

CHAPTER

7

**Cross-cutting issues
in post-acute care**

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Chapter summary

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries, about half of whom had a prior hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). In 2017, fee-for-service (FFS) program spending on PAC services totaled \$58.5 billion.

The Commission has previously discussed the challenges to increasing the accuracy of Medicare’s payments and overcoming the shortcomings of the separate FFS payment systems for PAC (Medicare Payment Advisory Commission 2018, Medicare Payment Advisory Commission 2017, Medicare Payment Advisory Commission 2015, Medicare Payment Advisory Commission 2014). Over more than a decade, the Commission has worked extensively on PAC payment reform, pushing for closer alignment of costs and payments and more equitable payments across different types of patients.

Despite some actions by the Secretary and the Congress, Medicare’s payments remain too high relative to the costs of treating beneficiaries in three of the four settings (SNF, HHA, and IRF). After years of research and recommendations by the Commission, the Secretary is poised to make substantial changes to the designs of the prospective payment systems

In this chapter

- Medicare’s payments remain high, and revisions to the SNF and HHA payment systems need to be implemented
- Quality measures should focus on claims-based outcome measures
- Conclusion

(PPSs) Medicare uses to pay HHAs and SNFs. These changes are overdue and are consistent with longstanding recommendations made by the Commission.

The Commission has two goals in making payment recommendations. The *update* recommendations aim to ensure that aggregate payments are adequate so that beneficiary access is preserved while taxpayers and the long-run sustainability of the program are protected. The recommendations to *revise the payment systems* aim to align program payments with the costs of treating patients with different care needs. Such targeting increases the equity of the program's payments, thereby minimizing the financial incentive for providers to treat some beneficiaries over others.

A uniform payment system for all PAC would increase the equity of payments across patients and providers in all settings, but its implementation is on a longer timetable. Until a unified PAC PPS is in place, Medicare must continue to improve its setting-specific payment systems. FFS Medicare continues to overpay for PAC services; moreover, the current HHA and SNF payment systems also create inequities across patients with different care needs and the providers that treat them. Furthermore, the overpayments and misalignments affect the benchmarks for Medicare Advantage plans and alternative payment models.

On the quality front, there has been progress on defining common outcome measures across PAC providers and establishing value-based purchasing policies for HHAs (on a demonstration basis) and for SNFs. However, the Commission is increasingly concerned that trends in some provider-reported quality measures raise questions about the accuracy and reliability of this information. The Commission has work underway to examine the accuracy of the patient assessment-based quality measures. ■

Medicare's payments remain high, and revisions to the SNF and HHA payment systems need to be implemented

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries, about half of whom had a prior hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). In 2017, fee-for-service (FFS) program spending on PAC services totaled \$58.5 billion.

Since 2008, the Commission has made recommendations to lower the level of program spending in each of the PAC settings by eliminating annual updates to payment rates, lowering payments below current levels, or both. To redistribute payments more equitably between therapy

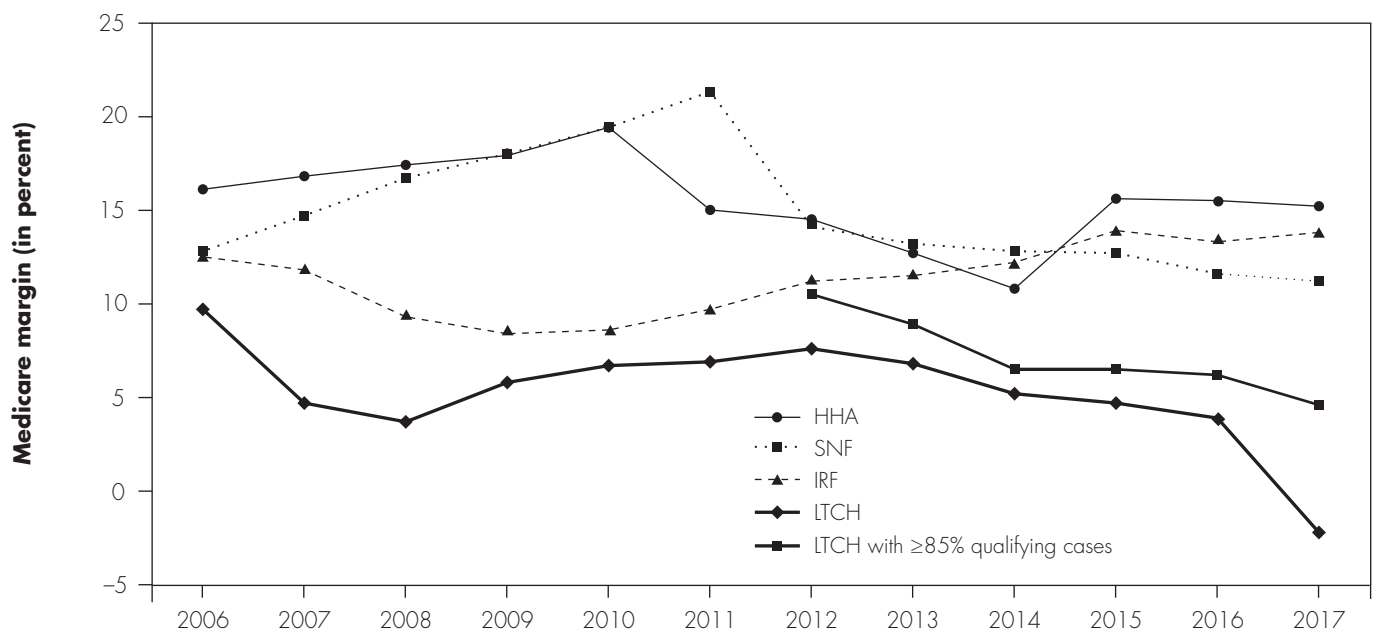
and medically complex care, the Commission has recommended redesigns of the HHA and SNF payment systems (in 2011 and 2008, respectively), which together pay for almost 80 percent of Medicare PAC stays.

