

TRENDWATCH

Medicare's Post-Acute Care Challenge

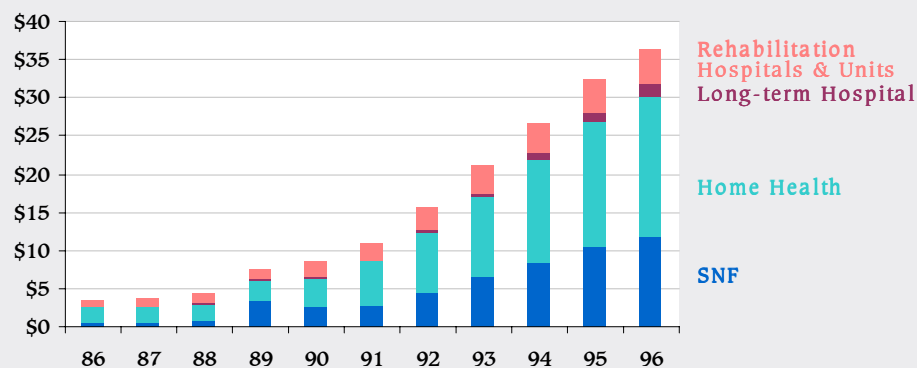
June 1999, Vol. 1, No. 3

The post-acute care field has grown dramatically over the past decade. Post-acute care services, which typically follow an inpatient hospital stay, span a continuum from non-medical supportive services provided in the home to high intensity skilled nursing care. This report focuses on post-acute care services provided to Medicare patients by skilled nursing facilities and units, home health agencies, long-term hospitals, and rehabilitation hospitals and units.

Medicare is the primary payer for most hospital-based post-acute providers. The number of Medicare patients receiving post-acute care has increased and those receiving post-acute services are receiving more intensive care. As a result, spending for post-acute care has grown at a faster rate than any other segment of the Medicare program. The Balanced Budget Act of 1997 (BBA) included several measures designed to curb the growth rate of post-acute expenditures. Due to the anticipated increase in the Medicare population, and especially the over-75 age group, demand for these health care services will undoubtedly continue to increase. However, it is unclear whether current federal payment policies for post-acute care will support either current or future health care needs of an aging Medicare beneficiary population.

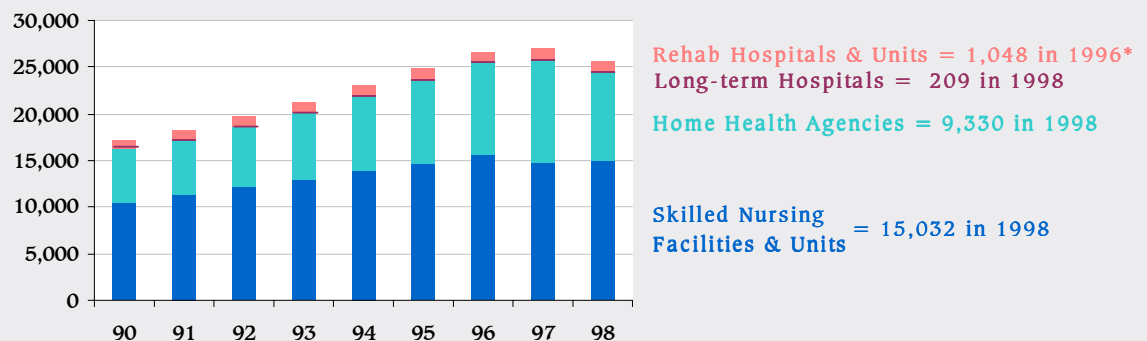
Medicare spending for post-acute has increased by more than \$33 billion since 1986...

Chart 1: Total Medicare payments from 1986 to 1996 by provider type (in billions)



And the number of post-acute providers increased as well.

Chart 2: Number of post-acute providers by provider type from 1990 to 1998



*Data for 1997-1998 are unavailable. 1996 data was used for 1997 and 1998 in the chart.

