Medicare Post-Acute Care Delivery and Options to Improve It

Testimony before the U.S. House of Representatives

Energy and Commerce Committee

Subcommittee on Health

Statement of

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Good morning, Chairman Pitts, Ranking Member Green, and members of the Subcommittee. Thank you for the opportunity to speak with you today regarding the development of a payment system for episodes of post-acute care (PAC).

My name is Melissa Morley, and I am a researcher in the Health Care Financing and Payment Program at RTI International. RTI is an independent, nonprofit institute that provides research, development, and technical services to government and commercial clients worldwide. I am a graduate of Tufts University; McMaster University, where I studied health economics and Canadian health policy as a Fulbright Scholar; and the doctoral program at the Heller School for Social Policy and Management at Brandeis University. Since 2007, I have worked on several projects with the Assistant Secretary for Planning and Evaluation (ASPE) Office of Health Policy and the Centers for Medicare & Medicaid Services (CMS), looking at both the composition of PAC episodes and the potential to predict episode spending using patient assessment data. On the basis of my experiences conducting research in this area, I will highlight several relevant findings and note data and analyses required to move this payment approach forward.

Understanding PAC Episodes and Variation across the United States

The proportions of Medicare beneficiaries discharged to PAC, episode utilization, and spending differ significantly across the United States because of varying practice patterns and availability of PAC providers. Exhibit 1 shows these differences across 10 states that are among the top 5, middle 10, and bottom 5 by mean episode spending per beneficiary discharged to PAC. For example, 50.5% of beneficiaries are discharged to PAC services in Massachusetts, compared with 31.9% in Montana (Morley, Bogasky, Gage, Flood, & Ingber, 2014). Differences in provider supply, particularly with regard to long-term care hospitals (LTCHs) and inpatient rehabilitation facilities (IRFs), are key drivers of differences in overall episode spending. Home health agencies (HHAs) and skilled nursing facilities (SNFs) are generally available across geographic areas.

Establishing an episode-based payment requires an understanding of service use and spending on average. However, this is challenging when considering high-cost but low-frequency services such as LTCH and IRF services. Exhibit 2 demonstrates this issue by showing the differences in the mean spending per beneficiary using a particular service compared with the mean spending per beneficiary discharged to PAC (regardless of whether a particular service is used). For example, although only 2 percent of beneficiaries discharged to PAC use LTCH services, the mean cost for those using LTCH is over $35,000. When this spending is averaged over all PAC users, the mean cost is less than $700. This difference demonstrates a challenge in establishing a payment rate that is sufficient to accommodate the range of PAC services, especially given the differences in the supply of providers across the country.

Data Required for Episode-Based Payment System Development

To build a payment system for PAC episodes that is risk adjusted based on patient characteristics, standardized patient assessment data are critical. However, standardized assessment data are not currently collected across PAC settings. As part of exploratory work with ASPE, we have examined the potential to develop risk adjustment models using items from the Continuity Assessment Record and Evaluation (CARE) data, collected as part of the Post-Acute Care Payment Reform Demonstration (PAC-PRD) from 2008 through 2010, as well as items from the currently mandated assessment instruments (Morley et al., 2013; Morley, Coomer, Ingber, Deutsch, & Briggs, 2015). These efforts have demonstrated the potential to use CARE items (including medical items and items related to motor functional and cognitive status) as risk adjustors to predict episode spending. Results of this work also highlight important differences in the predictive power of the models, depending on the first site of PAC after discharge from an acute hospitalization. This foundational work is valuable in demonstrating the potential to use CARE items in an episode-based payment system, but additional standardized patient assessment data are needed to test the models on larger

samples and to examine any differences in significant risk adjustors across diagnosis groups (such as neurologic, cardiovascular, orthopedic, and so on). With the passage of the Improving Medicare Post-Acute Care Transformation Act of 2014—the IMPACT Act—more data may become available over the next several years, although it is not clear at this time which items will be collected across PAC settings and whether the data that will be collected will be sufficient for the purposes of building an episode-based payment system.

