

CHAPTER

7

**Medicare's post-acute care:
Trends and ways to
rationalize payments**

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

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

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Medicare's post-acute care: Trends and ways to rationalize payments

Chapter summary

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries recovering from an acute hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). Medicare's payments to the more than 29,000 PAC providers totaled \$59 billion in 2013, more than doubling since 2001.

The Commission has frequently observed that Medicare's payments for PAC are too generous and that its payment systems have shortcomings. The high level of payments results both from base rates that are generous relative to the actual cost of services and from weaknesses in the payment systems that encourage providers to increase payments by strategically conducting patient assessments, increasing the amount of therapy they provide, and selecting certain types of patients over others. There is also significant variation in financial performance within categories of providers (e.g., ownership, freestanding vs. hospital based). Biases in the HHA and SNF prospective payment systems make certain patients, and the services provided to them, more profitable than others. Meanwhile, quality of care, as measured by the Commission, has not considerably improved, raising questions about the value of the program's purchases. In addition, providers' costs per unit of service vary enormously. Medicare has a responsibility to better its payment systems to ensure access for beneficiaries, appropriately reimburse providers for the

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patients they treat, and control costs for the beneficiary and taxpayer alike. It is up to providers to address their cost per unit of care.

But the Commission's concerns about PAC go beyond the shortcomings of the setting-specific payment systems. The need for PAC is not well defined. Similar patients are treated in different settings at widely varying cost to the Medicare program. Placement decisions often reflect local practice patterns, the availability of PAC in a market, patient and family preferences, and financial arrangements between a PAC provider and the referring hospital. Reflecting this ambiguity, Medicare per capita spending on PAC varies more than any other covered service, which is only partly explained by the large differences in the availability of LTCHs and IRFs across markets.

Because PAC can be appropriately provided in a variety of settings, Medicare ideally would pay for PAC using one payment system with payments based on patient characteristics, not on the site of service. Such fundamental payment reforms within fee-for-service (FFS) Medicare are on the distant horizon. The Commission recommended that CMS collect common patient assessment data from the PAC settings to enable more complete comparisons of providers' costs and outcomes. Under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, PAC providers will begin collecting uniform assessment data in 2018. After the Secretary of Health and Human Services has collected two years of data, she is required to submit a report to the Congress recommending a uniform payment system for PAC. The IMPACT Act also requires the Commission to develop a prototype prospective payment system spanning the PAC settings, using the uniform assessment data gathered previously during CMS's Post-Acute Care Payment Reform Demonstration (completed in 2011). The Act requires the Commission to submit a report in 2016 presenting an approach for a cross-setting PAC payment system.

In the near term, the Commission maintains that Medicare can and should move in the direction of uniform payments by aligning payments across settings for select conditions. Consistent with the Commission's approach to site-neutral payments in the ambulatory and acute care sectors, the Commission used criteria to identify conditions that may be appropriate for site-neutral payments between IRFs and SNFs. For the select conditions, the majority of cases are treated in SNFs and the risk profiles of patients treated in IRFs and SNFs are similar, yet Medicare's payments made to IRFs are considerably higher than those made to SNFs. To ensure that it proceeded cautiously, the Commission also examined differences in outcomes for patients treated in both settings. Because PAC providers do not collect uniform patient assessment information, it is difficult to compare outcomes. Key

measures (such as changes in patients' function) are not uniformly collected and cannot be adequately risk adjusted. However, neither CMS's PAC demonstration, which gathered comparable data, nor other research has found consistent differences in outcomes between the two settings. Where differences in outcomes have been detected, researchers concede that the comparisons cannot fully control for selection differences between the settings.

The Commission recommends that the Congress direct the Secretary to establish site-neutral payments between IRFs and SNFs for select conditions, using criteria such as those the Commission examined. For the selected conditions, the Commission recommends that the IRF base payment rate be set equal to the average SNF payment per discharge for each condition. The additional payments many IRFs receive for teaching programs and treating low-income patients and high-cost outliers are not changed by this policy. The policy should be implemented over three years to give IRFs time to adjust their cost structures and to give policymakers time to monitor the effects of the change on beneficiaries and providers. As part of the policy, IRFs should be relieved from the regulations governing the intensity and mix of services for the site-neutral conditions. CMS should use its rule-making process to first propose criteria to select conditions appropriate for a site-neutral payment policy and then to identify conditions that would be subject to the site-neutral policy. In this way, the Secretary can gather input from key stakeholders.

The Commission has also considered private sector strategies that FFS Medicare could pursue to direct beneficiaries to higher quality, more cost-effective providers. Although FFS Medicare is more limited in the tools it can use to manage care, certain options could be explored that shift use toward high-value providers while respecting beneficiaries' freedom of choice. ■

Trends in post-acute care

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries recovering from an acute hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). Among beneficiaries enrolled in fee-for-service (FFS) Medicare and discharged from an acute care hospital in 2013, 42 percent went on to post-acute care: 20 percent were discharged to a SNF, 17 percent were discharged to an HHA, 4 percent were discharged to an IRF, and 1 percent were discharged to an LTCH. Medicare is the dominant payer in all but the SNF setting; it is a minority payer in SNFs because most SNFs are predominantly nursing homes providing long-term care, which Medicare does not cover.

Medicare's outlays for PAC are substantial. In 2013, Medicare paid for 9.6 million PAC encounters (IRF and LTCH discharges, home health episodes, and SNF stays) to more than 29,000 PAC providers. Between 2001 and 2012, program payments to PAC providers doubled to \$59 billion. Yet despite this heavy investment, the need for PAC is not well defined, and Medicare gives providers considerable latitude in delineating which patients they admit among the patients referred to them by hospitals. Placement decisions often reflect a variety of nonclinical factors such as local practice patterns, the availability of PAC in a market, patient and family preferences, and financial arrangements between a PAC provider and the referring hospital (Buntin 2007). Reflecting this ambiguity, Medicare per capita spending on PAC varies more than any other covered service, which is only partly explained by the large differences in the availability of LTCHs and IRFs across markets. The Commission and others have noted that similar patients are treated in different settings with widely varying program payments, reflecting the separate systems Medicare uses to establish payments for each setting (Gage et al. 2011, Medicare Payment Advisory Commission 2014a).¹

Complicating the comparison of patients, outcomes, and costs of care across PAC settings is the lack of uniform assessment information about the patients treated in the various PAC settings. In 2014, the Commission recommended that PAC providers gather uniform assessment information from all four settings, which the Congress mandated in the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. These data

are critical to evaluating providers' selection practices, costs, and outcomes.

The most notable trend in the program's spending across PAC settings is the high and sustained level of Medicare margins (a measure that compares program payments with the costs to treat its beneficiaries) relative to other settings. For example, Medicare margins for HHAs and SNFs have been above 10 percent every year since 2001. Consistently high Medicare margins indicate that program payments are set too high relative to the costs of treating Medicare beneficiaries and are thus a poor use of taxpayer dollars. Another signal that payment rates are too high is the growth in the number of for-profit providers, especially among HHAs. Although the overall number of IRFs and SNFs has not increased, the share of for-profit providers in these industries has climbed.

Another trend in Medicare PAC is the wide variation in Medicare margins. Across all PAC settings, Medicare margins are higher in for-profit facilities compared with nonprofit facilities, and in freestanding providers compared with hospital-based providers. The disparity in margins reflects very different costs per unit of service. In general, larger, freestanding, for-profit facilities have lower unit costs (after controlling for differences in case mix and wages) than smaller, hospital-based, nonprofit facilities. Larger, freestanding providers may be able to achieve more economies of scale. In addition, for-profit entities may be more focused than their nonprofit counterparts on controlling costs so as to maximize returns to investors. In general, Medicare policy should not subsidize providers' inefficiencies except to ensure access (for example, in remote rural locations).

