

Testimony

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MEDICARE POST-ACUTE CARE

Cost Growth and Proposals to Manage It Through Prospective Payment and Other Controls

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Medicare Post-Acute Care: Cost Growth and Proposals to Manage It Through Prospective Payment and Other Controls

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss Medicare's skilled nursing facility (SNF), home health care, and inpatient rehabilitation benefits and the administration's forthcoming legislative proposals related to them. After relatively modest growth during the 1980s, Medicare's expenditures for SNFs and home health care have grown rapidly in the 1990s. Expenditures for inpatient rehabilitation facilities have grown rapidly since the mid-1980s. SNF payments rose from \$2.8 billion in 1989 to \$11.3 billion in 1996, while home health care costs grew from \$2.4 billion to \$17.7 billion over the same period. Rehabilitation facility payments increased from \$1.4 billion in 1989 to \$3.9 billion in 1994.¹ Over those periods, annual growth averaged 22 percent for SNFs, 33 percent for home health care, and 23 percent for rehabilitation facilities.

My comments today will focus on the reasons for cost growth and the administration's announced legislative proposals for these three Medicare benefits. The information presented today is based on our previous work and the most recent data on the benefits available from the Health Care Financing Administration (HCFA), which manages Medicare. Because the legislative proposals were only recently released by the administration, our analysis was primarily based on summaries of them that were publicly released earlier in the year and our discussions with HCFA officials about the proposals.

In brief, Medicare's SNF costs have grown primarily because a larger portion of beneficiaries use SNFs than in the past and because of a large increase in the provision of ancillary services. For home health care costs, both the number of beneficiaries and the number of services used by each beneficiary have more than doubled. Although the average length of stay has decreased for inpatient rehabilitation facilities, a larger portion of Medicare beneficiaries use them now, which results in cost growth. A combination of factors led to the increased use of these benefits:

- legislation and coverage policy changes in response to court decisions liberalized coverage criteria for the SNF and home health benefits, enabling more beneficiaries to qualify for them;
- these changes also transformed the nature of home health care from primarily posthospital care to more long-term care for chronic conditions;

¹Expenditure data for inpatient rehabilitation were obtained from the Prospective Payment Assessment Commission.

- earlier discharges from hospitals led to the substitution of days spent in SNFs for what in the past would have been the last few days of hospital care;
- use of ancillary services, such as physical therapy, in SNFs has increased, and specific controls for these services have not been implemented;
- rapid growth in the number of inpatient rehabilitation beds available and use of these beds by beneficiaries, as well as the likelihood of some substitution of rehabilitation days for general hospital days, led to higher expenditures for inpatient rehabilitation; and
- a diminution of administrative controls over the benefits, resulting at least in part from fewer resources being available for such controls, reduced the likelihood of inappropriately submitted claims being denied.

The administration's major proposals for both SNFs and home health care are designed to give the providers of these services increased incentives to operate efficiently by moving them from a cost reimbursement to a prospective payment system. What remains unclear about these proposals is whether an appropriate unit of service can be defined for calculating prospective payments and whether HCFA's databases are adequate for it to set reasonable rates.

Administration officials also have discussed their intention to propose in the future a coordinated payment system for all post-acute care as a method to give providers efficiency incentives. This concept has appeal, but we have concerns about it similar to those we have for SNF and home health prospective payments.

Finally, the administration is proposing that SNFs be required to bill for all services provided to their Medicare residents rather than allowing outside suppliers to bill. This latter proposal has merit because it would make control over the use of ancillary services significantly easier.

Background

Medicare covers up to 100 days of care in a SNF after a beneficiary has been hospitalized for at least 3 days. To qualify for the benefit, the patient must need skilled nursing or therapy on a daily basis. For the first 20 days of SNF care, Medicare pays all the costs, and for the 21st through the 100th day, the beneficiary is responsible for daily coinsurance of \$95 in 1997.

To qualify for home health care, a beneficiary must be confined to his or her residence ("homebound"); require part-time or intermittent skilled nursing, physical therapy, or speech therapy; be under the care of a

physician; and have the services furnished under a plan of care prescribed and periodically reviewed by a physician. If these conditions are met, Medicare will pay for skilled nursing; physical, occupational, and speech therapy; medical social services; and home health aide visits. Beneficiaries are not liable for any coinsurance or deductibles for these home health services, and there is no limit on the number of visits for which Medicare will pay.

