



Medicare's Post-Acute Care Payment: An Updated Review of the Issues and Policy Proposals

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OVERVIEW — Medicare spending on post-acute care provided by home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals accounted for about 10 percent of total program outlays in 2013. The Medicare Payment Advisory Commission and others have noted several long-standing problems with the payment systems for post-acute care and have suggested refinements to Medicare's post-acute care payment systems that are intended to encourage the delivery of appropriate care in the right setting for a patient's condition. The Patient Protection and Affordable Care Act of 2010 contained several provisions that affect the Medicare program's post-acute care payment systems, as well as broader payment reforms such as bundled payment models. Subsequent legislation, including the Pathway for SGR Reform Act of 2013, the Protecting Access to Medicare Act of 2014, and the Improving Medicare Post-Acute Care Transformation Act of 2014, all contain provisions that will affect future payments to one or more post-acute care providers. This issue brief describes Medicare's payment systems for post-acute care providers, evidence of problems that have been identified with the payment systems, and policies that have been proposed or enacted to remedy those problems.

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The traditional or fee-for-service (FFS) Medicare program pays for skilled care, therapy, and other services provided by home health agencies (HHAs), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs), collectively known as post-acute care (PAC) providers because they typically furnish care after an inpatient hospital stay. In 2013, FFS Medicare spent \$59 billion, about 10 percent of total program outlays, on post-acute care and more than double what the program spent in 2001.¹ Although the rate of spending growth for fee-for-service post-acute care grew more rapidly than other services between 2005 and 2010, spending growth has slowed or even declined for some sectors in recent years. This is due in part to the expanded enrollment of Medicare beneficiaries in Medicare Advantage plans,² and in part to a drop in the number of three-day inpatient hospital stays that would trigger eligibility for post-acute care in a skilled nursing facility.³ The decline in spending for post-acute care is also consistent with a general slowdown in both public and private sector spending on health care.⁴

Medicare uses a prospective payment system for each type of post-acute provider. These systems, implemented between 1998 and 2002, set rates on the basis of historical national average costs for each provider type. Several problems have plagued these systems, including excessive payments, imprecise adjustment for differences in patient needs (known as case mix adjustment), inadequate quality measurement, and insufficient appropriateness criteria. Multiple changes have been made to the post-acute care payment systems in law and in regulation since they were implemented. For example, the Patient Protection and Affordable Care Act of 2010 (ACA) included reductions⁵ in annual updates for inflation, requirements to reduce the HHA payments to better reflect average costs, a requirement for the Secretary of the U.S. Department of Health and Human Services (HHS) to develop a value-based purchasing plan for SNFs and HHAs, and penalties for LTCHs and IRFs that do not report quality data to the Centers for Medicare & Medicaid Services

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(CMS) starting in 2014. More recently, the Pathway for SGR Reform Act of 2013 phases in a policy that restricts LTCH-level payments to those patients who meet certain requirements related to the type and duration of their acute and post-acute care. For all other patients, the Act calls for Medicare to make payments that are based on the payment an acute care hospital would receive for the same patient.⁶

POST-ACUTE CARE IN MEDICARE

Broadly defined, post-acute care is skilled nursing care and therapy provided after an inpatient hospitalization. In some cases, it may shorten the hospital stay for patients who need ongoing care.⁷

Providers

The four post-acute providers discussed above—home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals—provide care to those patients who continue to need institutional care or otherwise may have difficulty accessing ambulatory care, but they are not the sole providers of post-hospital care. And not all Medicare beneficiaries are admitted to these settings after an inpatient stay. Patients may be admitted directly to an IRF or LTCH without a preceding hospital stay. A growing share of home health episodes are not preceded by an inpatient stay. In 2012, 66 percent of home health episodes were not preceded by an inpatient stay, up from 52 percent in 2001.⁸

There were more than 29,000 post-acute care providers in the United States in 2014: 12,461 HHAs; 15,173 SNFs; 1,177 IRFs; and 422 LTCHs.⁹ The numbers of institutional PAC providers have been relatively stable.¹⁰ In contrast, the number of HHAs increased substantially with the introduction of the home health prospective payment system in 2000. Between 2000 and 2013, the number of HHAs grew by 68 percent.¹¹ Concerns about aberrant patterns of utilization associated with potential fraud and abuse prompted the Secretary of HHS to exercise her authority under the ACA to impose a temporary moratorium on the enrollment of new agencies in parts of Florida, Illinois, Michigan, and Texas.¹² Between 2013 and 2014, the number of HHAs decreased by 1.2 percent, with declines concentrated in Texas and Florida.¹³

PAC providers are not evenly distributed across the country. Population concentration and state certificate of need laws affect the number and location of post-acute care providers. Skilled nursing facilities and home

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health agencies are widely available in every state. There is at least one IRF in each state and the District of Columbia, but they are concentrated in populous areas with high concentrations of Medicare beneficiaries.¹⁴ Some states have several LTCHs, whereas others have none. In places without IRFs and LTCHs, patients may be treated in other PAC settings or in acute care hospitals.

PAC providers must meet certain conditions to be eligible to receive Medicare payment. IRFs must meet Medicare conditions of participation¹⁵ for acute care hospitals and facility-level criteria that are designed to provide some assurance that the IRF setting is appropriate for admitted patients. Sixty percent of cases in a Medicare-certified IRF must have 1 of 13 diagnoses specified by Medicare; this requirement is known as the 60 percent rule.¹⁶ Long-term care hospitals must also meet the same conditions of participation as acute care hospitals, and their Medicare patients must have an average length of stay greater than 25 days.¹⁷ As noted, the Pathway for SGR Reform Act imposes additional restrictions, discussed in greater detail below, on payments to LTCHs based on beneficiaries' prior use of inpatient intensive care services and diagnosis at discharge from the LTCH.

Patients

Home health care is the most commonly used PAC provider, with 3.5 million Medicare users, followed by SNFs with 1.7 million users in 2013.¹⁸ Relatively few beneficiaries receive care in IRFs or LTCHs each year due to the specialized nature of the care they provide, program criteria, and their lack of availability in certain geographic areas. In 2013, 338,000 beneficiaries received care in an IRF and just 122,000 received care in an LTCH.¹⁹ Patients may use more than one type of post-acute care in an episode. For example, a person may be discharged from a SNF and receive home health care upon returning home. In a more unusual circumstance, a patient might be discharged from a SNF to an IRF when he or she has regained strength and is able to tolerate the more intensive therapy provided in an IRF setting.

