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INVITED COMMENTARY

Site-Neutral Payment for Postacute Care: Framing the Issue

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Abstract

This commentary evaluates the merits of proposals in the United States to create a site-neutral payment system for postacute care for patients with select rehabilitation-related conditions. Under a site-neutral payment system, Medicare would pay providers based on patients' clinical needs, not on the peculiarities of individual postacute settings such as skilled nursing facilities and inpatient rehabilitation facilities. This commentary frames the policy choices by taking into account the research evidence on setting costs and outcomes, the policy tools and preconditions needed for an effective site-neutral payment system, and the overall direction of American health and postacute policy.

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The administration, Congress, and Medicare Payment Advisory Commission have proposed using "site-neutral payment" to help arrest the growth of Medicare postacute care expenditures that, in fiscal year 2012, came to $62.1 billion in the fee-for-service portion of the Medicare program.[1] Under site-neutral payment, Medicare would pay postacute providers based on the types of patients they serve, not on the characteristics of each postacute setting. Currently, Medicare pays each type of postacute provider differently, often for similar types of patients, using different payment models and at greatly varying amounts. In short, the argument is how much Medicare pays should be driven by patient need, not by provider characteristics or particular setting of care. A site-neutral and patient-centric payment system would presumably help level the playing field among postacute providers and help steer patients to the less costly postacute settings commensurate with their clinical needs and goals.

Compelling as site-neutral payment may be, it is much less straightforward than it appears. I propose we hit the pause button, consider the research evidence to date, identify the preconditions needed for an effective site-neutral payment system (if that is where we choose to go), and consider the larger policy context—that is, where health care delivery and payment are going and where site-neutral payment fits into this longer journey. I fear that site-neutral payment may address today's perception of the problem only to create difficulties in developing a more rational and coherent payment system.

Two sets of site-neutral postacute payment have been proposed for postacute care. First is site-neutral payment for patients with select conditions such as major joint replacement, hip fracture, pulmonary disease, and possibly stroke going to skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs). These proposals presume that many patients with these types of conditions do not need the intensity of care rendered in IRFs and could be served in less resource-intensive and less costly SNFs. Predictably, the SNF industry champions the proposal,[2] and IRF representatives argue that their patients are different, have higher acuity needs, and are bounded by costly additional regulatory requirements that SNFs do not face.[3-6]

Second is site-neutral payment for long-term care hospitals (LTCHs) where Medicare would pay LTCHs for select patients using acute care hospital rates—that is, rates used in the prospective diagnoses-related group payment system. Remarks here focus on site-neutral payment with respect to SNFs and IRFs and only indirectly to site-neutral payment for LTCHs and acute care hospitals.

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The Research

Nearly 40% of Medicare patients are discharged from acute care to 1 of 4 postacute settings: SNFs, IRFs, LTCHs, or to their homes with home health services.[7,8] This estimate does not include patients who initially obtain their postacute care in an outpatient setting. Today's Medicare postacute patients typically use not just 1 setting, but multiple postacute settings during a given episode of care.[7,9-11]

The call for site-neutral payment stems from research related to (1) geographic variation in postacute expenditures, (2) varying postacute expenditures for similar patients, and (3) similarities in outcomes among seemingly similar patients served by different types of postacute providers.

Geographic variation

A recent Institute of Medicine report found that postacute care is the main driver in the geographic variation in Medicare expenditures.[12] The Institute of Medicine committee reports that 73% of the regional variation in Medicare expenditures across the nation's 300+ "health referral regions" is due to the variation in postacute expenditures, chiefly home health expenditures. This variation is, in part, a function of the widely varying postacute capacities across the nation relative to the numbers of Medicare beneficiaries in each geographic area.[13] In other words, what postacute care patients receive is driven not necessarily by patient need but by the types of postacute facilities in a given market area. Other research[10,14] suggests that geographic access is also driven by postacute provider relationships with referral sources. Implicit in these studies is the question of whether patients served in more costly postacute facilities in some markets would have been served in less costly postacute settings had they lived in other markets.