Medicare covers care in rehabilitation hospitals that specialize in such care and units within acute-care hospitals that also specialize. To qualify, beneficiaries must have one or more conditions requiring intensive and multidisciplinary rehabilitation services on an inpatient basis. In addition, to qualify as a rehabilitation facility, hospitals and units in acute-care hospitals must demonstrate their status by such factors as furnishing primarily intensive rehabilitation services to an inpatient population, at least 75 percent of whom require treatment of 1 or more of 10 specified conditions (for example, stroke or hip fracture). Rehabilitation facilities must also use a treatment plan for each patient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel. Inpatient rehabilitation is treated like any other hospitalization for beneficiary cost-sharing purposes.²

Medicare pays SNFs and home health agencies on the basis of their reasonable costs—those that are found to be necessary and related to patient care—up to specified cost limits. For SNFs, limits are imposed on the amount of routine costs—those for general nursing, room and board, and administrative overhead—that will be reimbursed. Separate limits are set for freestanding SNFs in urban and rural areas at 112 percent of mean routine costs. Hospital-based SNF limits are set midway between the freestanding limits and 112 percent of the mean routine costs of hospital-based SNFs in each area. Home health agency cost limits are established at 112 percent of the mean costs of freestanding agencies in urban and rural areas. Hospital-based agencies have the same limits. Separate limits are set for each type of visit (skilled nursing, physical therapy, and so on) but are applied in the aggregate; that is, an agency's costs over the limit for one type of visit can be offset by costs below the limit for another. Both SNF and home health cost limits are adjusted for differences in wage levels across geographic areas. Also, exemptions from the cost limits are available to newly opened SNFs and home health

²The beneficiary is responsible for a deductible, \$760 in 1997, and coinsurance for each day over 60 days during a spell of illness. A spell of illness ends when the beneficiary has not been in a hospital or SNF for 60 days. A transfer from an acute-care hospital to a rehabilitation hospital or unit does not result in a second deductible because the patient is in the same spell of illness.

agencies, and exceptions to the limits are available to those that can show that their costs are above the limits for reasons not under their control.

Inpatient rehabilitation care, provided at both rehabilitation hospitals and units of acute-care hospitals, is exempt from Medicare's hospital prospective payment system (PPS), but is subject to the payment limitations and incentives established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Under this law, Medicare pays these facilities the lower of the facility's average Medicare allowable inpatient operating costs per discharge or its target amount. The target amount is based on the provider's allowable costs per discharge in a base year,³ trended to the current year through an annual update factor. A TEFRA facility with inpatient operating costs below its ceiling receives its costs plus 50 percent of the difference between these costs and the ceiling or 5 percent of the ceiling, whichever is less. Rehabilitation facilities receive cost-based payments without regard to the TEFRA limits until they complete a full cost-reporting year, and that year is then used as their base year.

Long-term care hospitals are another category exempted from the hospital PPS. To qualify as long term, hospitals must have an average length of stay of a least 25 days for their Medicare patients. Medicare pays these hospitals on the basis of their costs, subject to TEFRA limits, just like rehabilitation hospitals. The number of long-term care hospitals has grown from 94 in 1986 to 146 in 1994, and Medicare payments to them have increased considerably from about \$200 million in 1989 to about \$800 million in 1994. However, these hospitals remain a small part of the Medicare program, representing less than 0.5 percent of expenditures, and little research or analysis has been done on them. As a result, little is known about the reasons for the growth that has occurred in the long-term care hospital area.

While the cost-limit provisions of Medicare's cost reimbursement system for SNFS, home health agencies, and rehabilitation facilities give some incentives for providers to control the affected costs, these incentives are considered by health financing experts to be relatively weak, especially for providers with costs considerably below their limit. On the other hand, it is generally agreed that a PPS gives providers increased cost-control incentives. The administration proposes establishing PPSS for SNF and home health care and estimates that Medicare would save more than \$10 billion over the next 5 fiscal years. PPS is also being designed for

³The base year depends on when the rehabilitation hospital or unit began operating. For those operating in 1987 or earlier, the base year is usually the cost-reporting year begun during fiscal year 1987.

rehabilitation facilities but is not included in the administration's fiscal year 1998 budget proposals.

Post-Acute Care Cost Growth

The Medicare SNF, home health, and inpatient rehabilitation benefits are three of the fastest growing components of Medicare spending. From 1989 to 1996, Medicare part A SNF expenditures increased over 300 percent, from \$2.8 billion to \$11.3 billion. During the same period, part A expenditures for home health increased from \$2.4 billion to \$17.7 billion—an increase of over 600 percent. Rehabilitation facility payments increased from \$1.4 billion in 1989 to \$3.9 billion in 1994, the latest year for which complete data were available. SNF payments currently represent 8.6 percent of part A Medicare expenditures; home health, 13.5 percent; and rehabilitation facilities, 3.4 percent.