Medicare margins for three of the PAC settings (HHA, SNF, and IRF) have been above 10 percent for most of the past 10 years (Figure 7-1). In each setting, Medicare margins increased substantially soon after a prospective payment system (PPS) was implemented, indicating that the initial base rates for each setting were too high and that providers rapidly adjusted to the new payment rules.

Medicare margins for HHAs and SNFs have been especially high, even after rebasing and productivity and other payment adjustments mandated by the Congress. Over the last decade, Medicare margins in HHAs and SNFs averaged over 15 percent. Close behind, IRF margins averaged 11.1 percent. The average margin for all LTCHs has been considerably lower, though higher for

FIGURE 7-1

Medicare margins have remained high for most post-acute care providers



Note: HHA (home health agency), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital). Medicare margin is calculated as (Medicare payments – Medicare costs)/Medicare payments. The Pathway to SGR Reform Act of 2013 established separate payment methodologies in cases that qualify as LTCH discharges and cases that do not. To qualify as an LTCH discharge, the stay either must have been immediately preceded by an acute care hospital stay that included at least three days in an intensive care unit or have had an LTCH principal diagnosis indicating prolonged mechanical ventilation. We did not calculate margins for LTCH-qualifying discharges before 2012.

Source: MedPAC analysis of Medicare cost reports 2006–2017.

**TABLE
7-1**

Commission’s payment recommendations since 2008

Years the Commission made the recommendation

| Recommended action | SNF | HHA | IRF | LTCH |
|----------------------------------|-------------------------|------------|------------|-------------|
| No update (0 percent update) | 2008–2011; 2016–2018 | 2008–2016 | 2008–2016 | 2009–2018 |
| Lower payments | 2012–2015 | 2009–2018 | 2017–2018 | |
| Revise the payment system design | 2008–2018 | 2011–2018 | | |

Note: SNF (skilled nursing facility), HHA (home health agency), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital). The table shows the years the recommendation was made by the Commission. A year can appear in the 0 percent update and lower payment categories because a recommendation covered multiple years, with a 0 percent update in one year and reductions in one or more subsequent years.

providers with at least 85 percent of stays that meet the new criteria to qualify to receive LTCH PPS payments.

Because the level of program payments has been high relative to the cost of treating beneficiaries, the Commission has recommended lowering and/or freezing Medicare’s payment rates for PAC for many years (Table 7-1). For HHAs, SNFs, and IRFs, the Commission recommended no updates (0 percent updates) or lower payments each year since 2008 and for LTCHs since 2009. In some years, the Commission made a multiyear recommendation that included no update to payment rates in one year and reductions in subsequent years. Yet during this period, without congressional action, SNF, IRF, and LTCH payments were increased by statutory updates. For HHAs, although the Patient Protection and Affordable Care Act of 2010 calls for annual rebasing of payments, the mandated reductions have been offset by updates to payment rates and consequently have not gone nearly far enough in realigning payments to costs.

