Advising the Congress on Medicare issues

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

Carol Carter and Dana Kelley

September 10, 2015

MEDPAC

Mandated report on a unified payment system for post-acute care

- Report must evaluate and recommend features of a PAC-PPS based on patient characteristics
- Consider the impact of replacing the current PAC payment systems with a unified PPS
- Report due June 30, 2016
- Complex undertaking will require multiple presentations over the coming months

Timeline for mandated report

- Today
  - Approach to designing a unified PAC PPS
  - Models and initial findings
- Future meetings
  - Additional PPS design features (e.g., other payment adjusters; short-stay adjusters)
  - Other policy considerations (e.g., changes to regulatory requirements)
  - Estimates of the impacts of a unified PAC PPS
  - Draft recommendations

Presentation outline

- Concerns about PAC
- Path to PAC reform
- Challenges ahead
- Key components of a PPS
- Approach to designing a unified PAC PPS
- Initial findings

Concerns about post-acute care

- Four separate payment systems for SNFs, HHAs, IRFs, and LTCHs
  - Similar services provided in all settings, but payments differ
- Little evidence of where care is best provided
- Some regulatory requirements for admission, but providers have considerable latitude
- Placement often reflects non-clinical factors such as provider availability

➢ Considerable overlap in patients across settings

Concerns about post-acute care, cont.

- Current approach to PAC payment encourages the provision of services
- Wide variation in PAC use and costs
  - Medicare adjusted per capita spending varies more for PAC than for most other covered services
- Lack of common patient assessment tool

Call for PAC reform

- MedPAC recommended
  - Use of common patient assessment information for PAC in 1999 and 2014
  - Development of a unified PAC classification system in 2001
  - Site-neutral payments for IRFs and SNFs for selected conditions in 2015

CMS's PAC Payment Reform Demonstration (PAC-PRD)

- Mandated by the Deficit Reduction Act of 2005
- Developed and tested common patient assessment tool
  - Continuity Assessment Record and Evaluation (CARE) tool
  - Assessment items included measures of clinical, functional, and medical complexity
- Measured and compared patient resource use and outcomes in four PAC settings
- ➢ RTI analysis of CARE data suggested a unified PAC PPS for routine and therapy services was possible