At Medicare's inception in 1966, the home health benefit under part A provided limited posthospital care of up to 100 visits per year after a hospitalization of at least 3 days. In addition, the services could only be provided within 1 year after the patient's discharge and had to be for the same illness. Part B coverage of home health also was limited to 100 visits per year. These restrictions under part A and part B were eliminated by the Omnibus Reconciliation Act of 1980 (ORA) (P.L. 96-499), but little immediate effect on Medicare costs occurred.

With the implementation of the Medicare inpatient PPS in 1983, use of the SNF and home health benefits was expected to grow as patients were discharged from the hospital earlier in their recovery periods. But HCFA's relatively stringent interpretation of coverage and eligibility criteria held growth in check for the next few years. As a result of court decisions in the late 1980s, HCFA issued guideline changes for the SNF and home health benefits that had the effect of liberalizing coverage criteria, thereby making it easier for beneficiaries to obtain SNF and home health coverage. Additionally, the changes prevent HCFA's claims processing contractors from denying physician-ordered SNF or home health services unless the contractors can supply specific clinical evidence that indicates which particular services should not be covered.

The combination of these legislative and coverage policy changes has had a dramatic effect on utilization of these two benefits in the 1990s, both in terms of the number of beneficiaries receiving services and in the extent these services are used. (App. I contains figures that show growth in SNF and home health expenditures in relation to the legislative and policy

changes.) For example, ORA 1980 and HCFA's 1989 home health guideline changes have essentially transformed the home health benefit from one focused on patients needing short-term posthospital care to one that serves chronic, long-term care patients as well. The number of beneficiaries receiving home health care more than doubled in the last few years, from 1.7 million in 1989 to about 3.9 million in 1996. During the same period, the average number of visits to home health beneficiaries also more than doubled, from 27 to 72. In a recent review of home health care,⁴ we found that from 1989 to 1993, the proportion of home health users receiving more than 30 visits increased from 24 to 43 percent and those receiving more than 90 visits tripled, from 6 to 18 percent, indicating that the program is serving a larger proportion of longer-term patients. Moreover, about a third of beneficiaries receiving home health care did not have a prior hospitalization, another possible indication that care for chronic conditions is being provided.

Similarly, the number of people receiving care from SNFs has also almost doubled, from 636,000 in 1989 to 1.1 million in 1996. While the average length of a Medicare-covered SNF stay has not changed much during that time, the average Medicare payment per day has almost tripled—from \$98 in 1990 to \$292 in 1996. Use of ancillary services, such as physical and occupational therapy, has increased dramatically and accounts for most of the growth in per-day cost. For example, our analysis of 1992 through 1995 SNF cost reports shows that reported ancillary costs per day have increased 67 percent, from \$75 per day to \$125 per day, while reported routine costs per day have increased only 20 percent, from \$123 to \$148. Unlike routine costs, which are subject to limits, ancillary services are only subject to medical necessity criteria, and Medicare does relatively little review of their use. Moreover, SNFs can cite high ancillary service use to justify an exception to routine service cost limits, thereby increasing payments for routine services.

Between 1990 and 1996, the number of hospital-based SNFs increased over 80 percent, from 1,145 such units to 2,088. Hospitals can benefit from establishing a SNF unit in a number of ways. Hospitals receive a set fee for a patient's entire hospital stay, based on a patient's diagnosis related group (DRG).⁵ Therefore, the quicker that hospitals discharge a patient into a SNF, the lower that patient's inpatient hospital care costs are. We found that in

⁴Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996). This report includes an extensive discussion of the reasons for home health care cost growth.

⁵DRGs are sets of diagnoses that are expected to require about the same level of hospital resources to treat beneficiaries suffering from them.

1994, patients with any of 12 DRGs commonly associated with posthospital SNF use had 4- to 21-percent shorter stays in hospitals with SNF units than patients with the same DRGs in hospitals without SNF units.⁶ Additionally, by owning a SNF, hospitals can increase their Medicare revenues through receipt of the full DRG payment for patients with shorter lengths of stay and a cost-based payment after the patients are transferred to the SNF.

