patients with dialysis, aphasia, pneumonia, cerebral palsy.

<sup>e</sup> Patients exhibiting symptoms such as wandering, hallucinations, or physical or verbal abuse of others.

Source: MedPAC summary of definitions in Table 2.C, Federal Register, May 12, 1998, Vol. 63, No. 91, p. 26262.

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assessment, a patient's RUG-III assignment is recorded on the claim sent to the fiscal intermediary for payment, and the MDS data are sent to the state survey and certification agency.

A payment weight was developed for each RUG-III group reflecting the average level of resources used to provide nursing services to patients in the group. The weights range from 1.70 for the extensive services classification group to 0.46 for the physical function reduced group. Payment weights for therapy services also were developed for the RUG-III

rehabilitation groups, ranging from a high of 2.25 to a low of 0.43.

To determine the payment for the nursing and therapy components of each RUG-III group, the skilled nursing and therapy payment weights for a classification group are multiplied by the applicable urban or rural federal base payment rates (see Table 5-4). (The same urban or rural rates apply to both freestanding and hospital-based SNFs.) Then, in recognition of the fixed costs associated with the care of nursing home patients, the adjusted nursing and therapy components are summed with a noncase-mix component rate to account for the average costs of general services and,

if applicable, a therapy noncase-mix component rate to account for the low-level rehabilitation services provided to patients not in the rehabilitation category.

The total federal rate for a RUG-III group is then adjusted by the hospital wage index to reflect the wage level in the SNF's market area. The labor-related component is multiplied by the wage index for the SNF's location and added to the nonlabor component. (Almost 76 percent of the total, the labor-related component reflects the combined expenditure share of the components of the SNF market basket index that are believed to be affected by local wages and salaries and employee benefits and locally produced services).

The per diem payment rates under this system are intended to provide full payment for all facility services. Except for costs of approved medical education programs, the rates cover all routine, ancillary, and capital costs, as well as those for most ancillary items and services for which payment previously was made under Part B.<sup>3</sup>

The federal base payment rates in the PPS were derived from the allowable per diem routine, ancillary, and capital costs incurred by SNFs in fiscal year 1995 and from an estimate of the per diem average amount paid for ancillary services (including deductible and coinsurance amounts) under Part B for Part A-eligible SNF patients during the same period.<sup>4</sup> Exceptions payments are excluded, as are all costs for exempt facilities. The

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3 The per diem rates exclude amounts for services furnished by physicians and certain other practitioners, such as qualified psychologists, and dialysis services and supplies. These services will continue to be covered and paid for under Part B. Costs for physical, occupational, and speech therapy services are included in the per diem rate even if they are furnished by or under the supervision of a physician.

4 Under the previous cost-based payment system, new providers were exempt from the routine cost limits for up to their first four years of operation. The costs of these providers are not included in the calculation of the new federal base payment rates. Exceptions payments (additional payments for providers with reasonable costs exceeding the limits) are also excluded.

## Elements of the skilled nursing facility prospective payment system

**T A B L E  
5 - 4**

**Unadjusted federal per diem rates in the skilled nursing facility prospective payment system**

Rate	Nursing case-mix	Therapy case-mix	Therapy noncase-mix	Noncase-mix
Urban	\$109.48	\$82.67	\$10.91	\$55.88
Rural	104.88	95.51	11.66	56.95

Source: HCFA, Federal Register. May 12, 1998, Vol. 63, No. 91, p.26260.

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resulting per diem cost for each provider was trended forward to the first payment period by applying an annual update factor equal to the

increase in the SNF market basket index minus one percentage point for each intervening year.

The updated per diem costs for each provider were standardized to remove

the effects of differences in wage levels across areas and variations in patient mix among facilities. The urban and rural federal rates were calculated separately as the simple average of two weighted averages. The first was the average per diem cost for all urban or rural facilities (weighted by the number of covered days in each SNF). The second was the average per diem cost for urban or rural freestanding facilities (also weighted by covered days). Calculating the simple average of these averages puts substantially more weight on freestanding facilities' costs than those of hospital-based SNFs.

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payment system by July 1, 1998. Under the SNF PPS, a case-mix-adjusted and wage-adjusted per diem payment is made to cover the routine, ancillary, and capital costs incurred in treating a skilled nursing facility patient. During a three-year transition period, each facility's per diem payment is based on a blend of a facility-specific rate and its wage-adjusted federal rate. In the first year, the blend is 75 percent facility-specific, dropping to 50 percent in the second year and 25 percent in the third year. SNFs that first received payments on or after October 1, 1995, will be paid based on the federal rates immediately, with no transition period.

The Commission recommends several changes to improve the classification system and payment rates and weights of the PPS. MedPAC also urges that methods be put in place to ensure SNFs classify patients appropriately.

### Refining the SNF classification system

The RUG-III classification system is based on the time providers spend furnishing nursing and therapy (physical, occupational, and speech) services. But patients also can vary systematically in their use of other ancillary services and supplies, such as respiratory therapy, lab

tests, imaging services, drugs and biologicals, and transportation. These differences are reflected in the payment system's nursing and therapy weights only to the extent that they are correlated with the use of nursing and therapy services.

Nevertheless, the PPS pays for nontherapy ancillaries prospectively, assuming that the use of these services and supplies is correlated with skilled nursing time. Payments therefore may not be adequate for patients who need relatively high levels of nontherapy ancillary services and supplies. This could result in access problems for medically complex patients, such as those classified in the extensive services RUG-III groups. These patients appear to have nontherapy ancillary charges that are higher than those of other residents (White et al. 1998). At the same time, payments may be too high for patients who use relatively few nontherapy ancillaries.