"Many of the decisions that we made were probably a bit more arbitrary than we would have liked. I think the data is beginning to indicate that a thorough reexamination is appropriate."

- Rep. Bill Thomas (R-CA), in reference to the BBA. *The Washington Post*, May 1999

The Rise in Post-Acute Care Spending

Quote from the field...

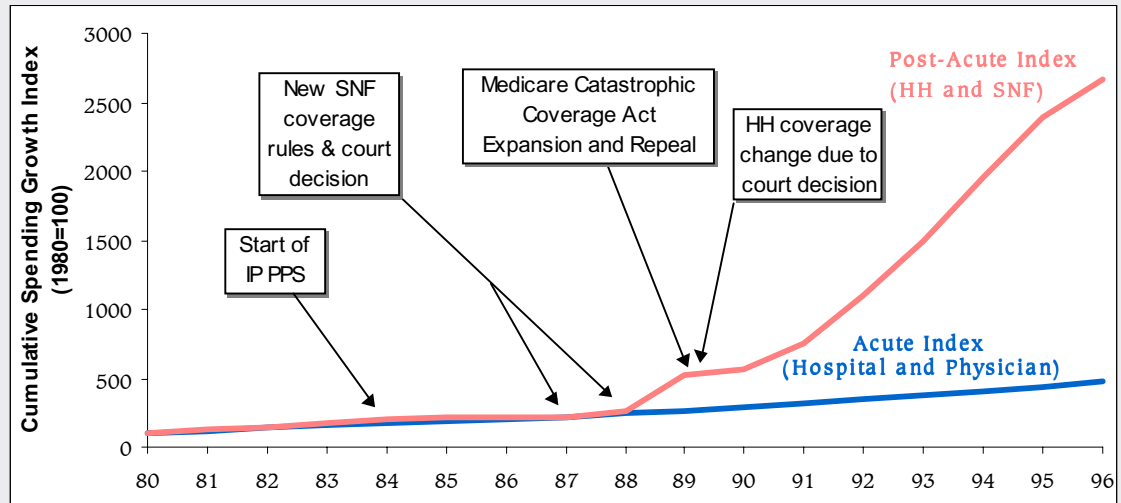
"The current market is forcing us to look at home health and question whether we should be in that business because of poor financial performance. The volume is there and strategically, we believe that we don't want to lose the continuum of care and it is effective in our utilization review process. And, we have a big commitment to our community. So, it is one of our core strategies. The current reimbursement situation is challenging each of our strategic initiatives."

- Survey respondent of the AHA Member Leadership Monitor, May 1999

The rapid increase in Medicare spending for post-acute services is due to a combination of several factors, including new laws, regulations, and court decisions. These changes have led to an increase in the number of people eligible to receive post-acute services and an increase in the number of services received by each person.

Growth in Medicare post-acute spending has outpaced other Medicare spending due to changes in Medicare policies and coverage...

Chart 3: Medicare spending growth index for acute and post-acute services



And due to rapid increases in both the number of people using services and in the amount of services used per person.