Medicare requires that beneficiaries meet certain criteria to be eligible for services provided in some post-acute care settings (**TABLE 1, next page**). Up to 100 days of SNF care are covered per spell of illness,²⁰ provided the beneficiary needs daily skilled nursing or therapy.²¹ The program requires at least a three-day inpatient hospital stay in the 30 days prior to a SNF admission. For Medicare to cover care provided in an IRF, patients

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TABLE 1
Facility and Patient Criteria and Common Conditions by Post-Acute Care Setting

	Skilled Nursing Facility	Home Health Agency	Inpatient Rehabilitation Facility	Long-Term Care Hospital
Facility criteria	n/a	n/a	At least 60 percent of the facility’s patients have one of several specific medical conditions that require inpatient therapy.	Average Medicare length of stay greater than 25 days.
Patient criteria	Patient needs skilled nursing services or skilled rehabilitation services for the short term on a daily basis in an inpatient setting after an inpatient stay of 3 or more days.	Patient needs fewer than 8 hours per day of intermittent skilled care. Must be unable to leave home without considerable effort.	Patient needs intensive rehabilitation therapy in an inpatient hospital environment. Patient requires and is expected to benefit from 3 hours or more of therapy at least 5 days per week.	n/a
Commonly treated diagnoses or conditions	<ul style="list-style-type: none"> • Joint replacement • Kidney and urinary tract infections • Hip and femur procedures • Heart failure and shock • Pneumonia 	<ul style="list-style-type: none"> • Diabetes • Hypertension • Heart failure • Skin ulcer • Osteoarthritis 	<ul style="list-style-type: none"> • Stroke • Lower extremity fracture • Neurological disorders • Debility • Major joint replacement • Brain injury 	<ul style="list-style-type: none"> • Respiratory diagnosis with prolonged mechanical ventilation • Pulmonary edema and respiratory failure • Severe septicemia or sepsis • Respiratory infections and inflammations • Skin ulcers with complications/ comorbidities

Sources: Facility and patient criteria are from Laura Dummit, “Medicare’s Bundling Pilot: Including Post-Acute Care Services,” *National Health Policy Forum, Issue Brief No. 841, March 29, 2011, p. 6*, www.nhpf.org/library/details.cfm/2850. Commonly treated diagnoses or conditions are from: Centers for Medicare & Medicare Services (CMS), Office of Enterprise Data and Analytics (OEDA), *Medicare and Medicaid Statistical Supplement, 2013 edition, table 7.6 (HHA), “Persons Using Medicare Home Health Agency Services, Visits, Total Charges, Visit Charges, and Program Payments, by Principal Diagnosis Within Major Diagnostic Classifications (MDCs): Calendar Year 2012,”* www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/Downloads/2013_Section7.pdf#Table7.6; Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, March 2015, p. 185 (SNF), www.medpac.gov/documents/reports/mar2015_entirereport_revised.pdf; MedPAC, A Data Book: Health Care Spending and the Medicare Program, June 2015, p. 125 (IRF), p. 128 (LTCH), www.medpac.gov/documents/data-book/june-2015-databook-health-care-spending-and-the-medicare-program.pdf.

must need and be expected to benefit from intensive rehabilitation therapy in a hospital environment.²² Patients receiving Medicare-covered home health care generally must be confined to the home and in need of skilled nursing care on an intermittent basis or have a continuing need for physical therapy, occupational therapy, or speech-language pathology services.²³

Although the Medicare program has different coverage criteria and facility requirements for each PAC setting, there is considerable overlap in services and expertise across providers. For example, a patient may receive post-acute care after a hip fracture from an HHA, SNF, or IRF. As described in the next section, the Medicare program and beneficiaries face different costs depending on the post-acute care setting in which a patient is treated. The significant differences in payment amounts in the absence of clear evidence regarding appropriateness of care or outcomes have been a concern for policymakers.²⁴

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Payment Systems

The Balanced Budget Act of 1997 (P.L. 105-33) mandated prospective payment systems (PPSs) for home health agencies, skilled nursing facilities, and inpatient rehabilitation facilities. The prospective payment system for long-term care hospitals was mandated in the Balanced Budget Refinement Act of 1999 (P.L. 106-113) and the Medicare and Medicaid Benefits Improvement and Protection Act of 2000 (P.L. 106-554). Before prospective payment systems were implemented for post-acute care providers, each provider was paid its average costs, subject to limits, for treating Medicare beneficiaries. Enabling legislation and subsequent rule-making specified the features of the prospective payment systems, including the unit of service (for example, a discharge, an episode, or a day of care), the base payment rates (the price Medicare pays for a unit of service), and the case mix adjustment systems, which raise or lower the base payment amount depending on the resources required to treat patients with certain characteristics. The phase-in of the prospective rates and phase-out of reasonable cost-based payments began for SNFs in 1998, for HHAs in 2000, for IRFs in January 2002, and for LTCHs in October 2002.²⁵

Under each PPS, Medicare pays providers a fee that is based on estimates of the national average cost of providing covered care for a specified period of time (**TABLE 2, next page**). In three of the settings, the program pays for an episode of care; payment for home health care is made in

TABLE 2: Unit of Payment, Average Payment Amount, and Length of Stay in Post-Acute Care Settings, 2013

	Skilled Nursing Facility	Home Health Agency	Inpatient Rehabilitation Facility	Long-Term Care Hospital
Unit of Payment	Day	60-day episode	Discharge	Discharge
Average payment per unit	\$11,357 per stay	\$2,720 per episode	\$18,258 per discharge	\$40,070 per discharge
Average length of stay	27.6 days	1.9 episodes	12.9 days	26.5 days

Source: Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, March 2015, p. 185, 188 (SNF), p. 221 (HHA), p. 244 (IRF), p. 268 (LTCH), www.medpac.gov/documents/reports/mar2015_entirereport_revised.pdf.

increments of 60-day episodes, whereas inpatient rehabilitation facilities and long-term care hospitals are paid per discharge, like acute care hospitals. For care in a skilled nursing facility, the Medicare program pays a daily rate that is inclusive of almost all services provided.²⁶ Program payments for each patient are determined by adjusting the base rates for expected resource needs of the patient (see below) and geographic variation in wages. Each of the payment systems, except for the SNF payment system, also has outlier policies that adjust payments for exceptionally high- or low-cost cases.²⁷