The availability of inpatient rehabilitation beds has also increased dramatically. Between 1986 and 1994, the number of Medicare-certified rehabilitation facilities grew from 545 to 1,019, an 87-percent increase. A major portion of this growth represents the increase in rehabilitation units located in PPS hospitals, which went from 470 to 824 over the same period. Inpatient rehabilitation admissions for Medicare beneficiaries increased from 2.9 per 1,000 in 1986 to 7.2 per 1,000 in 1993, or 148 percent. Some of this increase in beneficiary use was due to increases in the number of acute-care admissions that often lead to use of rehabilitation facilities. For example, the DRG that includes hip replacement grew from 218,000 discharges during fiscal year 1989 to 344,000 in fiscal year 1995. For the same DRG, average length of stay in acute-care hospitals decreased from 12 to 6.7 days over that period.

As was the case with SNFs, beneficiaries admitted to rehabilitation units in 1994 following a stay in an acute-care hospital had shorter average lengths of stay than beneficiaries admitted to rehabilitation hospitals. They also had shorter stays in the acute-care hospital. Moreover, the same scenario that applies to hospital-based SNFs applies to rehabilitation units. The quicker that hospitals discharge a patient to the rehabilitation unit, the lower that patient's acute-care costs are. By having a rehabilitation unit, hospitals can increase their Medicare revenues through receipt of the full DRG payment for patients with shorter lengths of stay and a cost-based payment after the patients are admitted to rehabilitation.

Rapid growth in SNF and home health expenditures has been accompanied by decreased, rather than increased, funding for program safeguard activities. For example, our March 1996 report found that part A contractor funding for medical review had decreased by almost 50 percent between 1989 and 1995. As a result, while contractors had reviewed over 60 percent of home health claims in fiscal year 1987, their review target had been lowered by 1995 to 3.2 percent of all claims (or sometimes, depending on available resources, to a required minimum of 1 percent).

⁶Skilled Nursing Facilities: Approval Process for Certain Services May Result in Higher Medicare Costs (GAO/HEHS-97-18, Dec. 20, 1996). This report also includes information on cost growth for SNF services and the characteristics of Medicare beneficiaries who receive SNF care.

We found that a lack of adequate controls over the home health program, such as little intermediary medical review and limited physician involvement, makes it nearly impossible to know whether the beneficiary receiving home health care qualifies for the benefit, needs the care being delivered, or even receives the services being billed to Medicare. Also, because of the small percentage of claims now selected for review, home health agencies that bill for noncovered services are less likely to be identified than they were 10 years ago. Similarly, the low level of review of SNF services makes it difficult to know whether the recent increase in ancillary service use is legitimate (for example, because patient mix has shifted toward those who need more services) or is simply a way for SNFs to get more revenues.

Medicare's peer review organization (PRO) contractors have responsibility for oversight of Medicare inpatient rehabilitation hospitals and units from both utilization and quality-of-care perspectives. However, the PROs' emphasis has changed in recent years, with a greater focus on quality reviews and less emphasis on case review. In fact, the current range of work for PROs requires no specific review for the appropriateness of inpatient rehabilitation use.

Finally, because relatively few resources have been available for auditing end-of-year provider cost reports, HCFA has little ability to identify whether home health agencies, SNFs, and rehabilitation facilities are charging Medicare for costs unrelated to patient care or other unallowable costs. Because of the lack of adequate program controls, it is quite possible that some of the recent increase in home health, SNF, and rehabilitation facility expenditures stems from abusive practices. The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), also known as the Kassebaum-Kennedy Act, has increased funding for program safeguards. However, per-claim expenditures will remain below the level they were in 1989, after adjusting for inflation. We project that, in 2003, payment safeguard spending as authorized by Kassebaum-Kennedy will be just over one-half of the 1989 per-claim level, after adjusting for inflation.

Administration's Proposals for Prospective Payment Systems

The goal in designing a PPS is to ensure that providers have incentives to control costs and that, at the same time, payments are adequate for efficient providers to furnish needed services and at least recover their costs. If payments are set too high, Medicare will not save money and cost-control incentives can be weak. If payments are set too low, access to and quality of care can suffer.

In designing a PPS, selection of the unit of service for payment purposes is important because the unit used has a strong effect on the incentives providers have for the quantity and quality of services they provide. Taking into account the varying needs of patients for different types of services—routine, ancillary, or all—is also important. A third important factor is the reliability of the cost and utilization data used to compute rates. Good choices for unit of service and cost coverage can be overwhelmed by bad data.

Proposal for a SNF PPS

We understand that the administration will propose a SNF PPS that would pay per diem rates covering all facility cost types and that payments would be adjusted for differences in patient case mix. Such a system is expected to be similar to HCFA's ongoing SNF PPS demonstration project that is testing the use of per diem rates adjusted for resource need differences using the Resource Utilization Group, version III (RUG-III) patient classification system.⁷ This project was recently expanded to include coverage of ancillary costs in the prospective payment rates.