Chart 4: Home Health Utilization Trends

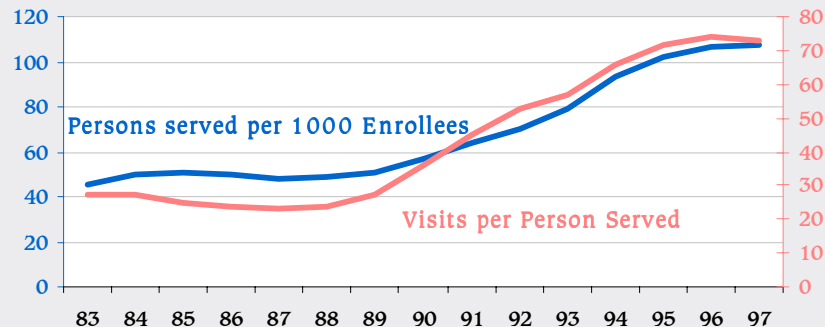
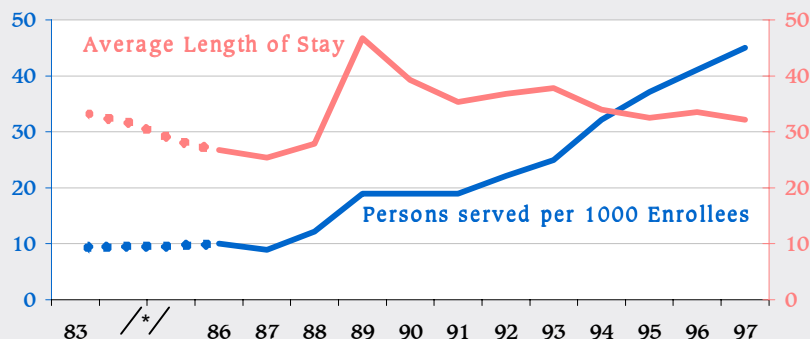


Chart 5: Skilled Nursing Utilization Trends



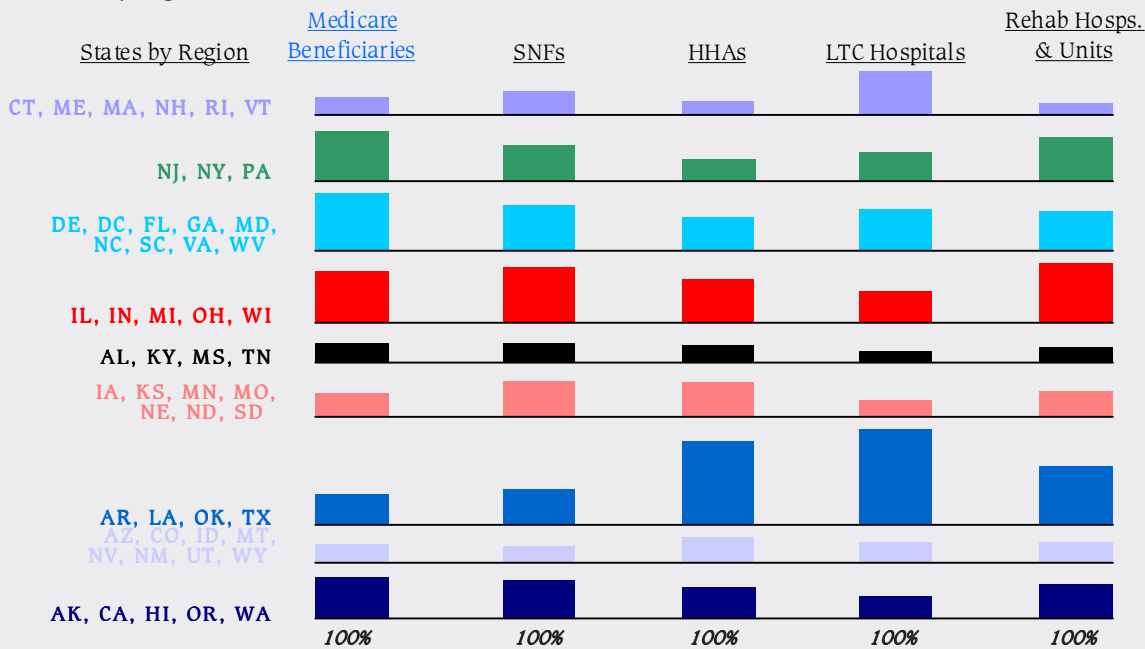
*1983, 1986-97 are actual, data for 1984-5 were interpolated

Use of post-acute care

The use of post-acute services and the increase in Medicare expenditures for these services reflect important changes in medical practice patterns. Improved technology has helped to shorten inpatient length of stay while at the same time allowing post-acute providers to expand the services they offer to sicker patients requiring higher intensity services. In addition, patients and payers are demanding more care alternatives. Although studies have shown that patient outcomes improve with post-acute care, it is difficult to draw firm conclusions about the appropriate level, setting and mix of post-acute care.

