MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Medicare post-acute care

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Statement of
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U.S. House of Representatives

Chairman Johnson, Ranking Member Stark, distinguished Subcommittee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this afternoon to discuss post-acute care (PAC) payment issues in Medicare.

Introduction

Medicare beneficiaries can seek care after a hospitalization in four different post-acute settings: skilled nursing facilities (SNFs), home health agencies (HHAs), long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs). Many factors influence Medicare beneficiaries' use of these services. For example, use of home health and SNF services grew rapidly after the introduction of the inpatient prospective payment system (PPS) in 1982. That payment system created an incentive for hospitals to discharge patients earlier. One strategy for doing so was to provide in a separate setting some of the recuperation and rehabilitation services that may have been formerly provided within the hospital stay. In the ensuing years, the four different post-acute settings have emerged to provide those recuperation and rehabilitation services. (A fifth type of service, hospice, overlaps somewhat with post-acute services in terms of patients and some services, although the goal is not recovery or rehabilitation.)

The overarching issue in PAC is that there are no clear and comprehensive criteria for which of these settings are best for patients with particular characteristics or needs. The recuperation and rehabilitation services provided are important for Medicare beneficiaries. Yet, these settings and their payment systems have developed separately over the years, and it is not clear that together they form an integrated whole that provides the highest quality, most appropriate care for beneficiaries or the best value for the Medicare program and the taxpayers who support it. Indeed, some parts of the country do not have all of these settings, yet Medicare patients are still receiving PAC services in those areas. A second issue is that within the SNF and home health settings payments are not well calibrated to patients and their conditions.

The Commission maintains that in the post-acute care sector, just as for the other sectors of Medicare, the services provided should meet the needs of the beneficiaries, Medicare payments should cover the costs of an efficient provider of those services, and higher quality services should be rewarded. Currently in post-acute care, none of these conditions is fully satisfied. The Commission has made recommendations for improving the payment systems for several of these sectors. It has recommended:

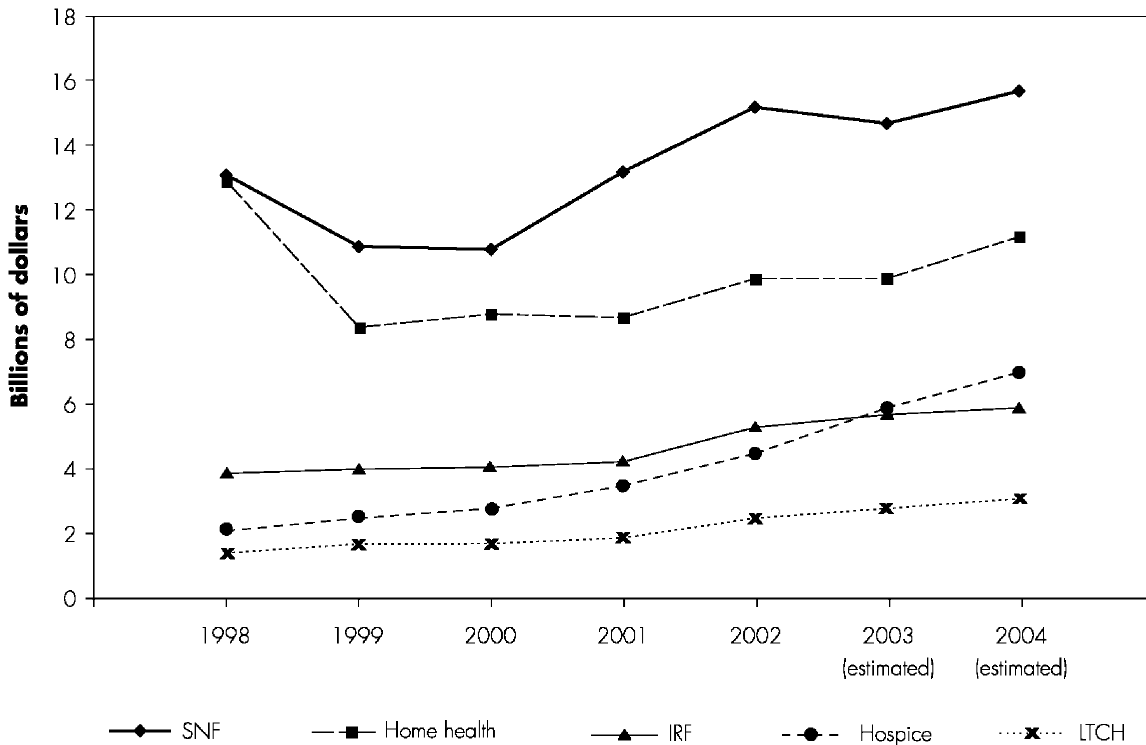
- Reforming the PPS for SNFs because the current system does not pay accurately for all of its patients and encourages providing rehabilitation services at the expense of caring for patients who have medically complex conditions.
- Reexamining the home health PPS because the services now provided are different than those provided when the system was created and payments may not be accurate.
- Creating facility level criteria to better define LTCHs, and patient level criteria to better define who should go to those facilities.
- Instituting a pay for quality performance program for home health, and creating quality measures for SNFs.

