White Paper

Site Neutral Payment Methodology and Long Term Services and Supports Implications

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Executive Summary

Currently, the Medicare system reimburses each type of post-acute care (PAC) provider according to different payment methodologies. Existing payment policies focus on phases of a patient’s illness defined by a specific service site, rather than on the characteristics or care needs of the patient. As a result, patients with similar clinical profiles may be treated in different settings at different costs to Medicare.

A site neutral payment methodology is constructed upon the following core concepts:

- Person- or patient-centered care;
- Use of a common assessment tool that would foster movement among various settings based on need; and
- Collaboration and coordination across multiple sites of care and disciplines intended to ensure efficient and effective recovery as well as return to home and community.

The following document offers background on various efforts which resulted in support for a site neutral payment methodology, additional detail on the core elements, and an estimated savings amount which could be used to address out-year long-term services and supports (LTSS) access needs and related costs.

Background

Currently, the Medicare system reimburses each type of PAC provider according to different payment methodologies. Existing payment policies focus on phases of a patient’s illness defined by a specific service site, rather than on the characteristics or care needs of the Medicare beneficiary. As a result, patients with similar clinical profiles may be treated in different settings at different costs to Medicare. This payment system fails to encourage collaboration and coordination across multiple sites of care and provides few incentives that reward efficient care delivery. Such misalignment has been understood and acknowledged for several years.

In May 2005, the CMS Administrator formed the Health Care Policy Council to serve as a vehicle for the Agency’s senior leadership to develop strategic policy directions and initiatives to improve our nation’s health care system. One of the Council’s first priorities was to develop a plan for PAC reform. The Council developed a set of PAC reform principles. Using these principles, the Council crafted a PAC vision to guide current and future reform activities.

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As a first step in addressing the current problems in the post-acute care system, the PAC Workgroup developed a set of principles for reform which were approved by the broader Policy Council. These principles are summarized below:

- Increasing consumer choice and control of PAC services by Medicare beneficiaries, their family members and caregivers.
- Providing high-quality PAC services in the most appropriate setting based upon patient needs. This requires delivering services to patients in the right PAC setting at the right time, as well as measuring patients’ progress and the quality of care provided in PAC settings.
- Developing effective measures (including process measures) in order to drive the PAC system toward the delivery of high-quality care in the most effective manner and, thus, improve payment efficiency.
- Providing a seamless continuum of care for beneficiaries through improved coordination of acute care, PAC and Long-Term Services and Supports (LTSS), including better management of transitions among care settings.

The central concept of CMS’ vision for PAC was that the system will become patient-centered; that is, the system will be organized around the individual’s needs, rather than around the settings where care is delivered. Such a person or patient-centered concept is at the core of a site neutral payment methodology.

In addition, the Deficit Reduction Act (DRA) of 2005 mandated a demonstration that supported PAC payment reform. Implementation of the DRA demonstration thus became a key element of CMS’ strategy for PAC reform. Under this provision, the Secretary was to establish a demonstration program by January 1, 2008 that would, for diagnoses or diagnostic conditions specified by the Secretary:

- Use a comprehensive assessment at hospital discharge to help determine appropriate PAC placement based upon patient care needs and patient clinical characteristics;
- Gather data on the fixed and variable costs for each individual and on care outcomes in various PAC settings; and
- Use a standardized assessment instrument to measure functional status and other factors during treatment and at discharge across PAC settings.

The demonstration was mandated for a three-year period. In January 2012, CMS provided a Report to Congress on the Post-Acute Care Payment Reform Demonstration (PAC-PRD).
The net result of this undertaking was the development of a common assessment tool and significant movement toward the ability to compare patients across settings. The demonstration collected comparable nursing and therapy resource use and developed a patient assessment instrument to be used across PAC settings. The evaluation found a common set of patient characteristics that explained much of the variation in nursing and therapy costs across settings and indicated that a common case-mix measure could be developed across the institutional settings (SNF, IRF, and LTCH). However, more analysis would be required to integrate HHAs into a common system. Some differences among settings were found, but the report concluded that comparable, risk-adjusted outcomes measures are possible across PAC settings with a common assessment tool (i.e., the CARE Tool).

In addition to CMS, the Medicare Payment Advisory Commission (MedPAC) has considered several proposals to expand site-neutral payment beyond the demonstration. Its proposals ranged over a wide array of provider types. For example, one proposal would expand the site-neutral policy to 66 additional ambulatory payment classifications. Another more targeted proposal would equalize payment between physician offices and hospital outpatient departments for three high-volume cardiac imaging APCs.