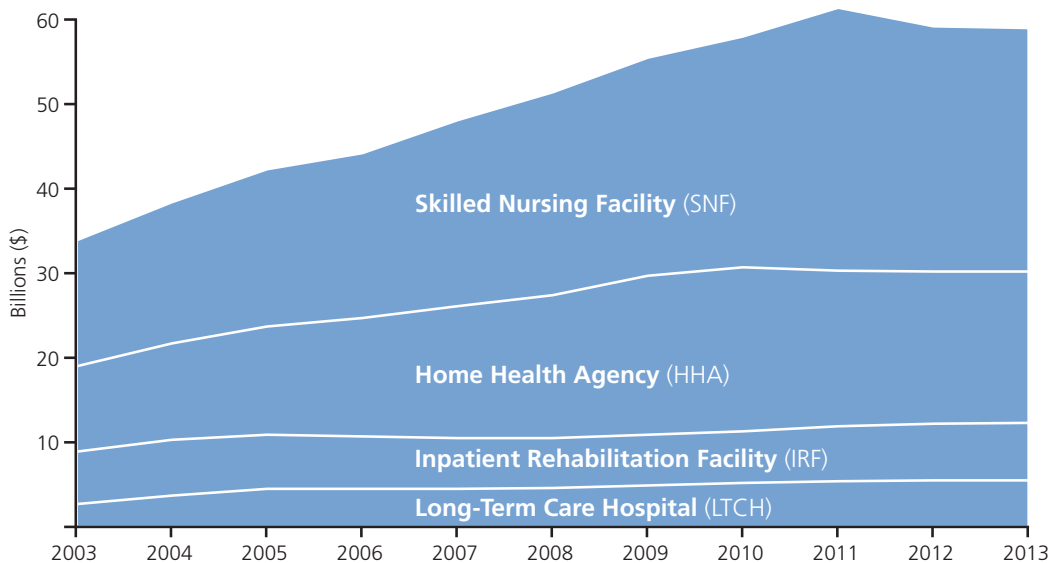
Beneficiaries are responsible for different cost-sharing amounts depending on the setting in which care is provided. Those receiving care in a SNF do not pay any cost sharing for the first 20 days. For days 21 to 100, beneficiaries pay a daily copayment equaling one-eighth of the hospital deductible (\$157.50 in 2015).²⁸ Beneficiaries who transfer to an IRF or LTCH within 60 days of being discharged from an acute care hospital pay no additional deductible beyond that paid during the acute care hospital stay. Beneficiaries admitted to an IRF or LTCH from the community are responsible for a deductible (\$1,260 in 2015) at the first admission during a spell of illness, and for a daily copayment (\$315 per day in 2015) for days 61 through 90.²⁹ Home health care is the only post-acute care service that does not require beneficiary cost sharing. MedPAC has recommended numerous times that the program add a requirement for beneficiary copayments for home health episodes that are not preceded by a hospitalization or other use of post-acute care. President Obama’s 2016 budget proposed a copayment of \$100 for home health episodes with five or more visits not preceded by a hospital or other inpatient post-acute care stay beginning in 2019.³⁰

Spending

Medicare fee-for-service spending for post-acute care totaled \$59 billion in 2013 or about 10 percent of total program expenditures of \$583 billion.³¹ SNF payments of \$28.8 billion accounted for nearly half of PAC dollars and 5 percent of total Medicare spending.³² In that same year, home health care spending was \$17.9 billion or about 3 percent of Medicare spending.³³ At \$6.8 billion for IRFs and \$5.5 billion for LTCHs, spending in these two sectors combined accounted for 2 percent of total program outlays.³⁴

Between 2003 and 2013, spending on post-acute care increased 74 percent (FIGURE 1).³⁵ Spending doubled for LTCHs and SNFs and increased by 77 percent and 10 percent, respectively, for HHAs and IRFs.³⁶ A variety of factors account for increased spending on PAC services. Home health spending growth has been driven by an increase in the number of agencies, the number of users, and the number of episodes per user, as well as a shift in the mix of services used away from home health aide visits toward more costly skilled nursing and therapy visits.³⁷ Spending on SNF services has not been driven by more users or more days of care, but mostly by an increase in the intensity of services, primarily therapy.³⁸

FIGURE 1
Medicare Spending on Post-Acute Care, 2003 to 2013



Source: Mark E. Miller, Medicare Payment Advisory Commission, “Medicare Post-Acute Care Reforms,” statement before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, April 16, 2015, p. 2, <http://docs.house.gov/meetings/IF/IF14/20150416/103327/HHRG-114-IF14-Wstate-MillerM-20150416.pdf>.

POST-ACUTE CARE POLICY AND PAYMENT SYSTEMS: PROBLEMS AND REMEDIES

MedPAC, the U.S. Government Accountability Office (GAO), and others have identified several problematic features of Medicare post-acute care policies and payment systems and their effect on care delivery, including:

- difficulty determining the appropriate post-acute care setting;
- payments considerably in excess of provider costs;
- case mix measures that do not accurately adjust payments for differences in the costs of treating different categories of patients; retrospective adjustments that incent greater use of therapy services; and threshold policies that encourage timing of discharges to maximize reimbursements; and
- uniform payment for care regardless of appropriateness or quality.

Recommended payment changes to address these problems include: recalculating the base payment rates (also known as rebasing) to ensure that payments are more in line with providers' costs; gainsharing (a process for sharing a portion of savings generated from efficiencies with providers) to encourage providers to be more efficient; modifying case mix measures to more accurately reflect the costs of treating different types of patients; moving toward a unified payment system for PAC services that would be based on patient characteristics rather than the site of care; and bundling payments. Some of these changes to the prospective payment systems to improve payment accuracy and care delivery have been made in law or in regulation, whereas others have not been adopted. This section discusses some of the problems with the post-acute care PPSs and the major recommendations to address these problems.