The availability of post-acute care services varies from region to region...

Chart 6: The distribution of Medicare beneficiaries by region compared to the distribution of post-acute services by region.



*Each bar represents a region's proportion of the national total of beneficiaries and services

And the use of post acute care varies as well.

Table 1: Discharges/visits per 1,000 Medicare beneficiaries by type of service, 1995

	Discharges per 1,000 Beneficiaries			Home Health Visits per 1,000 Beneficiaries
	Skilled Nursing Facility	Rehabilitation Facility	Long-term Care Hospital	
National Average	43.5	8.8	1.2	6,127
CT, ME, MA, NH, RI, VT	55.0	8.0	5.1	7,710
NJ, NY, PA	34.7	11.1	1.1	3,150
DE, DC, FL, GA, MD, NC, SC, VA, WV	35.8	7.3	0.8	5,623
IL, IN, MI, OH, WI	48.0	9.1	0.7	4,399
AL, KY, MS, TN	39.4	9.8	0.6	11,243
IA, KS, MN, MO, NE, ND, SD	61.8	7.5	0.6	3,080
AR, LA, OK, TX	48.2	15.0	2.5	18,804
AZ, CO, ID, MT, NV, NM, UT, WY	43.2	7.9	0.8	3,885
AK, CA, HI, OR, WA	42.4	4.2	0.4	2,675

Notable Note:

The US General Accounting Office recently reported that 1,436, or 14% of HHAs closed from October of 1997 to December 1998.

- > 14% were hospital-based
- > 83% were for profit
- > 75% were urban
- > 40% were in Louisiana, Oklahoma and Texas

The report states that most Medicare patients eligible for the home health benefit were not yet having difficulty accessing care. However, high-cost patients may be at risk of losing access to care.

- GAO Report to Congressional Requesters, May 1999

The BBA: Congress Reacts by Cutting Provider Payments

Notable Note:

"The head of a federal advisory commission, an influential Republican, said Wednesday that Congress should increase Medicare payments for certain nursing home and hospital services because budget cuts appeared to be harming the quality of care for some patients."

- The New York Times on Gail Wilensky's recent press conference, June 1999

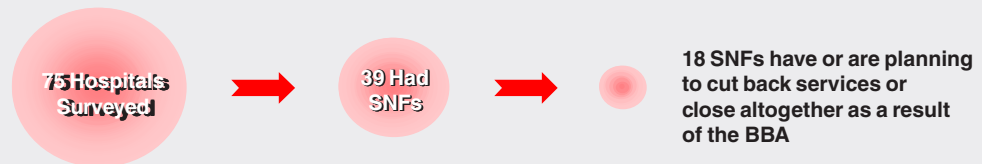
The BBA is projected to reduce Medicare payments to post-acute providers by approximately \$40 billion from 1998 to 2002. The BBA affects post-acute providers in many ways:

- Under the new prospective payment system (PPS), SNFs receive one bundled payment for both facility costs and ancillary costs (therapies, ambulance, rehabilitation, some drugs, etc.).
- For home health, the Interim Payment System reduced payments by setting "per visit" and "per beneficiary" limits -- until the home health PPS is developed.
- The home health PPS will cut Medicare payments by an additional 15%.
- PPS-exempt payments for long-term and rehabilitation facilities were capped. In addition to the 75th percentile cap, the BBA froze the 1998 update, reduced capital payments by 15%, and reduced bonus and relief payments.

Payment cuts may cause hospitals and health systems to consider reducing their post-acute care services. Additionally, anecdotal evidence from the field suggests that discharging patients from the hospital to post-acute settings may be increasingly difficult as post-acute care providers become unwilling to accept high-cost patients. This is reportedly causing some patients to be "backed-up" in the acute hospital setting.

