CHAPTER 3

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The recuperation and rehabilitation services that post-acute care (PAC) providers furnish are important to Medicare beneficiaries. Medicare beneficiaries can seek this care in four different PAC settings: skilled nursing facilities (SNFs), home health agencies (HHAs), long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs). As with any service, Medicare's goal is to ensure that beneficiaries receive appropriate, high-quality care in the least costly setting appropriate for their clinical condition.

Common themes across post-acute care settings

Before discussing the Commission's assessment of the adequacy of Medicare's payments in each sector, we note four common themes across the sectors:

- Payments are not accurately calibrated to costs in each sector.
- Services overlap among settings.
- The PAC product is not well defined.
- Assessment instruments differ among settings.

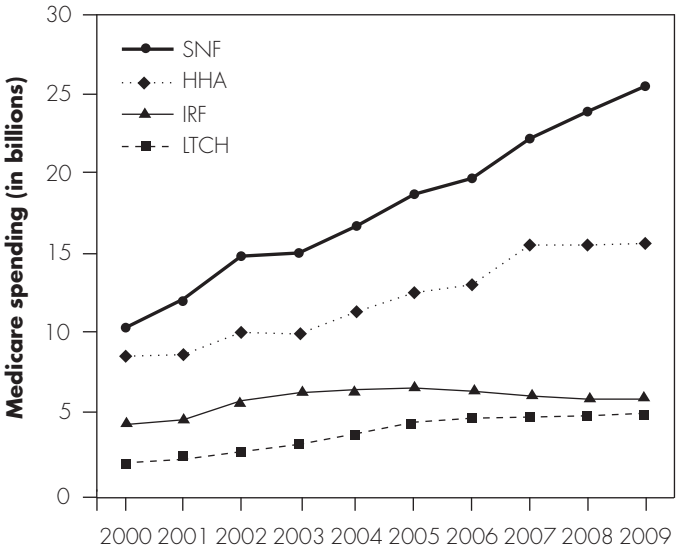
Refining the prospective payment systems (PPSs) and their case-mix systems will not fully resolve issues of whether patients go to the lowest cost, appropriate post-acute setting or whether they need PAC at all. Some patients might recover and recuperate at home using outpatient services or they might do best by staying a few more days in the acute care hospital. Medicare would also want to make sure that beneficiaries receive the most clinically appropriate and effective care, regardless of the setting.

To this end, the Commission is looking beyond payment adequacy to think more broadly about how to match patients who use PAC with the set of services that can provide the best outcomes at the lowest cost. Building on past Commission work, we discuss two possible next steps. First, CMS could implement readmission policies for all PAC settings so that providers' incentives are aligned and they share the responsibility for avoiding unnecessary rehospitalizations. Second, CMS could establish a pilot to test the concept of bundling payments around a hospitalization for select conditions and include PAC in those bundles. By affecting all aspects of care (not just readmissions), bundling payments represents a bigger step toward aligning financial incentives and provider responsibility for patient outcomes across settings.

Payments are not accurately calibrated to costs

New PPSs for PAC providers have led to changes in the patterns of PAC use. CMS developed a PPS for each type of provider, following mandates in the Balanced Budget Act of 1997. Some providers have responded to

FIGURE 3–1 **Changes in spending since 2000 vary by PAC service**



Note: PAC (post-acute care), SNF (skilled nursing facility), HHA (home health agency), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital).

Source: CMS, Office of the Actuary.

the new incentives of the PPSs in ways that may not serve the program or beneficiaries well. The Commission has documented changes in the number of providers and the mix of services furnished and the patients served. For example, the explosive growth in the number of HHAs and the decline in the visits furnished per home health care episode raise questions about the level of payments and the difficulty in defining this product. The increasing intensity of rehabilitation services furnished by SNFs reflects financial incentives to provide this care and select patients who will be cared for most profitably. Utilization and spending in LTCHs and IRFs grew rapidly until other policies were put in place to begin to control the types of patients treated in these high-cost settings (Figure 3-1).

