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

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MEDPAC

Objectives of a PAC PPS

- Current policy:
  - Four 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 four settings
  - Base payments on patient characteristics
  - Correct some shortcomings of the PPSs

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

- Evaluate and recommend features of a PAC PPS based on patient characteristics
- Estimate the impacts of a unified PAC PPS
- Report due June 30, 2016
- A second report must propose a prototype design on a PAC PPS (due June 2023)

Topics covered in report (previous Commission discussions)

- Feasibility of a PAC PPS (Sept., Nov., Jan.)
- Impacts on payments (Jan.)
- Implementation issues (Nov.)
- Possible changes to regulatory requirements (Nov.)
- Companion policies (Nov.)
- Monitor provider responses (Nov.)
- Move towards episode-based payments (all)

Topics for today and April presentations

- Today
  - New information on:
    - Outlier policies
    - Level of payments
  - Summary of findings
- April
  - Finalize report

Impact of an illustrative high-cost outlier policy on PAC PPS payments

- Example: 5% pool, 80% of costs paid above the fixed loss amount
- For most of 40+ groups of stays we examined, outlier policy made little difference in payments
- Payments increased to more closely align to the costs of stays for:
  - Ventilator (6% increase)
  - Severe wound care (3% increase)
  - Severely ill (3% increase)
  - Highest acuity (12% increase)

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

Impact of an illustrative short-stay outlier policy

- Example: For the shortest stays, per diem (or per visit) payments based on costs plus 20% for the first day (visit)
- Payments decreased for short stays to more closely align with costs

Group	Ratio of payments to actual costs without a short stay	Ratio of payments to costs with a short stay policy
Shortest HHA stays	3.36	1.36
Shortest SNF stays	4.81	1.77
Shortest IRF stays	1.80	0.80
Shortest LTCH stays	2.23	0.72

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

Level of payments relative to costs

- In 2013, payments exceeded costs by 19%
  - Does not account for policy and payment changes since 2013
- How to set the level of spending in a PAC PPS?
  - Keep at current level
  - Implement past Commission recommendations to lower payments
  - Costs of efficient providers
  - Consider geographic variation in spending

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

Feasibility of a PAC PPS

- A PAC PPS is feasible
- Features of a PAC PPS:
  - Common unit of payment and risk adjustment
  - Payments based on patient characteristics
  - Need to align payments for stays in HHAs with this setting's lower costs
  - Separate models to establish payments for
    - Routine + therapy services
    - Nontherapy ancillary services (e.g., drugs)

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

Feasibility of a PAC PPS continued

- Evaluated models for 40+ patient groups of stays
  - Includes 22 clinical groups, 4 definitions of medically complex stays, and demographic groups
- Administrative data could establish accurate payments for most types of stays
- Model predictions were less accurate for highest acuity stays. Explore further refinements to the risk adjustment
- As expected, predictions were not accurate for:
  - Groups defined by amount of therapy furnished
  - Stays treated in high-cost settings and high-cost providers

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

Feasibility of a PAC PPS continued

- Payment adjusters needed:
  - Unusually short stays—*to prevent large overpayments*
  - High-cost outliers—*to protect providers from large losses and ensure access for beneficiaries*
- No strong evidence for:
  - A broad rural adjuster or a frontier adjuster, but need to examine low-volume, isolated providers
  - IRF teaching adjuster
- Further study:
  - Highest-acuity patients
  - Providers with high shares of low-income patients

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

Impacts of a PAC PPS on payments

- Narrows the variation in profitability across stays
- Decreases the incentive to selectively admit certain types of patients

Average payments increase for:	Average payments decrease for:
• Medical stays • Medically complex stays	• Stays with physical rehabilitation services unrelated to patient condition • Stays also treated in lower cost settings and lower-cost providers

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

Implementation issues

- Transition policy
  - Level of payment relative to costs
  - How long? Allow providers to bypass transition?
  - Consider implementing a PAC PPS earlier using administrative data and refine when patient assessment information become available
  - Start with a larger high-cost outlier pool and make it smaller over time
- Periodic refinements to keep payments aligned with costs

Changes to regulatory requirements

- Give providers flexibility to offer a wide range of PAC services
- Short-term: Evaluate waiving certain setting-specific requirements
- Longer term: Develop “core” requirements for all providers, with additional requirements for providers opting to treat patients with highly specialized needs

Companion policies

- Implement policies to protect beneficiaries and program spending
  - Readmission policy
  - PAC Medicare spending per beneficiary measure
  - Organize policies as part of value-based purchasing
- Could consider contracting with a third party to manage PAC use

Monitor provider responses

- Quality of care
- Selective admissions
- Unnecessary volume
- Adequacy of Medicare payments

Episode-based payments would dampen undesirable incentives of FFS

- Providers are at risk for quality and spending
  - Focuses providers on care coordination
  - Avoids costly readmissions
  - Avoids unnecessary service volume
  - Limits ability to shift costs to other providers
- Reduces need for companion policies PAC

- PPS is not the end point but a good first step in broader payment reforms

A PAC PPS: Summary of findings

- A PAC PPS is feasible
- Design features
  - Common unit of service
  - Common risk adjustment using patient characteristics
  - Adjustment to align HHA payments to costs of these stays
  - Separate models to establish payments for NTA services and routine + therapy services
  - Two outlier policies: high-cost and short-stay
  - No strong evidence for broad rural or frontier adjuster, but need to examine low-volume, isolated providers

A PAC PPS: Summary of findings
continued

- Impacts
  - Payments would shift from rehabilitation care to medical care
  - Reduced variation in profitability, less incentive to selectively admit
  - Implementation issues
  - Level of payment
  - Transition
- Possible changes in regulatory requirements
- Companion policies
  - Readmission policy
  - Medicare spending per beneficiary measure

  } Value-based purchasing
- Monitor provider responses to PAC PPS
- Move towards episode-based payments

Discussion topics

- Questions on new material
- Reactions to overall report