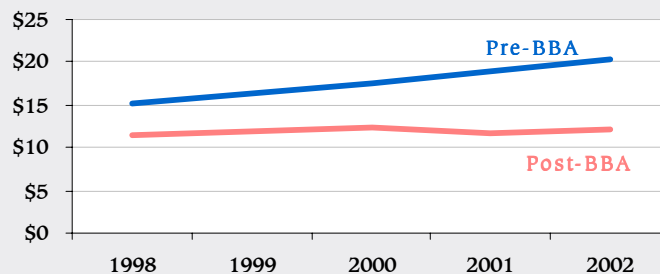
Many hospital-based SNFs are reducing services due to the BBA...

Figure 1: Reduction in SNF services by hospital-based providers based on a recent survey of 75 hospitals in the AHA Member Leadership Monitor, May 1999



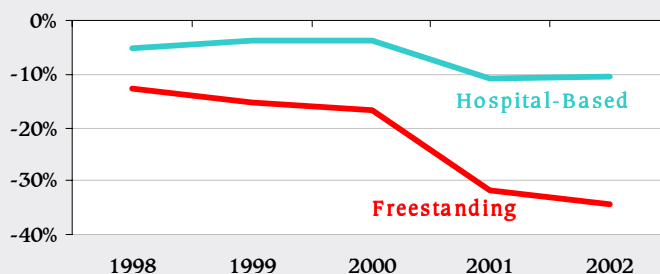
While post-BBA Medicare home health payments for 1998 through 2002 are projected to decrease by more than 33% overall...

Chart 7: Projected total Medicare payments to freestanding and hospital-based HHAs, pre-BBA and post-BBA (in billions)



Both hospital-based and freestanding home health agencies are projected to experience greater Medicare losses under the BBA.

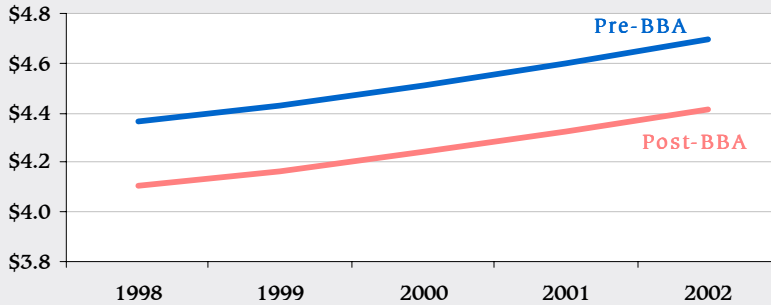
Chart 8: Projected post-BBA Medicare margins by type of HHA



Congress Reacts by Cutting Provider Payments

Post-BBA rehabilitation and long-term hospital Medicare payments are projected to decrease by \$1.4 billion from 1998 to 2002...

Chart 9: Total Medicare payments to long-term hospitals and rehabilitation facilities, pre-BBA and post-BBA (in billions)



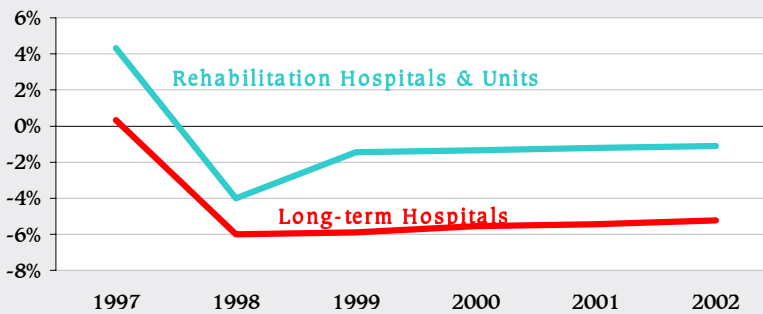
Quote from the field...