These provider responses have led us to call for refining the case-mix systems, measuring quality of care, and better defining the characteristics of the care that should be provided in each setting. The Commission has recommended that CMS refine the system for SNFs because of concerns that the payment system systematically pays too much for some types of patients and too little for others. Inaccurate case-mix systems in general create incentives for providers to select patients for whom profits are highest and to avoid other patients. Preliminary work by the Commission suggests that this area is one for further inquiry for the HHA PPS.

Services overlap among settings

PAC settings lack clear boundaries around the services furnished and the types of patients treated. For example, patients with joint replacements might go home with home health care or outpatient therapy, to a SNF, or to an IRF upon leaving the hospital. Patients with complex medical conditions (e.g., patients who need respirator care) may go to an LTCH or a SNF, or they might stay longer in the acute care hospital. Yet, the setting where a patient is treated has very different cost implications for the program (and for the beneficiary, through the copayments). But all patients do not overlap; some patients clearly are best suited to particular settings.

Given the high cost of LTCHs and their overlap with other providers, criteria are needed to delineate patients appropriate for them. The Commission has recommended that patient and facility criteria be used to delineate patients who need the level of care provided by LTCHs.

The post-acute care product is not well defined

The product Medicare buys in each setting is not always clearly defined or measured, making it difficult to interpret changes in the use of PAC services. For example, the range of home health care services is fairly broad and the benefit is fairly open ended. This year, the Commission is recommending that the Secretary identify categories of patients who are likely to receive the greatest clinical benefit from home health care and develop outcome measures to gauge the quality of care furnished to patients in each category. This recommendation is intended in part to identify patients most appropriate for this service and to better define the benefit. SNFs vary considerably in the range of the medical complexity of patients they are willing and able to treat, with some being a ready substitute for an LTCH, while others are not. Because LTCHs are not located in many markets, some hospitals seem to be treating beneficiaries in parts of the country without these facilities.

The lack of clarity in the products of each sector makes it difficult to interpret changes in PAC service use. As patterns of care change in response to the incentives of a PPS, we do not know if the changes represent gains in

efficiency (in the case of lower costs or fewer services), better care (in the case of expanded services), or stinting (in the case of fewer services). Better measures of quality and outcomes are needed to address this issue. In the longer term, Medicare should identify the type of care that patients need, not the type of setting.

Assessment instruments differ among settings

The PAC settings do not use the same patient assessment instrument, which complicates cost and quality comparisons across settings. Medicare requires three of the PAC settings (HHA, SNF, and IRF) to use a setting-specific patient assessment tool but does not require LTCHs to use one. Ideally, a common assessment tool would gather uniform information to help providers make appropriate placement decisions and enable CMS to evaluate patient outcomes within and across settings.

CMS has a congressionally mandated demonstration under way testing the use of a uniform patient assessment tool in hospitals at discharge and throughout the patient's episode of care, assessing patients at admission and discharge from each PAC setting. The demonstration is in 10 markets, with CMS required to submit an evaluation report to the Congress in July 2011. Participating providers are also gathering data on staff time and ancillary service use that will be utilized to develop a common payment method across PAC settings. A common payment method could go far toward reaching the Commission's long-term goal: to pay for PAC based on the patient's care needs, not the setting where the service is provided.

Toward a more integrated approach to post-acute care

The goal of an integrated approach to PAC is for patients to go to the settings that can provide the best outcomes at the lowest cost to Medicare. Payments should reflect the characteristics of the patients' care needs, not the setting. The themes just outlined lead us to consider two previous sets of recommendations the Commission has made that could improve care while more integrated solutions are designed: aligning readmission policies for hospitals and PAC providers and bundling payments for acute and post-acute care for select conditions. Both represent building blocks for broader, more integrated care.

