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

Carol Carter

April 7, 2016

MEDPAC

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)

Report is the culmination of multiple Commissioner discussions

2015

- September
  - Approach to mandate
  - Results modeling the cost of stays in PAC demonstration
- November
  - Companion policies
  - Changes to regulatory requirements
  - Monitoring provider responses

2016

- January
  - Results of modeling the cost of 2013 stays
  - Need for adjusters
  - Impact on payments
- March
  - Illustrative outlier policies
  - Level of payments
- All
  - Feasibility of PAC PPS
  - Need to move toward episode- based payments

MEDPAC

Topics covered in report

- Feasibility of a PAC PPS
- Impacts on payments
- Implementation issues
- Possible changes to regulatory requirements
- Companion policies to implement with PAC PPS
- Importance of monitoring provider responses
- Need to move toward episode-based payments

Summary of findings: Design features

- A PAC PPS is feasible
- Design features
  - Common unit of service
  - Common risk adjustment using patient characteristics
  - Adjustment to align HHA payments to costs
  - Separate models to establish payments for NTA services and routine + therapy services
  - Two outlier policies: high-cost and short-stay

Summary of findings: Design features
continued

- No strong evidence for the following adjusters:
  - IRF teaching providers
  - Rural
- Further study:
  - Low-volume, isolated providers
  - Highest-acuity patients
  - Providers with high shares of low-income patients

MEDPAC

Impacts of a PAC PPS on payments

- Estimates should be considered relative and directional, not point estimates
- Profitability across stays would be more uniform
  - Would decrease the incentive to selectively admit certain types of patients
- Shifts payments between different types of stays
- Lowers payments to providers and settings with high costs unrelated to patient characteristics

Implementation issues

- Transition policy
  - Level of payment relative to costs
  - How long to transition from setting-based payments to “new” PAC PPS payments
  - Implement sooner using administrative data and refine when patient assessment information become available
- 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 any provider opting to treat patients with highly specialized needs

Companion policies to implement at same time as a PAC PPS

- Readmission policy
- PAC Medicare spending per beneficiary measure
- Organize policies as part of value-based purchasing

MEDPAC

Monitor provider responses

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

Medicare needs to move toward episode-based payments

- Providers would be at risk for quality and spending over an episode of care
- Reduces need for companion policies
- PPS is not the end point but a good first step in broader payment reforms

Commission work on a unified PAC PPS and related policies will continue beyond June report

- Timeline of PAC PPS design
  - MedPAC report on PPS design features (2016)
  - Secretary's report on a prototype design using uniform patient assessment data (2020)
  - MedPAC report on a protoype design (2023)
- Integrate our findings into the annual update discussion
- Continue to develop and track outcome and resource use measures across PAC settings