### RECOMMENDATION 5D

**The Secretary should continue to refine the classification system used in the skilled nursing facility prospective payment system to improve its ability to predict the resources associated with nontherapy ancillary services.**

The Commission supports HCFA's efforts to assess the extent of problems concerning nontherapy ancillary services. A contractor is evaluating potential refinements to the classification system to improve its predictive capability. Preliminary findings point to some possible refinements to the classification system (White et al. 1998). A higher-weighted classification group could be created for patients who meet the requirements for both the extensive services and the rehabilitation RUG-III groups. These patients often require both costly nontherapy ancillaries and substantial amounts of rehabilitation services.

Alternatively, the classification system could be modified to incorporate more patient information, such as diagnosis items from the Nursing Severity Index (NSI), an instrument that predicts in-hospital mortality rates and lengths of stay for hospitalized patients. A strong relationship was found between a subset of 15 NSI diagnoses and SNF costs.

### Revising the rehabilitation groups of the classification system

The first and generally highest paid hierarchy in the RUG-III classification



system is the rehabilitation category. It comprises 5 subcategories and 14 final classification groups. Rehabilitation patients in SNFs are assigned to one of the five RUG–III groups based on an assessment of the weekly number of therapy minutes needed, days of therapy needed, and type of therapy needed (physical, occupational, and speech). Patients are further classified according to function, as measured by an assessment of their ability to perform activities of daily living.

#### **RECOMMENDATION 5E**

**The Secretary should explore the potential for revising the rehabilitation groups of the classification system used in the skilled nursing facility prospective payment system to reduce reliance on measurements of rehabilitation time.**

As described earlier, the Commission recommends the Secretary explore adapting the discharge-based FIM–FRG system for classifying intensive rehabilitation patients in SNFs. In the shorter-term, MedPAC is concerned about the potential for gaming that exists in the RUG–III system, particularly in the classification groups applying to SNF rehabilitation patients. In those groups, the minutes of therapy a rehabilitation patient undergoes largely determine that patient’s RUG–III assignment. This raises the likelihood that providers will manipulate patient assignments to maximize reimbursement. The rehabilitation RUG–III groups are vulnerable to both an overestimation of therapy needed and an underprovision of needed therapy. By contrast, other classification groups in the RUG–III system are defined by patient function and need for skilled nursing services (such as intravenous medications and tube feeding) that may be less easily manipulated.

The RUG–III classification system was designed with very little information about rehabilitation patients in SNFs.

More comprehensive information can be collected about these patients through the MDS–PAC. Using this instrument, the Secretary should explore methods to classify rehabilitation SNF patients that do not rely on minutes of therapy time consumed.

#### **Updating the payment weights**

Over time, the RUG–III weights should change as practice patterns, technology, and payment incentives affect the resources used to furnish nursing facility services. If the weights are not updated periodically, payment inequities and inappropriate financial incentives may develop.

#### **RECOMMENDATION 5F**

**The Secretary should develop a method for updating payment weights in the skilled nursing facility prospective payment system as soon as possible.**

The payment weights of the PPS are based on measurement of staff time in about 350 SNFs.<sup>5</sup> Options for updating the weights include either repeating those studies periodically for a larger and broader sample of SNF patients or recalibrating the weights using the average per diem charges associated with each classification group. Neither option is ideal, but some update mechanism is necessary.

Relying on staff-time measurement studies to update payment weights is problematic because such weights may reflect the “Hawthorne effect,” in which staff in the study settings know they are being monitored and do not perform as they normally do. Further, SNFs in the studies may classify patients more accurately than do other SNFs. The resulting weights reflect relative resources for patients in each classification group as they should be assigned—but they may not reflect cost differences among groups given patterns of patient classification by a typical

provider. These discrepancies would be greater to the extent that patient assignments are manipulated to obtain higher payments.

Another problem is that staff-time studies do not fully capture variations in expected costs associated with factors other than staff time. For example, patients may vary systematically in their use of nontherapy ancillary services and supplies, the costs of which may not be adequately reflected in the nursing and therapy weights. This cost variation also is not captured in the noncase-mix (general services) component of the payment because this component is set at a constant amount across all classification groups. Following HCFA’s refinements to payment for nontherapy ancillary services, a method for updating payments for those services also will be required.

An alternative approach to developing payment weights would use average per diem charges in each RUG–III group to recalibrate the weights, as is done in the acute care PPS. Payment weights in the hospital PPS automatically adjust over time, reflecting the effects of changes in technology and practice patterns on all inpatient costs and accounting for shifts in patient mix within and across each DRG. For example, if relatively low-cost cases that previously would have been classified in a low-weight DRG are coded so that they fall in a higher-weight DRG, then the weight for the higher category will fall (because the average charges in that category will decline). Thus, the effects of case-mix changes on payment weights in each DRG are automatically accounted for (albeit with a two-year lag, reflecting the availability of claims for use in recalibration). Using a claims-based recalibration method, however, does not prevent aggregate payments from rising inappropriately.

Whether and how SNF claims data could be used to recalibrate the SNF payment system depend on how well relative charges correspond to relative

5 The staff-time measurement studies were conducted in 12 states and included about 1 percent of all SNFs and about 0.2 percent of all SNF patients.

costs. They also depend on how closely the reported charges correspond to the PPS payment components. Under consolidated billing requirements, a SNF claim will include separate charges for routine services (room, board, and skilled nursing care) and ancillary services, whether they are furnished by a SNF or under arrangement with an outside supplier. Charges for therapy services will be reported separately from those for other ancillary services and supplies, such as imaging services or drugs. In addition, each claim will identify the patient's RUG-III assignments and the periods of days to which they apply.

These data could be used to calculate (or recalibrate) separate weights for therapy services and other ancillary services, but only if the charges for these services were recorded separately for each period corresponding to a different RUG-III assignment. Thus, if a patient's RUG-III classification changed during the stay—as would be expected for most patients—the charges for each type of service would have to be recorded separately for each period. Further, if use of other ancillary services varied systematically among RUG-III groups, then separate weights could be constructed for the general services rate component.