Difficulty Determining Appropriate Setting

Despite Medicare's attempt to define criteria for appropriate use of different PAC provider types, there are no definitive guidelines on determining which patients need or would benefit from PAC services.³⁹ Furthermore, distinctions between settings are unclear and evidence is lacking regarding which settings are best for treating which types of conditions. Not surprisingly, patients with similar needs are treated in different settings. As a result, there is wide geographic variation in both utilization and spending for PAC services. Comparing the highest-use to the lowest-use areas of the country, MedPAC found that post-acute care

spending varied eight-fold; spending for inpatient hospitals, in contrast, varied only 60 percent. Spending also varied three-fold for conditions that typically use PAC services.⁴⁰ These data suggest that patients in some areas may be treated in higher-intensity and more expensive settings than they need, and other patients may receive unneeded PAC services.

Researchers have examined characteristics of patients treated in different settings and looked at whether their outcomes are different. Through comparisons of patient risk profiles, market conditions where facilities were located, and patient outcomes, MedPAC has shown that LTCH patients cannot be clearly distinguished from chronically critically ill (CCI) patients receiving care in acute care hospitals and some SNFs.⁴¹ Although care for CCI patients in LTCHs is more expensive, studies have “failed to find a clear advantage in outcomes for LTCH users.”⁴² In areas without LTCHs, CCI patients are treated in SNFs or IRFs, or with longer stays in acute care hospitals, which suggests that medically complex patients can be treated appropriately in other settings. The treatment of certain CCI patients in LTCHs may also introduce distortions to the acute care hospital PPS, potentially causing payment rates that are too low for complex patients treated in acute care hospitals in areas where LTCHs aren’t available.⁴³

In an attempt to differentiate LTCH patients from those who could be treated in acute care hospitals, Congress included a provision in the Pathway for SGR Reform Act of 2013 restricting LTCH-level payments. Beginning in October 2015, LTCH-level payments will be made only for patients whose transfer to the LTCH was preceded by at least a three-day stay in an acute care hospital intensive care unit (ICU), or whose diagnosis at discharge from the LTCH indicates that they received mechanical ventilation services for at least 96 hours. Patients not meeting the three-day ICU stay or ventilation threshold will be paid at a rate comparable to that paid to an acute care hospital.⁴⁴ This threshold is considerably less than an eight-day stay threshold recommended by MedPAC in 2014 and 2015.⁴⁵ To address the issue of underpayment for some CCI patients in acute care hospitals, MedPAC has also proposed allocating funds that would have gone to LTCHs to the hospital PPS outlier pool.⁴⁶

MedPAC has also examined the potential overlap of patients in SNFs and IRFs and concluded that, for 22 conditions frequently treated in both settings, there is little difference in patient characteristics or outcomes.⁴⁷ On the basis of these findings, MedPAC has recommended that for selected conditions, “the IRF base payment rate be set equal to the average SNF payment per discharge for each condition.”⁴⁸ Other

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IRF payments would not be affected, and IRFs would not be required to comply with current regulations dealing with intensity and service mix for these conditions. President Obama's 2016 budget for HHS included a proposal to equalize payment for some conditions commonly treated in IRFs and SNFs. A second proposal in the budget would adjust the standard for classifying a facility as an IRF by requiring that 75 percent of cases admitted to an IRF, rather than 60 percent, have at least 1 of the 13 conditions as currently required. This change would encourage IRFs to avoid admitting low-acuity patients who may receive appropriate care in other, lower-cost settings.⁴⁹

Another avenue of post-acute care payment reform, sometimes referred to as site-neutral payment, would integrate individual PPSs and pay for care on the basis of patient rather than facility characteristics.⁵⁰ To understand costs and outcomes across different post-acute care sites and the feasibility of integrated post-acute care payment systems, Congress directed the Secretary of HHS to establish a demonstration program under section 5008 of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) by January 2008.⁵¹ The Post-Acute Care Payment Reform Demonstration (PAC-PRD) was conducted over three years, and findings were released in a report to the Congress in January 2012.⁵² It used a standardized patient assessment instrument, called the Continuity Assessment Record and Evaluation (CARE) tool, to collect data at discharge from acute care hospitals and at admission and discharge from post-acute care sites.

The demonstration analyzed factors that can help predict costs⁵³ in each of the different post-acute care sites, but developing an entirely new payment system was beyond the scope of the project. The demonstration focused on "creating a solid basis from which a payment system could potentially be built in the future and [providing] information on the extent it seemed advisable to proceed with development of a system that could cover more than one PAC setting."⁵⁴ Among the demonstration's key findings were that "evidence supports the potential for development of a common payment system for the three inpatient post-acute care settings: LTCHs, IRFs, and SNFs," but that "a payment model combining home health with the other types of PAC providers is not supported by the analysis."⁵⁵

Building on the PAC-PRD, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires post-acute care providers to begin collecting uniform assessment data in 2018. After two years of data collection, the Secretary is required to recommend a uniform payment system for post-acute care. The IMPACT Act also charges MedPAC with developing a prototype prospective payment system

encompassing all PAC settings using the data previously collected under the PAC-PRD. MedPAC's report is due in 2016.⁵⁶

While these proposals create incentives to place patients in appropriate lower-cost settings, they do not address the question of whether someone should be receiving PAC services at all. An episode payment that bundles payments for a hospitalization and any necessary PAC would create incentives for the provider receiving the payment to deliver only necessary PAC services in the lowest cost settings. MedPAC recommended testing bundled payment of PAC services in 2008 and has examined a variety of bundled payment designs in the ensuing years.⁵⁷ The ACA mandated that HHS test bundled PAC payments, and the Center for Medicare and Medicaid Innovation (CMMI) is mounting a demonstration of different models of bundling known as the Bundled Payment for Care Improvement (BPCI) initiative.⁵⁸ Rather than a single payment to one provider, BPCI involves usual payments to all providers serving a beneficiary and one provider able to earn shared savings if the total can be reduced below a targeted level. A similar approach is used in the hospital value-based purchasing proposal, where hospitals have an incentive to lower spending in the 30 days following discharge. Bundled payments do create a clear incentive for coordinating care and lowering episode costs, but those lower costs may result from greater efficiency through delivering only necessary, lowest-cost services or by stinting on needed services. Bundled payments will need to be accompanied by sufficient oversight and accountability to ensure patients' needs are being met.⁵⁹

