Mandated report: Evaluation of a prototype design for a post-acute care prospective payment system

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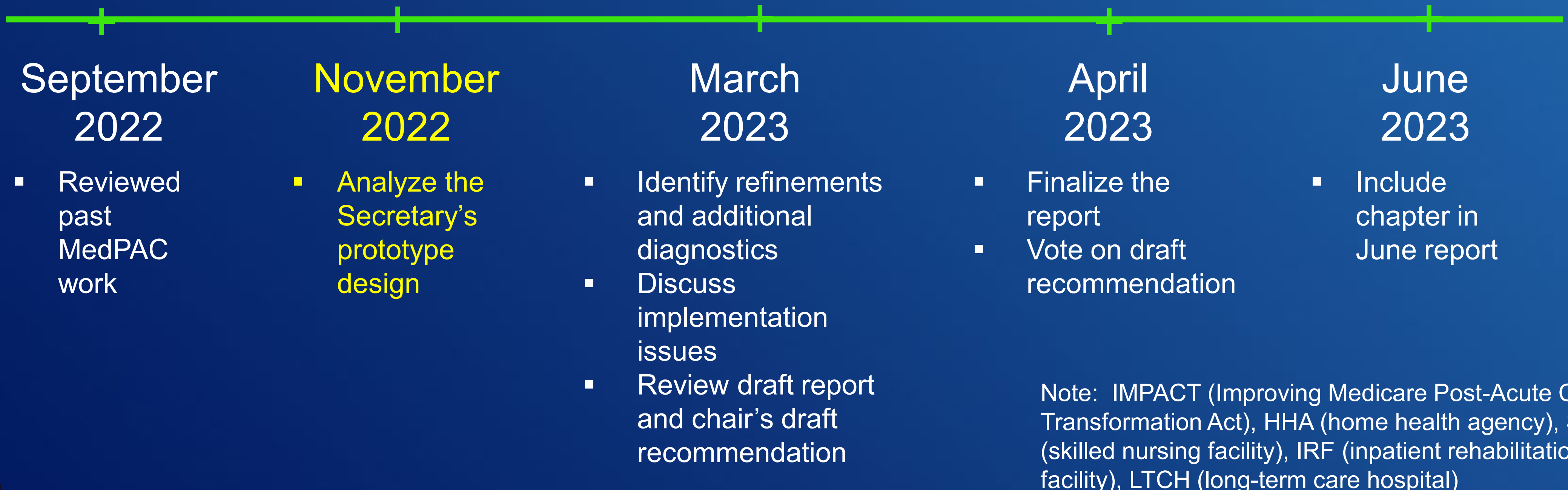
Timetable for preparing the mandated report

- IMPACT Act 2014 required MedPAC and the Secretary to design a prototype payment system to span HHAs, SNFs, IRFs, and LTCHs
- The designs must use patient characteristics—not setting—to set payment rates



MEDPAC

Analysis of Secretary’s PAC PPS prototype

Question	Analysis
1. Which design features help keep payments aligned with the cost of a stay and does the CMS/ASPE prototype include them?	MedPAC modeled a uniform design to assess the features needed to keep payments aligned with costs
2. Would the prototype establish accurate payments?	Accuracy reported by CMS/ASPE; compared prototype’s payments to actual costs of stays
3. Would the profitability of different types of cases be reasonably uniform?	MedPAC examined the variation in profitability reported by CMS/ASPE
4. What are the estimated impacts on providers’ payments?	Impacts estimated by CMS/ASPE

What features are needed to accurately predict the cost of a post-acute care stay?