Even if SNF charges for all service categories were recorded separately for each distinct classification period, however, claims data probably would not be adequate for recalibrating the skilled nursing weights. Skilled nursing charges are subsumed in routine service charges, which are paid at a constant per diem amount. Consequently, the per diem routine service charges do not reflect variations in skilled nursing intensity among the RUG-III groups.<sup>6</sup>

To address this problem, either skilled nursing services would have to be charged separately on the claim (with the amount varying to reflect intensity of care) or the skilled nursing weights would have to be developed from a different source. If nursing payment

weights were derived from a different method (such as staff-time studies) and therapy and other ancillary service weights were based on claims data, then the recalibration process would partially account for the effects of case-mix creep.

Under any case-mix adjusted PPS, case-mix creep affects aggregate spending for services. Under the SNF payment system, providers will face strong financial incentives to shift patients to higher-weighted classification groups, thereby raising aggregate Medicare spending. This shift could be offset by prospectively adjusting the annual federal payment update. The BBA granted the Secretary authority to make either prospective or retrospective adjustments for this purpose. If the payment rates were periodically adjusted to correct for case-mix creep, however, SNFs that do not shift cases would be penalized. Consequently, minimizing case-mix creep by improving the classification system is essential to protect both program integrity and payment equity among providers.

### Correcting distortions in base payment rates

In developing the federal base payment rates, HCFA standardized providers' allowable 1995 per diem costs to remove the effects of differences in wage levels across areas and variations in the mix of patients cared for by SNFs. These adjustments were made to estimate what each SNF's per diem costs would have been if it had operated in a labor market with national average wage levels and if it had served the national average patient mix in the base year. The adjustments affect both the overall level of payment and the distribution across facilities. Ideally, HCFA would have adjusted the labor component of facilities' costs using a wage index developed from SNF wages. The wage-adjusted per diem costs for each SNF would then have been case-mix adjusted using a facility-specific weight

developed from data on patient RUG-III assignments.

However, HCFA was forced to use the hospital wage index because a SNF wage index is not available. Data on patient RUG-III assignments were unavailable as well (except for the few facilities participating in the Nursing Home Case Mix and Quality demonstration program). To adjust for variations in case mix, HCFA developed a rough case-mix measure (called the MedPAR analog) based on the limited information about diagnoses and therapy charges available on the SNF claims data.

The information is particularly limited for the rehabilitation RUG-III groups because SNF claims do not record the minutes of therapy received, which is the main element used to classify rehabilitation patients in the SNF payment system. When HCFA compared the case-mix values generated from claims with those resulting from MDS assessments for a sample of SNFs, it found that the therapy case-mix values based on MDS data were 28 percent higher.

### RECOMMENDATION 5G

**The Secretary should identify any distortions in the base payment rates of the skilled nursing facility prospective payment system and explore options for correcting them as better data become available.**

The Commission is concerned that an unknown amount of error was introduced into the initial federal rates because of the use of the hospital wage index and the SNF claims data to adjust facility costs. The rates may be higher or lower than the Congress intended and may be somewhat distorted across areas and facilities. The accuracy of the rates could and should be improved as the data needed to do so become available.

<sup>6</sup> This differs from the situation for hospital inpatient care in which nursing intensity differences among the DRGs are largely captured by the correlation between nursing intensity and average length of stay, and by separate charges for intensive care.

## Ensuring accurate classification assignments

The MDS used for classification includes several subjective elements (such as patient performance on activities of daily living). The classification assignments also rely on judgments that are largely or wholly under the control of the SNF, such as whether to give the patient 480 or 500 minutes of therapy services per week. As a result, providers will face incentives to manipulate patient assignments to maximize reimbursement.

### RECOMMENDATION 5H

**The Secretary should develop ways to ensure skilled nursing facilities' accountability for accurately assessing patient needs and classifying them for payment purposes.**

Since the potential for manipulating RUG-III assignments to increase payments appears to be substantial, it will be necessary for HCFA to develop methods to ensure that SNFs accurately assess and report patient needs. The medical review process currently being developed for SNFs will provide an opportunity to examine trends in RUG-III classification assignments (see Recommendation 5B.) HCFA also will need to conduct periodic reviews of medical records to ensure that classification assignments reasonably match patient needs as reflected in their records.

## Developing a wage index for skilled nursing facilities

Medicare's payments to SNFs are adjusted by the hospital wage index to reflect differences in wage levels across geographic areas. However, applying that index to SNFs may contribute to inequitable payments because nursing facilities employ a different skill mix than do hospitals (nursing facilities use proportionately more aides.) Additionally, the relative level of aides' salaries compared with nurses' salaries may not be

the same across geographic areas.

Geographic differentials in labor prices for SNF employees also differ from those for hospital employees (ProPAC 1992). This may be because state regulations affecting nursing facility staffing differ from those affecting hospitals. States also may have a greater impact on nursing facility costs because of their Medicaid programs and survey and certification roles.

### RECOMMENDATION 5I

**The Secretary should develop a wage index based on skilled nursing facility wage data and use it to adjust payments for those facilities' services.**

An accurate wage index is needed to account for geographic differences in wages and to maintain payment equity among providers. To this end, the Social Security Amendments of 1994 required HCFA to collect data on wages and hours of paid employment for SNFs beginning no later than October 31, 1995. Until these data have been received and analyzed, the hospital wage index is the best available measure of geographic variation in wage levels. But it should be replaced as soon as possible with a more direct measure based on SNF wage data. If the quality of the data SNFs submit on their annual cost reports is not adequate for developing a wage index, then HCFA should resolve reporting problems as quickly as possible. Because a change in the wage index used would redistribute payments among SNFs, consideration should be given to phasing it in.

