

CHAPTER

7

**Post-acute care providers:
Steps toward broad
payment reforms**

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

- 7** The Congress should direct the Secretary to implement common patient assessment items for use in home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals by 2016.

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

Post-acute care providers: Steps toward broad payment reforms

Chapter summary

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries after 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 medically necessary, high-quality care in the least costly setting appropriate for their condition.

The Commission has long noted the shortcomings of Medicare's fee-for-service (FFS) payment systems for PAC and the clear need for reforms. High Medicare margins indicate that program payments are exceptionally high, and the wide variation across providers in Medicare margins highlights core problems with the design of the prospective payment systems (PPSs). The PPSs encourage providers to furnish certain services to boost payments or admit certain kinds of patients based on profitability. Although CMS has adopted setting-specific rules to delineate the types of patients appropriate for IRFs and LTCHs, there is overlap in the types of patients treated in different settings. Because Medicare pays very different rates across settings, treating similar patients in different settings can unnecessarily increase program spending.

In this chapter

- Challenges to improving Medicare's payments for post-acute care
- Broad reforms for post-acute care
- Moving forward with a common patient assessment tool

Broad reforms of the way Medicare FFS pays for PAC are hampered by the lack of common patient assessment information across the PAC settings. Common patient assessment items would allow us to evaluate differences in the mix of patients treated in different settings, the care providers furnish, and the outcomes patients achieve. Currently, three of the four settings (HHAs, IRFs, and SNFs) are required by CMS to use different assessment instruments. While CMS successfully tested a common assessment tool across PAC settings and in acute hospitals at discharge, CMS has not established a time line to require PAC settings to gather consistent patient assessment information. To help prevent undue delays in the collection of comparable data, the Commission recommends that the Congress direct the Secretary to implement common patient assessment items for use in the four PAC settings beginning in 2016, and we lay out a possible time table for CMS activities in 2017 and 2018. ■

Challenges to improving Medicare's payments for post-acute care

Though Medicare payments for post-acute care (PAC) must be reformed, making improvements is challenging for several reasons. First, the need for PAC is not well defined; some patients can go home from the hospital without it, while others need it but receive varying amounts of service in different settings. Still others remain in the acute care setting a few days longer and avoid PAC altogether. While Medicare rules (conditions of participation and payment and coverage rules) provide some guidance regarding placement in PAC, providers of PAC have considerable latitude in terms of which patients they admit among the patients referred to them by hospitals. The Commission and others have documented the similarity of patients treated in different PAC settings (Gage et al. 2011, Medicare Payment Advisory Commission 2013). Reflecting this ambiguity, Medicare per capita spending (adjusted for prices and health status) on PAC varies more than on most other covered services. Geographic areas (core-based statistical areas) with the highest and lowest per capita spending (comparing the 10th and 90th percentile) vary by more than a twofold difference for PAC services but by only about 20 percent for acute inpatient and ambulatory services (Medicare Payment Advisory Commission 2011). The range in spending indicates opportunities for more effective purchasing of PAC services by the Medicare program.

Second, PAC providers treat similar types of patients, yet Medicare pays different prices depending on the setting (Medicare Payment Advisory Commission 2013). For example, patients recovering from strokes and hip replacements are treated in inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs), but Medicare's payments per stay to IRFs are 40 to 50 percent higher than its payments to SNFs for these conditions.

Further complicating reform efforts are utilization patterns that do not reflect efficient care. There are no financial incentives for hospitals to refer patients to the most efficient or effective setting, so actual PAC use does not indicate where patients would best receive their care or how much care is optimal. Instead, placement decisions often reflect the availability of PAC settings in a local market (and whether there is an available bed), the hospital's and family's 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 with which it contracts).

Finally, there is no common patient assessment instrument used across PAC settings. Medicare requires three of the PAC settings (home health agencies (HHAs), SNFs, and IRFs) to use setting-specific patient assessment tools in determining a patient's resource requirements. Although the tools are similar in the domains covered by the questions, each tool asks different questions, defines the activities being assessed differently, uses different scales to gauge patient functional status, and assesses patients over varying time frames (Table 7-1, p. 172). The questions regarding cognition are especially different across the tools. In addition, the tools vary in how independence and dependence are gauged. For example, tools differ in whether they consider verbal cues or the use of assistive devices in determining level of assistance required. In addition, the tools differ in whether they assess a patient over a period of time and record the patient's most dependent level of functioning or whether they record the patient's functioning at a single point in time. Acute care hospitals are not required to submit patient assessment data at discharge, while long-term care hospitals (LTCHs) began submitting limited information in their quality reporting program in October 2012. LTCHs are required to report information related to pressure ulcers and in the future will be required to submit information on the administration of influenza vaccine (October 2014) and patients experiencing one or more falls with major injury (January 2016). LTCHs are not required to submit comprehensive patient assessment information at admission and discharge.