Additional Considerations: Complexities of Episode-Based Payments

Addressing the complexities of an episode-based payment system will require additional analyses as well as consideration of the results of the evaluation of the CMS Bundled Payments for Care Improvement (BPCI) Initiative. The BPCI Initiative is currently testing whether a bundled payment can reduce costs while maintaining or improving quality of care for Medicare beneficiaries (Dummit et al., 2015). Evaluation results to date on Model 3, which defines an episode as including PAC service use only, are limited in that there only nine episode initiators, seven of which are skilled nursing facilities. The first evaluation report is an early assessment of the BPCI Initiative based on one quarter of data. However, results of analyses looking at cost-shifting to the post-bundle period; beneficiary outcomes, using assessment data; and beneficiary experience, using surveys, are expected in future evaluation reports. Evaluation results comparing PAC-service-only episodes (Model 3) with more integrated episodes that include both the acute hospitalization and PAC services (Model 2) will also provide valuable information on provider incentives across episode definitions, as well as on differences in overall episode utilization and spending, cost-shifting, and beneficiary outcomes.

The foundation of an episode-based payment system is the diagnosis groups on which payments are made. Significant analyses and input from clinicians will be needed to develop the categories of diagnoses and to define unrelated readmissions for all diagnosis groups. Analyses to develop payment adjustments for geography will be important to

address differences in provider supply and differences in costs of care across geographic areas to ensure that payments are sufficient to provide care. Consideration of provider networks and resources to support beneficiary choice will also be important. For example, networks will need to accommodate care for beneficiaries in rural areas that may be far from where a beneficiary has his or her index acute hospitalization. Another consideration is related to the establishment of payments for services that continue past the end of an episode period. If an episode-based payment is made prospectively, as is the case across the current PAC payment systems, establishing a payment for services falling after the episode window will be important to consider. If establishing payment for post-episode services requires patient assessment data, there are implications for the timing of assessment data collection. End-of-episode patient assessment data could not only support any post-episode service payment but also could be valuable information for ensuring quality of care in episodes.

Episode-based payments offer the opportunity to coordinate across settings to provide care more efficiently and with greater beneficiary focus. The results of the ongoing analyses in the BPCI evaluation as well as availability of national standardized patient assessment data will be very important to moving this payment design forward. Thank you for the opportunity to speak with you today.

References

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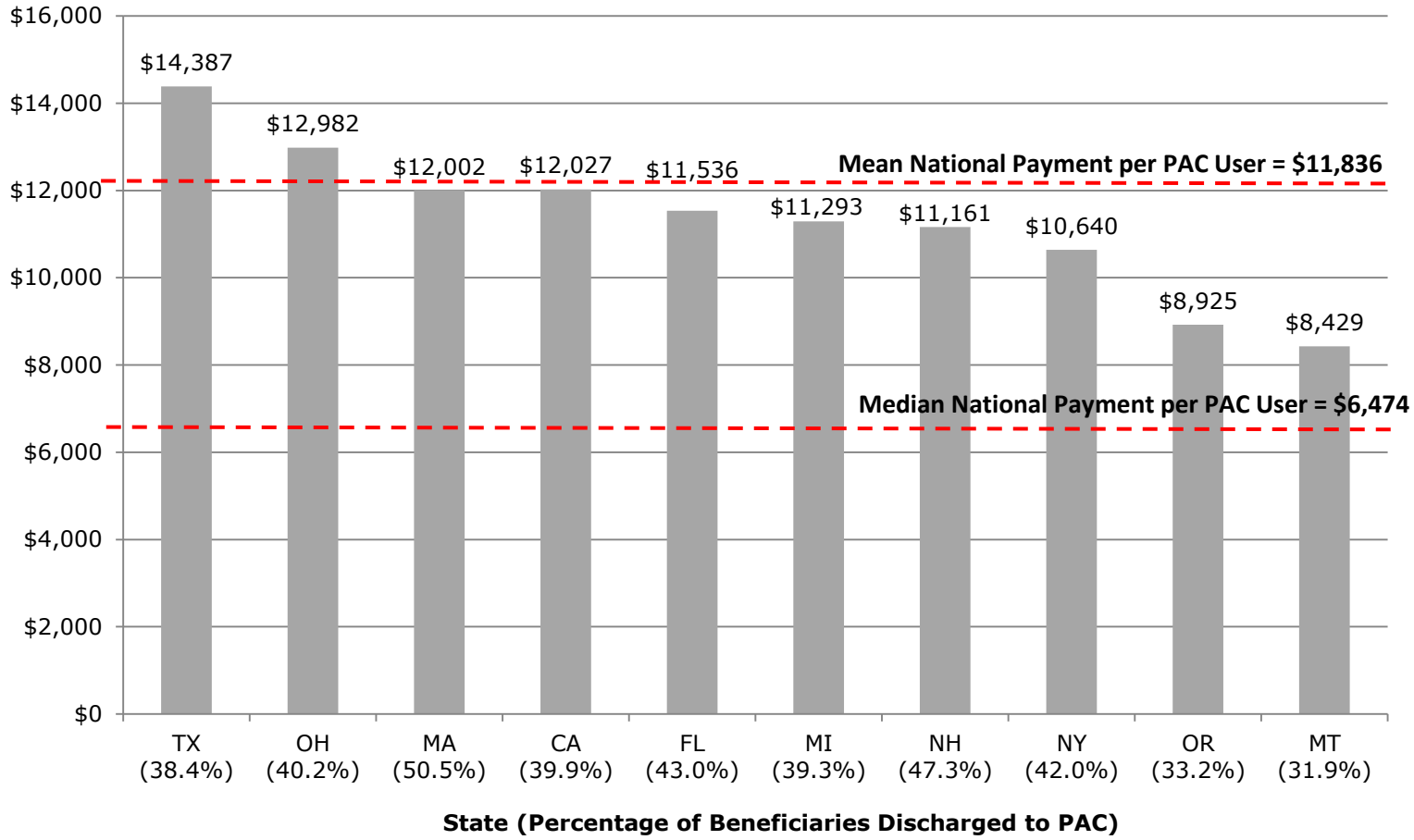
Dummit, L., Marrufo, G., Marshall, J., Bradley, A., Smith, L., Hall, C., et al. (2015, February). *CMS Bundled Payments for Care Improvement (BPCI) Initiative models 2-4: Year 1 evaluation & monitoring annual report* (Prepared for the Centers for Medicare & Medicaid Services [CMS]; Project Officer Shannon Flood]. Retrieved from http://innovation.cms.gov/Files/reports/BPCI-EvalRpt1.pdf

