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

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Post-acute care overview

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

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

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

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

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

Possible future Medicare strategies to better manage post-acute care

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

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

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

Deliberative approach to identify conditions for site-neutral payments

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

Conditions considered for a site-neutral policy

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

Site-neutral policy for qualifying conditions has several components

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

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

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

Draft recommendation

- The Congress should direct the Secretary of Health and Human Services to eliminate the differences in payment rates between inpatient rehabilitation facilities and skilled nursing facilities for selected conditions. The reductions to inpatient rehabilitation hospital payments should be phased in over 3 years. Inpatient rehabilitation facilities should receive relief from regulations specifying the intensity and mix of services for site-neutral conditions.

Draft recommendation: Impacts

- Program spending: Lower relative to current law.
  5- year estimate: $1 billion to $5 billion lower

- Providers: Would reduce payments to IRFs. If cases are shifted to SNFs, SNF volume may increase.

- Beneficiaries: Do not anticipate negative impacts because we do not expect a large shift in cases and we do not see consistent differences in outcomes between the two settings.

22 conditions considered for site-neutral policy

003	ECMO or tracheostomy w/MV 96hr+
190	COPD w/ MCC
193-194	Pneumonia w/MCC and w/CC
208	Respiratory system diagnosis w/ ventilator support <96 hr
219	Cardiac valve w/out catheterization w/MCC
233	Coronary bypass w/cath w/MCC
239-240	Amputation for circulatory disorders w/MCC and w/CC
291-292	Heart failure and shock w/MCC and w/CC
467	Revision of hip or knee replacement w/CC
469-470	Major joint replacement w/MCC and w/out MCC
480-482	Hip and femur procedures w/MCC, w/CC, and w/out CC
536	Fractures of hip & pelvis w/o MCC
690	Kidney & urinary tract infection w/o MCC
853	Infectious & parasitic disease w/OR procedure w/MCC
871-872	Septicemia or severe sepsis w/out MV w/ MCC and w/out <MCC

Factors that affect the margins of hospital-based IRFs

- Higher routine, ancillary & indirect costs than freestanding IRFs
  - Hospital-based IRFs' routine costs were 70% higher
- Much more likely to be not-for-profit
- Tend to be smaller with lower occupancy
  - 67% have fewer than 25 beds

➢ *One-fourth of hospital-based IRFs had Medicare margins > 10%*

➢ *Acute care hospitals with an IRF unit have an average Medicare margin that is almost 1 percentage point higher than acute care hospitals without an IRF unit*

Results are preliminary and subject to change.
Source: MedPAC analysis of Medicare cost report data from CMS.