Finally, the Commission has recommended zero updates for both SNF and home health because Medicare overpays these sectors overall. Over payment makes it even more difficult to determine where cost effective services are available, in addition to placing unnecessary burdens on taxpayers and beneficiaries.

However, even if the payment systems were improved as we have recommended, there would still be a need to evaluate outcomes and the quality of care and to ensure that beneficiaries are sent to the most clinically appropriate and cost effective setting. We discuss later in this testimony patient assessment instruments, which could contribute to evaluating outcomes and quality. Further efforts will be needed to assure that payments are balanced across and within settings and, more importantly, that patients go to the best setting for their conditions. In the longer term, a seamless PAC sector—with uniform assessments and payment tied to patients, their conditions, and their outcomes—could provide better care for beneficiaries and better value for the Medicare program.

Background
Altogether, Medicare spending on PAC services and hospice totaled about $43 billion in 2004, accounting for about 14 percent of total Medicare spending. As shown in figure 1, spending has been growing rapidly in the last few years. Overall spending has increased by over 50 percent since 2000, with hospice spending increasing by 150 percent and long-term care hospitals spending by about 80 percent. The number of providers has grown as well. Home health agencies increased by 10 percent in the last year alone, and there were over 50 percent more LTCHs in 2005 than in 2000. The increase in spending is the result of both higher payments and greater use. For example, SNF admissions and days increased by about 14 percent in 2002.