Exhibit 1. Mean PAC Episode Payment per PAC User, by State, 30-Day Fixed Episode



NOTES:

1. Adapted from Exhibit 5 from Morley, M., Bogasky, S., Gage, B., Flood, S., & Ingber, M. (2014). Medicare post-acute care episodes and payment bundling. *Medicare & Medicaid Research Review, 4*(1), E1–E12. doi:10.5600/mmrr.004.01.b02. 2. The 30-day fixed-length episode includes all long-term care hospital (LTCH), inpatient rehabilitation facility (IRF), skilled nursing facility (SNF), home health agency (HHA), and therapy claims initiating within 30 days of acute hospital discharge. 3. PAC, post-acute care.

Exhibit 2. Mean PAC Episode Payments, By PAC Service, 2008

Episode Definition	30-Day Fixed Length Episode
Home health agency (HHA)	
Percentage with claim	52.2
Mean payment per service user	$2,786
Mean payment per PAC user	$1,455
Skilled nursing facility (SNF)	
Percentage with claim	45.3
Mean payment per service user	$11,476
Mean payment per PAC user	$5,204
Inpatient rehabilitation facility (IRF)	
Percentage with claim	9.0
Mean payment per service user	$16,504
Mean payment per PAC user	$1,489
Long-term care hospital (LTCH)	
Percentage with claim	2.0
Mean payment per service user	$35,203
Mean payment per PAC user	$691
Acute hospital readmission	
Percentage with claim	14.8
Mean payment per service user	$11,594
Mean payment per PAC user	$1,718

NOTES:

1. Adapted from Exhibit 4 from Morley, M., Bogasky, S., Gage, B., Flood, S., & Ingber, M. (2014). Medicare post-acute care episodes and payment bundling. *Medicare & Medicaid Research Review, 4*(1), E1–E12. doi:10.5600/mmrr.004.01.b02.
2. The 30-day fixed-length episode includes all long-term care hospital (LTCH), inpatient rehabilitation facility (IRF), skilled nursing facility (SNF), home health agency (HHA), and therapy claims initiating within 30 days of acute hospital discharge.
3. PAC, post-acute care.