In a reference to the SNF PPS for Medicare, Thomas Zwicker, who runs a Milwaukee nursing home, said, "The system has created certain types of patients who a nursing home will not admit."

- The Washington Post, June 1999

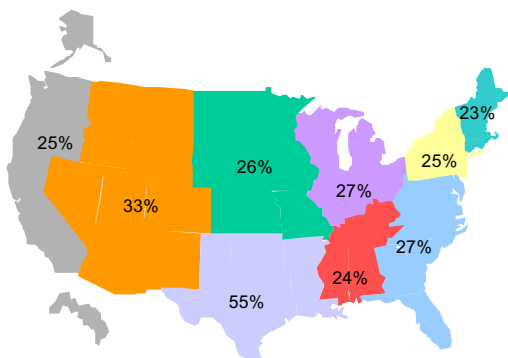
And post-BBA Medicare margins drop to negative levels for long-term hospitals and rehabilitation facilities...

Chart 10: Projected post-BBA margins by type of facility

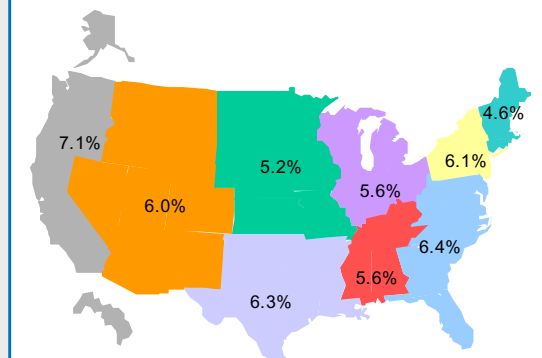


Hospital-based post-acute providers in the West South Central and Mountain regions are among the hardest hit.

Map 1:
Percent Reduction in Payments to Hospital-Based Home Health Agencies from 1998 to 2002



Map 2:
Percent Reduction in Payments to Rehabilitation Facilities and Long-term Care Hospitals from 1998 to 2002



What does the future hold for post-acute care?

Quote from the field...

"As a result, a genuine 'Catch-22' has been created: Hospitals are unable to discharge Medicare patients when acute care is completed and nursing home placement or home health support is needed. At the same time these hospitals are being penalized by the system for not discharging these patients. We now have an ever-increasing number of patients in the hospital awaiting placement. Recently, this number reached 80 - as opposed to about 25 prior to the Balanced Budget Act."

- Charles Smith, M.D., president and CEO of Christiana Care Corporation, Wilmington, DE
In testimony before the Senate Finances Committee, June 1999

Medicare payment reductions for post-acute care are having a significant impact on providers of post-acute care services. In addition, post-acute providers are also being pressured in other ways. Some state Medicaid agencies have instituted policies similar to Medicare, such as SNF PPS, and may be able to further reduce payments with the repeal of the Boren Amendment. Additionally, managed care is tightening reimbursement and these pressures will increase as more Medicare beneficiaries join Medicare+Choice plans.

Unanswered Policy Questions

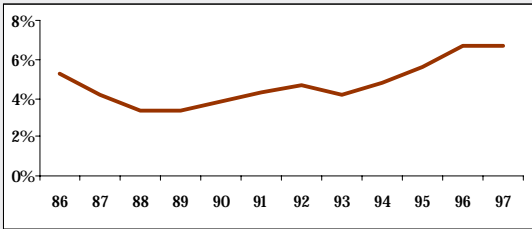
- ◆ *Will hospitals continue to own or operate post-acute services?*
- ◆ *Will hospitals be able to discharge patients appropriately and in a timely manner? Or, will patients back-up in the inpatient hospital setting or go home without the appropriate follow-up care?*
- ◆ *How will closures and increased financial pressures on post-acute care providers affect patient access?*
- ◆ *Do current federal policies appropriately prepare for the aging of baby boomers and the likely increase in demand for post-acute services?*
- ◆ *Would a payment system based on patient needs and characteristics be more efficient and effective than the current system that pays based on the type of provider?*
- ◆ *How might the promotion of private long-term care insurance affect Medicare, Medicaid and the continuum of post-acute care?*
- ◆ *Can the Medicare and Medicaid programs work more effectively together to provide more coordinated care at a lower cost?*
- ◆ *Should Congress increase payments to post-acute providers due to the unintended consequences of the BBA?*

