Developing a unified payment system for post-acute care

Carol Carter and Dana Kelley

November 6, 2015

MEDPAC

Timeline for PAC PPS

IMPACT Act requirements	Due date
MedPAC report on recommended features of a PAC PPS and likely impacts	June 2016
CMS collection of patient assessment data	Oct 2018–Oct 2020
Secretary's report on unified PPS using 2 years' patient assessment data	Sometime in 2022
MedPAC report on a PAC PPS, including recommendations and technical prototype	June 2023 (?)

Continued discussion of mandated report on a PAC PPS

- In September
  - Presented our approach to the mandate
  - Reviewed our initial results of modeling stays in CMS's PAC demonstration
- Today's topics
  - Discuss issues raised in September meeting
- In January
  - Review results of modeling all PAC stays in 2013
  - Estimate impacts on payments

A unified, patient-based PAC PPS is a first step towards broader reform

- A new PAC PPS should not be the end point for PAC payment reform
- Even with unified pricing, FFS incentives will remain
  - Minimize the care provided during the stay
  - Discharge patients quickly to next setting
  - Multiple PAC stays that do not support care coordination
- ➢ Medicare should move towards putting providers at risk over longer periods of time

Review of September findings

- Developed a common unit of service and a common risk-adjustment method
- Designed two models to pay for PAC
  - Routine + therapy services across 4 settings (HHA, SNF, IRF, and LTCH)
  - Nontherapy ancillary services across 3 settings (SNF, IRF, and LTCH)
- Models are accurate and could be used to establish payments
- A unified PPS will change how and where PAC services are furnished

Issues raised at September meeting

- Approach to estimating costs and payments under a PAC PPS
- Additional preliminary results
- Even with improved PPS, companion policies are needed to dampen FFS incentives
- Comparison of outcomes across PAC settings
- Changes to regulatory requirements

Approach to estimating costs and payments under a PAC PPS

- Ideal: Base payments on cost of efficient care at the most appropriate setting
- Current: Use reflects many factors; no evidence-based guidelines on best care
- Unified PPS:
  - Proposed approach: Base payments on current practice
  - Over time, revise payments to reflect changes in practice

Preliminary analysis of PAC-PRD stays: Groups examined

Previous groups:	New groups:
4 Clinical groups	10 Clinical groups
Chronically critically ill	2 Functional status
	1 Cognitively impaired
	2 Patient severity
Community admit	Community admit
Disabled	Disabled
Dual eligible	Dual eligible

Preliminary results of PAC-PRD stays: Ratios of average predicted costs to average actual costs

Patient group	Routine + therapy (r^2 = .56)	Routine + therapy + NTA (r^2 = .36)
All stays	1.0	1.0
10 Clinical groups	0.98 - 1.01	0.98 - 1.06
2 Function groups	0.96 -1.04	0.97 - 1.0
Cognitively impaired	1.0	0.99
2 Patient severity groups	0.97 – 0.98	1.0
Community admit	0.97	1.01
With prior hospital stay	1.01	1.0
Disabled	1.0	1.0
Dual-eligible	0.97	0.96

Results are preliminary and subject to change.

Source: The Urban Institute analysis of the PAC-PRD data.

Why companion policies to unified PAC PPS are needed

A unified PPS will:

- Establish a common base payment for PAC
- Payments will vary based on patient characteristics, not the setting or amount of service provided

A unified PPS will not correct FFS incentives:

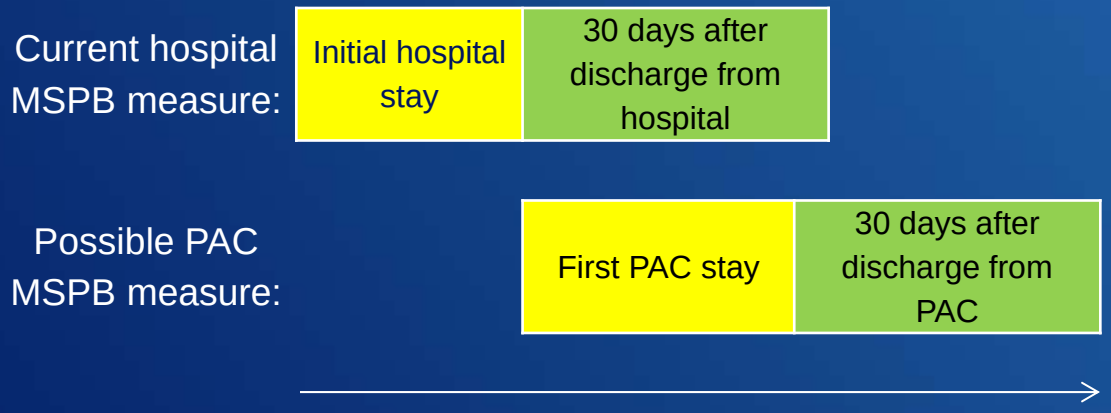
- Minimize care during the stay
- Discharge patients quickly to next setting
- Multiple PAC stays do not support care coordination

Policies to consider when implementing a PAC PPS

- Companion policies to dampen FFS incentives
  - Value-based purchasing to reward high quality and episode efficiency
  - A measure of resource use over a defined period of time
  - Readmission and transfer policies
- Pay a third party to manage PAC
- Monitor provider responses to PAC PPS
- Implement provider-supportive policies as part of the PPS (outlier policies, transition)

Medicare spending per beneficiary: A measure of resource use

- Hold PAC providers accountable for resource use during the episode of care



- Would align incentives across PAC settings and hospital

Comparison of outcomes across PAC settings

- Few studies compare outcomes across PAC settings for all patients
- Evaluation of CMS's PAC-PRD compared risk-adjusted outcomes
  - Few differences in readmission rates
  - No differences in changes in mobility
  - Mixed differences in changes in self-care

Changes to regulatory requirements for PAC providers

- Providers should have flexibility to treat a broad mix of patients
- Near-term: Consider waiving certain setting-specific requirements
  - IRFs: 60% rule, full-time physiatrist, intensive therapy requirement
  - LTCHs: 25-day average length of stay
- Longer-term: Could ensure a baseline level of competency across all PAC

Longer-term: Develop a common set of PAC requirements

Possible domains:

- Staffing
- Physician/NP/PA presence
- Frequency of assessments
- Staff training and competence
- Care and discharge planning
- Infection control
- Patient rights
- Ethics and compliance

Common requirements could:

- Raise the level of care furnished in SNFs
- Effectively lower the IRF and LTCH requirements
- Specify competencies to treat certain conditions (e.g., wound or ventilator care)

Summary

- A reasonably accurate PAC PPS can be designed
  - Begin with payments set to reflect current practice and revise over time
- Consider additional policies to improve incentives and ease transition
- Setting-specific regulations
  - Near-term: Waive certain requirements
  - Longer-term: Develop a common set of requirements for PAC providers

Discussion topics

- Additional policies to implement concurrently with a unified PAC PPS
- Regulatory requirements to consider waiving
- Other issues