## Developing a prospective payment system for rehabilitation facilities

The Congress requires that the Secretary implement a prospective payment system for rehabilitation hospitals and units by October 1, 2000. During the first year of a two-year transition, payments will be a

blend of two-thirds of what a facility would have been paid under TEFRA and one-third of the prospective payment amount. In the second year, payments will consist of one-third of the TEFRA amount and two-thirds of the prospective payment amount. During this period, aggregate payments must be 2 percent less than what they would have been solely under TEFRA.

The BBA does not specify a particular patient classification system or unit of payment for the payment system.<sup>7</sup> One classification system that could be used is the FIM-FRG system. That system was originally designed using data from 37,000 rehabilitation patients in hospitals and units during 1990 and 1991. It was further refined using 1994 data on 90,000 patients. Payment weights and other payment system elements (such as outlier policies) were constructed using Medicare allowed charges.

The FIM-FRG system is a discharge-based classification system that sorts patients into one of 21 diagnostic categories such as stroke, spinal cord, and cardiac and uses assessments of patient functional and cognitive abilities and age to classify them into one of about 70 groups (see Table 5-5). The patient assessment data used to design the classification system were obtained from the Uniform Data System for Medical Rehabilitation (UDSMR). The UDSMR is an ongoing national repository of information on rehabilitation patients operated by the State University of New York at Buffalo. The UDSMR collects data on patient age, sex, living situation prior to hospitalization, diagnosis leading to disability, and functional status at admission and discharge. It also includes patient admission and discharge information and hospital charges. Over one-half of all rehabilitation hospitals and units submit information to UDSMR.

The FIM-FRG classification system is considered to be stable over time and predictive of length of stay and per discharge resource use (Carter et al. 1997). The system was found to predict 33 percent of the variation in both resource use and length of stay across patients.

7 The BBA specifies that the Secretary may include patient impairment, age, related prior hospitalization, comorbidities and functional capability as case-mix adjustment factors. It requires wage adjustments, update factors based on the market basket index, outlier payments to not exceed 5 percent of prospective payments, and special payment adjustments allowed for Alaska and Hawaii.



## Rehabilitation facilities

Medicare is the largest single payer for inpatient rehabilitation services. In 1996, rehabilitation hospitals and units treated over 450,000 patients, 70 percent of whom were Medicare beneficiaries. Patients treated in the inpatient rehabilitation setting must be capable of undergoing, and likely to improve functionally from, receiving approximately three hours of therapy daily. Medicare requires that at least 75 percent of a rehabilitation facility's patients be admitted for care for one or more of 10 specified neurological, musculoskeletal, or burn conditions. The most common diagnoses of beneficiaries admitted to rehabilitation facilities, though, are stroke, hip fracture, and major joint reattachment procedures such as hip replacement. Those diagnoses describe more than half of beneficiaries in rehabilitation facilities.

Rehabilitation hospitals and units have responded to changes in the post-acute care environment as well as to a

set of Medicare payment rules under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) that have encouraged growth in spending and patient volume (see Chapter 4). Aggregate spending has increased at a fairly rapid pace, reflecting increased patient volume rather than increased payments per discharge. Aggregate Medicare operating payments to rehabilitation facilities rose 18 percent annually between 1990 and 1996, from \$1.9 billion to \$4.3 billion. Since 1990, payments per discharge have risen less than the rate of inflation, reaching \$10,500 in 1996.

Most of the approximately 1,100 rehabilitation facilities are units of acute care hospitals (representing almost one-fifth of such hospitals). Recently, freestanding rehabilitation hospitals have undergone substantial ownership consolidation. In 1997, one corporation owned or managed over one-half of all rehabilitation hospitals and about 15 percent of hospitals and units combined (Japsen 1998, Wheatley et al. 1998).

data gathered. HCFA intends to use rehabilitation facility staff-time measurements taken during the study to create the payment weights needed for a rehabilitation facility PPS.

### RECOMMENDATION 5J

**The Secretary should develop a discharge-based prospective payment system for rehabilitation facility patients based on the Functional Independence Measure-Function Related Groups classification system. Policies to address transfers and short-stay outliers would be necessary components of such a system.**

The Commission is concerned about the adequacy of the sample size in HCFA's rehabilitation staff-time study. Based on its statistical analyses of estimating an adequate sample size for such a study, MedPAC believes that a substantial increase in patients is necessary to devise a robust classification system and reliable and valid payment weights. Such a sample should include the range of diagnoses and functional disabilities treated in rehabilitation facilities and should allow for a statistically sufficient number of patients within each classification group created. An insufficient sample size may undesirably limit the number of classification groups and increase the variation estimated within each group.

In general, any facility operating under a prospective payment system relies on payments for less costly patients within a group to average out losses incurred from more costly patients within that group. A high degree of patient variability within a group, however, increases the chances for overall underpayment or overpayment to a particular facility. Such variability encourages facilities to seek patients likely to be less costly and thus can discourage access for patients with more extensive rehabilitation needs.

Recently, a modification to the FIM-FRG system (called the functional gain FRGs) has been developed that incorporates patient assessment at both admission and discharge (Stineman et al. 1997). If built into a payment system, that type of information could allow provider payments to be adjusted to reflect differences in patient outcomes, which could help counteract incentives to inappropriately reduce costs and care quality.

As noted earlier, rather than pursue a per discharge payment system based on the FIM-FRG system, HCFA is moving toward more uniform payment policies across post-acute care settings by designing a system that is conceptually similar to the per diem PPS recently implemented for SNFs. The SNF PPS

uses a classification system that relies on the MDS patient assessment tool, which was designed for use only in nursing facilities.