The lack of comparable information undermines our ability to fully evaluate whether patients treated in different settings are, in fact, the same or whether one PAC setting is more appropriate than another for patients with specific conditions. As a result, we do not know whether there are selection practices that are common across settings in terms of the patients admitted. Furthermore, without comparable information, we cannot systematically evaluate the cost and outcomes of the care that beneficiaries receive across settings. Providers may look more efficient or able to achieve better outcomes, when actually they treat fewer complex cases. Adequate risk adjustment is critical to make fair comparisons across providers and give beneficiaries accurate information about high-quality providers.

**TABLE
7-1**

Frequency, time period covered, and measurement scales differ across post-acute patient assessment tools required by Medicare at admission and discharge

Dimension	Inpatient rehabilitation facilities	Skilled nursing facilities	Home health agencies
Tool	IRF-PAI	MDS	OASIS
Frequency of assessments	At admission and discharge	Initial (day 1-8); day 14; day 30; thereafter every 30 days up to day 100; change in therapy; and significant change in status	At admission; every 60 days thereafter and discharge
Time period covered	Lowest level within first 3 days (at admission) and last 3 days (at discharge)	Generally 7-day look back	Status of patient on day of assessment
Method of assessment	Direct observation preferred but can be combined with reported performance	Information gathered from multiple caregivers' descriptions and documentation. Direct observation not required.	Direct observation preferred but often use interviews with patient in-home caregiver
Minutes to complete	51 minutes	90 minutes	90 minutes

Note: IRF-PAI (Inpatient Rehabilitation Facility-Patient Assessment Instrument), MDS (Minimum Data Set), OASIS (Outcome and Assessment Information Set). Long-term care hospitals are required to submit limited information for quality reporting but are not required to submit comprehensive patient assessment information at admission and discharge.

Source: MedPAC's June 2005 report and CMS's Paperwork Reduction Act disclosure statement, available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Downloads/IRF-PAI-FINAL-for-Use-Oct2014-updated-v4.pdf>.

Broad reforms for post-acute care

Across all services, the Commission believes Medicare needs to move away from fee-for-service (FFS) payment and toward integrated payment and delivery systems to control unnecessary volume and enhance patient outcomes. Our work on accountable care organizations (ACOs) and bundled payments are examples of reforms that center payments on the beneficiary or episode of care rather than on specific services furnished or the site of delivery. Under these approaches, providers are encouraged to furnish the lowest cost mix of services necessary to achieve the best outcomes and to coordinate care across settings.

While broad payment reforms are needed, the Commission acknowledges that FFS methods remain important because they are likely to remain an option for providers and beneficiaries for the near term and may remain the dominant option in certain markets even longer. Therefore, CMS needs to continue to improve the accuracy of program payments for PAC. At the same time, CMS

needs to ensure the comparability of payments across settings when providers treat similar patients. A common set of patient assessment information would also assist beneficiaries and providers in making decisions about whether PAC is needed and, if so, the setting and provider best able to meet a beneficiary's care needs. ACOs and Medicare Advantage plans, with the focus on the entire episode of care, could use the information to lay out the best trajectory of care across settings. Finally, comparable patient-level information will facilitate the refinement of risk adjusters for quality and cost measures.

The Commission has also begun to develop outcome-based quality measures that are risk adjusted so that the efficacy of settings and services can be evaluated. For example, risk-adjusted rates of rehospitalization are a good gauge of the care furnished by the facility and, when the measures extend to a period after discharge, hold providers accountable for safe care transitions. Aligning measures across settings allows quality to be compared.

Broad reforms require common patient assessment information across the PAC settings so we can evaluate

differences in the mix of patients treated in different settings, the care providers furnish, and the outcomes patients achieve. Yet CMS has been slow to implement the gathering of common assessment information. In 1999, the Commission recommended that the Secretary collect a core set of patient assessment information across all PAC settings (Medicare Payment Advisory Commission 1999). In 2005, with no tool yet in place, the Deficit Reduction Act of 2005 required the Secretary to conduct a demonstration to develop and test a tool. CMS successfully developed, validated, and tested a uniform tool (the Continuity Assessment Record and Evaluation, or CARE) in its Post-Acute Care Payment Reform Demonstration (PAC-PRD) (Gage et al. 2011). The tool was tested in each PAC setting (at a patient's admission and discharge) and at acute care hospitals (only at discharge). CMS confirmed the tool's inter-rater reliability within and across settings. Providers in the five settings were generally positive about the CARE items, noting the specificity of the items measuring severity and change in function and the standardization of measuring pressure ulcers and other factors that affect staffing (Centers for Medicare & Medicaid Services 2012).