An alternative to the proposal's choice of a day of care as the unit of service is an episode of care—the entire period of SNF care covered by Medicare. While substantial variation exists in the amount of resources needed to treat beneficiaries with the same conditions when viewed from the day-of-care perspective, even more variation exists at the episode-of-care level. Resource needs are less predictable for episodes of care. Moreover, payment on an episode basis may result in some SNFs inappropriately reducing the number of covered days. Both factors make a day of care the better candidate for a PPS unit of service. Furthermore, the likely patient classification system, RUG-III, is designed for and being tested in a per diem PPS. On the other hand, a day-of-care unit gives few, if any, incentives to control length of stay, so a review process for this purpose would still be needed.

The states and HCFA have a lot of experience with per diem payment methods for nursing homes under the Medicaid program, primarily for routine costs but also, in some cases, for total costs. This experience should prove useful in designing a per diem Medicare PPS.

Regarding the types of costs covered by PPS rates, a major contributor to Medicare's SNF cost growth has been the increased use of ancillary

⁷RUG-III is a method for classifying SNF residents according to health characteristics and the amount and type of resources they need.

services, particularly therapy services. This, in turn, means that it is important to give SNFs incentives to control ancillary costs, and including them under PPS is a way to do so. However, adding ancillary costs does increase the variability of costs across patients and places additional importance on the case-mix adjuster to ensure reasonable and adequate rates.

Turning to the adequacy of HCFA's databases for SNF PPS rate-setting purposes, our work, and that of the Department of Health and Human Services' (HHS) Inspector General, has found examples of questionable costs in SNF cost reports. For example, we found extremely high charges for occupational and speech therapy with no assurance that cost reports reflected only allowable costs.⁸ Cost-report audits are the primary means available to ensure that SNF cost reports reflect only allowable costs. However, the resources expended on auditing cost reports have been declining in relation to the number of SNFs and SNF costs for a number of years. The percentage of SNFs subjected to field audits has decreased as has the extent of auditing done at the facilities that are audited. Under these circumstances, we think it would be prudent for HCFA to do thorough audits of a projectable sample of SNF cost reports. The results could then be used to adjust cost-report databases to remove the influence of unallowable costs, which would help ensure that inflated costs are not used as the base for PPS rate setting.

Proposal for a Home Health PPS

The summary of the administration's proposal for a home health PPS is very general, saying only that a PPS for an appropriate unit of service would be established in 1999 using budget neutral rates calculated after reducing expenditures by 15 percent. HCFA estimates that this reduction will result in savings of \$4.7 billion over fiscal years 1999 through 2002.

The choice of the unit of service is crucial, and there is limited understanding of the need for and content of home health services to guide that choice. Choosing either a visit or an episode as the unit of service would have implications for both cost control and quality of care, depending on the response of home health agencies. For example, if the unit of service is a visit, agencies could profit by shortening the length of visits. At the same time, agencies could attempt to increase the number of visits, with the net result being higher total costs for Medicare, making the per-visit choice probably not appropriate. Using an episode of care over a

⁸Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

period of time such as 30 or 100 days as the unit of service has a greater potential for controlling costs. However, agencies could gain by reducing the number of visits during that period, potentially lowering quality of care. If an episode of care is chosen as the unit of service, HCFA would need a method to ensure that beneficiaries receive adequate services and that any reduction in services that can be accounted for by past overprovision of care does not result in windfall profits for agencies. In addition, HCFA would need to be vigilant to ensure that patients meet coverage requirements, because agencies would be rewarded for increasing their caseloads. HCFA is currently testing various PPS methods and patient classification systems for possible use with home health care, and the results of these efforts may shed light on how to best design a home health PPS.

We have the same concerns about the quality of HCFA's home health care cost-report databases for PPS rate-setting purposes that we do for the SNF database. Again, we believe that adjusting the home health databases, using the results of thorough cost-report audits of a projectable sample of agencies, would be wise.

We are also concerned about the appropriateness of using current Medicare data on visit rates to determine payments under a PPS for episodes of care. As we reported in March 1996, controls over the use of home health care are virtually nonexistent. Operation Restore Trust, a joint effort by federal and state agencies in several states to identify fraud and abuse in Medicare and Medicaid, found very high rates of noncompliance with Medicare's coverage conditions in targeted agencies. For example, in a sample of 740 beneficiaries drawn from 43 home health agencies in Texas and 31 in Louisiana that were selected because of potential problems, some or all of the services received by 39 percent of the beneficiaries were denied. About 70 percent of the denials were because the beneficiary did not meet the homebound definition. Although these are results from agencies suspected of having problems, they illustrate that substantial amounts of noncovered care are likely to be reflected in HCFA's home health care utilization data. For these reasons, it would also be prudent for HCFA to conduct thorough on-site medical reviews of a projectable sample of agencies to give it a basis to adjust utilization rates for purposes of establishing a PPS.