FIGURE 1 **PAC spending shows recent growth**

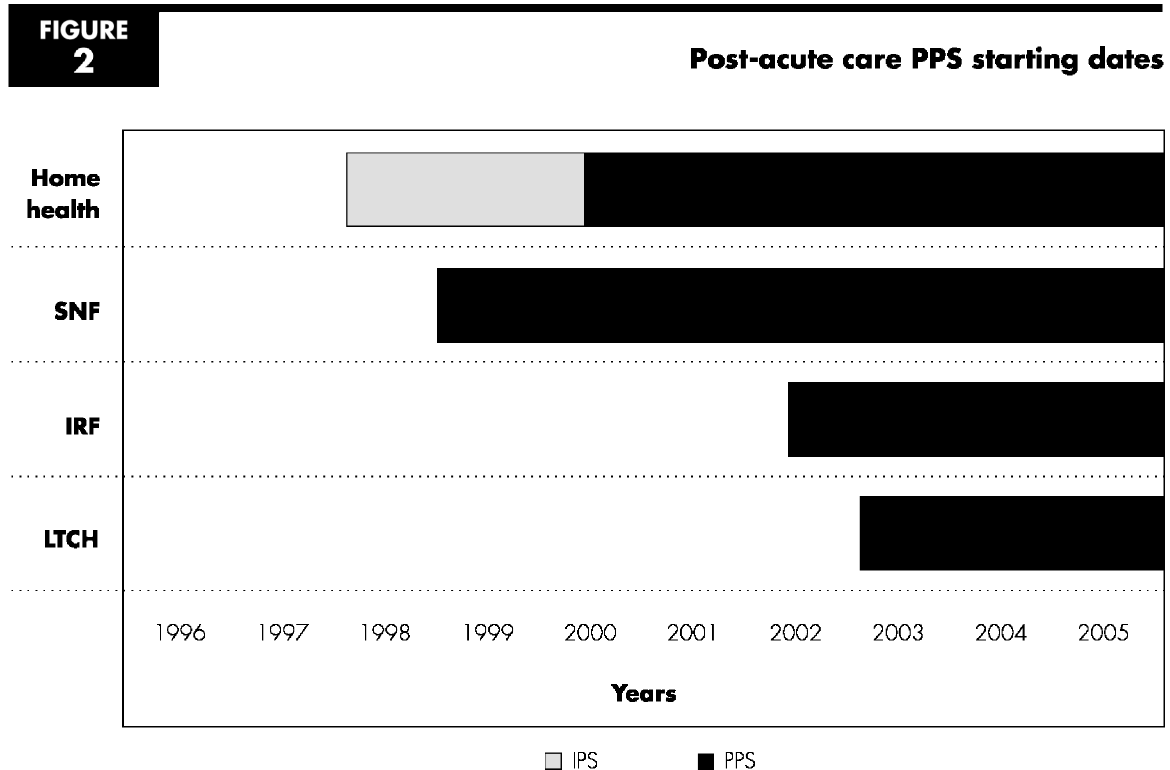


Note: PAC (post-acute care), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital). These are program spending only; does not include beneficiary co-pays.

Source: Center for Medicare & Medicaid Services, Office of the Actuary.

In 2002, about one third of Medicare beneficiaries discharged from PPS hospitals went to a post-acute care setting. About one third of those went to a SNF, one third to home health, and the remainder either to other or multiple settings. PAC use is not uniform either across or within diagnoses groups. For some conditions, few beneficiaries use PAC services. For other conditions, where beneficiaries commonly do use PAC services, some beneficiaries will not. This lack of uniformity complicates analyses of this sector.

During the last era of rapid growth in post-acute care, the Congress passed the Balanced Budget Act of 1997. That act required the establishment of prospective payment systems (PPSs) for most PAC settings in the hope of curbing the rapid increase in Medicare spending for post-acute services. Figure 2 shows the implementation dates for each of the new PPSs.



Note: PPS (prospective payment system), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital), IPS (interim payment system).

As these payment systems have been implemented, and as providers have in turn reacted to the payment systems, some of the strengths and weaknesses of the PPSs have become apparent. MedPAC's key findings and recommendations for three of the individual systems are discussed below, followed by a discussion of a cross-setting issue—the lack of comparable patient assessment instruments.

Skilled nursing facilities

Medicare payment levels for SNFs have been favorable. SNFs have received a full market basket update in both FY 2004 and 2005. In addition, SNFs received an additional update in FY 2004 to correct for past market basket projection errors since the implementation of the PPS. In the past two years, for the 90 percent of SNFs that are freestanding, margins have been in the double digits. This finding in conjunction with other factors such as access and growth in use of services have led the Commission to recommend zero updates for 2003, 2004, 2005, and 2006.

Problems with the SNF case mix system

MedPAC has recommended that the SNF PPS should be reformed for two reasons: First, the case mix system does not adjust payments for the costs of certain services that tend to be higher for medically complex SNF patients. Second, the payment rate is determined, in part, by the amount of therapy provided rather than by patient characteristics that predict therapy needs.