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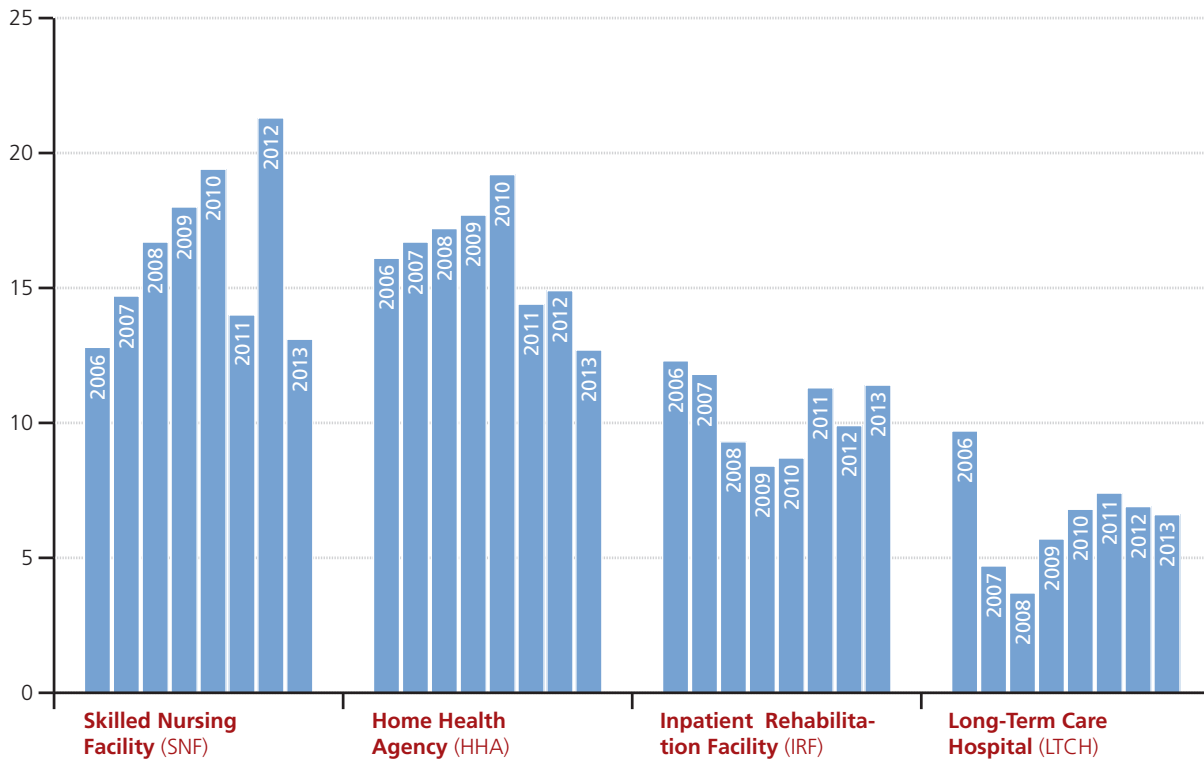
Payments Well in Excess of Providers' Costs

Medicare net revenue or profit margins, calculated using data from providers' cost reports, are a measure of program spending relative to the costs of treating beneficiaries. Average Medicare margins of post-acute care providers are high and have been for many years, particularly in HHAs and SNFs (**FIGURE 2, next page**). High margins, along with other indicators of Medicare payment adequacy, had led MedPAC to recommend for several years that the Congress eliminate the annual inflation updates for SNFs, HHAs, IRFs, and LTCHs. The ACA included provisions to reduce the market basket updates for all post-acute care providers. They involved (i) productivity adjustments to the annual inflation updates in all four PAC settings, and (ii) a fixed percentage point reduction to the inflation updates for HHAs, IRFs, and LTCHs for multiple years. With the exception of IRFs, all PAC providers saw declines in their

2013 Medicare margins as a result of such payment changes. Nevertheless, because indicators continue to signal more-than-adequate Medicare payments, MedPAC recommended no market basket updates for 2016.⁶⁰

MedPAC has also recommended that the home health and SNF payment systems be rebased to better align Medicare payments and providers' costs. Generally, payment systems may need to be rebased when there is evidence that the nature or mix of the services provided have changed since the base rates were initially determined. Home health patients now receive fewer visits and a different mix of services than when the rates were established using cost data from 1997, contributing to significant overpayment.⁶¹ The growth in SNF margins was driven by a growing concentration of days in the highest paying case mix groups (discussed more below), where payments grew even more than providers' costs.⁶²

FIGURE 2: Medicare Margins by Post-Acute Care Sector, 2006 to 2013



Note: Margins for SNFs and HHAs are for freestanding facilities; margins for IRFs and LTCHs are for all facilities.

Sources: Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, March 2015, www.medpac.gov/documents/reports/mar2015_entirereport_revised.pdf; and MedPAC, Report to the Congress: Impact of Home Health Payment Rebased on Beneficiary Access to and Quality of Care, December 2014, p. 7, <http://medpac.gov/documents/reports/december-2014-report-to-the-congress-impact-of-home-health-payment-rebased-on-beneficiary-access-to-and-quality-of-care.pdf>.

The ACA mandated that the home health PPS be rebased between 2014 and 2017, but the effect of rebasing is partially offset by payment updates.⁶³ Although the ACA requires a rebasing reduction of 3.5 percent, payment updates and growth in the size of the base rate will result in a net cumulative reduction in payments of only about 2 percent for an industry that has experienced annual double-digit margins for many years, according to MedPAC estimates.⁶⁴ The ACA did not require rebasing the SNF PPS.⁶⁵

High average Medicare margins have raised some concerns, but so have the distributions of those margins. The high averages are the result of some HHAs and SNFs having margins well above the average, whereas others fall far below and may incur losses. In 2013, over one-quarter of HHAs and SNFs had Medicare margins in excess of 21.5 percent, 70 percent higher than the average. At the other extreme, the margins for providers in the lowest quartile were -3.4 percent or lower for freestanding HHAs and 3.7 percent or lower for freestanding SNFs.⁶⁶ These distributions raise questions about the underlying cause for the variation in financial performance, and whether it is due to differences in provider efficiency, patient populations, or the quality of care delivered— aspects that are difficult to measure.

The range of margins also raises concerns about rebasing as the mechanism to reduce average margins. Rebasing will likely be successful in changing that average, but it simply shifts the distribution. Some HHAs and some SNFs will earn margins well in excess of the average, indicating that Medicare pays too much. Some HHAs and some SNFs will incur larger losses. To the extent those losses reflect inadequate adjustment of Medicare payment rates to reflect the needs of patients being served, care for those patients may be jeopardized. Gainsharing has been suggested as an alternative to rebasing.⁶⁷ It could reduce average margins as well as affect the distribution of margins because both higher profits and larger losses are shared between Medicare and providers. Incentives that come from prospective payment for providers to minimize costs would be reduced somewhat, but gainsharing provides some protection for patients while there is uncertainty about whether the prospective rates adequately reflect patients' needs.