Across all settings, the margin trends are consistent with some providers maximizing revenues by taking advantage of payment system rules and shortcomings. These revenue approaches include strategically assessing patients to take advantage of the case-mix groups, providing additional (potentially unnecessary) therapy to increase revenues (in the case of SNFs and HHAs), and admitting patients who may not need the setting's intensity of care. Further, in HHAs and SNFs, the prospective payment system (PPS) designs result in payments for therapy services that are much higher than these services' costs. As a result, providers benefit financially when they furnish therapy services that may not be medically necessary. The Commission recommended revisions to the SNF and HHA payment systems that would redistribute payments across different types of cases and dampen the

incentives to select certain patients over others and to provide care for financial rather than clinical reasons. The Commission also recommended, and the Congress has partly implemented, revisions to the LTCH PPS to lower payments for patients who are not chronically critically ill.

Despite the large increase in program spending on PAC, quality has not consistently improved among the settings and the measures the Commission tracks. Improvements have generally been nominal or nonexistent. For example, across the measures the Commission tracks, SNF quality did not substantially improve for many years; more recent trends indicate improvements in some measures and no change in others. Similarly, in home health care, there have been improvements in functional change but no improvement in hospitalization rates. IRFs have achieved nominal improvements in quality, while observed LTCH measures have been stable or slightly improved. These lackluster results raise questions about the value of Medicare's purchases of PAC.

The Commission works to improve Medicare's payments for PAC in several ways. First, through its annual review of payment adequacy and its recommendations to revise the Medicare PPSs, the Commission seeks to establish an aggregate level of payments commensurate with the cost to efficiently treat beneficiaries, as well as a more equitable distribution of payments across types of cases, to help ensure access for beneficiaries. Second, to align incentives and improve care across settings, the Commission has recommended penalties to HHAs and SNFs with high readmission rates. These policies would align PAC providers' interests with those of hospitals and support the already growing interest in hospitals and accountable care organizations (ACOs) partnering with high-quality PAC providers. The Congress enacted a SNF readmission policy to begin in 2018.

While these revisions within individual PAC settings will increase the value of Medicare's purchases, the Commission's primary concern is that having separate payment systems for post-acute care does not facilitate rational pricing, encourage coordinated care, or establish a set of consistent incentives across providers. The patient populations in the four PAC settings overlap to some extent, and some PAC services are offered in more than one setting. Yet, because the payment systems differ, Medicare has different prices for similar patients based on the site of service. The Commission believes that Medicare needs a more uniform approach to payment for PAC and continues to make recommendations toward this goal. Uniform

patient assessment data are needed for Medicare to develop a common PAC payment system. The recently enacted IMPACT Act includes new requirements for uniform data collection beginning in 2018. After the Secretary of Health and Human Services has collected data for two years, she is required to submit a report to the Congress recommending a uniform payment system for PAC. The Act also requires the Commission to develop a prototype PPS to span the PAC setting using data CMS gathered during its PAC demonstration and to report to the Congress in July 2016. Given the timing of the data gathering and analysis, the implementation of a uniform payment system could be achieved in 2023 at the earliest. In the near term, carefully crafted site-neutral policies can begin the process of establishing one price for similar patients, regardless of the setting in which the care is provided.

Site-neutral payments for select conditions treated in inpatient rehabilitation facilities and skilled nursing facilities

The Commission's annual review of Medicare payment adequacy for FFS providers has two objectives: (1) to recommend an appropriate aggregate level of payments using the update and (2) to ensure that payments are equitable across providers and patients. As a prudent purchaser, the program should not pay more for care in one setting than in another if the care can be provided safely in a lower cost setting. Rather than base its payments on the setting in which a beneficiary is treated, Medicare should base its payments on the resources needed to treat patients in the most efficient setting, adjusting for patient severity differences that could affect providers' costs. Even as Medicare moves toward integrated payment and delivery systems, the FFS payments underlying these reforms should reflect the most cost-effective site of care.

Price differentials based on site of service create distortions in provider incentives. For example, previous Commission analyses found that when hospital outpatient department payments are not aligned with rates paid for the same services in a physician's office, hospitals have an incentive to acquire physician practices and bill for these services at the higher hospital outpatient rate, increasing program spending and out-of-pocket costs for beneficiaries. Thus, the Commission has recommended a reduction or elimination of price differences for office

visits and selected ambulatory services provided in physicians' offices and hospital outpatient departments. The Commission also has recommended that payments to long-term care hospitals for non-chronically critically ill patients should be equal to those for comparable patients in acute care hospitals (Medicare Payment Advisory Commission 2014b, Medicare Payment Advisory Commission 2012).

In June 2014, the Commission reported on its analysis of payment differences for select services provided by SNFs and IRFs (Medicare Payment Advisory Commission 2014a). While both settings furnish rehabilitation services to beneficiaries after a hospitalization, there are several important differences in the way Medicare pays for SNF and IRF services (see online Appendix 7-A, available at <http://www.medpac.gov>). Medicare pays for patients admitted to SNFs on a per day basis, but pays on a per discharge basis for patients admitted to IRFs.² Many IRFs receive separate payments for teaching, disproportionate share, or outliers, whereas SNFs do not. In addition, IRFs must meet a threshold compliance regarding the facility's mix of cases; SNFs do not have this requirement. In addition, each setting has different services and requirements (see online Appendix 7-A, available at <http://www.medpac.gov>). IRFs are licensed as hospitals and have more extensive requirements regarding the amount of therapy and the frequency and level of medical supervision their patients receive. IRF patients must be able to tolerate and are expected to benefit from an intensive therapy program (often interpreted as requiring three hours of therapy a day). IRF requirements may cut in opposite ways for patient referrals. On the one hand, patients who require additional nursing or physician care may be more likely to go to IRFs; on the other hand, patients must be able to tolerate intensive therapy.

The Commission found that for selected conditions, IRFs and SNFs care for patients with similar risk profiles, despite differences in the mix of services provided and Medicare's facility requirements. Often, SNFs care for more severely ill patients, most likely because of the intensive therapy requirement for IRF patients. Our research and analysis did not consistently find differences in patient outcomes. Yet, Medicare's spending for beneficiaries who used IRFs was more than 60 percent higher than for comparable patients who used SNFs during the initial PAC stay, and IRF patients continued to have higher spending during the 30 days after discharge from facilities. Since SNF and IRF patients are often similar but do not uniformly have different outcomes, it

is not clear what Medicare is purchasing with its higher IRF payments. In some cases, the disparity in Medicare's payments for patients treated in IRFs and SNFs could influence providers' decisions about settings of care and may result in excessive program spending.

Identifying conditions for site-neutral payments

To identify possible conditions and services for site-neutral policies, the Commission used a consistent set of criteria previously described (Medicare Payment Advisory Commission 2014a). We examined conditions for which the majority of patients were treated in SNFs in markets (defined as hospital service areas) with both types of providers.³ In addition, we compared the risk profiles of patients treated in both settings to assess whether SNFs treat the same complexity as patients referred to IRFs. To err on the side of caution, we also examined differences in outcomes. Ideally, we would compare risk-adjusted outcomes, but the Commission recognizes that this information is often not available.