Criticisms of the CARE tool focused on two aspects: the tool was too long and did not adequately measure clinical complexity. CMS estimated that the assessment took 30 minutes to 60 minutes, depending on the complexity of the patient (Gage et al. 2011). This estimate is consistent with the time required by tools currently in use. Second, some providers thought the tool would not adequately assess complex or vulnerable patients. With input from providers in LTCHs and acute hospitals, the CARE tool included items to specifically measure medically complex patients, such as whether the patient had severe pressure ulcers or required ventilator support/weaning or hemodialysis.

CMS found considerable overlap in the mix of patients across some of the settings (for example, between SNFs and IRFs). In addition, two risk-adjusted outcomes (rehospitalization rates and changes in mobility) did not differ significantly across SNFs, IRFs, and HHAs. LTCHs had lower rehospitalization rates, reflecting their capacity as hospitals to handle medically complex patients. Risk-adjusted changes in self-care were higher for patients treated in IRFs and HHAs than the changes for patients treated in SNFs, though thresholds for defining clinically meaningful differences were not established. These findings suggest that the settings generally provide similar quality of care when they serve similar patients.

The overlap in patients treated across settings and the relatively similar outcomes suggest that, in the near term, payment differences could be narrowed for similar patients receiving similar services in different settings. In the longer term, at least some of the PAC settings could be consolidated into a single payment system. Common information would enable us to develop a single case-mix system to adjust payments based on patient characteristics, not the setting. Using a common set of factors gathered with the CARE tool, CMS was able with reasonable accuracy to predict direct staffing (predominately nursing) and therapy resources across the PAC settings. CMS concluded that a common case-mix system was feasible for at least the institutional settings, with further work perhaps required to consider payments for HHAs, given their lower acuity patients on average.

Moving forward with a common patient assessment tool

The findings of the demonstration provide strong support for a common assessment tool. The demonstration found that a common tool not only was possible but also allowed us to meet three objectives simultaneously: to compare the mix of patients, the outcomes achieved, and costs of care across settings. In contrast, the setting-specific tools were not designed with these three objectives in mind nor tested across all PAC settings and at hospital discharge. While some providers have developed assessment tools to guide PAC placement decisions, the tools often do not gather the information needed to meet all three objectives.

Common assessment items must gather the information needed to define comparable outcomes and to risk adjust costs and outcomes. A core set of domains—in combination with diagnoses and comorbidity information from claims—predicts resource use, changes in functional status, and hospital readmissions (Table 7-2, p. 174). Given the focus on rehabilitation for many patients receiving PAC, starting the collection of common assessment information with functional status and cognitive status (at admission and discharge) would facilitate the comparison of resource use and outcomes across the settings. Other key predictors of resource use and outcomes include the provision of special services (such as ventilator and dialysis), certain medical conditions (such as the presence of severe pressure ulcers), and patient impairments (such as the inability to see). The gathering of information needs to balance the objectives

**TABLE
7-2****Key predictors of readmissions, changes in functional status, and resource use**

Source	Domain	Examples
Claims	Demographics	Age
	Clinical	Diagnoses
		Comorbidities
Patient assessment	Functional status	Mobility and self-care; sitting endurance
	Cognitive function	Able to express ideas, able to understand, comatose, depression
	Special services	Ventilator, dialysis, chemotherapy, central line placement, total parenteral nutrition, IV medications
	Medical condition	Severe pressure ulcers, major wound present
	Impairments	Inability to hear, see, swallow; incontinence
	Prior service use	Hospital or PAC use within past 2 months, ICU days
	Prior functioning	Mobility and self care; history of falls

Note: IV (intravenous), PAC (post-acute care), ICU (intensive care unit).

Source: Carter et al. 2012, Gage 2011, Kramer et al. 2014, and Nuccio et al. 2011.

of its use with the need to minimize the time required to complete the assessment. Because the select items make up only part of the CARE tool, they should take less time to complete than the entire tool. At the same time, questions must avoid observer bias or manipulation.

It is possible that one or two questions within each domain are sufficient to meet these multiple objectives. A shortened version of the CARE tool being used by participants in CMS's bundling initiative (the Bundled Payments for Care Improvement Initiative–Continuity Assessment Record and Evaluation, or B–CARE, tool) includes key predictors from all patient assessment domains but is shorter than the tool used in the PAC–PRD demonstration. For example, the sections on skin integrity, physiological factors, cognitive status, impairments, and functional status include fewer items. While the required items need not be some version of the CARE tool, it is readily available, meets these multiple objectives, and could be implemented relatively quickly.

