



CMA Weekly Alert – August 2, 2007

NOW IS THE TIME TO EXPRESS CONCERNS ABOUT CMS’ DEMONSTRATION PROJECT REGARDING POST-ACUTE CARE UNDER MEDICARE

Medicare beneficiaries who need additional care following discharge from an acute care hospital can currently receive care in one of four “post-acute” settings: skilled nursing facilities, at home, long-term care hospitals, and inpatient rehabilitation facilities. Each of these four settings has its own prospective payment reimbursement system. Three of the settings (all but long-term care hospitals) use a federally-mandated assessment instrument that is specific to the setting. Assessments are used for a variety of functions, including care planning, quality surveys, and reimbursement.

For many years, policymakers have been concerned about the different costs and outcomes of care in the four post-acute settings, but have had limited ability to make accurate comparisons among them. In section 5008 of the Deficit Reduction Act of 2005, Congress required the Centers for Medicare & Medicaid Services (CMS) to establish a demonstration program to understand “costs and outcomes across different post-acute care sites” and to develop and test “a standardized patient assessment instrument across all post-acute care sites to measure functional status and other factors during the treatment and at discharge from each provider.”

The post-acute care payment reform demonstration (PAC-PRD) program now in process is developing and testing a standardized patient assessment tool for use both by acute care hospitals at discharge (to determine Medicare beneficiaries’ post-acute care needs) and by post-acute settings, at both admission and discharge. In addition, the project is conducting a PAC payment reform demonstration “to examine differences in costs and outcomes for PAC patients of similar case mix who use different types of PAC providers.” RTI International is the lead researcher on both aspects of the demonstration.

Barbara Gage, the RTI principal investigator, and staff from CMS discussed PAC-PRD at a CMS-sponsored Open Door Forum on July 26. Since November 2006, the project has developed a uniform assessment instrument – Continuity, Assessment, Record and Evaluation (CARE) – and pilot-tested the instrument in Chicago. CARE includes a core set of items, which can be supplemented, and is shorter in length than the assessment instruments currently used by skilled nursing facilities and home health agencies. The project has also developed a cost and resource use (CRU) tool to measure “staff and ancillary resources associated with different types of patients” and pilot-tested the tool in Boston. Testing will expand in 2008.

Beneficiary Concerns

CMS believes the uniform post-acute care assessment instrument will lead to a post-acute Medicare reimbursement system that is patient-focused instead of facility-focused. While this sounds like a change that beneficiaries should support, there are potential problems.

If a single, comprehensive instrument accurately captures all relevant information that post-acute providers need in order to assure appropriate post-acute care for beneficiaries, use of the instrument could

lead to more uniformity, more accuracy, less confusion, and improved care outcomes for beneficiaries. *But if a key purpose of a uniform assessment instrument is saving Medicare reimbursement, beneficiaries will be harmed.* Costs may shift from one setting to another; uniform rates may give windfalls to some providers and eliminate other providers, while not improving care for beneficiaries; and beneficiaries may lose the right to make choices about where to receive health care.

Cost-shifting: How are costs measured? If only Medicare costs are considered, health care costs that are shifted to Medicaid, private insurance, or beneficiaries themselves will be ignored. Overall health care costs may remain constant, or even increase, but only savings to Medicare will be identified and measured.

When the prospective payment system for hospitals was introduced more than 20 years ago, hospital lengths of stay were reduced as patients moved to skilled nursing facilities to receive care. Research found that Medicare costs moved to SNFs and that many residents who would have gone home from the hospital remained in nursing homes for lengthy periods of time, often as Medicaid beneficiaries. Rehabilitation costs shifted from hospitals to SNFs and from Medicare to Medicaid.

Uniform Rates: PAC-PRD is intended to establish uniform rates, based on residents' assessed needs and services. However, if assessments are not sufficiently comprehensive and if not all the necessary services are identified, uniform rates will adversely affect providers that provide more comprehensive services. This concern arises with inpatient rehabilitation facilities that provide more comprehensive rehabilitation services than skilled nursing facilities, with better patient outcomes. See, "[Maintaining Quality Rehabilitation Options for Medicare Beneficiaries](#)" (*CMA Weekly Alert*, March 8, 2007).

Choice: Federal law generally guarantees Medicare beneficiaries the right to choose among all post-acute providers that are certified to provide them with care. A uniform assessment instrument may limit beneficiaries' choice to the least expensive care setting, regardless of beneficiary choice.

Statements by CMS suggest that beneficiaries may lose their ability to choose among post-acute providers. CMS stated in the July 27 Federal Register notice, and in a September 2006 "Post-Acute Care Reform Plan" developed by CMS's Policy Council, that it will use the project's data "to develop a setting neutral post-acute care payment model." The Policy Council's Reform Plan combines its discussion of site neutrality with a description of the President's 2007 Budget as including "a proposal to reduce the excessive difference in payment" between inpatient rehabilitation facilities and skilled nursing facilities. Whether the payment difference is appropriate or excessive is one of the issues that the PAC-PRD is intended to learn. CMS's pre-judging of the PAC-PRD's findings suggests that a "setting neutral" payment model may lead to limitations on beneficiaries' choice of providers.

Conclusion

The post-acute care payment reform demonstration holds promise, but also significant challenges, for Medicare beneficiaries. On July 27, CMS published a notice in the Federal Register announcing the availability of the CARE instrument and providing a 60-day public comment period. RTI also solicits public comments on the demonstration which can be submitted to pat-comments@rti.org. Advocates need to participate in the demonstration and to share their concerns about CARE, CRU, and the demonstration with CMS and RTI.

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References

Deficit Reduction Act of 2005, section 5008

CMS website on demonstration, with link to Open Door Forum documents, Federal Register notice, <http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,%20keyword&filterValue=post%20acute&filterByDID=0&sortByDID=3&sortOrder=ascending&itemID=CMS1201325&intNumPerPage=10>

72 Federal Register 41328 (July 27, 2007) (availability of CARE instrument for public comment)

CMS Policy Council, “Post-Acute Care Reform Plan” (Sep. 28, 2006), http://www.cms.hhs.gov/SNFPPS/Downloads/pac_reform_plan_2006.pdf

Center for Medicare Advocacy, “Maintaining Quality Rehabilitation Options for Medicare Beneficiaries” (Weekly Alert, March 8, 2007), http://medicareadvocacy.org/AlertPDFs/2007/07_03.08.IRFsVsSNFs.pdf