In the Commission's June 2014 Report to the Congress, we examined three high-volume conditions: major joint replacement, hip and femur procedures, and stroke (Medicare Payment Advisory Commission 2014a). The majority of beneficiaries recovering from the orthopedic conditions were treated in SNFs. These patients were similar to orthopedic patients in IRFs in terms of their average risk scores, age, comorbidities, functional status at admission, predicted cost for therapy and nontherapy ancillary services, and eligibility for Medicaid as well as Medicare.

The Commission's analysis of stroke as a potential condition for site-neutral payment was inconclusive. Stroke severity can vary widely, and patients with stroke may suffer from a wide range of comorbidities. We found that, although similar or larger shares of patients treated in SNFs had comorbidities, IRFs treat the majority of stroke patients. Therefore, at this time, the Commission did not include stroke in a site-neutral policy (see online Appendix 7-A, available at <http://www.medpac.gov>, for a discussion of the stroke results), although it is possible that a subset of stroke cases could be considered in the future.

In our consideration of the two orthopedic conditions for a site-neutral policy, we also compared outcomes for patients treated in the two settings. The differences were mixed, in large part because not all the measures were risk adjusted. CMS's PAC demonstration found that

risk-adjusted rates of readmission and changes in patient mobility were comparable, and while IRFs had larger improvements in patients' self-care across all types of cases, their gains were comparable with patients treated in SNFs for musculoskeletal conditions. Spending during the 30 days after discharge from an IRF was higher than the spending after discharge from a SNF. Unadjusted mortality rates were lower for IRFs, but differences would narrow with risk adjustment. The Commission concluded that the two orthopedic conditions (represented by five Medicare severity–diagnosis related groups (MS–DRGs)) would be a good starting point for site-neutral payments.

To identify additional conditions for consideration, we examined conditions frequently treated in IRFs but for which the majority of patients are treated in SNFs (Table 7-A1 in online Appendix 7-A, available at <http://www.medpac.gov>).⁴ Seventeen conditions met the criterion of having the majority of cases treated in SNFs; the MS–DRGs comprised other orthopedic, pulmonary, cardiac, and infection conditions. They make up about 17 percent of IRF cases and spending. When the 17 conditions are combined with the 5 orthopedic conditions we previously reported on in June 2014, the share of spending and cases increases to 30 percent of total IRF spending and cases.

There are large payment differences for the patients treated in IRFs and SNFs for the conditions we examined. On a per stay basis, total Medicare payments in 2012 (including the add-on payments made to many IRFs) averaged 64 percent higher for patients treated in IRFs compared with those treated in SNFs.⁵ Excluding these add-on payments, IRF payments were 49 percent higher than those made to SNFs (Table 7-A2 in online Appendix 7-A, available at <http://www.medpac.gov>).

Similarity of patients treated in IRFs and SNFs

To assess the similarity of risk profiles of patients treated in IRFs and SNFs, we compared their demographics and comorbidities. In markets with both IRFs and SNFs, patients treated in SNFs were older and more likely to be female or dually eligible for Medicare and Medicaid compared with patients treated in IRFs (Table 7-A3 in online Appendix 7-A, available at <http://www.medpac.gov>). In 2012, either the patients treated in IRFs and SNFs had similar Medicare risk scores (the hierarchical condition categories, or HCCs) or the patients treated in SNFs had higher scores (Table 7-A4 in online Appendix 7-A, available at <http://www.medpac.gov>). The most common comorbidities either were more frequent in SNFs or were similar between the two settings (Table 7-A5 in online

Appendix 7-A, available at <http://www.medpac.gov>). Across the conditions, SNFs typically treated the majority of the most severely ill patients, as measured by the severity of illness at discharge from the hospital using all-patient refined–severity of illness levels (Table 7-A6 in online Appendix 7-A, available at <http://www.medpac.gov>). We also compared the severity of illness of patients treated in SNFs in markets with and without IRFs and found them to be similar, suggesting that, for the select conditions, SNFs treat comparable severity mixes of patients, regardless of whether there is an IRF in the market. Finally, CMS's PAC demonstration found considerable overlap in the functional status at admission between patients admitted to SNFs and IRFs (the patients in their analysis spanned all conditions, not just the 17 studied here). We conclude that for the selected conditions, SNFs can treat patients who are discharged to IRFs, and in markets without IRFs, they do.

Outcomes for patients treated in IRFs and SNFs

It is difficult to compare outcomes for patients treated in different settings because of the lack of comparable assessment information about patients' function and cognitive abilities at admission and at the end of treatment. This type of analysis is exactly the reason the Commission recommended the collection of uniform information across PAC settings, which the Congress mandated in 2014. Even with comparable data, there is no way to fully control for the selection of certain types of patients by providers, which is reinforced by program requirements. We fully expect to see differences in outcomes between IRFs and SNFs because IRFs tend to treat healthier patients who must be able to tolerate intensive therapy.

But to proceed cautiously, we compared four outcomes for SNFs and IRFs—hospital readmission rates, changes in functional status, mortality rates, and total Medicare spending during the 30 days after discharge from the qualifying stay—and examined the literature comparing outcomes across the two settings (see text box on outcomes, pp. 168–169). The comparisons yielded mixed results, in part because some of the measures were not risk adjusted. Ideally, all measures would be risk adjusted, but the data needed for risk adjustment were not always available, and even when they were, we could not fully control for differences in patient mix because of selection.

Observed differences in readmission rates for IRF and SNF patients were effectively eliminated with risk adjustment. The PAC demonstration conducted by CMS gathered comparable patient assessment information for beneficiaries treated in participating SNFs and IRFs and enabled careful,

cross-setting study of the patients and their outcomes. The evaluation found that risk-adjusted readmission rates and changes in patients' mobility were comparable between the two settings across all patients and for the four subgroups of patients examined (nervous system, respiratory, circulatory, and musculoskeletal) (Gage et al. 2011). Changes in self-care were larger for patients treated in IRFs compared with patients treated in SNFs, although there was no difference between the settings for the musculoskeletal patients. An IRF-industry sponsored study of 13 groups of conditions found that differences in readmission rates varied by condition group (DaVanzo et al. 2014).

Some researchers have focused on comparing mortality rates of patients treated in both settings. We examined mortality rates without risk adjustment during the SNF and IRF stays and during the 30 days after discharge and found that both were higher for patients treated in SNFs compared with patients treated in IRFs. The difference in rates partly reflects differences in the patient populations: SNF patients were older and often had more comorbidities. It is likely the differences would be much smaller after risk adjustment, but we would expect some differences to remain. Each setting's mortality rates reflect inherent differences in the patient population. Because IRF patients must be able to tolerate and benefit from intensive therapy, we would expect their mortality rates to be very low. Furthermore, because post-acute services are restorative, not curative, it is not the best measure of outcomes for these settings. The IRF industry-sponsored study found that compared with IRFs, SNFs had higher mortality rates during the two years after discharge (DaVanzo et al. 2014). Given the differences between the populations, we would expect patients treated in SNFs to be more likely to die within the next two years compared with patients treated in IRFs.

Finally, we examined Medicare spending during the 30 days after discharge from IRFs and SNFs. We found that program spending was 7 percent higher for beneficiaries discharged from IRFs than for beneficiaries discharged from SNFs. Although IRF patients had considerably lower costs for readmission, they had much higher subsequent PAC spending, perhaps because patients continued to need rehabilitation (see Table 7-A7 in online Appendix 7-A, available at <http://www.medpac.gov>).

