

CHAPTER

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**Post-acute care providers:  
Shortcomings in Medicare's  
fee-for-service highlight the  
need for broad reforms**

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## Post-acute care providers: Shortcomings in Medicare's fee-for-service highlight the need for broad reforms

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). As with any service, the Commission's goal is to recommend policies related to payments for PAC providers that ensure beneficiaries receive appropriate, high-quality care in the least costly setting appropriate for their clinical condition.

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### Shortcomings in how Medicare defines and pays for PAC services

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Medicare's definition of and payments for PAC services fail to establish incentives for providers to deliver efficient, high-value care. First, PAC is not well defined and the need for these services is not always clear—some patients can go home from an acute hospital stay without PAC while others need it but receive services in varying amounts. Still other patients may do best by staying a few more days in the acute care hospital and avoiding the transition to a PAC setting.

Further, many PAC providers furnish similar services, yet Medicare pays different rates for them depending on the setting. For example, patients recovering from the lowest severity strokes are treated in IRFs, SNFs, LTCHs, and

with home health care. Conditions of participation and coverage rules do not clearly delineate the types of patients who belong in each setting. In addition, without a common assessment instrument for PAC services, the quality of care and patient outcomes cannot be compared across settings, making it impossible to evaluate the comparative efficacy of services provided in different settings.

Current use patterns do not necessarily reflect how much or where patients would best receive their care because there are no financial incentives for providers to refer patients to the most efficient and effective setting. Instead, placement decisions can reflect a local market's availability of PAC settings, geographic proximity to PAC providers, patient and family preferences, or financial relationships between providers (for example, a hospital may prefer to discharge patients to providers that are part of its system or those it contracts with). Providers also have no incentive to consider the cost to Medicare of a patient's total episode of care. Providers receiving a fixed prospective payment may discharge patients to another provider or setting to keep their own costs below Medicare's payment, even if that increases Medicare's spending over the course of treatment.

Current use patterns also reflect the financial incentives under fee-for-service to increase volume when services are paid for on a per service basis. For example, Medicare's day-based payments to SNFs encourage more days, while the episode-based home health payment system

encourages more 60-day episodes. Furthermore, the design of Medicare's payment systems for both SNF services and home health care encourages providers to furnish rehabilitation therapy to boost payments above costs. Current practice patterns reflect these financial incentives to provide more and certain types of service, regardless of their clinical value for the patient. Finally, the separate PAC silos of payment—each setting is paid under a separate payment system, each of which has its own set of financial incentives—do not include any incentives to coordinate care across multiple providers or encourage safe transitions to the patient's home. Instead, providers have an incentive to focus on their narrow, near-term gains, which may not best serve the beneficiary.

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## **Broad reforms that would move Medicare beyond PAC silos**

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Recognizing the shortcomings in Medicare payment systems, the Commission has worked on four broad reforms to encourage a more seamless, patient-centered approach to match services and settings to the needs of each patient. Under these reforms, payments would reflect the characteristics of the patient, not the services furnished or the setting, and would encourage the use of the lowest cost mix of services necessary to achieve the best outcomes. These reforms include bundled payments and accountable care organizations (ACOs); a common patient assessment instrument; the development of risk-adjusted, outcomes-based quality measures; and the alignment of readmission policies across settings.

### **Bundled payments and ACOs**

Bundled payments and ACOs would pay an entity for an array of services over a defined period. Under bundled payments, one payment bundle would cover all PAC services following a hospitalization. Under an ACO, participating health care providers assume some financial risk for the cost and quality of care delivered to a defined population and share in savings if they can limit costs while maintaining quality. Under both reforms, providers have an incentive to get patients the right services at the right time, coordinate care, and use resources efficiently. The Commission recommended testing bundled payments for PAC services in 2008 and continues to work on these PAC bundle reforms. In 2011, the CMS Innovation Center launched a bundling initiative with two models that include PAC (one model includes the hospital stay

and PAC; the other includes only PAC during a period after discharge from the hospital). In June 2012, entities interested in participating in the initiative submitted proposals that described the conditions that would be included, the length of the bundle (30, 60, or 90 days after discharge from the hospital), and the target price. After reviewing the applications, CMS announced a preliminary list of 48 conditions candidates can select to test. There are 69 participants in models that include PAC, involving 357 health care organizations. Pending contract finalization and program integrity audits, awardees are expected to be at risk midyear 2013.

The Commission commented on the proposed rules for ACOs and continues to monitor their progress. Shared savings programs for ACOs represent an opportunity to reward providers who control their costs, improve quality of care, better coordinate care, and become more engaged in their care management. Given the wide variation in Medicare spending, both bundled payments and ACOs could yield considerable savings over time by replacing inefficient and unneeded care with a more effective mix of services.

### **A common assessment instrument**

The second broad reform would require all PAC providers to use the same patient assessment tool. In 2005, the Commission called for such a tool so that patients, their service use, and outcomes could be compared across settings. CMS completed a mandated demonstration of a common assessment tool in 2011. It found that such a tool was feasible, and its analysis of resource use indicated the potential for a single-payment system across institutional settings.

### **New quality measures**

The Commission has begun to develop risk-adjusted, outcomes-based measures for some PAC settings so that the efficacy of settings and services can be assessed. Because much PAC aims to get the patient home, we have developed measures for risk-adjusted rates of discharge to the community for SNFs and IRFs. Rehospitalization rates, especially for conditions that are potentially avoidable, are a good gauge of the care furnished by the facility, and we now use this measure in evaluating the quality of SNFs, IRFs, and HHAs. We have developed measures for these same three settings that extend rehospitalization measures to include a period after discharge. This inclusion holds providers accountable for safe care transitions. Aligning measures across sites allows comparisons of providers' quality and could eventually be used to tie payments to outcomes.

## **Expanded readmission policies**

The Commission has examined expanding readmission policies to PAC settings so that hospital and PAC incentives are aligned and focused on unnecessary rehospitalizations. Such policies would hold PAC providers and hospitals jointly responsible for the care they furnish in their own settings and for safe transitions to the next one. Such policies discourage providers from

discharging patients prematurely or without adequate patient and family education. Aligning policies would emphasize the need for providers to manage care during transitions between settings, coordinate care, and partner with providers to improve quality. We have recommended readmission policies for hospitals (now in place) and SNFs, and we are working on similar policies for home health care and IRFs. ■

