

Inside Washington Publishers'

Inside CMS

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from Vol. 11, No. 21, October 16, 2008

MedPAC LOOKS TO DROP PAYMENTS FOR FREQUENT REHOSPITALIZATIONS

Looking to shake up a system that many believe rewards skilled nursing facilities (SNFs) for re-hospitalizations, the Medicare Payment Advisory Commission (MedPAC) is mulling proposals to shrink CMS payments for SNFs with unduly high readmission rates. Staff for the congressionally mandated Medicare payment commission is also pitching a recommendation to further develop the idea of bundling hospital stays with high-cost SNF and other post-acute care (PAC) services.

The deliberations come as lawmakers and stakeholders in the health care reform debate are increasingly looking for ways to save health care dollars by stemming unnecessary hospital visits. They also coincide with CMS' development of a demonstration project, currently in the Office of Management and Budget clearance process, that would use potentially avoidable re-hospitalization rates as a performance measure in a pay-for-performance quality program.

MedPAC staff spelled out for commissioners at an Oct. 2 meeting its concerns that financial incentives play a role in repeat hospitalizations and SNF admissions. More than one-third of SNF patients had two or more hospital-to-SNF admission within a day of each other and 7 percent had four or more, staff said. A recent HHS Office of Inspector General study on patients who had three or more back-to-back hospital and SNF stays found that 35 percent of those stays were associated with quality of care problems, at a cost of \$4.5 billion in 2007, they said.

It's not just the cost to Medicare that's disconcerting about frequent re-hospitalization, commission staff said, noting that the trend is also indicative of poor care and transition for patients who are especially vulnerable. Hospitals, lacking a disincentive, will continue to readmit patients, even if they could have been treated by the sending institution, staff said. And separate insurance programs create incentives to re-hospitalize long-stay nursing home residents to shift costs between payers, notably between Medicaid and Medicare thus qualifying patients for the latter's higher payment rates.

To repair what they view as a costly and unhealthy pattern, MedPAC commissioners mulled over lowering SNF payments for facilities with relatively high hospital readmission rates for select conditions. The move would align SNF policy with earlier panel recommendations for hospitals.

The idea saw wide, but not universal, support from commissioners. Mitra Behroozi, executive director of 1199SEIU Benefit and Pension Funds, said applying the payment change to facilities with high re-hospitalization rates for custodial patients was an obvious move.

"It seems like that's sort of the lowest hanging fruit," Behroozi said. "I just don't see why we wouldn't right now say any institution that is not caring for its patients — the ones that it has in-house, the custodial patients — well enough that they are re-hospitalized too often for potentially avoidable conditions shouldn't pay some consequence in payment."

But some commissioners warned against penalizing facilities for outcomes they said would be out of their hands. Referencing patients that might not take prescribed medications or do their part with follow-up exams, Ronald Castellanos, a urologist with Southwest Florida Urologic Associates said, "the hospital or the physician should not be, excuse me, dinged for that." And Harvard Medical School's Michael Chernenew said that he wasn't convinced that a facility with a high readmission rate is "a bad institution, as opposed to having a worst-case mix, although I'm pretty sure that some of these institutions are bad institutions.

"I am convinced that the payment incentives are probably really bad, and so that does probably create a lot of problems," Chernenew continued. "And it creates problems, in my opinion, that probably extend well beyond readmissions for these things but extend to a whole series of things. The measurement issues become complicated in terms of where you define a readmission versus a first admission versus how you do the case-mix adjustments."

Chernenew suggested equalizing Medicare payments to for-profit and not-for-profit SNFs.

MedPAC staff pitched a second recommendation to further develop the idea of bundling stays with high-cost

SNF and other post-acute care (PAC). Bundling, staff said, could reduce unnecessary hospitalizations, eliminate therapy services of little clinical value and encourage hospitals to find the most appropriate post-acute setting for their patients.

Over the years, studies have shown hospital-level risk could be lowered if a certain number of days' worth of post-hospital, post-acute care was integrated with inpatient stay costs and paying for both via an all-inclusive, single-fee basis. Staff told commissioners that certain number could be 30 days or 100 days.

This effort would best be done incrementally, staff said. For example, it could start with confidential reporting back to SNFs about their episode costs, then public posting of that information, then reducing payments to SNFs with high re-hospitalization rates and then finally a bundling pilot.

But the majority of the commission's time at the Oct. 2 meeting was spent reasoning out the payment recommendation. Commissioners noted that repeat users, in comparison to non-repeat users, are more likely to be dual-eligible and sicker. The second or third readmission tended to have higher shares of medically complex days, as well. MedPAC has previously recommended to CMS that the agency revise its publicly reported quality measures to include facility rates of potential re-hospitalizations. That recommendation stated that the SNF PPS encouraged some SNFs to re-hospitalize patients with high non-therapy ancillary costs rather than treat the patients themselves.

MedPAC commissioners are still clamoring for more details. William Scanlon, a Virginia-based health policy consultant, echoed the questions of other members when he asked, "How do we measure care for a deteriorating person? What's a good outcome measure for that?" While it's unclear exactly what MedPAC will ultimately recommend, the consensus appeared to be moving forward with some strong language.

"The particularly explosive combination is for-profit skilled nursing facilities whose measure of performance is maximizing their Medicare percent of revenue," said Nancy Kane from Harvard School of Public Health. "And if you read any of these guys' SEC filings, that is their measure of success and that's what makes them profitable. And when you've got vulnerable Medicaid patients who are custodial in those settings it's just too darn tempting to get them back on a Medicare basis for profitability, for having to provide the best quality care and helping your costs. It's just too tempting."

Peter Butler, of Rush University in Chicago, agreed: "For the most part, hospitals don't want these patients. They don't tend to be profitable. They tend to be medical. They tend to be hard." Some patients, such as those not unstable enough to justify an acute admission, but still in need of a great deal of attention due to ongoing problems, are difficult no matter what caregivers do, other commissioners said.

The critical tone of the discussion troubled at least one member of the small audience. Larry Lane, vice president of Genesis HealthCare, a private company with 250 LTC facilities, told commissioners he was pained to hear the suggestion that some SNFs might move patients around purely with an eye on dollar values.

"The bias assuming inappropriate behaviors and demonizing ownership is not particularly constructive," Lane said. "The truth of the matter is I've met scholars and scoundrels on both sides. Don't demonize our people who are trying to do their best."

Lane also had critical words for the bundling discussion, calling the notion "a conclusion looking for a justification" in his comments to commissioners. "Let's not go too far in a stampede there because you'll find the issue has been on the table over 40 years and still has not moved," he said.

The American Association of Homes and Services for the Aging told Inside CMS the group is urging Congress to revise the SNF payment system to more accurately reimburse for non-therapy ancillaries and to eliminate financial incentives for medically-inappropriate therapy services.