HCFA has modified the MDS for use in rehabilitation facilities and long-term hospitals, as well as SNFs. The new instrument, the MDS-PAC, is promising as a patient assessment tool in rehabilitation and other post-acute care facilities. However, because the instrument is new, there is almost no repository of MDS-PAC information on rehabilitation patients. Consequently, HCFA is now sponsoring a study of approximately 2,000 rehabilitation patients to collect patient assessment information using the new instrument and devise a classification system from the

**TABLE  
5-5**

**Components of the Functional Impairment Measure–Function Related Groups classification system for rehabilitation patients**

Rehabilitation impairment category	Number of function related groups	Variables
Stroke	9	motor, cognitive, age
Brain dysfunction, traumatic	5	motor, cognitive
Brain dysfunction, nontraumatic	4	motor, age
Spinal cord dysfunction, traumatic	4	motor
Spinal cord dysfunction, nontraumatic	4	motor
Guillain Barre	2	motor
Neurological, other	2	motor
Orthopedic, lower extremity fracture	4	motor, cognitive
Orthopedic joint replacement	7	motor, cognitive, age
Orthopedic, other	2	motor
Arthritis, osteo	2	motor
Arthritis, rheumatoid and other	2	motor
Amputation, lower extremity	2	motor
Amputation, other	1	—
Cardiac	3	motor
Pulmonary	2	motor
Pain syndrome	2	motor
Major multiple trauma	2	motor
Major multiple trauma with brain/spinal injury	3	motor, cognitive
Miscellaneous	3	motor
Evaluation only	2	motor
Total number of classification groups	67	—

Note: Variables are used to divide rehabilitation impairment categories into function related groups. Motor and cognitive refer to subscales used to assess patient function. Age is patient age.

Source: Margaret G. Stineman et al., Development of function-related groups version 2.0: a classification system for medical rehabilitation, Health Services Research. October 1997, Vol. 32, No. 4, p.529-548.

Because of its concerns about the sample size and the tight time frame during which HCFA aims to develop the new PPS, the Commission is more confident at the outset in the validity of the patient groups and payment weights of the FIM–FRG system as the basis for a rehabilitation PPS. Further, such a system could be implemented relatively easily since the data elements needed to classify patients under the FIM–FRG system have been integrated into the MDS–PAC assessment tool.

Even if the FIM–FRG system is not used as the basis for the rehabilitation PPS, there are several ways that, at a minimum, it could be used to improve the PPS constructed from HCFA’s rehabilitation staff-time study. For

example, FIM–FRG classification group assignments easily could be analyzed along with the MDS–PAC classification data obtained on patients in the staff-time study. Since the FIM–FRGs have been widely used in the rehabilitation community for several years, that process could help validate the MDS–PAC. In addition, the payment weights of the FIM–FRG system could be updated using the most recent Medicare data available and compared with the measurement of resource use gathered during the staff-time study. This comparison could lead to improved payment weights and offer insight on the most appropriate method to recalibrate payment weights after the PPS is in operation.

Selection of the payment unit to be

used in Medicare’s rehabilitation PPS has evoked considerable debate. In moving toward a uniform payment policy across post-acute care settings, HCFA intends to pay rehabilitation facilities on a per diem basis, as is done in the SNF PPS. Indeed, a common payment unit could reduce any financial steering of patients who might be treated in either the rehabilitation or SNF setting.

Nevertheless, the Commission believes that a discharge-based PPS is most appropriate for services provided to patients in rehabilitation facilities. Ideally, the unit of payment under a prospective payment system should reflect the product of the provider. For patients in rehabilitation facilities, that product is the discharge because the goal of inpatient rehabilitation is to maximize function following a debilitating event and furnish patients with the skills to return home. Given this, MedPAC believes the Secretary should adopt a discharge-based payment system for rehabilitation hospitals and units.

A discharge-based rehabilitation payment system also would be consistent with the acute care PPS. Over 60 percent of rehabilitation facilities are units of acute care hospitals, and those units account for 80 percent of all rehabilitation patient days.

Rehabilitation (and other PPS-exempt) hospitals and hospital units also have operated under a discharge-based system since 1982. Further, most policymakers assume a per diem system would increase lengths of stay in rehabilitation facilities. If HCFA responded to that trend by reducing the per diem rates, some fear that cycle ultimately could diminish the intensity of inpatient rehabilitation.

The chief weakness of a discharge-based rehabilitation payment system is that it could encourage inappropriately early discharges and an increased use of other post-acute care providers following the rehabilitation stay. These are important concerns, but they could be mitigated by policies addressing short-stay outliers and transfers. Under a short-stay outlier policy, a provider would receive a reduced

payment if it discharged a patient home within an exceptionally short amount of time. Under a transfer policy, a provider's payment also would be reduced if it prematurely transferred a patient to another post-acute care provider.

Monitoring discharge patterns and lengths of stay would help determine the adequacy of outlier and transfer policies. In 1996, roughly 45 percent of rehabilitation patients were discharged home, another 40 percent were discharged home with home health services, and 10 percent went to skilled nursing facilities (MedPAC 1998). This represents a doubling since 1990 of home health service use following rehabilitation stays and a slight increase in transfers to SNFs. In 1996, the average length of stay in rehabilitation facilities was about 17 days. About 5 percent of patients with the most common diagnoses treated in rehabilitation facilities stayed an average of four days (see Table 5-6).

Regardless of the unit of payment used in the rehabilitation PPS, trends in lengths of stay and discharge patterns should be monitored to help assess changes in patient mix and practice patterns associated with prospective payment.

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## Ensuring appropriate use of home health services

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Medicare home health expenditures have grown rapidly in the last decade because of increases in both the number of beneficiaries receiving home care and the number of services per user. Between 1988 and 1996, the number of beneficiaries receiving home health services doubled while the average number of visits per user climbed from 23 to 79 (MedPAC 1998). Recent changes in payment policies appear to have reversed this trend. Current

estimates suggest that Medicare spending for home health services decreased slightly in 1998 compared with 1997 levels.