Varying expenditures across postacute settings

Considerable research has shown that Medicare postacute expenditures for similar patients vary across postacute sites. Using a 5% sample of Medicare claims data for 2007 and 2008, the Medicare Payment Advisory Commission reports, for example, that stroke patients cost $40,881 if initially discharged to an IRF, $33,266 if discharged to a SNF, and $13,344 if discharged home with home health care for a given 90-day episode of both acute and postacute care. Analysts used standardized payments that took into account varying wage levels and other facility payment adjusters.[15] Data were risk adjusted using medical severity diagnosis related groups. These differences do not take into account differences not captured in administrative claims data such as admission functional status, although we know that admission functional status is a robust risk adjuster and predictor of outcome.[7,16-25] Even with additional risk adjusters, it is unlikely that these differences can be explained fully based on patient health and functional status.

Since 2007-08, the period from which these data were obtained, differences in payment levels between SNFs and IRFs have narrowed with the revisions to the SNF resource utilization group payment methodology that have allowed SNFs to classify more patients into higher-paying resource utilization groups.[26]

List of abbreviations:

IRF **inpatient rehabilitation facility**
LTCH **long-term care hospital**
SNF **skilled nursing facility**

Overlap in patients and outcomes across postacute settings

Although different postacute settings are aimed at different sets of patients, there is considerable overlap in the types of patients admitted to postacute settings.[7] Research has been mixed with respect to outcomes across settings for similar types of patients. In one of the largest studies (N = 13,544) in postacute outcomes, Gage et al[7] found that after controlling for patient differences, IRFs had 30% better self-care outcomes than did SNFs but did not have significantly better self-care outcomes among patients with musculoskeletal conditions. Home health agencies had 35% better self-care outcomes among patients with musculoskeletal conditions than did either SNFs or IRFs. However, IRFs had 35% better self-care improvement outcomes among patients with neurologic conditions such as stroke. When examining mobility outcomes, however, Gage[7] found that provider setting was not associated with outcomes in either the musculoskeletal or neurologic subpopulation when controlling for patient acuity. With respect to 30-day hospital readmission rates, the Research Triangle Institute study found "no significant differences between IRFs or home health agencies and SNFs" when adjusting for patient acuity. Its analysis did not take into account reasons for readmissions, which may have been planned or unplanned.[7(p20)]

The study by Gage[7] joins an array of studies[16,18,20-22,27-30] that have compared outcomes across postacute sites. Most of these have been smaller studies that have failed to find striking differences in outcomes for similar patients, except that studies have found that IRFs have better functional outcomes with respect to neurologic conditions such as stroke.[18,28] Cross-site outcome studies have often been problematic, however, owing to 1 or more study limitations: small sample sizes, potential selection effects, reliance on administrative claims data, lack of appropriate outcome measures, and lack of uniform patient assessment by which to risk adjust for differences in patient clinical profiles and patient outcomes. SNF-IRF comparisons often lack uniform periods. For example, when outcomes are measured at discharge, we may be comparing a 20-day stay in an SNF and a 12-day stay in an IRF when 8 additional days result in additional gains, not captured in the comparison. Moreover, within-site differences in outcome may be greater than cross-site differences.[16]

Randomized trials are lacking in cross-setting outcomes research owing to challenges in patient recruitment within acute care before postacute placement. Most research findings are often far more nuanced than a simple "yes" or "no" answer to the questions asked: Is one setting more effective than another for a given type of patient? Does setting matter? All of this is compounded further by the fact that a given setting may be only one of several postacute settings used by the patient in a given episode of care. The study by Gage,[7] for example, only examined outcomes after the first postacute placement.

Larger Policy Questions

Apart from research findings, we need to ask (1) whether the policy tools are in place to effectively administer a site-neutral payment system for select groups of patients; (2) whether a site-neutral payment system for select conditions should and can coexist with existing postacute payment systems; (3) whether site-neutral payment between SNFs and IRFs is too narrowly