Advancing PAC reform: The IMPACT Act of 2014

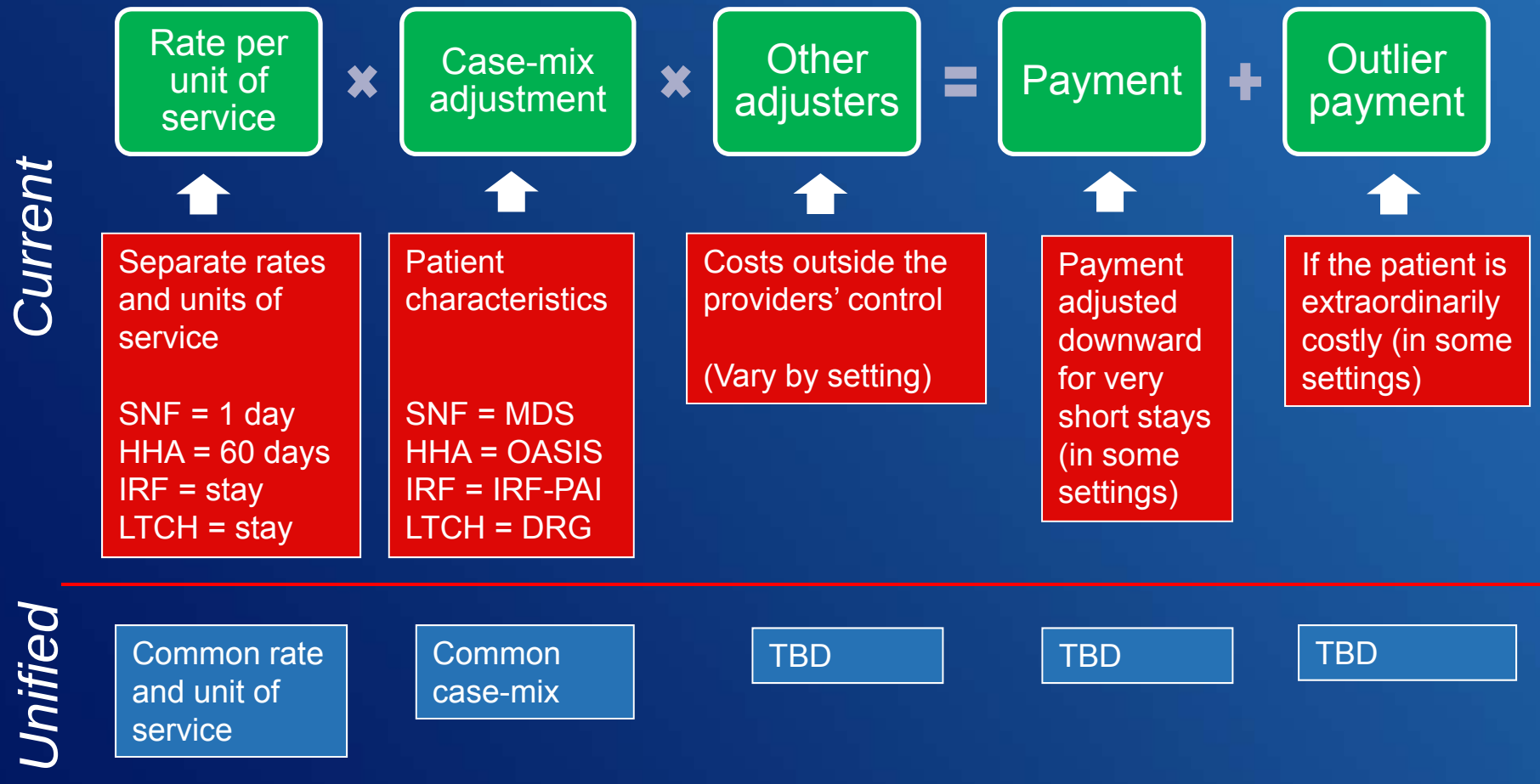
- Requires MedPAC to report on a unified PPS for PAC by June 30, 2016
- Requires the Secretary to:
  - Collect common patient assessment data beginning in 2018
  - After collecting two years of data, report to Congress recommending an approach for a unified PAC PPS

Advancing PAC reform: Objectives

- Payments that are based on patient needs, not site of service
- Better alignment of payments with care costs

➢ Important to remember: The current system does not reflect efficient delivery of PAC services. Under a reformed PAC payment system:
  - Payments will shift from some types of cases, providers, and settings to others
  - Providers may change how and where PAC services are furnished

Components of prospective payment systems: PAC settings



Using the PAC-PRD data to design a uniform PPS

- Establish a common unit
- Develop a common case-mix adjustment method
- Use patient information for the sample's stays to predict cost per stay
- Predicted cost would form basis for common payment

Using the PAC-PRD data

Advantages

The only data source for:

- Uniform patient assessment information (e.g. functional status)
- Patient-level routine resource use (e.g. nursing)

Limitations

- Small, non-representative sample

Develop a strategy to estimate impacts of a uniform PPS

- The PAC-PRD sample is too small to estimate impacts
- To address this limitation, we will:
  - Replicate the model that predicted PAC-PRD stay costs using only information available for all PAC stays
  - Apply this revised model to all PAC stays in 2013
  - Estimate impacts by comparing actual costs and payments to the predicted costs (a proxy for the new payments under a uniform PPS)

Designing a uniform PPS: Differences in coverage requires two models to predict costs

- HHA benefit does not cover nontherapy ancillary (NTA) services such as drugs
- Given this coverage difference, we developed two models to predict cost per stay for:
  - Routine and therapy services
  - NTA services
- Predicted cost would be used to establish payments

Translating prediction models into payment policy

For patients admitted to SNFs, IRFs, and LTCHs

Payment for routine + therapy services

+

Nontherapy ancillary services

For patients admitted to HHAs

Payment for routine + therapy services

Criteria to evaluate the models predicting cost per stay

- How much of the variation in cost across stays is explained by the model (r- squared)?
- Is the average predicted cost per stay (used to set payment) equal to the average actual cost per stay?
- Is the average predicted cost per stay equal to the average actual cost per stay for selected clinical and beneficiary groups?