The BBA required the Secretary to develop a case-mix adjusted prospective payment system for home health services by October 1999. The Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999 delayed that implementation date to October 2000. In the meantime, home health agencies are paid under an interim payment system put in place in October 1997. Under the interim system, agencies are paid their costs subject to the lower of an aggregate per visit limit or an aggregate per beneficiary limit. In fiscal year 1998, the aggregate per visit limits were reduced from 112 percent of the national mean cost per visit provided by the agency to 105 percent of the median of that cost. The per beneficiary limits are based on a blend of agency-specific historical costs and historical costs of agencies in the same geographic region or the national median of these limits.<sup>8</sup>

The home health industry expressed concern that the payment limits established by the BBA are too low, claiming that agencies bound by the aggregate per beneficiary limit would attempt to reduce costs by providing fewer visits but then would be bound by overly stringent per visit cost limitations. Agencies argued that they face the difficult choice of incurring financial losses or denying patients services for which they are eligible. The Congress responded to these concerns by increasing slightly the per visit limits and some of the per beneficiary limits for fiscal year 1999.<sup>9</sup>

Because the per beneficiary limits are based on inflation-adjusted historical costs, however, these limits may not reflect home health agencies' current patient mix. Under typical circumstances, agencies would

serve a mix of high and low cost patients and mirror the earlier mix on which their limits are based. Some agencies, however, report they are unable to achieve this balance.

Ideally, a prospective payment system creates appropriate incentives by adjusting the payment rates to reflect the relative costs of serving different types of patients. Designing such a system has not been easy, however, because users of home health services have extremely diverse needs. In particular, it has been difficult to design a PPS that appropriately classifies patients who require both short and longer-term home health services.

In addition to implementing a prospective payment system, the Commission recommends the Congress and the Secretary explore additional methods to ensure appropriate use of home health services. These include clearly defining home health eligibility and coverage guidelines, requiring an independent needs assessment for beneficiaries making extensive use of home health care, standardizing coding for home health visits, and implementing beneficiary cost-sharing.

## Establishing clear eligibility and coverage guidelines

The scope of home health care has changed markedly since Medicare began covering it. For example, before 1980, beneficiaries were required to have a three-day hospital stay before becoming eligible for home health services and were limited to 100 visits per year. The Omnibus Reconciliation Act of 1980 removed these restrictions. In the mid-1980s, HCFA made administrative changes to the coverage guidelines with the intention of slowing the growth in the number of beneficiaries receiving home care and reducing the number of visits per user. In 1988, the legal basis of the agency's guidelines was

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8 During fiscal year 1998, the per beneficiary limits for established agencies (those with full cost reporting periods ending in fiscal year 1994) were 75 percent of 98 percent of agency-specific costs in fiscal year 1994 plus 25 percent of 98 percent of costs of agencies in that region in fiscal year 1994. The per beneficiary limits for "new" agencies were the median of the limits for established agencies. Both the per beneficiary limit and the per visit limits are adjusted upward for inflation by the home health market basket except during a two year freeze period.

9 Fiscal year 1999 per beneficiary limits for agencies whose fiscal year 1998 limits were below the national median were set at one-third the difference between the 1998 limits and the national median. P.L. 105-277 also set the per beneficiary limits for "new" agencies at the median of the per beneficiary limits based on 100 percent of costs rather than 98 percent. The law established limits for agencies certified on or after October 1, 1998, at 75 percent of the limit for "new" agencies as defined in the Balanced Budget Act. The law also increased the per visit limits to 106 percent of the median cost per visit for cost reporting periods beginning in fiscal year 1999.



**T A B L E**  
**5 - 6**

**Distribution of length of stay in rehabilitation facilities, by diagnosis related group of prior acute care hospital admission, 1996**

DRG of prior acute hospital admission	Percentile (in days)							
	5th	10th	25th	50th	75th	90th	95th	Average
209 Major joint and limb reattachment procedure of lower extremity	4	5	7	11	15	20	23	11.8
14 Specific cerebrovascular disorders except transient ischemic attack	4	7	11	18	26	35	42	19.8
210 Hip and femur procedures except major joint, age >17 with CC	5	7	11	15	21	27	32	16.4
113 Amputation for circulatory system disorders except upper limb and toe	4	7	11	16	23	31	38	18.1
214 Back and neck procedures with CC	4	5	8	12	18	26	33	14.4
1 Craniotomy age >17 except for trauma	4	6	10	16	24	34	42	18.5
471 Bilateral or multiple major joint procedure of lower extremity	4	5	8	11	15	19	23	11.8
211 Hip and femur procedures except major joint age >17 without CC	5	7	10	14	19	25	29	15.3
106 Coronary bypass with cardiac catheterization	3	5	8	14	20	27	31	14.8
127 Heart failure and shock	4	6	9	14	19	26	31	14.9

DRG (diagnosis related group). CC (complication and/or comorbidity). These DRGs accounted for 64 percent of rehabilitation facility patients. Source: MedPAC analysis of 1996 claims data from HCFA.

challenged in court (*Duggan v. Bowen* 1988). As a result of this lawsuit, HCFA revised its guidelines to clarify eligibility and coverage for home health care. The revised guidelines allowed more beneficiaries to qualify for home health care and permitted more services to be furnished to users of the benefit.

Medicare eligibility requirements are narrow but vaguely defined. Moreover, coverage guidelines regarding services for eligible patients may be broad. To qualify, beneficiaries must be homebound and require intermittent skilled nursing services or physical or speech therapy as certified by physicians. Once eligible, individuals may receive any number or combination of these qualifying services as well as occupational therapy, medical social services, and home health aide visits on a part-time or intermittent basis.

These guidelines are not applied uniformly across home health providers. Eligibility and coverage determinations are made largely by fiscal intermediaries, which screen claims to identify services that are not covered or do not qualify as reasonable and necessary. Because home health practices vary widely by region, though, it has been difficult to develop national guidelines. Consequently, coverage determinations may be inconsistent across geographic areas.