Establishing a site-neutral policy for IRFs and SNFs

Ideally, Medicare would pay for PAC using a single payment system that based payments on patient

characteristics, not the site of service. Such fundamental payment reforms within FFS Medicare are on the distant horizon. As required by the IMPACT Act of 2014, the Commission is developing a prototype prospective payment system to span the PAC settings using the uniform assessment data gathered as part of CMS's PAC payment demonstration. The law also requires PAC providers to submit patient assessment data using a uniform assessment tool beginning in 2018 and requires the Secretary of Health and Human Services to recommend a uniform payment system for PAC based on two years of uniform patient assessment data. Thus, a new PAC payment system is unlikely to be in place until 2023 at the earliest.

However, the Commission believes that Medicare should not delay reforms that encourage cost-effective care. Even as Medicare moves toward integrated payment and delivery systems, Medicare can and should move in the direction of uniform payments by establishing a site-neutral policy for IRFs and SNFs to align payments across the two settings for select conditions. For each condition selected, the Commission's site-neutral policy would set the IRF base payment at the average rate paid to SNFs for patients with that condition.⁶ Specifically, CMS would replace the IRF base rate with the average payment per discharge for the same case type for a SNF in the same geographic location. The policy would not change the additional payments many IRFs receive for teaching programs and treating low-income patients and high-cost outliers. At the same time, for patients with conditions paid under the site-neutral policy, IRFs would be relieved of certain regulatory requirements that govern patient care, such as the requirement for intensive therapy, the frequency of physician visits, and the physician-conducted preadmission screening and the postadmission evaluation.⁷ Waiving these requirements would lower IRFs' costs of treating patients with site-neutral conditions. (Regulatory requirements for IRFs would remain the same for conditions not affected by the site-neutral policy.) To identify candidate conditions for a site-neutral policy between IRFs and SNFs, Medicare should establish a set of criteria that considers how frequently the condition is treated in SNFs and the similarity of the risk profile. Outcomes should also be compared to ensure that they do not substantially differ between the two settings.

For conditions not affected by the site-neutral policy, CMS should refine and recalibrate the IRF case-mix groups (CMGs), establish new average standardized costs for the non-site-neutral cases, and recalibrate the weights associated with each CMG. The selection of

Comparing outcomes of rehabilitation care in skilled nursing facilities and inpatient rehabilitation facilities

Researchers and policymakers have frequently sought to compare outcomes for patients treated in different post-acute care settings. Such comparisons are generally compromised by a lack of comparable assessment information about patients' function and cognitive abilities at admission and at the end of treatment. Even with comparable data, there is no way to fully control for the patient selection by providers—selection that is reinforced by program requirements such as the requirement that patients admitted to inpatient rehabilitation facilities (IRFs) be able to tolerate and benefit from intensive therapy.

Studies of costs and outcomes of patients treated in skilled nursing facilities (SNFs) compared with IRFs have largely focused on patients needing rehabilitation following a stroke, hip fracture, or joint replacement. Overall, research studies do not conclusively identify a particular post-acute care setting as having better outcomes for rehabilitation patients. Studies of patients after joint replacement and hip fracture do not have consistent conclusions (Buntin et al. 2010, Dejong et al. 2009a, DeJong et al. 2009b, Deutsch et al. 2006, Deutsch et al. 2005, Herbold et al. 2011, Mallinson et al. 2014, Mallinson et al. 2011, Munin et al. 2005, Walsh and Herbold 2006). Studies of stroke patients found that patients in IRFs had better outcomes than those in SNFs, though selection bias could have contributed to these findings (Buntin et al. 2010, Deutsch et al. 2006).

A 2010 CMS report to the Congress analyzed peer-reviewed research on the effectiveness of IRFs compared with other post-acute care settings and concluded that many studies are limited because they do not adequately control for selection bias (Gage et al. 2010). The report also found inconsistent results across studies comparing outcomes for lower extremity joint replacement patients and hip fracture patients in IRFs and SNFs. The report was unable to conclude definitively whether shifts in discharge destination due to the IRF compliance threshold have affected beneficiaries' access to appropriate rehabilitation services. The ambiguous results of these studies may also suggest that reasonable treatment approaches may differ across beneficiaries. Some patients may be more appropriate for longer stays in less intensive settings while others benefit from shorter, more intensive therapy (Stineman and Chan 2009).

Standardized data from the Continuity Assessment Record and Evaluation (CARE) tool—a uniform post-acute care assessment tool tested through the Medicare Post-Acute Care Payment Reform Demonstration (PAC-PRD)—can help CMS compare outcomes for rehabilitation care across settings. The demonstration used the CARE tool to compare outcomes across sites of care, including readmission to the hospital and improvements on two functional measures, mobility and self-care function. The 2011 report summarizing the findings compared outcomes among IRFs, SNFs, home health agencies, and long-term care hospitals

(continued next page)

the final conditions for a site-neutral policy may remove certain CMGs entirely from the IRF PPS or remove select conditions within a CMG. Because the waiving of certain regulations for treating the site-neutral conditions may lower the costs of the site-neutral cases, the cost of cases remaining under the IRF PPS could increase relative to the average cost, even if actual cost is unchanged. Thus, without recalibration, payments for cases remaining under the IRF PPS could increase simply as a result of the site-neutral policy. Recalculating the relative weights for the cases remaining under the IRF PPS is a way to retain

budget neutrality for these cases; aggregate IRF payments for them would be held to the same aggregate payments these cases receive currently. Such recalibration is typically undertaken by CMS when new case-mix systems are implemented.

A set of relative weights would be estimated using all cases to retain add-on payments at current levels for all cases. IRF PPS add-on payments for teaching program status and share of low-income patients would be calculated by multiplying the applicable IRF teaching and low-income percentages by the wage- and case-

Comparing outcomes of rehabilitation care in skilled nursing facilities and inpatient rehabilitation facilities (cont.)

(Gage et al. 2011). Risk-adjusted readmission rates that controlled for differences in patient acuity did not differ significantly between IRFs and SNFs.

On functional outcomes, the risk-adjusted analysis of data from the PAC–PRD found no significant difference in the average degree of improvement in mobility, but did find a somewhat higher gain in self-care outcomes among patients who received care from IRFs compared with patients treated in SNFs (Gage et al. 2011). But differences in outcomes varied by clinical condition. The demonstration study examined improvement in self-care for the subgroups of patients with musculoskeletal and nervous system conditions, two conditions for which beneficiaries typically receive significant amounts of therapy. For nervous system conditions, the average risk-adjusted gain in self-care improvement was higher in IRFs than in SNFs. In contrast, for musculoskeletal conditions, there was no significant difference in the risk-adjusted degree of improvement between IRF and SNF patients. Where results varied, the difference in improvement among settings was relatively small, less than 5 points on a 100-point scale.

Although the PAC–PRD was able to control for differences in patients to a degree unparalleled by most other research, the study did not randomly assign patients to post-acute care settings, so unobserved factors regarding patient characteristics may have remained and influenced outcomes. For example, the more intensive therapy requirements in IRFs may have resulted in IRFs attracting patients who were more engaged or more motivated to improve. Likewise, factors such as informal

caregiver support that were not included in the model could have influenced both the likelihood of referral to different post-acute care providers and patient outcomes.