Groups of beneficiaries examined

Clinical groups

- Ventilator cases
- Severe wound cases
- Rehabilitation (ex. recovering from a stroke, joint replacement)
- Other medical (ex. respiratory infection, CHF)

Other groups

- Disabled
- Dually eligible for Medicare & Medicaid
- Chronically critically ill
- Admitted directly from the community

Results of the routine and therapy model

- Overall: Explains a high share (56%) of the variation in costs across all stays
  - Includes an indicator the stay was treated in a HHA to prevent large over- and under-payments
- Explains a high share of variation in costs for the beneficiary groups we examined
- Payments (based on the average predicted cost) would equal the average actual costs of stays for most groups

Data are preliminary and subject to change

Results of the nontherapy ancillary (NTA) services model

- NTA make up 13% SNF costs, 17% IRF costs, and 44% of LTCH costs
- Overall: Explains a high share (47%) of the variation in NTA costs across all stays
- Beneficiary groups:
  - Predicts 22 to 49% of variation in costs
  - Payments based on the average predicted cost would be close to equaling the average actual costs of stays for five of eight groups

Data are preliminary and subject to change

Combining the results of the routine + therapy and NTA models

- Overall: Predicts 36% of the variation in costs across all stays
- Beneficiary groups:
  - Predicts 22% to 38% of variation in costs for most groups
- Payments based on average predicted cost would equal average actual costs of stays for most patient groups

Data are preliminary and subject to change

Implications for the design of a unified PPS

- It is possible to design a unified system that
  - Uses a common unit of service (a stay or HHA episode)
  - Uses a common case-mix adjustment method
  - Establishes a common rate for a patient stay
- Using the PAC-PRD sample, the models explain high share of variation in costs across stays

Implications for the design of a unified PPS (continued)

- Payments to HHAs will need to be adjusted to account for their much lower costs
- A unified PPS will shift payments:
  - Between different types of patients
  - Between providers within a setting
  - Between settings

Translating our results into payment policy

Patient admitted to SNFs, IRFs, and LTCHs

Routine + therapy services

+

Nontherapy ancillary services

Patients admitted to HHAs

Routine + therapy services

– Payment adjustment

Future presentation topics

- Further analysis by additional patient groups
- Possible payment adjusters
- An outlier policy
- Changes to setting-specific regulatory requirements
- A transition period
- Companion policies to dampen the incentive to refer patients to unneeded PAC

Discussion topics

- Additional beneficiary groups of interest
- What adjusters should we analyze
- Policies to accompany a unified PPS to dampen FFS volume incentives

Comparison of mix of cases in our sample versus national data

	Sample	Nationwide
HHA	60%	70%
SNF	12	25
IRF	17	4
LTCH	11	1
Total	100%	100%

Routine and therapy model results: Beneficiary groups

Group	% variation in costs explained	Ratio of average predicted to average actual costs
All stays	56%	1.00
Ventilator care	27	1.00
Severe wound care	55	0.99
Rehabilitation	58	1.00
Other medical	53	1.00
Disabled	56	0.99
Dual-eligible	56	0.97
Chronically critically ill (in law)	14	0.92
Community admit	31	0.97

Nontherapy ancillary services model results: Beneficiary groups

Group	% variation in costs explained	Ratio of average predicted to average actual cost per stay
All stays	47%	1.00
Ventilator care	28	1.00
Severe wound care	39	0.98
Rehabilitation	22	0.98
Other medical	29	1.01
Disabled	49	0.96
Dual-eligible	46	1.03
Chronically critically ill (in law)	22	0.83
Community admit	41	0.91

Combined results for routine, therapy and NTA services

Group	% variation in costs explained	Ratio of average predicted to average actual cost per stay
All stays	36%	1.00
Ventilator care	25	1.00
Severe wound care	31	1.01
Rehabilitation	36	0.99
Other medical	23	1.00
Disabled	38	0.97
Dual-eligible	31	0.96
Chronically critically ill (in law)	22	0.87
Community admit	23	1.01