CMS has outlined several follow-on activities for the CARE tool and the PAC–PRD data. CMS has begun efforts to assess the feasibility of using CARE-based assessment items (instead of the setting-specific patient assessment items) in the current PAC prospective payment systems (PPSs). A refined set of quality measures based

on the CARE items is also under development, beginning with the standardization of pressure ulcer items. CMS plans to use the consistent measures in its quality reporting programs. As these efforts are completed, CMS intends to integrate CARE items into the existing assessment tools for IRF, SNF, and home health care. Time frames for using the CARE tool items in existing PPSs and the adoption of the CARE tool (or items from it) have not been established. We are concerned that without the motivation of a statutory mandate and deadlines, the implementation may continue to lag far behind the imperative for a common set of items, particularly if the efforts are overtaken by other priorities.

RECOMMENDATION 7

The Congress should direct the Secretary to implement common patient assessment items for use in home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals by 2016.

RATIONALE 7

The PAC demonstration found that establishing a set of common patient assessment items is operationally feasible, that there was considerable overlap in the patients treated in different PAC settings, patient outcomes were similar, and a core set of patient characteristics could establish

**TABLE
7-3****A possible phased approach to implement common assessment items**

Year	Activity
2016	<ul style="list-style-type: none">• Common items are added to existing tools• For long-term care hospitals, the common items are required
2017	<ul style="list-style-type: none">• Test post-acute care prospective payment systems using the common items instead of items from existing tools• All post-acute care providers continue to gather common items• Existing assessment tools remain in place
2018	<ul style="list-style-type: none">• Replace overlapping “old” assessment items with common items• Use common assessment items in current post-acute care prospective payment systems• Long-term care hospitals continue to submit common items• Existing assessment tools remain in place, with standardized items substituted for “old” items

a common payment system. Common assessment items would gather the information necessary to develop comparable outcomes measures and facilitate adjusting payments and outcomes to reflect differences across patients. Knowing which sites produce the best outcomes for each condition could be used to inform PAC placement decisions and could possibly serve as evidence for Medicare to refine its coverage policies for these services.

One pathway to implement common elements would be for the Secretary to begin with a required set of elements to be collected at all four sites and to expand this core set over time. The initial core would include a limited number of items from select domains that are the most important for having comparable outcomes data and for adjusting outcomes and payments for patient differences. These domains would include functional status, cognitive status, and the provision of special services. This core set should be added to the existing patient assessments and required in fiscal year 2016 (Table 7-3). For LTCHs, this initial core set would constitute the required tool for assessing their patients at admission and discharge.

In subsequent years, CMS would focus on integrating the use of the new tool in its case-mix systems for the PAC PPSs and on streamlining the reporting requirements for providers. During 2017, CMS would verify that the common new items, instead of the current assessment tool items, can be used in the existing PPSs. Providers would continue to use the tools required of each setting in addition to the new common core elements. In 2018, CMS would replace the “old” overlapping assessment items with the common items. By dropping duplicated items, the reporting burden for HHAs, SNFs, and IRFs

would be reduced. The existing (now modified) patient assessment tools would continue to be used by HHAs, SNFs, and IRFs, with LTCHs using the common core as their assessment tool. The core set could be expanded over time if CMS decides that additional items are needed to more accurately describe clinically complex or vulnerable patients seen across PAC settings. Consistently defined, publicly reported quality measures would make it easier to compare performance across PAC settings and providers. In the future, the common items could be required at discharge from the hospital to facilitate placement decisions and to link PAC use to patients’ abilities when they left the hospital.

Given the importance of the assessment items for comparing patients, assessing quality across settings, and risk-adjusting payments and outcomes, the Commission urges the Congress to require the Secretary to move as quickly as possible in implementing common assessment items. If this effort can be made sooner than the possible time frame discussed above, the Secretary should make every effort to do so.

To meet the implementation time frame, CMS should consider implementing elements from the B-CARE tool. The Commission is concerned that using another tool that needs to be validated and tested would further delay the 15-year wait since it first recommended gathering uniform patient assessment information. Moreover, this tool is in use by providers participating in CMS’s Bundling Initiative and includes the key factors required for risk-adjusting resource use, change in functional status, and readmission rates.

Spending

- There would be no direct impact on program spending. CMS will incur additional costs to modify the PPSs to use elements from the commonly collected items in the case-mix classification systems for IRFs, HHAs, and SNFs. In the long run, administrative costs may decline if CMS has to maintain fewer silo-specific assessment items.

Beneficiary and provider

- Beneficiary care may improve because providers will have common information about relative PAC performance. Providers can use this information to facilitate appropriate placement at hospital discharge, improve transition care, and refine the care processes that improve their outcomes. If commonly

defined outcome measures were publicly reported, beneficiaries and their caregivers would have consistent information to independently compare and select PAC providers.

In the initial years of implementation, providers will incur modest costs associated with integrating the new patient assessment items into their information collection systems and training their clinical staff on these new items. These costs will vary by setting. However, for providers already using an assessment instrument, the added costs would be short term, since the new assessment items will replace existing items. On the benefit side, PAC providers will be better able to compare their performance with that of other providers. ■

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