MedPAC analysis

- Payments would be based on predicted costs of a stay
- Want features that help correctly predict the costs of a stay
- Results would indicate features needed to keep payments aligned with costs

Patient and stay characteristics

- Primary reason for treatment
- Comorbidities
- Functional, cognitive, disability status
- Frailty
- Age
- Other characteristics
- Treated in a home health agency

Data used

- Claims
- Cost reports
- Patient assessments
- All from 2019

MedPAC model was accurate for most of the patient groupings we examined

- PAC PPS could establish accurate payments with existing data
- We examined the results for 50+ reporting groups
  - 35 clinical categories
  - 15 measures of medical complexity, frailty, function and cognitive status, disability
- Predicted costs were within 2% of actual costs
- Characteristics with less accurate results indicate need for specific risk adjustment (such as a case-mix group)
- As expected, predicted costs were not accurate for IRF and LTCH stays

Note: PAC (post-acute care), PPS (prospective payment system), IRF (inpatient rehabilitation facilities), LTCH (long-term care hospitals)

Preferred features of a PAC PPS

Feature	Include in model?
Stay as unit of service	Yes
HHA adjuster	Yes
Adjustment for SNF, IRF, and LTCH stays	No
Uniform case-mix adjustment	Yes
Outlier policies for short stays and high-cost stays	Yes

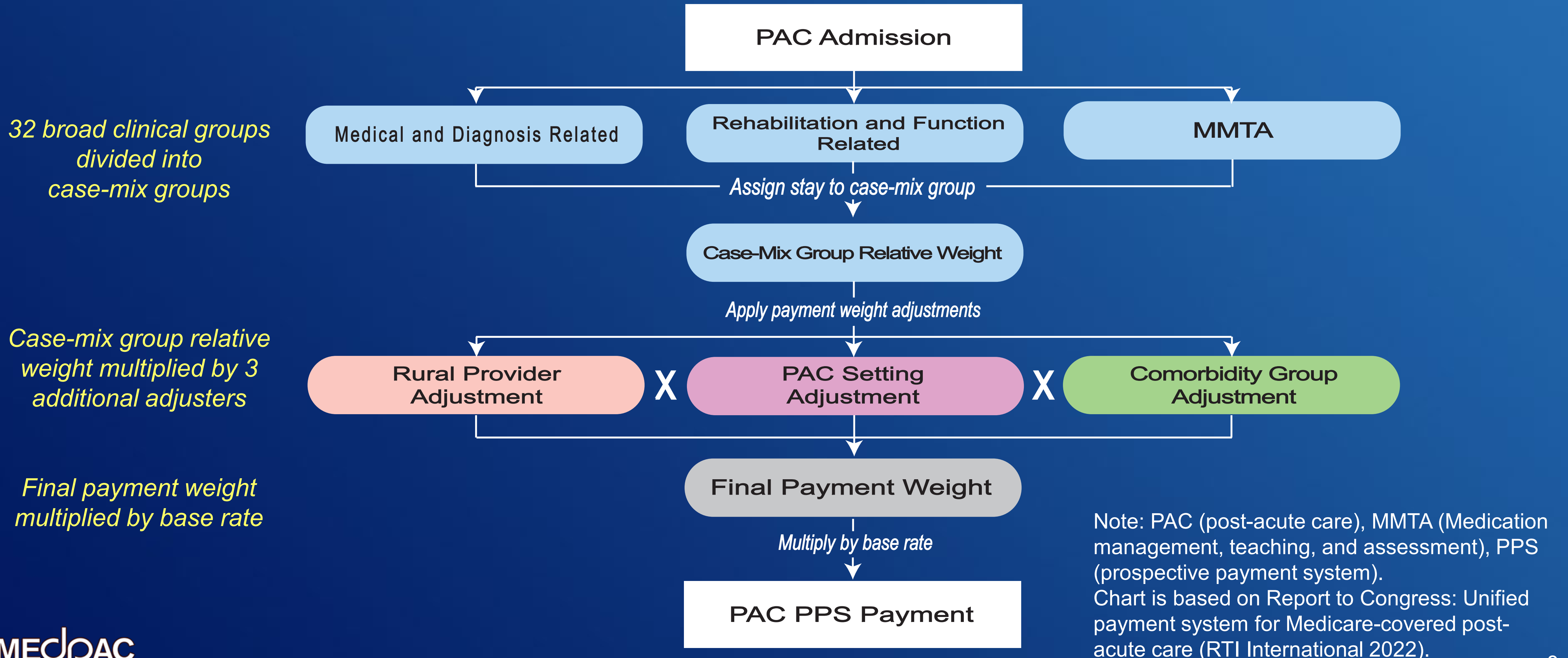
Note: PAC (post-acute care), PPS (prospective payment system), HHA (home health agency), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital)