The BBA and other financial pressures on the post-acute care field will affect the way in which Medicare beneficiaries access health care. Hospitals and health systems may need to rethink care delivery and discharge planning – future options may be limited. Similarly, those providing acute and post-acute care services will need to evaluate their patient care strategies as the relative payment for post-acute care changes.

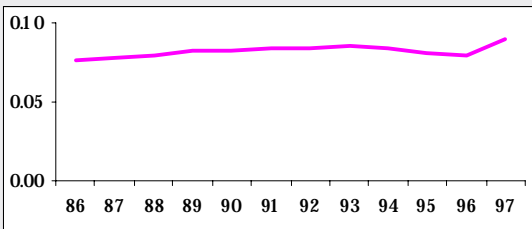
Stats to know

Hospital Sector

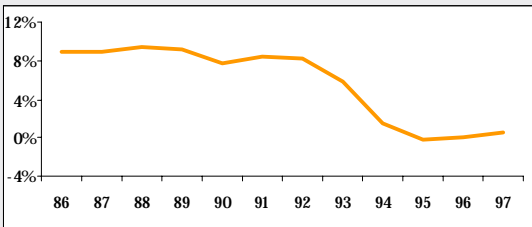
Total Margin:	1995	1996	1997
86 to 97 Trend	5.6%	6.7%	6.7%



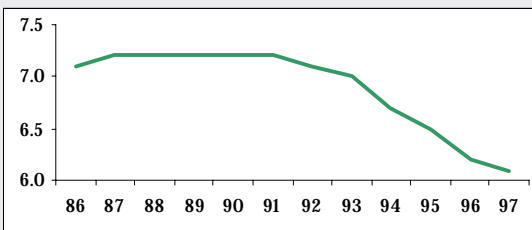
FTE per Adjusted Admission:	1995	1996	1997
86 to 97 Trend	0.08	0.08	0.09



Percent Change in Cost per Case:	1995	1996	1997
86 to 97 Trend	-0.2%	0.2%	0.6%

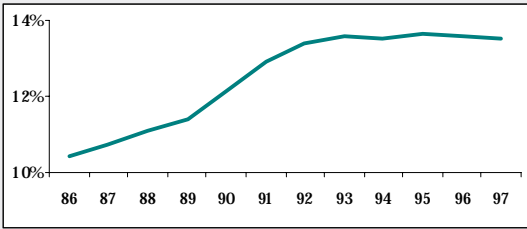


Average Length of Stay (in Days):	1995	1996	1997
86 to 97 Trend	6.5	6.2	6.1

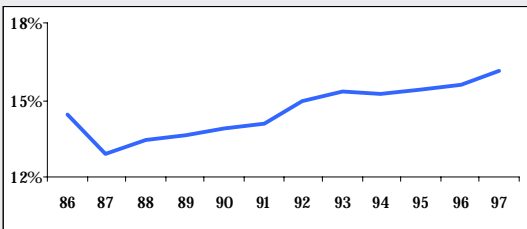


Healthcare Industry

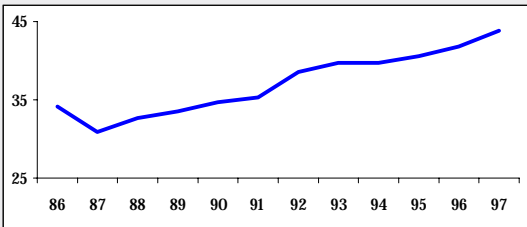
National Health Expenditure	1995	1996	1997
as a % of GDP: 86 to 97 Trend	13.6%	13.6%	13.5%