Case mix adjustment

Medicare pays SNFs a set amount for each day of care adjusted for the case mix of the patients. The SNF PPS case mix system, the resource utilization groups (RUG-III) system, adjusts payments for the services provided. However it does not properly adjust payments for one category of services—nontherapy ancillary services (NTAs), such as prescription drugs and respiratory therapy—that are more heavily used by medically complex SNF patients. The BBA required that Medicare's prospective payment for SNFs include payment for NTAs. In compliance with this mandate, CMS included the cost of NTAs as part of the total costs used to develop Medicare's SNF base payment rates. However, NTA costs were not used to develop the RUG–III case-mix indexes that adjust the base payment rates according to patients' resource use. Instead, the payment system distributes payments for NTAs using the weights that are used to allocate payment for nursing care. As a result, the payment system does not distribute payments for NTAs according to variation in expected NTA costs across different patient types and thus pays relatively too much for patients receiving therapy and relatively too little for medically complex patients.

Payment based on therapy to be provided

Another problem is that the SNF PPS is overly oriented to therapy and that it determines the payment rate based on the amount of therapy services the patient uses—or is expected to use—rather than on patient characteristics and clinical appropriateness. (Therapy includes physical therapy, speech therapy, and occupational therapy.) The system pays based on the number of therapy minutes per week. It pays a fixed rate for ranges of therapy minutes—45 to 149 minutes (low), 150 to 324 minutes (medium), 325 to 499 minutes (high), 500 to 719 minutes (very high), and more than 720 minutes (ultra high). A SNF simply has to estimate the amount of therapy a patient will receive to get payments for the first three categories for the first 14 days. Payments for the two highest categories require the therapy actually be provided.

This system creates two incentives: The first is to classify patients into a higher payment category even though the patient may not benefit from additional therapy. The second is to provide the fewest number of minutes in the highest achievable payment category because therapy times at the bottom of the categories have the lowest cost relative to revenue.

Several studies suggest that SNFs have responded to these two incentives. First, studies found that the proportion of residents receiving no rehabilitation therapy declined between 1997 and 2000. Second, at initial assessment, fewer patients were categorized

into the low group where payments are lowest. More patients were grouped into the medium and high groups where payments are higher and estimated, not actual, therapy minutes are sufficient for categorization. (According to the GAO, providers report payments for these medium and high rehabilitation groups also had the highest payment relative to costs.) Fewer patients were grouped into the very high and ultra high groups in which therapy must be provided for payment to be received. Finally, consistent with incentives to provide minutes of therapy at the low end of the range for a given payment category, patients in the medium and high rehabilitation categories received at least 30 fewer minutes of therapy per week in 2001 than in 1999; half of the patients initially categorized into these two groups did not actually receive the minimum minutes to be classified into these groups.

As a result of this orientation of the payment system towards therapy, beneficiaries who do not need rehabilitation services but do need certain nontherapy ancillary services may experience delays in accessing SNF care because the Medicare payment rates for these services may not be aligned with their costs. MedPAC and the GAO have pointed out that the RUG–III classification system may not pay enough to cover the costs of patients who require nontherapy ancillary services, such as expensive drugs and ventilator care services. There is enough money in the payment system to pay more for the care of these medically complex patients; the money must be redistributed from the therapy categories, which requires that the case mix system be reformed, as we have recommended for the past two years. We have also recommended that CMS focus on developing and improving quality measures, including collecting necessary information, for skilled nursing facility patients, and that patients be assessed at discharge from SNFs.

CMS has described its reform of the SNF PPS in its proposed rule for the system issued in May. We are studying the proposed rule and will provide CMS and the Congress with our comments. We will be looking for reforms that will reorient the payment system as we have described, and thus provide accurate payment and ensure access to SNF care for medically complex patients.

Home health

The number of home health users and the amount of services they used grew rapidly in the early 1990s, prompting the creation of the home health PPS and other actions by the Secretary and Congress on integrity standards and eligibility. Margins for home health providers have been consistently high since the implementation of the PPS. Initially, agencies were slow to enter the market; however, in the past 12 months, the number of agencies grew by more than 10 percent. CBO projects annual double-digit growth in spending in the next five years. In recognition of the high margins and other factors, MedPAC recommended a zero update for 2004, 2005, and 2006.

