Analyzing Site-Neutral Payments in Post-Acute Settings

Kristine A. Betz, M.A., NHA, Consultant

The March 6 and 7 Medicare Payment Advisory Commission (MedPAC) meeting discussed preliminary issues with site-neutral payments between inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs) for conditions that are treated in both settings.

Summary

Although services provided in IRFs and SNFs differ, there is considerable overlap in the patients treated for some conditions. MedPAC is exploring a policy that would base payments to IRFs on the payments made to SNFs for select conditions.

To illustrate the issues raised by site-neutral payments, MedPAC selected the following three conditions: stroke, major joint replacement, and hip and femur procedures. These conditions make up a sizable share of IRF volume and spending, and are frequently treated in SNFs. Additionally, these are conditions that have been included in studies comparing IRF and SNF costs and outcomes, such as the Post-Acute Care Payment Reform Demonstration.

Using 2011 MedPAR data, MedPAC examined various characteristics of the patients treated in both settings and selected outcomes to assess whether the patients are similar. MedPAC found that, for the three selected conditions, patients who went to IRFs and SNFs were very similar in terms of their incoming functional status, as measured by mobility and self-care. Also, MedPAC found characteristics of IRF and SNF patients in the same market are similar: risk score (HCC), age, dual eligible, percent minority, and percent female.

MedPAC summed the SNF daily payments to a discharge basis to compare with IRF payments. Based on MedPAC's analysis, IRF payments range from 40 percent higher for major joint replacement (without major complications or comorbidities) to about the same payment made to SNFs for hip fracture patients. Per MedPAC's analysis, IRF stays had higher predicted mean costs per day compared to SNF patients, reflecting the higher intensity of services furnished to those patients given their short stays.

Despite this, the overlap in the distributions was still considerable for non-therapy ancillary and therapy costs. The relatively low overlap for therapy costs for hip and femur procedures reflects the larger differences in the SNF and IRF lengths of stay that translate into higher IRF costs per day and, therefore, less overlap in the distributions.

4400 Baker Road, Suite 100 | Minneapolis, MN 55343 | 763.537.5700 | www.healthdimensionsgroup.com

To assess the financial impact of paying IRFs the same rate as SNFs, MedPAC compared base payments to IRFs under current IRF policy for 2014 with two SNF scenarios: payments using the current SNF PPS, and payments under a MedPAC-recommended alternative SNF PPS design (because the Commission has long criticized the shortcomings of the current SNF PPS).

The alternative design bases payments on patient and stay characteristics rather than the amount of therapy furnished. It better targets payments for patients with high care needs for non-therapy ancillary services, such as drugs. Under each SNF scenario, MedPAC modeled the payment that the case would have received based on the characteristics of each individual case. To do this, MedPAC had to address a few differences in the IRF and SNF payments systems. First, MedPAC converted the SNF day-based payment to an IRF discharge-based payment. Also, the IRF PPS includes add-on payments per case, which the SNF PPS does not, for indirect medical education, share of low-income patients, and high-cost outliers. MedPAC assumed that IRFs would continue to receive full add-on payments for the cases paid under a site-neutral policy. The site-neutral policy would only affect the base payment. MedPAC modeled impacts at the individual DRG level and impacts to total payments at the facility level.

For the DRGs examined, both SNF payment scenarios resulted in a substantial decrease in payment for stroke and hip and knee replacement, and in increases in payment for hip fracture. Under SNF current policy for 2014, payments for IRF discharges would decrease by about 22 percent for stroke DRG 65, and 23 percent for hip and knee replacement DRG 470, while payments would increase by about 5 percent for hip fracture DRG 481. The impacts under the SNF alternative design were similar to those for current SNF policy.

Impacts on IRF payment rates were fairly consistent across the broader definitions of the conditions. Based on the per-discharge payment differences, MedPAC estimated the total financial impact on IRFs of site-neutral payment for the select conditions. For the three DRGs, MedPAC found that paying SNF rates under current SNF PPS policy in 2014 would save a net of about $300 million, which would represent about 4 percent lower total IRF payments, including add-on payments. For the broader set of eight DRGs, the payment impact was larger because more cases are included. In this case, Medicare savings would be about $415 million, or a 5 percent decrease in total IRF payments, including add-on payments. MedPAC found that the total payment impacts were smaller with the SNF alternative model.

Conclusion

Overall, the impact of site-neutral payments on total IRF revenue was similar between provider types. Non-profit, for-profit, hospital-based, and freestanding IRFs all had Medicare payments decrease by around 4 percent under site-neutral payments for the three DRGs. Payment of rural facilities decreased slightly more, by about 5 percent.

Site-neutral payments would decrease the total base payments slightly more for non-profit and hospital-based facilities, compared with for-profit and freestanding facilities, as non-profits and hospital-based IRFs have higher shares of patients with the three conditions; however, site-neutral payments in the MedPAC model did not change add-on payments, which typically add about 9 percent to all IRF-based payments on average.

Non-profit and hospital-based facilities receive more of these payments than for-profit and freestanding facilities, and receiving these add-on payments lessens the total financial impact of site-neutral payment policy for these providers. While these providers have larger shares of patients with the selected conditions, add-on payments make up a larger share of total revenue for these providers, and this revenue source is not impacted. Therefore, overall, the financial impacts of site-neutral payments on total revenue are similar between these provider types.

While MedPAC recognizes that IRFs face some fixed costs in their requirements, such as having a medical director of rehabilitation, IRFs could choose to provide less intensive therapy or medical care for individualized patients based on the patient's particular needs.

The Commission will provide further input on cases and conditions to focus on, whether there should be exemptions and which, and whether some IRF requirements should be waived to create a more level playing field between IRFs and SNFs for these cases. Next steps for advancing PAC reform include:

- Refine which conditions could qualify for site-neutral payments
- Identify key factors that predict admission to IRFs versus SNFs

About the Author

Kristine A. Betz, MA, CPG, NHA
Consultant, Continuum Strategies

Health Dimensions Group
4400 Baker Road, Suite 100
Minneapolis, MN 55343
P: 763.210.6722

E-mail: kristineb@hdgi1.com

Ms. Betz has a master's degree in gerontology and is a board-certified gerontologist and licensed nursing home administrator. As a consultant at Health Dimensions Group, Ms. Betz's areas of emphasis include market research and strategy development. She has considerable experience in population health across a variety of senior care environments and expertise in conducting market and regulatory research and data analysis across the entire senior care continuum. Previously, Ms. Betz was the director of home and community-based services for a multi-campus senior care organization in Minnesota and lead development and start-up efforts to open the organization's first palliative care residence.

About Health Dimensions Group

Health Dimensions Group is a fully integrated senior living health care management and consulting firm. For more than 20 years, we have partnered with hospitals, health systems, and long-term care and senior living providers to help them meet the ever-changing needs in their markets and plan for the future, while maintaining a healthy bottom line. For more information, visit www.healthdimensionsgroup.com or call 763.537.5700.