MedPAC established criteria for selecting potential services related to the mix of sites used, patients’ severity, similarity of service definitions, and frequency of an associated emergency department visit (which raises the service costs). This year, MedPAC began an examination of how Medicare could equalize payments for similar patients treated in long-term care hospitals (LTCHs) and acute care hospitals. And, in his remarks to Congress in 2013, the MedPAC executive director indicated that equal payments for similar PAC services would build on the Commission’s work examining Medicare’s payments for select ambulatory services.

The Commission has recommended and discussed many changes to PAC that would increase the value of Medicare’s purchasing power and improve beneficiaries’ care coordination of care. These include site-neutral payments which would create more equity across providers in different sectors. MedPAC believes that such a change could be implemented in the near-term and would serve as building blocks for broader payment reforms such as bundled payments and ACOs.

MedPAC stresses that without uniform information about the patients discharged from the hospital and treated in different PAC settings, it is difficult to make appropriate placement decisions and to compare the costs and outcomes across settings. CMS completed a mandated demonstration of a common assessment tool in 2011 and concluded that the tool it developed could serve as a single

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tool for all settings. MedPAC calls on CMS to outline its plans for how to adopt the CARE tool, or a subset of its elements, across PAC settings and in hospitals.

Recent Proposals

In the April 2013 Moment of Truth Project report, “A Bipartisan Path Forward to Securing America’s Future,” the Co-Chairs, Erskine Bowles and Senator Alan Simpson proffered a plan to put America’s fiscal challenges. As part of the plan, they proposed reforming PAC payments and included in that proposal equalizing payments between rehabilitation services provided in different settings.

In the condensed budget of the U.S. Government, the Administration expresses support for policies that will encourage efficient utilization of services and improve the quality of care. The Budget’s proposals include adjusting payment updates for certain PAC providers and equalizing payments for certain conditions, which is projected to save about $81 billion over 10 years. The Budget also encourages appropriate use of inpatient rehabilitation hospitals and adjusts SNF payments to reduce unnecessary hospital readmissions with projected savings of $5 billion over 10 years.

In the “President’s Plan for Economic Growth and Deficit Reduction, Legislative Language and Analysis,” the Budget proposes to restructure PAC payments. The legislative language adjusts Medicare payments for three conditions involving hip and knee replacements, and hip fracture as well as other conditions selected by the Secretary at her discretion. The named conditions are:

- Unilateral knee replacement;
- Unilateral hip replacement; and,
- Unilateral hip fracture.

The Budget document indicates that these conditions are commonly treated in different PAC settings but at differing costs. This section would reduce differences in payment for treatment of the specified conditions to limit inappropriate financial incentives and encourage the provision of care in the most clinically appropriate setting for the beneficiary.

1 *Budget of the U.S. Government, Fiscal Year 2014*

2 *President’s Plan For Economic Growth And Deficit Reduction, Legislative Language And Analysis, 2*
Site Neutral Savings Model & LTSS Implications

As discussed above, many believe that a site-neutral payment system would produce savings and achieve better outcomes for patients. In an effort to improve quality of care and generate cost-saving concepts, a new patient-focused payment model would be developed that would reduce PAC spending while facilitating movement toward a more rational system for PAC payment and delivery. Under a site neutral payment system, patients would be grouped by clinical condition and severity of illness using a single assessment tool and the payment for patients within each group would be the same regardless of where the patient is receiving treatment. The payment rates for each category would cover the expected costs of providing the appropriate type, duration and mix of services. A single Medicare payment would be made to each PAC provider to cover the services provided to the patient.

The patient assessment tool would also be used at points within the patient’s episode of care, particularly at care transitions, to ensure high-quality care delivery throughout the care continuum. Such a tool will allow CMS to monitor the quality of care provided and collect patient information in a standardized form. Providers can then share that information with each other and enable better care coordination and increase care efficiencies.

At a minimum, this new model would cover the services currently covered under Medicare Part A and delivered in long-term care hospitals, skilled nursing facilities, home health care services, and inpatient rehabilitation facilities. The concept would focus patients, first, empowering them and their physicians to determine the best PAC plan and placement.

A site neutral payment system would allow people using LTSS to be served in the right setting, at the right time and in a cost effective manner when they require PAC services.