**RECOMMENDATION 5 K**

**The Congress should establish in law clear eligibility and coverage guidelines for home health services.**

The BBA requires the Secretary to submit a report to the Congress regarding the requirement that beneficiaries receiving home health services be homebound. The report will discuss approaches to applying the homebound requirement for determining eligibility. In addition, the BBA requires the Secretary to develop normative standards for coverage determination. To that end, HCFA contractors are developing qualitative standards of home health use based on patient characteristics and need. These standards of service frequency and intensity are intended to replace the current edits performed by the fiscal intermediaries. Moreover, the standards may be used to provide feedback to physicians and other providers involved in the post-acute treatment plan.

Although the guideline revisions are important steps to clarifying coverage and eligibility rules, they are likely to be controversial. As in the past, the Department of Health and Human Services could face lawsuits regarding its coverage and eligibility guidelines. Greater legislative

authority is necessary if the Secretary is to defend the policies in court. Therefore, the Commission urges the Congress to give the Secretary clear authority to enforce eligibility and coverage guidelines by defining them in statute.

**Standardizing coding for visits**

Home health agencies are not required to specify the content of home health visits to receive Medicare payment. Agencies report the type of visit provided (skilled nursing services; physical, occupational, or speech therapy; medical social services; or home health aide services). Some of the aggregate payment limits apply to visits, although the definition of a visit within each of the six visit categories is not standardized. Because the content of visits in each category varies in and across agencies, this inconsistency precludes accurate cost comparisons of visits.

**RECOMMENDATION 5 L**

**The Secretary should require home health agencies to use consistent, service-specific codes on all bills for services provided during home health visits.**

Since October 1998, agencies have been

required to specify the length of home health visits in 15-minute increments on their Medicare bills. Although time-increment coding is a significant improvement over prior practices, information concerning the specific services provided in the visit is still lacking. The lack of a standardized coding system to describe services during home health visits permits agencies to reduce the number of services provided during visits to keep costs below their payment limits.

Information about the services furnished during a home health visit would allow HCFA to better monitor the adequacy and appropriateness of care as well as compare practice patterns across agencies before and after implementation of a PPS. Although the payment unit under the PPS is likely to be an episode of care rather than a visit, clearly defined service codes would allow for easier detection of quality problems. The HCFA Common Procedure Coding System should be used in developing the visit codes so that service descriptions will be consistent across sites that provide similar care.

### **Independently assessing need**

Under current coverage guidelines a beneficiary may continue to receive home health care indefinitely. Better management of patients who make extensive use of home health services is necessary to ensure that care is appropriate.

#### **RECOMMENDATION 5 M**

**The Congress should require independent assessments of need for beneficiaries receiving extensive home health services to ensure the appropriateness of such care. Beneficiaries receiving 60 or more home health visits should qualify for assessments. Assessors should confer with prescribing physicians to modify care plans as needed.**

For beneficiaries receiving home health services, Medicare rules require

physicians to certify the need for care every 62 days. Prescribing physicians confer with agency-employed nurses to develop and modify patient care plans and determine ongoing patient needs. In some cases, physicians determine patient needs without having examined them during the preceding period of care. Physicians may face pressures from beneficiaries, their families, and home health agencies to continue services. The Commission believes an independent assessment of need would reduce the uncertainty physicians may face when evaluating the need for home care.

Independent evaluations also would provide more objective assessments than those furnished by agencies. Nurses employed by agencies may be influenced by financial incentives facing their employers. For example, a cost-based payment system encourages agencies to furnish services of marginal clinical value. To the extent these incentives exist under the interim payment system, an independent assessment would help minimize the provision of those services. Under an episode-based PPS, providers may face incentives to stint on care. Independent assessments would help ensure that patients receive the care they need.

The Commission recognizes there are several issues that would need to be addressed if this policy were implemented, and a demonstration may be an appropriate way to solve them. For example, methods to pay for this service in the context of Medicare's fee-for-service program would need to be explored. The frequency of assessments also would need to be determined. In addition, to ensure the quality of the assessments, it would be important to establish clear guidelines concerning the qualifications of individuals performing assessments and acceptable case-load levels.

### **Cost-sharing for home health services**

Cost-sharing serves an important function in insurance plans. When the cost of a service is borne entirely by the insurer, the recipient of the service has little incentive to decline the service if it

provides even the smallest benefit. By making individuals responsible for a portion of the costs associated with the service, beneficiaries will consider the value of that service more carefully. For that reason, most benefits under Medicare require cost-sharing. Clinical laboratory services and home health care are the only major Medicare benefits that currently do not require cost-sharing.

#### **RECOMMENDATION 5 N**

**The Congress should require modest beneficiary cost-sharing for home health services, subject to an annual limit. Low-income beneficiaries should be exempt from cost-sharing.**

The Commission believes that the need for home health services would be evaluated more critically if beneficiaries shared some costs of that care with the Medicare program. In addition, cost-sharing for home health services could help identify fraud and abuse. Beneficiaries currently receive a summary notice of Medicare bills submitted on their behalf, but cost-sharing may more effectively encourage beneficiaries to review the number and types of services billed.

Beneficiary cost-sharing for home health services could take several forms depending on the method used for paying agencies. Under the current system, which relies heavily on visit costs to determine payment rates, a per visit copayment is a logical choice. A deductible could be used in a prospective system that uses an episode of care as the payment unit. A per visit copayment also would be possible under episode-based prospective payment, because visits furnished to individual beneficiaries will continue to be tracked to determine whether services are paid under Medicare Part A or Part B.

The Commission appreciates the burden that cost-sharing would pose for beneficiaries and therefore recommends that cost-sharing be nominal and subject to annual limits. Regardless of the level of cost-sharing, though, home health users with supplemental insurance coverage

would not directly incur these costs, but would bear them indirectly through higher premiums for Medigap coverage.