A source of concern for some policymakers has been that the number of home health users fell by about one million in the years preceding the implementation of the PPS. We do not find that this concern is justified. Our study found that the greatest decreases in use occurred among beneficiaries with the lowest predicted need for home health service, that the areas with the highest use of services (pre-PPS) had the greatest declines, and that

beneficiaries eligible for both Medicaid and Medicare were not affected disproportionately.

Any decrease in use of home health services does not appear to be from lack of access to home health agencies. In 2003 and 2004, almost all beneficiaries (99 percent) lived in an area that was served by at least one home health agency. Nearly 90 percent of beneficiaries who responded to a CMS survey about their experience in 2003 said they had “little or no problem” accessing services. We found that rural beneficiaries reported even better access to care than their urban counterparts.

The home health PPS has moved the payment system from cost-based reimbursement and introduced an episode-based payment. While this has encouraged the provision of efficient care, the PPS has its shortcomings as well. The home health product has changed considerably since the current PPS was designed. Quality has improved, yet episodes now contain fewer visits, and the share of therapy and home health aide visits has shifted towards therapy. The case mix system should be revisited to make sure it corresponds with the new home health product. We have found that minutes of service per episode (and hence costs) may vary widely within the current case mix groups, and that some patient characteristics that are associated with cost variation are not now included in the case-mix adjustment.

The Commission has determined that Medicare should pay for higher quality to encourage better care for beneficiaries and better value for Medicare. It has also determined that the home health sector is ready to be paid for quality performance. The sector has a set of well-accepted, valid measures of the quality of outcomes of care. This measure set is currently collected by CMS from all agencies; it does not present an additional data burden. Quality has shown small improvements since the implementation of the PPS, but there is room for further improvement. Moving toward pay for performance has a special benefit in this setting because the product is not well-defined. By attaching dollars to outcomes, the program can purchase what it seeks—improvement in physical functioning or healing for wounds for example—rather than units of services with largely unknown content.

Long-term care hospitals

Long-term care hospitals are licensed as hospitals and are intended to treat medically complex patients. Medicare’s only additional requirement is that the average Medicare length of stay be more than 25 days. (The average length of stay in hospitals under the Medicare inpatient PPS is approximately 5 days.) The number of these facilities has been growing rapidly—at a 12 percent annual rate since 1993. Medicare spending for LTCHs has been growing even more rapidly—five fold from $398 million in 1993 to $1.9 billion in 2001; and Medicare is the predominant payer. LTCHs are also usually the most costly post-acute care setting.

In our June 2004 report, we found that in general LTCH patients cost Medicare more than similar patients using alternative settings; but for patients with the highest severity, the cost is comparable. We concluded that the growth in LTCHs may be due in part to the

financial incentives in other Medicare payment systems. Hospitals under the inpatient PPS may want to transfer patients who are stable but have unresolved underlying complex medical conditions—for example, patients needing ventilator support for respiratory problems—because of the fixed payments in that system and the high costs of those patients. SNFs may find it less profitable to admit these patients than less complex patients because of the shortcomings in the SNF PPS we described earlier. These considerations make a new, clearer definition of LTCH care imperative. Therefore, we recommended that the Congress and the Secretary should define LTCHs by facility and patient criteria that ensure the patients admitted to these facilities are medically complex and have a good chance for improvement. Facility-level criteria should characterize this level of care by features such as staffing, patient evaluation and review processes, and mix of patients. Patient-level criteria should identify specific clinical characteristics (such as open wounds), and treatment modalities such as need for frequent intravenous fluid or medication.

We also recommended that the Secretary require the quality improvement organizations to review LTCH admissions for medical necessity and monitor that these facilities are in compliance with defining criteria.