Aligning readmission policies for hospitals and post-acute care providers

One interim step toward more integrated PAC is to align payment incentives to prevent potentially avoidable rehospitalizations. Spending on readmissions is considerable. In 2005, potentially avoidable readmissions cost the program more than $12 billion, though even with the best standards of care being practiced not all of them can be avoided (Medicare Payment Advisory Commission 2008). In 2007, more than 18 percent of SNF stays resulted in a potentially avoidable readmission to a hospital (see Chapter 3A on SNFs).

Aligning the payment incentives across acute and post-acute care providers would hold providers jointly responsible for the care furnished to beneficiaries. It would discourage hospitals from discharging patients prematurely or without adequate patient and family education and would encourage PAC providers to furnish adequate care to avoid unnecessary hospitalizations (for conditions such as urinary tract infections and congestive heart failure). Aligned incentives would also emphasize the need for providers to manage the care during beneficiary transitions between settings and to coordinate all care so that total episode spending does not exceed the episode payment.

The Commission previously recommended that hospitals be penalized for high readmission rates and that SNFs have their payments tied to quality metrics such as their rate of potentially avoidable rehospitalizations. Readmission policies could be expanded to include all post-acute settings.

Bundling services across an episode of care

Under any PPS, providers have an incentive to limit their financial liability by discharging patients to other providers or settings. Yet, such fragmentation of care runs counter to the broad long-term goal of the Commission to have providers assume more responsibility for the services a beneficiary receives over the entire episode of care. Bundling payments for services centered around a hospital stay would create incentives for providers to place patients in the appropriate PAC setting so that care is coordinated and efficient over the entire episode of care. Given the wide variation in and magnitude of PAC spending in the post-discharge period, expanding the window of care to include PAC services could yield considerable efficiencies.

The Commission previously recommended that the Congress require CMS to create a pilot program to test

the feasibility of bundled payments for services around a hospitalization for select conditions. Bundles that include post-acute services would have the added benefit of reducing variation in health care spending across geographic areas and providers. Under models that the Commission has explored, Medicare would pay a single provider (a hospital and its affiliated physicians) an amount intended to cover a patient's inpatient, outpatient, and PAC needs centered on an initial hospitalization. Providers would have incentives to furnish the right mix of services because their financial performance would be tied to their combined efficiencies and appropriate use of services. Providers would have an incentive to control their own costs, to partner with other efficient providers, to be mindful of their combined service use, and to coordinate care and manage beneficiary transitions between settings. Coupled with pay-for-performance and readmission policies, providers would also have joint responsibility for patient outcomes.

The Commission acknowledges that bundling acute and post-acute services will be challenging. Most obviously, not all PAC is preceded by a hospital stay. For example, about half of home health care patients are referred from the community. For patients without hospital stays, bundled payments are not a solution for improving their care. In addition, certain conditions (in which clinicians agree on best practices) lend themselves more readily to bundled payments. In clinical areas with disagreement about the best way to treat a certain type of case, establishing a bundled payment would be controversial. Furthermore, bundling will require a level of integration between hospitals, physicians, and PAC providers that does not exist in most markets. Establishing arrangements between providers to accept and distribute bundled payments will be difficult even for providers that are well integrated, let alone for the majority of providers that are not. For example, post-acute providers may resist an arrangement that has them being paid by a hospital. Another obstacle will be the provider and program resources needed to develop the tools necessary to track service use, costs, and payments over time and across settings.

Concluding remarks

As beneficiaries live longer with multiple chronic conditions, the use of PAC will continue to increase. It is imperative therefore that Medicare better define post-acute services and their use to ensure beneficiaries have access to high-quality, high-value care most appropriate to their care needs. Bundling and readmission policies are ways to force some of this decision making onto providers so that they consider beneficiaries' care over longer episodes of care and begin to assume responsibility for managing beneficiary care during the transitions between settings. ■

References

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