Case Mix Adjustment

Prospective payments to PAC providers are adjusted for patient acuity and services provided, also called case mix. Case mix systems (i) categorize

patients into groups that are expected to have similar resource use based on patient characteristics and (ii) adjust base rates up or down to pay for the cost of care to each patient type. With accurate case mix adjustment, providers would be indifferent to the acuity and resource needs of the patient, which is important to ensuring access for all types of patients under a prospective payment system. If case mix systems fail to accurately categorize patients, or are based on characteristics that are subjective and can be manipulated by providers, certain patients become more or less profitable which could lead providers to prefer some types of patients and to over- or under-provide services. Inadequate case mix adjustment may also be a factor in the wide distribution of margins discussed above.

Medicare’s case mix systems for the four PAC settings adjust payments on the basis of some generally similar characteristics (TABLE 3), such as functional status (for example, the ability to walk or dress), clinical conditions, and amount of therapy. But the case mix systems are still distinct from each other and use different specific patient characteristics and metrics. Medicare requires SNFs, HHAs, and IRFs—but not LTCHs—

TABLE 3: Post-Acute Care Case Mix Systems, by Setting

	Skilled Nursing Facility	Home Health Agency	Inpatient Rehabilitation Facility	Long-Term Care Hospital
Case mix system name	Resource Utilization Groups	Home Health Resource Groups	Case Mix Groups	Medicare Severity Long-Term Care Diagnosis Related Groups
Number of case mix groups	66	153	92	753
Patient characteristics that determine case mix group	<ul style="list-style-type: none"> • Minutes of therapy per week • Functional status • Clinical conditions • Other services like respiratory therapy or specialized feeding 	<ul style="list-style-type: none"> • Number of therapy visits per episode • Functional status • Clinical conditions 	<ul style="list-style-type: none"> • Reason for rehabilitation • Age • Cognitive and functional status • Comorbidities 	<ul style="list-style-type: none"> • Principal and secondary diagnoses • Procedures • Age • Sex • Discharge status
Patient assessment instrument	MDS	OASIS	IRF-PAI	none

Source: Medicare Payment Advisory Commission (MedPAC), *Payment Basics for skilled nursing facility and home health agency services*, October 2014, <http://medpac.gov/-documents/-payment-basics>; MedPAC, Report to the Congress: Medicare Payment Policy, March 2014, p. 246 (IRF), http://medpac.gov/documents/reports/mar14_entirereport.pdf; Centers for Medicare & Medicaid Services, *LTC-DRG Files: in FY2015 MS-LTC-DRG File, “Table 11, MS-LTC-DRGS, Relative Weights, Geometric Average Length of Stay, Short-Stay Outlier (SSO) Threshold, and ‘IPPS Comparable Threshold’ for Discharges Occurring From October 1, 2014 through September 30, 2015 under the LTCH PPS,”* www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/ltdcrg.html.

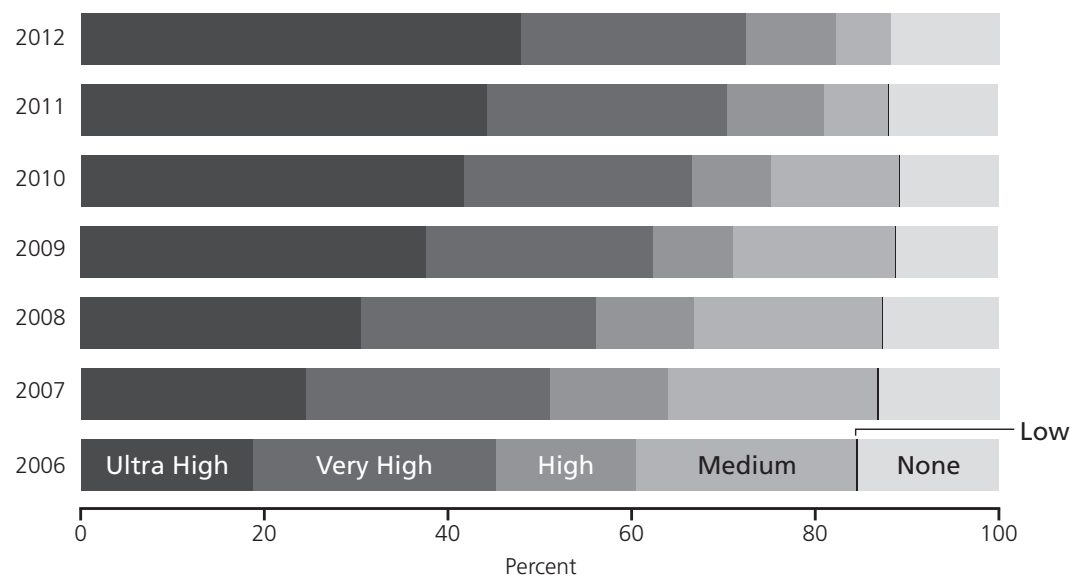
to use a patient assessment instrument specific to each setting for assigning patients to case mix groups. The IMPACT Act of 2014, however, requires PAC providers to begin collecting uniform assessment data beginning in 2018. These data are intended to provide the foundation for the development of a uniform payment system for PAC services.⁶⁸ They could, for example, be used to develop a common case mix system that could be used to align payments across PAC settings.