The Commission also recommended revising the payment systems for HHAs (in 2011) and SNFs (in 2008) to increase the equity of program payments. The Commission is pleased that the Secretary is poised to implement changes to the HHA and SNF PPSs that will base payments on the clinical and functional characteristics of patients, not on the amount of therapy furnished. The Bipartisan Budget Act of 2018 requires CMS to implement major changes to the home health PPS

in calendar year 2020, and CMS plans to overhaul the SNF PPS in fiscal year 2020. Both redesigns are consistent with the Commission’s recommended changes and would rebalance payments between therapy cases and medically complex cases. By increasing the equity of program payments, providers will have less financial incentive to favor admitting beneficiaries with certain care needs over other beneficiaries. The Commission urges the Secretary to proceed with these planned reforms.

Quality measures should focus on claims-based outcome measures

Since 1999, the Commission has called for a variety of quality initiatives, including the collection of uniform patient assessment information, the reporting of outcome-based quality measures that focus on the key goals of PAC, and the implementation of value-based purchasing policies. The Congress and CMS have acted on many of the Commission’s recommendations, including the development and collection of uniform patient assessment items, outcome-based quality measures, and value-based purchasing for HHAs and SNFs. To meet the requirements in the Improving Medicare Post-Acute Care Transformation Act of 2014, CMS has undertaken the development of measures of function and cognition, skin integrity, Medicare spending per beneficiary,

discharge to community, hospital readmissions, medication reconciliation, and incidence of major falls. The Commission has raised concerns that not all of the measures are outcome based or uniformly defined across the settings, though such refinements may be made in the future.

Because the maintenance of and improvement in function are key goals of PAC, the Commission recommended the development of uniform patient assessment items across the four PAC settings. Information on a patient's functional status, cognitive status, and changes in function are used to establish care plans for patients, risk adjust payments, and measure quality of care. The HHA, SNF, and IRF PPSs use patient assessment data to define the case-mix groups that establish payments for most of the patient groups cared for. In addition, the HHA value-based purchasing demonstration uses measures of function to calculate provider performance.

Because patient assessment information affects payments and quality results, it is important that it consistently and accurately reflects patients' levels of function. However, the use of this information to set payments and measure and reward quality creates incentives for providers to report it in ways that boost payments. Over time, we have become increasingly concerned about the validity and utility of provider-reported patient assessment information. Our recent analyses of provider-reported measures calculated from patient assessment information have raised concerns that information gathered from these sources may not be accurate. For example, on average, HHAs have reported considerable improvement over the course of an episode in patients' abilities to conduct activities of daily living (such as walking and transferring). Yet, during the same time period, there was little or no improvement in claims-based measures (such as hospitalization and emergency room use).¹ These divergent trends raise questions about the accuracy of the provider-reported information. In IRFs, where lower function at admission translates into higher payments, we found that high-margin IRFs appear to record lower patient function compared

with other IRFs for like patients. The Commission is concerned that when provider-reported patient assessment information affects a provider's payments, providers respond inappropriately to these financial incentives.

Given these disturbing trends, the Commission is increasingly wary of the accuracy of the provider-reported patient assessment information. The Commission has work underway to assess these data. Although these data are important for measuring patient outcomes and establishing care plans, they may not be key to establishing accurate payments. Our initial work on a unified PAC PPS found that payments could be accurate without measures of patient function. The Commission will continue its work on design elements of a PAC PPS, including whether function is a necessary component of a case-mix system.

Conclusion

As evidenced by years of high Medicare margins, the program is paying more for services than is warranted. Further, its payment systems unfairly advantage some providers and encourage the admission of patients with certain care needs over others. Because FFS payment rates form the basis of Medicare Advantage benchmarks and accountable care organization targets, the overpayments also affect non-FFS payment models and their success. From the taxpayers' perspective, unnecessarily high payments contribute to the projected insolvency of the Hospital Insurance Trust Fund (2026). The Secretary plans to implement long overdue changes to the SNF (in fiscal year 2020) and HHA (in calendar year 2020) PPSs. The Commission urges the Secretary to follow through with these plans.

Until the implementation of a unified PAC PPS, Medicare must continue to improve its setting-specific payment systems so that it does not overpay for services and create inequities that can affect beneficiaries' access to care. ■

Endnotes

- 1 We would expect similar trends in the provider-reported and claims-based measures. Studies have found that functional status is related to hospitalization rates and the use of emergency departments (Laudisio et al. 2015, Middleton et al. 2018, Slocum et al. 2015, Soley-Bori et al. 2015).

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