Rehabilitation PPS Also Is Being Developed

The administration has not proposed a PPS for rehabilitation facilities, but HCFA has an ongoing research project to develop such a system. A report

detailing a model for a PPS is currently undergoing review. The research was directed at designing a per-episode payment system adjusted for case mix, using a measure of patient functional status—for example, the patient’s mobility—as the adjuster. In general, this and other research has shown that patients in the rehabilitation facilities are more homogeneous than those in SNFs or home health care. Because the goals for the care are also more homogeneous and defined, an episode may be a reasonable choice for a unit of service. Again, the per-episode payment should be structured to reduce the incentives for premature discharge, and adequate review mechanisms to prevent such discharges and other quality problems would be needed.

As with SNFs and home health care, we have concerns about the reliability of HCFA’s databases for rate-setting purposes for rehabilitation hospitals because of the low levels of utilization review and cost-report auditing. As we stated earlier, HCFA should do enough audits and medical review to enable it to adjust its databases to remove the effects of any problems. HCFA would also need an adequate review system under a PPS because rehabilitation facilities would probably have incentives to increase their caseloads, cut corners on quality, or both.

Long-Term Care Hospital Proposal

HCFA is not currently studying a PPS for long-term care hospitals. Rather, the administration is proposing that any hospitals that newly qualify for long-term care status be paid under the regular inpatient hospital PPS. Also, HCFA officials told us that the agency plans to recommend in the future a coordinated payment system for post-acute care and that long-term care hospitals are being considered for inclusion under such a payment system. I will discuss the coordinated payment concept later in this statement.

Consolidated Billing for SNFs

The administration has also announced that it will propose requiring SNFs to bill Medicare directly for all services provided to their beneficiary residents except for physician and some practitioner services. We support this proposal as we did in a September 1995 letter to the House Ways and Means Committee. We and the HHS Inspector General have reported on problems, such as overutilization of supplies, that can arise when suppliers bill separately for services for SNF residents.

A consolidated billing requirement would make it easier for Medicare to identify all the services furnished to residents, which in turn would make it easier to control payments for those services. The requirement would also

help prevent duplicate billings for supplies and services and billings for services not actually furnished by suppliers. In effect, outside suppliers would have to make arrangements with SNFs under such a provision so that nursing homes would bill for suppliers' services and would be financially liable and medically responsible for the care.

“Bundling” Post-Acute Care Services

There can be considerable overlap in the types of services provided and the types of beneficiaries that are treated in each of the three post-acute care settings. For example, physical therapy and other rehabilitation services can be provided by a SNF, a home health agency, or a rehabilitation facility. Both HCFA and the prospective payment assessment commission (ProPAC) have noted that the ability to substitute care among post-acute settings may contribute to inappropriate spending growth, even after payment policies are improved for individual provider types.⁹ Although prospective payment encourages providers to deliver care more efficiently, facility-specific payments may encourage them to lower their costs by shifting services to other settings. The administration has therefore announced that it will in the future recommend a coordinated payment system for post-acute care services. Such a system will be designed to help ensure that beneficiaries receive quality care in the appropriate settings, and that any patient transfers among settings occur only when medically appropriate rather than in efforts to generate additional revenues. While no details are available about how a coordinated post-acute payment system would operate, presumably it will entail consolidated (bundled) payments to one entity for the different types of providers. In fact, ProPAC has suggested a system that bundles acute and post-acute payments.

One of the most important design issues in a bundled payment approach is deciding which provider would receive the payment. Because this provider would have to organize and oversee the continuum of services for beneficiaries, it would bear the risk that payments would not cover costs. Options for this role include an acute-care hospital, a post-acute care provider, or a provider service network.

Another important design issue involves developing an appropriate payment rate. Under the current inpatient PPS, payment rates are based on DRGs. But research has shown that DRGs are poor predictors of post-acute care use. In extending PPS to include post-acute services, future post-acute

⁹HCFA Administrator's statement on "Reforming the Medicare Home Health Benefit," before the Subcommittee on Health and Environment, House Committee on Commerce (Mar. 5, 1997), and Report and Recommendations to the Congress (Washington, D.C.: ProPAC, Mar. 1, 1997).

care utilization needs to be accurately predicted to ensure that prospective rates are adequate to cover costs but also give an incentive to provide cost-effective care.