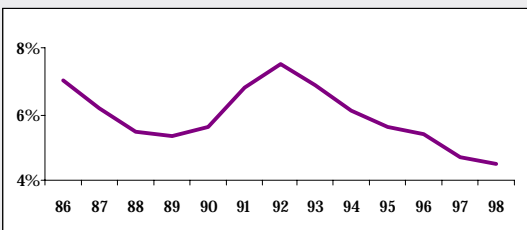
Percent Uninsured:	1995	1996	1997
86 to 97 Trend	15.4%	15.6%	16.1%



Number Uninsured (in Millions):	1995	1996	1997
86 to 97 Trend	40.6	41.7	43.7



Percent Unemployed:	1996	1997	1998
86 to 98 Trend	5.4%	4.7%	4.5%



Sources:

Chart 1: Health Care Financing Administration, Office of the Actuary, as included in Prospective Payment Assessment Commission. (June 1997). *Medicare and the American Health Care System: Report to the Congress*, 137.

Chart 2: Health Care Financing Administration, Office of Survey and Certification and Bureau of Program Operations, as included in Prospective Payment Assessment Commission. (June 1997) *Medicare and the American Health Care System: Report to the Congress*, 105.

Chart 3: Health Care Financing Administration, Office of the Actuary, as included in Prospective Payment Assessment Commission. (June 1997). *Medicare and the American Health Care System: Report to the Congress*, 137.

Chart 4: *Health Care Financing Review Annual Statistical Supplement*, 1983-1997.

Chart 5: Persons Served per 1000 Enrollees: CY 1983 and 1993-97 data from Health Care Financing Administration, Office of Research and Demonstrations. *Health Care Financing Review Annual Statistical Supplement*; Fiscal Year 1986-92 data from Prospective Payment Assessment Commission. (June 1997). *Medicare and the American Health Care System: Report to the Congress*. Note: After 1994 persons enrolled do not include Medicare beneficiaries in managed care plans.

Days per Person Served: FY 1986-93 data from Prospective Payment Assessment Commission. (June 1997). *Medicare and the American Health Care System: Report to the Congress*; CY 1983 and 1994-97 data from Health Care Financing Administration, Office of Research and Demonstrations. *Health Care Financing Review Annual Statistical Supplement*.

Chart 6: Health Care Financing Administration, Office of Survey and Certification and Bureau of Program Operations, as included in Prospective Payment Assessment Commission. (June 1997). *Medicare and the American Health Care System: Report to the Congress*, 119.

Table 1: ProPAC analysis of MedPAR and home health claims data from the Health Care Financing Administration, as included in Prospective Payment Assessment Commission. (June 1997). *Medicare and the American Health Care System: Report to the Congress*, 119.

Figure 1: AHA Member Leadership Monitor, May 1999 results.

Charts 7 through 10 and Maps 1 and 2: The Lewin Group Analysis

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FTE/Adjusted Admission: American Hospital Association Annual Survey, 1986-1997

Percent Change in Cost per Case: American Hospital Association Annual Survey, 1986-1997

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National Health Expenditure as a Percent of GDP: Compiled by HCFA on www.hcfa.gov/stats/nhe-oact/tables/t09.html

Percent Uninsured: Compiled by Bureau of the Census on <http://www.census.gov:80/hhes/www/hlthins.html>

Number Uninsured: Compiled by Bureau of the Census on <http://www.census.gov:80/hhes/www/hlthins.html>

Percent Unemployed: Compiled by Bureau of Labor Statistics on <http://stats.bls.gov:80/wh/cpsbref2.html>

TrendWatch is a quarterly report produced by the American Hospital Association and The Lewin Group highlighting important and emerging trends in the hospital and health care field.



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TrendWatch June 1999, Vol. 1, No. 3
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