Cross-setting issue: Patient assessment instruments
Patient assessment tools should help providers assess patients' care needs and evaluate the quality of care and patient outcomes. While Medicare requires three of the post-acute settings to use patient assessment tools, each uses a different one. SNFs use the minimum data set (MDS); HHAs the Outcome and Assessment Information Set (OASIS); and IRFs the IRF-Patient Assessment Instrument (IRF-PAI). LTCHs are not required to have a patient assessment tool. Uniform information would allow comparisons to be made across post-acute settings and provide an opportunity to assess cost, quality, outcomes and patient placement.

We found that although the tools measure the same broad aspects of patient care—functional status, diagnoses, comorbidities, and cognitive status—the timeframes covered, the scales used to differentiate patients, and the definitions of the care included in the measures vary considerably. These differences make it very difficult, if not impossible, to compare the quality of care and patient outcomes across all settings.

The tools vary substantially in how frequently clinicians must administer them, how long the assessments take to complete, and what time period the assessment covers. For example, the MDS is conducted close to (but not necessarily at) admission and periodically throughout the patient's stay (but not at discharge); generally asks about the patient's condition over the past 7 days; and takes about 90 minutes to complete. In contrast, the IRF-PAI is typically administered on day 3 of the admission and at discharge, captures the patient's status on that day, and is much shorter (taking about 25 minutes). As a result, it is impossible to evaluate whether differing assessment information truly reflects differences in the patients' condition, or just when the assessment was conducted, or the time period covered by the evaluation.

Further limiting the comparison of information gathered from the instruments is that even for the common aspects of patient care, the definitions of the measures are different. For example:

- Functional status: The MDS evaluates whether and how frequently the patient needed weight bearing or verbal encouragement to walk; the OASIS records a patient's ability to walk safely, once in a standing position; and the IRF-PAI includes the distances walked.
- Cognitive status: These measures and definitions varied the most across the three tools—including whether the tools distinguished between short versus long-term memory; how depression and delirium were evaluated; and the types of decisions patients are able to make.
- Diagnoses and comorbidities: Although these measures are generally considered straightforward to compare, the tools lack consistency in how this information is recorded. The MDS does not use ICD-9 codes to record diagnoses or comorbidities and the OASIS does not require the use of all 5 digits of the ICD-9 code, limiting the comparisons of the severity of patients treated in different settings.

Finally, even for measures where the definitions are the same, the instruments use varying scales and can measure different aspects of a task (such as independence) to differentiate patients. For example, the MDS uses a four-point scale and measures the number of times a patient needs assistance with dressing and the type of help involved (weight bearing or verbal encouragement), whereas the IRF-PAI uses a seven-point scale to distinguish what share of the dressing a patient performs.

Conclusion

Ideally, the program would use a uniform patient assessment tool to assess whether a patient can go home safely or which post-acute setting would be most appropriate, and outcomes and quality would be measured over subsequent assessments. The PPS for each setting would then match payments to the cost of an efficient provider, and quality care would be rewarded. Medicare post-acute care is far from this ideal state. The Commission has made recommendations to improve payment systems in the individual settings and to bring quality into Medicare payment; but these recommendations have not yet been acted upon. In addition, a uniform patient assessment tool is still elusive. Developing a common instrument will be complex, even if it can build on some aspects of the current tools. The longer term goal is a seamless PAC sector—with uniform assessments and payment tied to patients, their conditions, and their outcomes.

Until a common instrument becomes available, we will investigate other approaches for improving post-acute care for Medicare beneficiaries. One approach could be to specify admission criteria for each setting, as we have recommended for long-term care hospitals. A different approach would concentrate on developing a "front-end" assessment tool to be administered prior to either discharge from the hospital or admission to a PAC setting on a physician's referral. Alternatively, care coordination by a case manager for post-acute care may be feasible. This approach could be modeled on CMS's chronic care

improvement program with case managers assuming risk for achieving savings and quality targets.

The Commission will continue to inform the Congress as it deliberates on these issues. MedPAC will also continue to make recommendations to improve the incentives in the payment systems and the tools that support getting Medicare beneficiaries to the post-acute care setting that is right for them—with the objective of getting the best care for beneficiaries and the best value for the Medicare program.