There is very little literature comparing outcomes across many conditions. An industry-sponsored study compared several outcomes of patients treated in IRFs and SNFs and found differences across conditions (DaVanzo et al. 2014). To risk adjust the comparisons of the outcomes, the study matched various characteristics of the IRF patients to the patients treated in SNFs, though measures of function were not among the adjusters. Of the various groupings of conditions the study examined, six overlapped with those considered by the Commission. Hospital readmission rates were not consistently better for patients treated in IRFs: They were lower for two condition groups, higher for one, and no different for three condition groups. Four measures—mortality rates, average days alive (a corollary of mortality rate), days residing at home, and program spending—examined outcomes over two years. Given the differences in ages and comorbidities between patients treated in IRFs and SNFs, the study unsurprisingly found that IRFs had lower mortality rates and more days alive, while there were no differences in the number of days patients resided at home between the two settings for patients with hip or knee replacement or other orthopedic condition groups. Emergency room visits per 1,000 patients were no different between the 2 settings for 5 of the 6 conditions, and IRFs had fewer ER visits than SNFs for 1 condition. The spending over two years was higher for patients treated in IRFs for four condition groups and no different for two. ■

mix-adjusted IRF rate. For site-neutral cases with extraordinarily high costs, an outlier payment would be calculated using the IRF PPS fixed loss amount.

Revising the IRF compliance requirements

The implementation of site-neutral payment for IRFs and SNFs would necessitate changes to the IRF compliance rule. The intent of this rule is to distinguish IRFs from acute care hospitals (not from SNFs). Currently, to qualify as an IRF for Medicare payment, facilities must meet a compliance threshold (the “60 percent rule”)

requiring that a certain proportion of all patients have 1 of 13 conditions specified by CMS as typically requiring intensive rehabilitation. An IRF’s compliance rate is calculated by dividing the total number of compliant conditions (the numerator) by the total number of cases (the denominator). Some of the conditions that meet the Commission’s criteria for site-neutral payment—such as hip fracture and amputations—are among CMS’s list of compliant conditions. If patients with these conditions can be treated appropriately in SNFs, they likely do not require the intensity of the IRF setting. Thus, conditions that are

appropriate for site-neutral payment should not count toward the 60 percent rule. Furthermore, the Commission has commented before that more refined criteria are needed to identify patients appropriate for IRFs (Medicare Payment Advisory Commission 2013). The criteria have already narrowed the hip and knee replacement cases and arthritis conditions that count toward the 60 percent rule. Likely there are subsets of other conditions that are appropriate for IRF care and should count toward IRF compliance; conversely, others are not appropriate for IRF care and should not count. The Commission believes that detailed criteria should be developed for all 13 conditions under the 60 percent rule.

The site-neutral policy is not intended to make it more difficult for IRFs to maintain compliance, but this unintended consequence could result if the current threshold policy were not refined. Under a site-neutral policy, the fairer way to calculate the compliance rate would be to remove the site-neutral cases from the numerator and denominator; however, mathematically, this change would lower a facility's compliance rate. Thus, reducing the conditions that count toward the compliance threshold could necessitate a reduction in the threshold itself. For example, nine of the conditions we identified as candidates for a site-neutral policy are among the specified conditions counting toward the 60 percent compliance threshold. If these conditions were selected for site-neutral payment, CMS would calculate each IRF's compliance threshold by subtracting the number of IRF cases with the nine conditions from both the numerator and the denominator. Removing these cases from the calculation would lower the share of cases meeting the compliance threshold; policymakers therefore might consider lowering the compliance threshold correspondingly. Any change to the compliance threshold should be empirically based, with consideration of the set of conditions selected for site-neutral payments and whether those conditions currently count toward threshold compliance. Consistent with current practice, IRFs are likely to continue to treat cases that do not count toward compliance, keeping the share of noncompliant cases below the threshold so they retain their status to be paid as an IRF for conditions unaffected by the site-neutral policy. For facilities treating a large share of site-neutral cases, CMS would need to consider whether they continued to meet the IRF conditions of participation.

Likely effects of a site-neutral policy on program spending

We assessed the impact of a site-neutral policy on payments for the 17 conditions the Commission

considered candidates for the policy in addition to the orthopedic conditions (5 MS-DRGs) previously identified. A site-neutral policy would lower total program spending (including the add-on payments) for the 22 conditions by 7 percent.⁸ The impact on total payments is tempered by two factors. First, the conditions represent a minority of IRF cases. Second, the policy assumes site-neutral payments would not change the add-on payments many IRFs receive for the site-neutral conditions. In 2012, the estimated reductions to aggregate IRF base payments would have totaled \$497 million: \$309 million for the 17 additional conditions and \$188 million for the 5 orthopedic conditions. If a different set of conditions were selected for site-neutral policy, the impact would be different.

Like many major changes to payment policy, the site-neutral policy should be phased in over multiple years. This time frame would give IRFs time to adjust their cost structures and admitting practices and would give policymakers time to evaluate the initial effects of the policy. The Commission considered a period of three years for fully transitioning payments for site-neutral conditions, a time period used in other policies. During the transition, payments for site-neutral conditions could be a blend of IRF and SNF payments, such as a 75 percent IRF/25 percent SNF blend in the first year, a 50/50 blend in the second year, and a 25/75 blend in the third year, with site-neutral payments fully implemented in the fourth year.

The effects on spending assume the current SNF PPS. The Commission has recommended that the SNF PPS be revised so that payments are based on patient characteristics, not the amount of therapy provided. Under the proposed design, payments would be higher for patients whose clinical and functional characteristics increase their need for services. The proposed redesign is assumed to be budget neutral, so that aggregate SNF payments would be the same as under current policy. Our prior work found that the site-neutral effects on IRFs would not be substantially different under a revised SNF PPS (Medicare Payment Advisory Commission 2014a). Differences in effects between current SNF policy and the proposed redesign would depend on the final selection of conditions for the site-neutral policy.

Likely effects of site-neutral payments on IRF patient mix and volume

We cannot estimate how IRF costs, patient mix, and volume would change in response to a site-neutral policy.

With greater regulatory flexibility to adjust their service intensities, IRFs are likely to continue to treat site-neutral conditions, especially given their relatively low occupancy rates (the average is 63 percent) and the high profit margins possible under the SNF PPS. Because some regulations would be waived for site-neutral conditions, IRFs could adjust their cost structures by varying the number of physician face-to-face visits each week and providing fewer hours of therapy each day, as IRF clinicians deem necessary. Such changes would reduce IRF costs for treating site-neutral conditions, thereby leveling the playing field between IRFs and SNFs.

Still, facilities would likely vary in how quickly they could adjust their variable costs. Larger facilities have more options for adjusting those costs (for example, by adjusting the staffing for an entire nursing unit). However, many small IRFs are hospital based, so their affiliation with acute care hospitals affords them opportunities to adjust their cost structures. The Commission's analysis indicates that a large share of acute care hospitals' costs is variable.

Despite lower payments, site-neutral cases could still be profitable for some IRFs or could cover a facility's patient care costs and contribute toward covering a facility's fixed costs (and would be preferable to an empty bed). Hospital-based IRFs could continue to boost total hospital margins (they add about a percentage point to the overall hospital margin). Under the current IRF PPS, hospital-based facilities have break-even Medicare margins, but their contribution margin (a measure of whether Medicare payments cover direct patient care costs) is a healthy 35 percent. Once IRFs have adjusted their cost structures, they—like SNFs—may find that Medicare's SNF payments are highly profitable while achieving comparable outcomes. And because some hospital-based IRFs are low cost (in 2013, 40 percent of the facilities in the lowest cost quartile were hospital based), we believe hospital-based IRFs can manage their costs to remain profitable. Still, as IRFs change the mix of services, therapy intensity, and lengths of stays for cases paid under a site-neutral policy, it will be important to monitor outcomes and the quality of care furnished to these patients.