Bundling acute and post-acute care would have a number of potential advantages and disadvantages. Optimally, bundling of payments would encourage continuity of care. If, for example, the inpatient hospital has a greater stake in the results, bundling could lead to both better discharge planning as well as improved transfer of information from the hospital to the post-acute provider. Bundling payments to the hospital could also eliminate a PPS hospital's financial incentive to discharge Medicare patients before they are ready, because patients discharged prematurely may require extensive post-acute services for which the hospital is liable. Furthermore, bundling with an appropriate payment rate would give providers more incentive to furnish the mix of inpatient and posthospital services that yield the least costly treatment of an entire episode of care and thus help control growth in the volume of post-acute services. Finally, to the extent that the bundling arrangement promotes joint accountability, combining responsibility for hospital and post-acute providers could lead to better outcomes.

There are a number of potential disadvantages as well. Because bundled payments would represent some level of financial risk, whoever received the bundled payment would need to have the resources to accept the risk. Moreover, bearing risk often gives incentive to shift the risk to others and raises concerns about quality. A key to the success of any bundling system is coordinating care and continuously monitoring a patient during the entire episode. However, some providers might not have the capabilities to do this. For example, if, as ProPAC has suggested, both acute- and post-acute care were bundled and if hospitals received the bundled payment, some hospitals might not have the resources, information, or expertise to properly manage patients' post-acute care. The same could be said for SNFs and home health agencies. An additional concern is that whoever received the bundled payment could have dominance over the other providers and make choices about acute- and post-acute care settings that are driven primarily by concerns about cost. For example, hospitals might try to maximize their profit by limiting post-acute services or be tempted to screen admissions to avoid patients with high risks of heavy posthospital care.

Another important issue involves how to deal with home health patients who have had no prior hospitalization. About a third of home health visits

fall into this category. A bundled payment system would not affect home health agency incentives for such patients. Finally, beneficiary advocacy groups have expressed concern about potential harmful effects of this system on patients' freedom of choice and how the quality and appropriateness of care could be ensured.

In conclusion, it is clear from the dramatic cost growth for SNF, home health, and rehabilitation facility care that the current Medicare payment mechanisms for the providers need to be revised. As more details concerning the administration's or others' proposals for revising those systems become available, we would be glad to work with the Committee and others to help sort out the potential implications of suggested revisions.

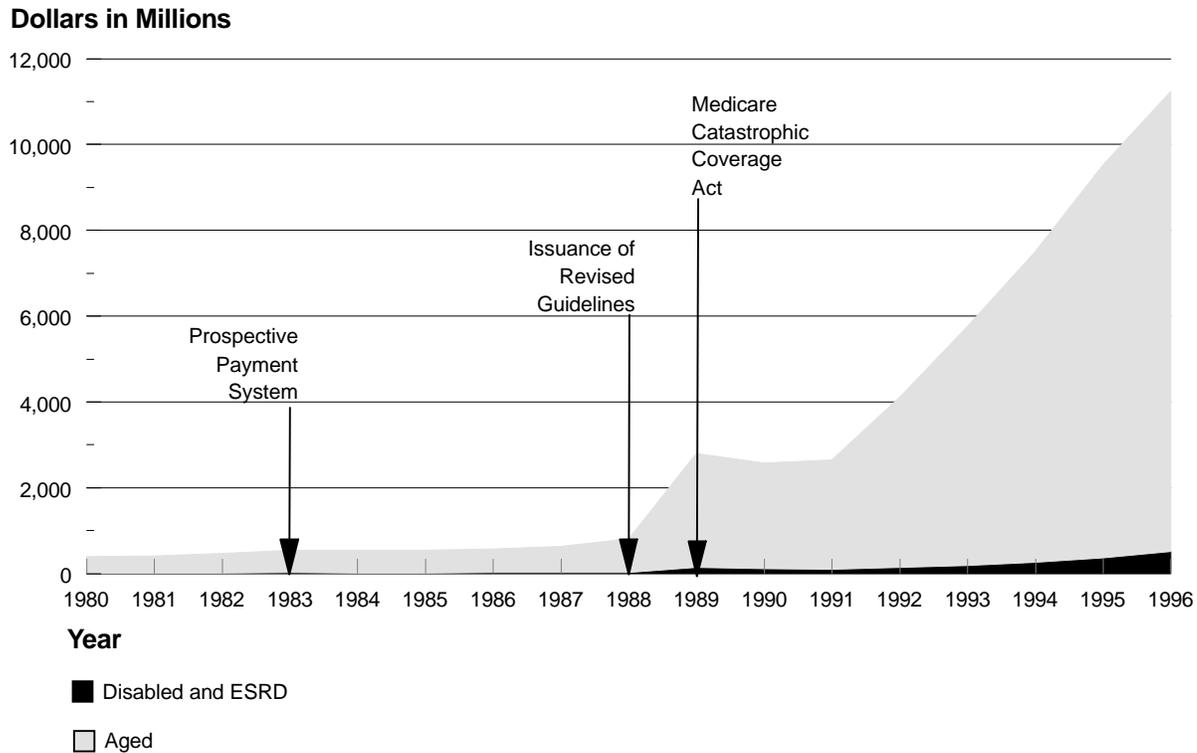
This concludes my prepared remarks, and I will be happy to answer any questions.

