Mandated report: Developing a unified payment system for post-acute care

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Objectives of a PAC PPS

- Current policy:
  - 4 separate, setting-specific payment systems
  - Different payments for similar patients
  - SNF and HHA PPSs encourage therapy unrelated to patient care needs
- A unified PAC PPS would
  - Span the 4 settings
  - Correct some shortcomings of the PPSs
  - Base payments on patient characteristics

Previous sessions on the PAC PPS

- In September
  - Approach to the mandate
  - Results modeling stays in CMS's PAC demonstration
- In November
  - Possible complementary policies to counter volume incentives
    - Readmission policy, value-based purchasing, third-party PAC benefit manager
  - Waive certain setting-specific regulations and move toward a common set of conditions of participation

Today and future sessions

- Today's meeting
  - Results of analysis of PAC stays in 2013
  - Consider need for certain payment adjusters
  - Estimate impacts on payments
- March discussion topics
  - Payment adjuster for low-volume, isolated providers
  - High-cost outlier policy
  - Level of payments
- April
  - Finalize report

Overview of mandate and approach

	Mandate	Methodology	Purpose
1.	Evaluate and recommend features of a PAC PPS using data from the PAC-PRD	"Full" model (**model 1**) uses data from PAC-PRD sample to predict the relative costs of PAC-PRD stays	Use unique data in the PAC-PRD to test feasibility of PAC PPS
2.	Consider the impact of implementing a unified PAC PPS	• "Administrative" model **(model 2)** predicts relative costs of PAC-PRD stays • Compare the accuracy of models using same stays • If equally accurate, use "administrative" model to estimate impacts with all 2013 PAC stays **(model 3)**	• Assess the accuracy of administrative model (without the unique data) that could be used on a large sample of stays • Estimate impacts using a large sample of stays

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Comparison of the models used to evaluate a PAC PPS and estimate impacts

Factors included in models	Full model (1)	Administrative model (2)	Administrative model (3)
Patient age	X	X	X
Diagnoses	X	X	X
Impairments	X	Proxies	Proxies
Functional status	X	No	No
Cognitive status	X	Proxies	Proxies
Routine costs	X	X	Estimated
Analytic sample	**PAC-PRD stays**		**2013 stays**
PAC stays	6,409	6,409	8.9 million
PAC providers	107	107	24,953

Patient groups examined to evaluate the model results

Clinical groups

- Based on MS-DRG

Impairment and severity

- Functional status
- Cognitively impaired
- Frailty
- Severity
- Chronically critically ill

Other groups:

- High therapy
- Low therapy
- Community-admitted
- Disabled
- Dual-eligible
- Very old
- ESRD

Compared with full model, administrative model can establish accurate relative costs of stays

- Using the same PAC-PRD stays, the full and administrative models:
  - Predicted very similar relative costs of stays for most groups
  - Explained similar shares of the variation in costs across stays (60% vs 57%)
- Conclusions: Administrative data can be used to:
  - Establish accurate relative weights for most groups
  - Estimate impacts of PAC-PPS using 2013 stays

Results are preliminary and subject to change.
Source: The Urban Institute analysis of the PAC-PRD data.

2013 PAC stays: Administrative model would establish accurate relative weights for most patient groups

- Average predicted costs ≈ average actual costs
  - Almost all clinical groups
  - Frailty groups
  - Severely ill group
  - Multiple body system diagnoses group
  - Community admissions
  - Disabled, dual-eligible, ESRD, and very old groups
  - Most rural groups
  - Stays treated in teaching IRFs

Results are preliminary and subject to change.
Source: The Urban Institute analysis of 2013 PAC stays.

Groups where average predicted costs deviate from average actual costs

- Differences that were expected:
  - Low therapy share of costs
  - High therapy share of costs

  Actual costs reflect current therapy practices & PPS incentives

  - Stays treated in IRFs
  - Stays treated in LTCHs

  Similar stays are treated in lower-cost settings

Groups where average predicted costs deviate from average actual costs *continued*

- Differences that may warrant payment adjustment
  - Unusually short stays—*to prevent large overpayments*
  - High-cost outliers—*to protect providers from large losses*
- Differences that may warrant further study
  - Low volume, isolated providers—*to ensure access*
  - Extremely sick patients– *to ensure access*

Estimates of impacts

- Assume budget neutrality
- Do not reflect policy changes since 2013
- Do not assume changes in provider behavior
- Estimates should be considered as directional and relative, not as point estimates

Across stays, a PAC PPS would narrow differences between payments and costs

Group	Ratio current payments to actual costs	Ratio of PAC PPS payments to actual costs
All stays	1.18	1.18
Multiple body systems	1.03	1.18
Severely ill (SOI=4)	1.05	1.18
Respiratory medical	1.08	1.20
Severe wound	1.09	1.15
Most frail	1.14	1.18
Cardiovascular medical	1.19	1.19
Orthopedic surgical	1.24	1.19
Orthopedic medical	1.28	1.20

Payments assume budget neutrality. Results are preliminary and subject to change.
Source: The Urban Institute analysis of 2013 PAC stays.

A PAC PPS is estimated to shift payments across stays

Payment increases:

- Ventilator care
- Severe wound care
- Hematology
- Respiratory medical
- Chronically critically ill
- Multiple body system diagnoses
- Low therapy
- ESRD

Payment decreases:

- Neurology medical (non-stroke)
- Orthopedic
- Least frail
- High therapy
- Community admits

Results assume budget neutrality. Results are preliminary and subject to change. Source: The Urban Institute analysis of 2013 PAC stays.

Estimated changes in payments by provider type and setting

Payment increases:

- SNFs
- Hospital-based
- Nonprofit

Why?

- *Payments reflect patient characteristics, medically complex care*

Payment decreases:

- IRFs and LTCHs
- Freestanding
- For-profit

Why?

- *Payments decrease for stays with therapy services unrelated to patient characteristics*
- *Many types of stays treated in higher-cost settings are also treated in lower-cost settings*

Payments assume budget neutrality. Results are preliminary and subject to change.
Source: The Urban Institute analysis of 2013 PAC stays.

Summary of estimated impacts of a PAC PPS

- Shift payments from rehabilitation care to medical care
- Narrow the profitability by type of case
- Decrease the incentive to selectively admit certain types of patients
- Raise payments to providers that treat medically complex patients
- Lower payments to providers whose costs and service mix are unrelated to care needs

Impacts on an individual provider will reflect many factors

- Mix of patients treated
- The setting's current PPS design and incentives
- Provider's practice patterns
  - Services provided that are unrelated to a patient's care needs
- Ability to reduce costs to match payments

Conclusions

- A PAC PPS is feasible and would break down the silos between settings
- Payments would be based on patient characteristics, not the setting
  - Correct some of the shortcomings of current PPSs
- A unified PPS would:
  - Dampen incentives to selectively admit some types of patients over others

Implications of our findings for the design of a unified PAC PPS

- Administrative data could form the basis of a PAC PPS
  - Functional assessment data are needed to calibrate payments for certain types of patients
- Payments for stays in HHAs will need to be aligned with this setting's lower costs
- Payment adjusters
  - Short-stay policy is likely to be needed
  - A broad rural adjustment and an IRF teaching adjustment did not appear to be needed, but low-volume isolated providers may need protection

Implications of our findings for the design of a PAC PPS *continued*

- A high-cost outlier policy will help ensure beneficiary access to care and protect providers from large losses
- A transition will give providers time to adjust their costs and protect beneficiary access
- Risk-adjustment factors can be refined over time
- Relative weights should be recalibrated regularly
- Need to consider the level of payments

Discussion topics

- Questions
- Comments