Preferred features of a PAC PPS (continued)

Feature	Include in model?
Broad rural adjuster	No
Teaching adjustment	No
Adjustment for provider’s share of low-income patients	No
Adjustment for follow-on home health stays	Yes
Adjustment for source of admission	Yes

Note: PAC (post-acute care), PPS (prospective payment system)

CMS/ASPE prototype design



Note: PAC (post-acute care), MMTA (Medication management, teaching, and assessment), PPS (prospective payment system).
Chart is based on Report to Congress: Unified payment system for Medicare-covered post-acute care (RTI International 2022).

MEDPAC

CMS/ASPE prototype generally includes preferred features of a PAC PPS

Feature	MedPAC: Include in model?	CMS/ASPE prototype
Stay as unit of service	Yes	Yes, except for consecutive home health stays
HHA adjuster	Yes	Yes
Adjustment for SNF, IRF, and LTCH stays	No	Yes
Uniform case-mix adjustment	Yes	Yes, mostly
Outlier policies for short stays and high-cost stays	Yes	Yes

Note: PAC (post-acute care), PPS (prospective payment system), HHA (home health agencies), SNF (skilled nursing facilities), IRF (inpatient rehabilitation facilities), LTCH (long-term care hospitals)

CMS/ASPE prototype generally includes preferred features of a PAC PPS (continued)

Feature	MedPAC: Include in model?	CMS/ASPE prototype
Broad rural adjuster	No	Yes
Teaching adjustment	No	No
Adjustment for provider's share of low-income patients	No	No
Adjustment for follow-on home health stays	Yes	Yes, but applies to all PAC stays
Adjustment for source of admission	Yes	Yes, but applies to all PAC stays

MEDPAC

Note: PAC (post-acute care), PPS (prospective payment system)

CMS/ASPE prototype appears to establish accurate payments

- Assessed accuracy of payments for broad clinical groups; accuracy for more granular case-mix groups was not assessed
- Predicted payments were within 2% of costs for almost all broad clinical groups for 2017-2019 stays
- Payments were less accurate for 2020 stays (most within 10% of predicted payments)

Source: RTI, Inc. 2022. Report to Congress: Unified payment system for Medicare-covered post-acute care.

Profitability under the CMS/ASPE prototype appears to be relatively uniform

- Uniform profitability helps ensure equal access regardless of a patient's characteristics
- CMS did not evaluate whether profitability was uniform across clinical groups
- Our examination of the reported payment-to-cost ratios for the broad clinical groups found:
  - Ratios varied by 6 percentage points for 2017-2019 stays
  - Far more variation in in 2020 stays (21 percentage points)

Source: RTI, Inc. 2022. Report to Congress: Unified payment system for Medicare-covered post-acute care.

CMS/ASPE estimated that its prototype would redistribute payments

Provider group	Percent change in payments
All stays	0%
HHA	−4
SNF	1
IRF	−6
LTCH	17
Urban	0
Rural	3

Note: HHA (home health agencies), SNF (skilled nursing facilities), IRF (inpatient rehabilitation facilities), LTCH (long-term care hospitals)

Source: RTI, Inc. 2022. Report to Congress: Unified payment system for Medicare-covered post-acute care.

Takeaways

- CMS/ASPE prototype is a good starting point
- A refined design should:
  - Use more recent data to capture changes in costs and site of service
  - Propose a timetable to phase out the SNF, IRF, and LTCH adjusters
  - Reconsider the definition of a HHA stay and follow-on PAC stays
  - Re-evaluate the need for any rural adjuster and, if warranted, design a targeted policy for low-volume isolated providers
  - Specify outlier policies and include them in their evaluations
  - Consider the tradeoff between accuracy and uniform adjusters for source of admission (community admission and prior hospital stay)

Note: SNF (skilled nursing facilities), IRF (inpatient rehabilitation facilities), LTCH (long-term care hospitals), HHA (home health agency), PAC (post-acute care)

Discussion

- Questions about our preferred design features or CMS/ASPE prototype
- Other analyses to evaluate a prototype design
- Tradeoffs between accuracy and uniform design features