Contributors

For more information on this testimony, please call William Scanlon on (202) 512-7114 or Thomas Dowdal, Senior Assistant Director, on (202) 512-6588. Other major contributors include Patricia Davis, Roger Hultgren, and Sally Kaplan.

Medicare Skilled Nursing Facility and Home Health Expenditures, 1980-96

Figure I.1: Medicare Skilled Nursing Facility Expenditures, 1980-96

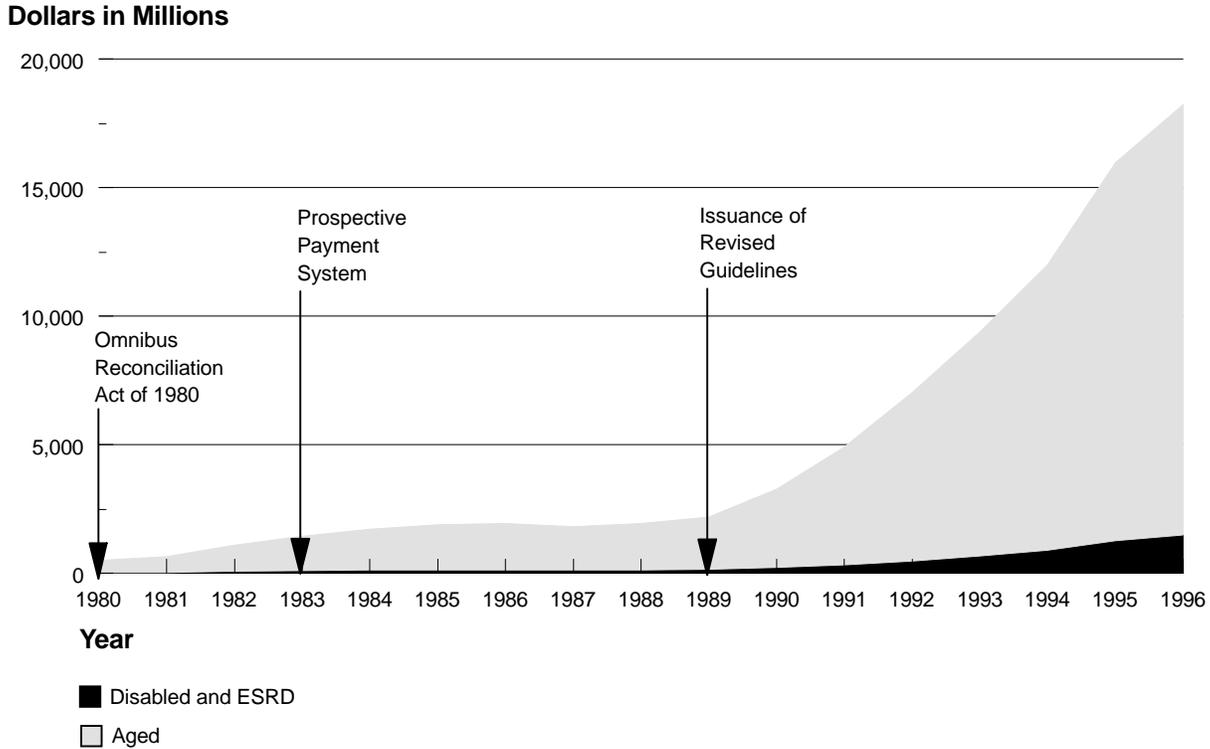


Note: ESRD = end-stage renal disease.

Source: HCFA's Office of the Actuary.

**Appendix I
Medicare Skilled Nursing Facility and Home
Health Expenditures, 1980-96**

Figure I.2: Medicare Home Health Expenditures, 1980-96



Note: ESRD = end-stage renal disease.

Source: HCFA's Office of the Actuary.

Ordering Information

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