Therapy Payment in Home Health and SNF Payment Systems

Home health and SNF payments vary with the amount of therapy provided; they are not determined prospectively. MedPAC has found that the increased payments for patients in higher case mix groups (where patients get more therapy) more than cover the providers' costs of providing that additional therapy.⁶⁹

Because payments are determined by the amount of therapy provided, and not by the expected need for therapy based on patients' characteristics, this creates an incentive and an opportunity to furnish therapy that may exceed a patient's needs in order to receive additional payments. Home health and skilled nursing facility providers have responded to these incentives by shifting patients to higher payment therapy case mix groups over time. For example, **FIGURE 3** shows that SNF case mix has changed between 2006 and 2012, such that the percentage of

FIGURE 3: Share of SNF Patient Days in Therapy, by Intensity of Case Mix Groups



Source: Centers for Medicare & Medicaid Services (CMS), Office of Enterprise Data and Analytics (OEDA), Medicare and Medicaid Statistics Supplement, 2007-2013 editions, table 6.9 (2008-2013 editions) and table 6.9b (2007 edition), www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare/Medicaid-StatSupp/index.html.

total patient days in therapy has grown overall, and the share of therapy days in the “ultra high” case mix groups has increased substantially. According to MedPAC, this shift to more intensive therapy days is not explained by changes in the health status of beneficiaries receiving care in SNFs.⁷⁰ The Office of the Inspector General in HHS also found that therapy care provided to SNF patients was not related to patient characteristics.⁷¹ Since the implementation of the SNF payment system, CMS has revised the way it pays for therapy delivered in groups or delivered concurrently and added a requirement for patients to be reassessed (and for payment to be adjusted accordingly) when therapy is discontinued or when the amount of therapy increases or decreases. Even with these changes, the incentive to furnish therapy to achieve higher payments remains part of the SNF payment system.⁷²

The changes in home health case mix also illustrate providers’ responsiveness to therapy payment policy. From 2001 to 2007, episodes with ten or more therapy visits received a higher payment than those with fewer than ten therapy visits.⁷³ During this period the number of episodes with ten therapy visits grew.⁷⁴ In 2008, CMS changed the therapy payment policy to lower payments for episodes with 10 to 13 therapy visits and increase payments for episodes with 6 to 9 and 14 or more therapy visits.⁷⁵ Subsequently, providers delivered fewer episodes with 10 to 13 therapy visits and more episodes with 6 to 9 and 14 or more therapy visits, resulting in the “largest one year shift in therapy volume since the PPS was implemented.”⁷⁶ In 2011, CMS added a requirement for HHAs to review the need for therapy at points throughout the episode, and increased payments for non-therapy episodes and lowered payments for therapy episodes. Despite these changes, payments are still higher for therapy patients, and over 90 percent of the increase in episode volume since 2008 is attributable to episodes with six or more therapy visits.⁷⁷

MedPAC has recommended that Medicare discontinue using the amount of therapy as a factor in the home health and skilled nursing facility PPSs. It suggested that the payment systems instead use patient characteristics that predict therapy needs to set payment.⁷⁸

In addition to changes to the way therapy is factored into the case mix systems, MedPAC and others have recommended further refinements to case mix systems to improve the accuracy of Medicare’s PAC payments. For example, although SNF payments in aggregate more than cover providers’ costs, the SNF payment system does not accurately target payment for certain non-therapy ancillary services, such as expensive prescription drugs and parenteral feeding.⁷⁹ GAO and MedPAC have

The changes in home health case mix also illustrate providers’ responsiveness to therapy payment policy.

recommended that the payment system be refined to address this, both to avoid access problems for patients needing such services and to prevent under-provision of these services in SNFs.⁸⁰ CMS has made some changes to the SNF case mix system over time, but MedPAC has found these refinements inadequate to target payments properly for patients who need non-therapy ancillary services.

Short-Stay Discharge Thresholds for LTCHs

Changes in the timing of discharges after implementation of the prospective payment system for LTCHs in fiscal year (FY) 2002 also illustrate providers' responsiveness to payment incentive changes. A "short-stay" outlier policy was included as part of the PPS under which LTCHs were paid substantially less—less than half, in some cases—for patients discharged before a DRG-specific length-of-stay threshold. A recent analysis⁸¹ of lengths of stay for patients with a respiratory system diagnosis needing prolonged mechanical ventilation found that, before implementation of the PPS, lengths of stay were evenly distributed before and after the short-stay threshold. After implementation of the short-stay threshold, however, very few live patients "were discharged before the short-stay threshold, and there was a significant increase in the percentage of discharges on or immediately after the threshold."⁸² Discharges of patients who died did not follow this pattern. MedPAC has discussed changes to LTCH payment policy that would reduce the payment cliff associated with failing to cross the short-stay threshold,⁸³ but the study's authors remain skeptical of the efficacy of any policy that relies on length-of-stay thresholds to determine payment amounts.

Quality Measurement and Payment

Medicare's post-acute care PPSs do not currently pay on the basis of the quality of care provided. However, the ACA, the Protecting Access to Medicare Act of 2014 (PAMA), and the IMPACT Act all contain provisions that require one or more post-acute care providers to report on quality measures and impose financial penalties for not doing so. The ACA, for example, mandated CMS to require LTCHs and IRFs to report quality data by 2014 or face a 2 percent reduction in the applicable market basket update. Data collection for three LTCH quality measures began October 1, 2012, and data collection for two additional measures related to influenza vaccinations for patients and staff began January 1, 2014. Payment updates in 2016 and beyond will be affected by reporting on these measures.⁸⁴ In

2015, LTCHS will be required to report on two types of facility-acquired infections with consequences for payment updates beginning in FY 2017. Also beginning in FY 2017, CMS will begin calculating LTCHs' all-cause unplanned readmission rates to acute care hospitals. Four more measures will be added in FY 2018, bringing the total number of LTCH quality measures to 12.⁸⁵ In 2015 IRFs are required to report on two adverse events and additional quality measures related to influenza vaccinations for health care workers and patients.⁸⁶ Depending on the measure, payment updates will be affected in FY 2016 or FY 2017.

The 2014 IMPACT Act required a quality reporting program for SNFs. According to CMS, the program will use measures related to skin integrity, incidence of major falls, and functional and cognitive status. Reporting on these measures will begin in FY 2018.⁸⁷ PAMA required the Secretary to develop a potentially preventable readmission measure for SNFs who must begin publicly reporting on the measure in October 2017.