It is possible that some IRFs would opt to no longer treat patients with site-neutral conditions. After CMS began enforcing the compliance threshold in 2004, IRFs significantly shifted their mix of patients, admitting more cases that counted toward the compliance threshold. It is

possible that some IRFs would again adjust their mix of cases to preferentially admit those paid under the IRF PPS, with site-neutral cases shifting to SNFs. However, industry reaction to site-neutral payment would likely differ across facilities because, with the waiving of requirements, facilities could change their cost structures and service mix to accommodate the change in payment.

An IRF's ability to shift its patient mix toward cases not affected by a site-neutral policy would depend in part on characteristics of the market in which it is located. IRFs located in markets without competitors might find it easier to shift their mix of patients toward those cases that the average SNF is not staffed or equipped to manage, such as patients receiving rehabilitation care for burns or traumatic brain injury. IRFs that compete with other IRFs or specialized SNFs to treat IRF-compliant cases might be limited in the extent to which they can shift their focus toward non-site-neutral cases.

The Commission's analysis indicates that, if some portion of site-neutral cases shifted to SNFs, the SNF industry would have the capacity to treat these cases. In 2012, although the average SNF occupancy rate was high (82 percent), the additional volume associated with movement of site-neutral conditions from IRFs to SNFs would be small relative to total SNF volume. Furthermore, one-quarter of SNFs had occupancy rates at or below 76 percent, indicating capacity to treat additional cases. Average occupancy rates also varied by market (defined as hospital service areas). One-quarter of markets had an average occupancy rate at or below 76 percent and one-quarter had an average occupancy rate at or above 91 percent. In markets with very high SNF occupancy rates, accessing a SNF bed could become more difficult, depending on the extent to which IRFs shifted their case mix.

The method used by the Secretary to identify site-neutral cases could encourage IRFs to change their coding of cases to shift cases out of site-neutral conditions to case-mix categories not affected by the policy, thereby retaining IRF PPS-based payments. For example, if IRF case-mix groups were used, IRFs could shift their coding to avoid those groups. Instead, the use of the hospital MS-DRG system to identify cases would minimize such coding changes. Further, using MS-DRGs as at least part of the method to identify cases for site-neutral payments will allow IRFs and auditors to clearly identify cases as eligible for site-neutral payment before admission. Finally, the MS-DRG system would provide a consistent way to

categorize patients treated in IRFs and SNFs since the SNF and IRF payment systems use different case-mix groups. Critics of this approach posit that MS–DRGs are too broadly defined to identify site-neutral conditions. MS–DRGs could be supplemented with specific diagnoses coded by the hospital or other patient characteristics not subject to manipulation by IRFs, which would mitigate any disadvantages of using MS–DRGs while avoiding the incentives for IRFs to code cases specifically to avoid site-neutral payments.

Hospitals that have affiliations with IRFs may have a greater incentive to code inpatient cases more favorably (avoiding site-neutral conditions), so CMS and the Commission would need to closely monitor their coding practices. For example, certain respiratory conditions lend themselves to alternative coding that could avoid the site-neutral policy. Entities that operate both IRFs and SNFs, including hospitals (185 of the approximately 900 hospitals with IRFs also have SNFs) may have an advantage over other providers to direct cases to one setting or another to maximize total facility revenue.

Likely effects of site-neutral payments on beneficiaries

The effects on beneficiaries would depend on how IRFs responded to the site-neutral policies, but we expect the impact would be small. Clinicians, in consultation with patients and their families, would continue to be the decision makers about where patients received rehabilitation care after discharge from the hospital. The site-neutral policy is not intended to preempt the clinician’s prerogative to select the best and most appropriate setting for beneficiaries. Further, the site-neutral policy does not change the program’s benefits for beneficiaries. It simply pays providers a different rate for select conditions. Beneficiaries could still be admitted to IRFs, and IRF days would not count toward the 100-day limit of SNF care following a 3-day hospital stay.

Many IRFs are likely to continue to treat these conditions, so the impact on beneficiaries would be minimal. Access to care would remain at current levels. Beneficiary financial liability would not change since most beneficiaries meet the inpatient deductible during their preceding acute hospital stay. The comparability of most outcomes for patients treated in SNFs and IRFs indicate that even if IRFs changed the services they provide, patient outcomes would not necessarily be affected. Moreover, optimal treatments are likely to differ across patients,

with some patients benefiting from longer, less therapy-intensive stays and others benefiting from shorter, more intensive stays.

Under a site-neutral payment policy, the cost-sharing liability of beneficiaries who were shifted to SNFs would remain the same if they stayed less than 21 days. For the conditions considered for site-neutral payment, the vast majority (94 percent) of IRF users had stays of 20 days or less. Patients who were shifted to SNFs and stayed 21 or more days would have higher financial liability than they do currently. However, because most beneficiaries have supplemental coverage and the most common policies cover SNF payments, beneficiary liability for most will not change. Some beneficiaries could opt to go home rather than be admitted to SNFs. For them, cost sharing would depend on whether they opted to receive home health care (with no cost sharing) or outpatient therapy services (with 20 percent copayments).⁹

Given the similarity in readmission rates and functional outcomes between IRFs and SNFs, we expect that patient outcomes would not be affected by the implementation of a site-neutral policy. However, monitoring both access to and quality of care for site-neutral conditions in both settings would be important. This monitoring, which the Commission plans to conduct, will focus on detecting inappropriate provider responses, such as impairing access to care for beneficiaries and furnishing poorer quality of care resulting in worse outcomes. The analysis will consider access to services in markets with high SNF occupancy rates and the potential changes in coding to avoid site-neutral payments.

Recommendation on site-neutral payments for IRFs and SNFs for select conditions

The Commission’s recommendation extends site-neutral payment policies to PAC, starting with select conditions treated in IRFs and SNFs. Because the policy would require some changes to the IRF PPS that are set in statute, our recommendation is directed to the Congress. The Secretary should use a set of criteria such as those considered by the Commission to identify appropriate conditions for site-neutral payment. For the selected conditions, the Commission’s recommendation would set the IRF base rate at the average payment per discharge made to SNFs. By aligning payments between the two settings, Medicare would move away from paying for services based on the setting in which they are provided and toward a common payment for comparable patients.

RECOMMENDATION 7

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

RATIONALE 7

To identify conditions appropriate for site-neutral payments, the Secretary should establish a set of criteria to identify conditions for the site-neutral policy. For its own criteria, the Commission considered whether the majority of patients were treated in SNFs (thus ensuring that the setting is safe for the treatment of the condition) and whether the patients treated in IRFs and SNFs had similar risk profiles. The Commission also evaluated the research on outcomes for the select conditions to be certain that IRFs did not consistently have higher quality. There is little evidence that IRFs consistently have better outcomes than SNFs. The Secretary should publish the criteria applied and data analyses conducted to identify proposed conditions and should use a notice-and-comment period to gather information in making its final selections. This process will help ensure that the Secretary proceeds cautiously in selecting criteria and conditions for the site-neutral policy. The Commission offers its criteria and analyses of 22 orthopedic, pulmonary, cardiac, and infection conditions to inform the Secretary's process.

For the conditions selected by the Secretary, the base payments to IRFs should be set at the average payment per discharge paid to SNFs for the select set of conditions. The Secretary should replace the IRF base rate with the average payment per discharge for a SNF in the same geographic location for the same case type. The additional payments many IRFs receive for teaching programs and treating low-income patients and high-cost outliers should not change.