The Commission also recommends that low-income Medicare beneficiaries be exempt from cost-sharing for home health services. Because Medicaid pays premiums and deductibles for some low-income beneficiaries, these costs would be borne partially by states.

## Exploring prospective payment options for long-term hospitals

The BBA did not require implementation of a prospective payment system for long-term hospitals. However, the Congress signaled its intent to pay these hospitals on a prospective basis in the future by requiring the Secretary to submit a report in 1999 concerning a prospective system for them.

Currently, inpatient operating payments to long-term hospitals are based on each hospital's costs per discharge, subject to facility-specific limits established by TEFRA and to national limits established by the BBA (see Chapter 4). TEFRA was intended as an interim system until a PPS would be implemented; however, the system has remained in effect longer than expected. The unintended consequences of sustaining TEFRA have included a steady growth in the number of long-term hospitals (and other PPS-exempt facilities) and a substantial payment inequity between older and newer ones. Across all PPS-exempt providers, that disparity is most evident among older and newer long-term hospitals. Almost 30 percent of long-term hospitals that have operated under TEFRA cost limits since 1990 or earlier were paid less than their reported costs in 1996, while less than 5 percent of newer long-term hospitals were reimbursed less than their costs in that year.

While the BBA's provisions are aimed at reducing payment inequities across these facilities, the TEFRA system still cannot account for differences in patient mix and treatment patterns. Given the continuing difficulties in ensuring fair

and adequate payments to facilities under TEFRA, the Commission encourages the exploration of all relevant methodologies

to help HCFA develop a valid and reliable PPS that adequately predicts resource use of long-term hospital patients.

## Long-term hospitals

Long-term hospitals are exempt from the acute care PPS if they have an inpatient length of stay greater than 25 days and are not otherwise classified as a rehabilitation or psychiatric hospital. These hospitals constitute a small (about 200 facilities) but heterogeneous group that furnishes a range of intensive services including trauma and cancer treatment, respiratory therapy for ventilator-dependent patients, pain and wound management, and comprehensive rehabilitation. Roughly one-third of these facilities specialize predominately in treating ventilator-dependent patients.

Long-term hospitals are unevenly distributed geographically (see Table 5-7). Many of the oldest hospitals are located in the northeast area of the country, while much of the growth in these facilities has occurred in southern states. In other areas, patients with characteristics like those treated in long-term hospitals are probably

cared for during extended stays in acute care hospitals and in skilled nursing facilities that furnish medically complex care.

Most patients in long-term hospitals have several diagnosis codes on their medical records, indicating that they have multiple comorbidities and likely are less stable upon admission than patients admitted to other post-acute settings (ProPAC 1996, ProPAC 1992). Additionally, a higher share of daily patient costs in long-term hospitals are attributable to ancillary costs (49 percent) relative to other post-acute settings (42 percent in rehabilitation hospitals and SNFs). Over three-fourths of long-term hospital patients are admitted within a month following acute care hospital stays. Patients without a prior acute care stay are more likely to be younger and eligible for Medicare due to a disability compared to patients with prior acute care stays (ProPAC 1996).

**TABLE 5-7**

**Geographic distribution of long-term hospitals and Medicare beneficiaries, 1998**

HCFA region	Number of hospitals	Share of hospitals	Share of beneficiaries
Total	207	100%	100%
Boston	25	12.1	5.5
New York	9	4.3	10.3
Philadelphia	15	7.2	10.9
Atlanta	32	15.5	20.2
Chicago	33	15.9	18.6
Kansas City	7	3.4	5.2
Denver	8	3.9	2.8
Dallas	58	28.0	10.3
San Francisco	18	8.9	12.5
Seattle	2	1.0	3.7

Source: MedPAC analysis of data from the Offices of Survey and Certification and Strategic Planning, HCFA.

## RECOMMENDATION 50

### **The Secretary should evaluate all relevant case-mix and prospective payment methodologies for their utility in developing a prospective payment system for long-term hospitals.**

The BBA requires that the Secretary develop and submit to the Congress by October 1, 1999, a proposal for legislation that would establish a case-mix adjusted PPS for long-term hospitals. The Secretary must consider several methodologies, including an extension to long-term hospitals of the current payment system for acute care hospitals. The Commission will comment publicly on the Secretary's report once it is developed.

Under its goal of moving to a uniform payment policy for post-acute care providers, HCFA may favor developing a PPS that is similar to the one it recently implemented for SNFs and is proposing for rehabilitation hospitals. In concept,

such a plan would entail conducting a study of patients in long-term hospitals to characterize patients using the MDS-PAC instrument and measure clinical staff time associated with patient care. From that, a classification system and set of relative weights would be constructed to predict the daily resource use of long-term hospital patients. As discussed earlier, the Commission encourages the collection of a core set of common patient assessment elements across all post-acute settings and supports the development and refinement of the MDS-PAC. It is necessary, however, that such a study include a sufficient sample size to ensure development of a valid classification system.

The BBA also requires the Secretary to also explore an extension to long-term hospitals of the discharge-based DRG system used for acute care hospital payment. The Commission agrees that development efforts for a long-term hospital PPS should include an assessment of that system. Such work would entail, for example, a comparison of patients, costs, and payments of long-

term hospitals with the outlier cases of acute care hospitals.

Similarly, some researchers have taken the discharge-based DRG approach and modified it for long-term hospital patients (Maynard et al. 1996). This design uses 179 DRGs that were found to describe long-term hospital patients, plus an additional five groups that combine patients with other DRGs into similar cost categories. Relative weights for those 184 groups were calculated using allowed charges for long-term hospital patients. The researchers found this design as predictive of per discharge resource use as the acute care PPS. Main advantages of the design include its administrative simplicity and efficiency, its consistency with the discharge basis of the current long-term hospital payment system, and its similarity to the DRG-based PPS for acute care hospitals. This proposal is the most developed of the long-term hospital proposals and should be considered for its potential as a long-term hospital PPS. ■

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