Home health agencies were required by the Deficit Reduction Act of 2005 to submit data from the Outcome and Assessment Information Set (OASIS) to the Secretary, which would allow for the assessment of quality of care. A 2012 report by the HHS Office of the Inspector General critical of CMS's oversight of HHAs' compliance with reporting requirements led to the development of a new pay-for-reporting program. Beginning July 2015, HHAs that fail to meet a reporting threshold will see a 2 percent reduction in their market basket updates.⁸⁸

Some PAC providers' future payments will also be adjusted based on their actual performance on various measures. The ACA required CMS to develop a plan to pay SNFs and HHAs for the quality of care they provide to Medicare beneficiaries. PAMA requires the Secretary to implement a value-based purchasing program by 2019 that would adjust a SNF's payments on the basis of its readmission rate.⁸⁹ This proposal is based on MedPAC research showing that 15 percent of Medicare patients discharged from a hospital to a SNF experience potentially avoidable readmissions to the hospital, either during their SNF stay or within 30 days after discharge.⁹⁰

Measuring quality in PAC settings is difficult for a number of reasons including lack of data on outcomes of care. It is also difficult because some patients receiving post-acute care will not regain function or recuperate from their illness. For this reason, adequate risk adjustment is key to making fair comparisons across providers and for avoiding penalizing providers who treat patients unlikely to recover from their

Measuring quality in PAC settings is difficult for a number of reasons, including lack of data on outcomes of care and because some patients will not regain function or recuperate from their illness.

condition. Creating financial incentives in the payment systems to improve quality of care may be especially difficult in a sector with such high Medicare margins. Providers can easily absorb small payment penalties or may not be motivated by rewards that are small in comparison to their profit margins. These dynamics may shift, however, if the size of penalties increases and as episode-based bundled payments for PAC services become more prevalent.

LOOKING AHEAD

Although spending on post-acute care has slowed of late, that slowdown reflects broader health care spending trends and only minimally reflects refinement of Medicare PAC policies. Long-standing problems with Medicare's payment systems for PAC providers persist: case mix systems poorly target payments and are easily manipulated, base rates set the level of payment too high, and data on risk-adjusted outcomes and appropriateness are lacking. For these reasons, MedPAC has frequently recommended the elimination of payment updates for PAC providers, urged CMS to rebase payments for some services, and called for moving toward a unified system that would peg payments to patient characteristics rather than sites of care. MedPAC has also recommended intermediate steps such as "aligned readmission policies [that] would hold PAC providers and hospitals jointly responsible for the care they furnish."⁹¹

Some have argued that adopting site-neutral payment, which MedPAC proposes for a limited number of conditions frequently treated in SNFs and IRFs, is simply a stop-gap measure until there is a more wholesale adoption of broader reforms such as bundled payment mandated by the ACA.⁹² The number of providers willing to go "at-risk" under the BPCI initiative has been limited, however, and few have taken on a full complement of episodes. Bundled payment models are still in their infancy and present conceptual and operational challenges that must be resolved before they can be fully adopted.⁹³ Efforts to impose value-based purchasing rubrics on PAC providers are also at the very early stages of implementation. The current payment systems will continue to be the dominant payment models while broader reforms are being developed and tested. Refinements to the post-acute care PPSs recommended by MedPAC and others could be pursued to reduce spending growth, redistribute payments within payment systems to better target payments to costs, and ensure that the program is purchasing quality PAC services.

Such refinements could improve the post-acute care prospective payment systems and could strengthen the foundation on which to build broader payment reforms.

ENDNOTES

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3. MedPAC, *A Data Book*, p. 116.
4. Mark E. Miller, MedPAC, “Medicare Post-Acute Care Reforms,” statement before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, April 16, 2015, p. 2, <http://docs.house.gov/meetings/IF/IF14/20150416/103327/HHRG-114-IF14-Wstate-MillerM-20150416.pdf>.
5. The adjustments are: (i) productivity adjustments to market basket updates for all four post-acute care settings, and (ii) a fixed percentage point reduction to the market basket updates for HHAs, IRFs, and LTCHs.
6. MedPAC, *Report to the Congress*, March 2015, p. 269.
7. Typically, post-acute care has been characterized as restorative or recuperative in nature, but in accordance with the *Jimmo v. Sebelius* Settlement Agreement, CMS has revised the program manual used by Medicare contractors to clarify that coverage for skilled nursing and skilled therapy services “does not turn on the presence or absence of a beneficiary’s potential for improvement, but rather on the beneficiary’s need for skilled care.” According to CMS, skilled care may be needed to “improve a patient’s current condition, to maintain the patient’s current condition, or to prevent or slow further deterioration of the patient’s condition.” CMS Manual System, Pub 100-02 Medicare Benefit Policy, Transmittal 179, January 14, 2014, p. 1, www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R179BP.pdf.
8. MedPAC, *Report to the Congress*, March 2015, p. 222.
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11. MedPAC, *Report to the Congress*, March 2015, p. 218.
12. MedPAC, *Report to the Congress*, March 2015, p. 220.
13. MedPAC, *A Data Book*, p. 113.
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15. Conditions of participation are minimum health and safety standards that are intended to protect beneficiaries and ensure quality care. Examples include staffing requirements, requirements for a range of services, and safety standards.
16. The 13 diagnoses are stroke; spinal cord injury; congenital deformity; amputation; major multiple trauma; hip fracture; brain injury; neurological disorders such as multiple sclerosis or Parkinson's disease; burns; three arthritis conditions for which appropriate, aggressive, and sustained outpatient therapy has failed; and hip or knee replacement when bilateral, when body mass index ≥ 50 , or age 85 or older. See MedPAC Payment Basics on IRFs, revised October 2014, <http://medpac.gov/documents/payment-basics/inpatient-rehabilitation-facilities-payment-system-14.pdf>.
17. MedPAC, *Report to the Congress*, March 2015, p. 265.
18. MedPAC, *Report to the Congress*, March 2015, p. 213 and p. 181.
19. MedPAC, *Report to the Congress*, March 2015, p. 239 and p. 261.
20. A spell of illness begins with the first day of a hospital or SNF stay and ends after 60 consecutive days during which a patient was not in a hospital or a SNF.
21. Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that (i) require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and (ii) must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result. CMS, *Medicare Benefit Policy Manual Chapter 8—Coverage of Extended Care (SNF) Services Under Hospital Insurance*, Rev. 204, March 13, 2015, www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf.
22. For a full description of IRF requirements see section 110, "Inpatient Rehabilitation Facility (IRF) Services," in the *Medicare Benefit Policy Manual Chapter 1—Inpatient Hospital Services Covered Under Part A*, Rev. 189, June 27, 2014, www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf.
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27. For a description of each payment system and a schematic diagram of all the adjustments made to the base rate in each setting, see MedPAC's Payment Basics series for each setting at <http://medpac.gov/documents/payment-basics> (filter by Post-Acute Care under Research Areas).

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