As part of a site-neutral policy, the Secretary should relieve IRFs of the regulatory requirements related to the intensity and mix of services furnished to beneficiaries with the select conditions. Requirements for consideration include providing daily intensive therapy, the weekly face-to-face physician visits, and the physician-conducted preadmission and postadmission evaluation. Waiving these

requirements would be expected to lower IRFs' costs. A three-year transition would give IRFs time to adjust their cost structures and provide policymakers time to monitor the initial effects of the policy.

IMPLICATIONS 7

Spending

- The site-neutral policy would lower IRF base rates to the average payment per stay made to SNFs in the same geographic location for the same condition. Add-on payments IRFs receive (for having a teaching program or treating low-income patients or high-cost outlier cases) are not changed by this policy. Over five years, the site-neutral policy would lower program spending relative to current policy by between \$1 billion and \$5 billion. This estimate is consistent with the Commission's estimate of the reductions in payments for a fully implemented policy.

Beneficiary and provider

- The policy lowers payments to IRFs for site-neutral conditions, but the Commission believes many IRFs will continue to treat these cases. IRFs are likely to adjust their cost structures in response to the regulatory relief and continue to admit patients with site-neutral conditions. To the extent that IRFs elect not to treat these patients, some SNFs could experience a commensurate increase in volume.
- We do not anticipate that a site-neutral policy would negatively affect beneficiaries. We expect many IRFs will continue to treat patients with these conditions and, for these beneficiaries, the effects will be minimal. The site-neutral policy will not change the SNF benefit, and the IRF days paid at site-neutral rates will not count toward the 100-day SNF benefit. Some beneficiaries' care may be shifted to SNFs but—because we do not see significant differences between the two settings in terms of readmission rates and mortality—much of their care is expected to be comparable. Cost-sharing liability is not expected to increase for the vast majority of beneficiaries, though it could increase for the small number of beneficiaries who are shifted to SNFs and whose stays exceed 20 days. However, most beneficiaries have supplemental coverage and the most common policies cover the SNF copayments, so the actual cost sharing for most beneficiaries would remain unchanged.

Private sector ideas for managing post-acute care

The Commission examined strategies used by private sector entities to explore additional ways to more effectively manage PAC. A contractor and Commission staff interviewed PAC benefit management vendors, PAC providers participating in CMS's PAC Bundled Payment for Care Improvement Initiative, and officials at health systems with Medicare Advantage (MA) plans or ACOs.

FFS and MA plans differ in the approaches they take

The approaches used by FFS entities (for example, ACOs, providers, and integrated health systems that are paid FFS) and MA plans to manage PAC differ considerably. FFS entities typically guide patient decisions about the choice of PAC setting and provider, whereas MA plans typically establish rules about PAC use. In part, this difference reflects the differences in Medicare rules governing each. MA plans can establish networks of providers in which services are covered and use prior authorization and recertification to direct where enrollees go and how much care they receive, with an appeals process tempering this control somewhat. In contrast, even FFS entities at financial risk (ACOs and entities participating in CMS's bundling initiatives) must allow beneficiaries the freedom to select the provider of their choice and cannot use tiered provider payments, beneficiary copayments, or prior authorization to influence service use. FFS providers must rely on "softer" approaches that guide decisions made by clinicians and patients toward using lower cost, higher quality providers.

Strategies to manage post-acute care under FFS Medicare

Discussions with private sector entities identified two strategies that FFS Medicare could pursue to better manage PAC. First, some ACOs have established partnerships with selected PAC providers. Under this arrangement, ACOs select PAC partners by reviewing the cost and quality metrics for each provider and its geographic coverage. Hospital discharge planning teams then choose from the selected pool of PAC providers when referring patients. Although preferred networks may narrow beneficiary choice, they create a preferred set of higher quality PAC providers that could improve care for beneficiaries without impairing access to care. The process is intended to guide, but not dictate, decision making; beneficiaries retain their choice about where to go. To the

extent that these practices prove successful in referring beneficiaries to appropriate sites of care and lowering readmissions, broader adoption of these practices within FFS has the potential to improve care for beneficiaries and lower costs for the program.

Some FFS provider organizations have concerns about the information on preferred providers they are allowed to present without violating beneficiary freedom of choice rules. In general, "soft steering" is achieved by describing the relative merits of using a preferred provider: higher quality of care, more integrated medical staffs, and better coordinated care. If preferred networks are allowed, CMS should clarify what is and is not allowed in guiding decision making.

Future efforts could permit tighter linkages between ACOs and preferred networks. Because some ACOs are at financial risk for the cost of care, CMS could consider allowing those ACOs to establish formal networks to direct beneficiaries to high-value providers. Likewise, CMS could consider allowing hospitals to partner with high-value PAC providers, though many issues would need to be resolved to ensure hospitals acted responsibly. CMS would need to establish criteria for defining "preferred" status, such as network adequacy, quality and cost measures, and capabilities for managing special care (such as tracheostomy and ventilator care). An idea to explore is whether hospitals would also have to earn this "right" to maintain preferred networks by meeting certain benchmarks, such as achieving low readmission rates or other indicators that suggest they could responsibly manage preferred PAC networks.

A second strategy Medicare could use is to expand beneficiary incentives to use certain settings or providers over others. The PAC cost-sharing structure has not significantly changed since Medicare's inception. Inherent in this structure are financial incentives, unrelated to clinical decisions, that encourage the use of certain settings over others and for certain time periods. For example, the SNF cost-sharing requirement creates an incentive for providers to keep beneficiaries for 20 days, regardless of whether they need this much care. Alternately, cost-sharing incentives could be created to encourage beneficiaries to use preferred providers that offer high-value care. However, changes to beneficiary cost sharing would also have to be sensitive to the amounts beneficiaries already incur. For example, policies could lower the incurred cost sharing when beneficiaries select providers that meet standards for quality and cost of care.

Strategies to manage post-acute care under managed care

Three strategies—prior authorization for the use of high-cost PAC settings, contracting with third-party vendors to manage PAC, and establishing networks that include high-value providers—are used by MA plans. All involve restricting, to varying degrees, beneficiary choice. Prior authorization would require beneficiaries to get approval before the program covered the care, which is not allowed under Medicare rules. Under the traditional FFS program, beneficiaries may be given information about the relative advantages of some providers or settings, but the beneficiary ultimately is free to choose a setting and provider. In addition, to implement prior authorization would require significant administrative resources to identify the settings that would require approval, develop the standards to determine coverage, and establish a process for review and appeals of decisions.

Under a third-party vendor arrangement, a benefit manager receives a monthly fee to manage (and is at financial risk for) the use of PAC. Beneficiaries may appreciate some of the education tools (such as care pathways that detail expected care through the episode) and extra assistance these vendors can provide. However, some beneficiaries may not want their PAC services influenced by an entity that is not their regular source of care. The benefits of guiding beneficiary decision making toward higher value care would need to be evaluated relative to the cost of inserting an additional administrative layer into the placement decision-making process.

A network of preferred providers would identify high-value providers, and beneficiaries who use them would incur lower cost sharing compared with beneficiaries who use out-of-network providers. In this way, freedom of choice is retained, but beneficiaries could face different financial liabilities, depending on their use of in-network or out-of-network providers. MA plans often establish formal networks, delineating where care is covered and generally excluding coverage for out-of-network care. Beneficiary freedom of choice is preserved because beneficiaries choose to enroll in an MA plan.

Conclusion

The complexity and cost of PAC indicates that Medicare needs a range of policies to ensure the appropriate and efficient use of these services. In the near term, the Commission is recommending policies that ensure that program payments under PPS are commensurate with costs, a particularly important policy given the high payments for several PAC settings. In addition, Medicare can begin to move toward site-neutral payments where there is clear overlap in the services provided, such as for certain patients served by SNFs and IRFs. In the longer run, Medicare is beginning efforts to develop a common payment system that will eliminate the adverse incentives and inefficiencies resulting from multiple uncoordinated systems.

The Commission's review of private sector practices suggests that further efforts to improve the management of PAC services in FFS are possible. A refined referral process, one that better supports beneficiary choice by providing beneficiaries with better information about available providers, could encourage the use of higher quality providers. These approaches could be particularly appropriate for ACOs or other models of delivery reform where hospitals and other providers are at risk for the cost of care and quality indicators. However, other approaches may be necessary when no entity is available to assume these risks (for example, holding PAC providers accountable for quality like the Commission has recommended for SNFs and home health agencies). Other changes may include aligning incentives for referring physicians and beneficiaries (for example, through the expanded use of quality information for comparing different PAC providers or by creating incentives through reformed PAC cost sharing). ■

Endnotes

- 1 Each payment system uses its own unit of payment. Skilled nursing facilities are paid on a per day basis, the home health prospective payment system pays for care in 60-day episodes, and the LTCH and IRF systems pay on a per discharge basis.
- 2 Summaries of the SNF and IRF PPSs are available at <http://www.medpac.gov/-documents-/payment-basics>.
- 3 *Majority* refers to the percentage of patients discharged to an IRF or SNF who went to SNFs. It does not consider other discharge destinations.
- 4 To assess whether the majority of cases were treated in SNFs, we examined shares of cases treated in each setting in markets with both types of facilities. Our reasoning is that if the majority of cases elect to go to SNFs even in markets with an IRF, the condition can generally be considered safe in the SNF. Nationwide, the number of SNFs far outnumbers the IRF count. Three-quarters of markets (defined as hospital service areas, or HSAs) do not have IRFs, but the majority of beneficiaries (69 percent) live in markets with at least one IRF. Almost all HSAs with IRFs also have at least one SNF. Because IRFs and SNFs use different case-mix classification systems, we identified comparable conditions using the MS-DRG of the preceding acute care hospital stay.
- 5 For each condition, we summed the daily payments for each SNF stay to compare them with the stay-based payments for IRFs. The average SNF payment excludes the separate payments for outpatient services furnished to SNF patients but excluded from the SNF PPS. Because the services must be infrequent to be excluded from the SNF daily rate, we do not think the average SNF payments would differ substantially from the payments reported here.
- 6 Each condition's average SNF payment reflects the average SNF length of stay and mix of SNF case-mix groups for that condition.
- 7 Having a facility provide two levels of care would not be a unique policy for Medicare. Under current swing bed policies, some rural hospitals provide both acute inpatient hospital and skilled nursing facility services.
- 8 An industry-sponsored study examined the impact of a site-neutral policy for stroke, unilateral joint replacement, and hip and femur procedures, including a broader set of conditions (DaVanzo et al. 2014). This study modeled the President's budget proposals for fiscal years 2014 and 2015 to narrow (but not eliminate) differences in payments between SNFs and IRFs. The proposals allow 25 percent of the difference in overhead costs between SNFs and IRFs and allows 33 percent of the difference in patient care costs. Its findings are similar to the estimates of the three conditions we examined in June 2014.
- 9 For beneficiaries who opt to receive outpatient therapy services, their care could be limited by the annual per beneficiary limits placed on these services.

References

- Buntin, M. B. 2007. Access to post-acute rehabilitation. *Archives of Physical Medicine and Rehabilitation* 88, no. 11 (November): 1488–1493.
- Buntin, M. B., C. H. Colla, P. Deb, et al. 2010. Medicare spending and outcomes after postacute care for stroke and hip fracture. *Medical Care* 48, no. 9 (September): 776–784.
- DaVanzo, J., A. Dobson, A. El-Gamil, et al. 2014. *Assessment of patient outcomes of rehabilitation care provided in inpatient rehabilitation facilities and after discharge*. Vienna, VA: Dobson DaVanzo and Associates.
- DeJong, G., S. D. Horn, R. J. Smout, et al. 2009a. Joint replacement rehabilitation outcomes on discharge from skilled nursing facilities and inpatient rehabilitation facilities. *Archives of Physical Medicine and Rehabilitation* 90, no. 8 (August): 1284–1296.
- DeJong, G., W. Tian, R. J. Smout, et al. 2009b. Long-term outcomes of joint replacement rehabilitation patients discharged from skilled nursing and inpatient rehabilitation facilities. *Archives of Physical Medicine and Rehabilitation* 90, no. 8 (August): 1306–1316.
- Deutsch, A., C. V. Granger, A. W. Heinemann, et al. 2006. Poststroke rehabilitation: Outcomes and reimbursement of inpatient rehabilitation facilities and subacute rehabilitation programs. *Stroke* 37, no. 6 (June): 1477–1482.
- Deutsch, A., C. V. Granger, R. C. Fiedler, et al. 2005. Outcomes and reimbursement of inpatient rehabilitation facilities and subacute rehabilitation programs for Medicare beneficiaries with hip fracture. *Medical Care* 43, no. 9 (September): 892–901.
- Gage, B., L. Smith, M. Morley, et al. 2011. *Post-Acute Care Payment Reform Demonstration: Report*. Prepared under contract to the Centers for Medicare & Medicaid Services. Baltimore, MD: CMS. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.
- Gage, B., L. Smith, L. Coots, et al. 2010. *Analysis of the classification criteria for inpatient rehabilitation facilities (IRFs): Report to Congress*. Prepared by RTI International for the Centers for Medicare & Medicaid Services. Baltimore, MD: CMS.
- Herbold, J. A., K. Bonistall, and M. B. Walsh. 2011. Rehabilitation following total knee replacement, total hip replacement, and hip fracture: A case-controlled comparison. *Journal of Geriatric Physical Therapy* 34, no. 4 (October–December): 155–160.
- Mallinson, T., A. Deutsch, J. Bateman, et al. 2014. Comparison of discharge functional status after rehabilitation in skilled nursing, home health, and medical rehabilitation settings for patients after hip fracture repair. *Archives of Physical Medicine and Rehabilitation* 95, no. 2 (February): 209–217.
- Mallinson, T. R., J. Bateman, H. Y. Tseng, et al. 2011. A comparison of discharge functional status after rehabilitation in skilled nursing, home health, and medical rehabilitation settings for patients after lower-extremity joint replacement surgery. *Archives of Physical Medicine and Rehabilitation* 92, no. 5 (May): 712–720.
- Medicare Payment Advisory Commission. 2014a. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2014b. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2013. MedPAC comment letter on the Centers for Medicare & Medicaid Services' proposed rule entitled: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2014; Proposed Rule. June 25.
- Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Munin, M. C., K. Seligman, M. A. Dew, et al. 2005. Effect of rehabilitation site on functional recovery after hip fracture. *Archives of Physical Medicine and Rehabilitation* 86, no. 3 (March): 367–372.
- Stineman, M. G., and L. Chan. 2009. Commentary on the comparative effectiveness of alternative settings for joint replacement rehabilitation. *Archives of Physical Medicine and Rehabilitation* 90, no. 8 (August): 1257–1259.
- Walsh, M. B., and J. Herbold. 2006. Outcome after rehabilitation for total joint replacement at IRF and SNF: A case-controlled comparison. *Archives of Physical Medicine and Rehabilitation* 85, no. 1 (January): 1–5.

