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

Carol Carter

March 2, 2023

MEDPAC

Road map

- Recap: Design of PAC PPS
  - Congressional mandate and rationale
  - Conclusions
- New material: Considerations for implementing a PAC PPS
  - Transition policy
  - Level of aggregate payment
  - Companion policies
- Key takeaways
- Chair's draft recommendation

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

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

- Required Secretary to design and collect uniform patient assessment items and quality measures
- Mandated reports on a PAC PPS design
  - ✓ MedPAC report submitted in June 2016
  - ✓ Secretary of HHS (CMS/ASPE) report submitted in July 2022
  - ❑ MedPAC report due by June 30, 2023
- PAC PPS design must span the four PAC settings and base payments on patient characteristics, not setting
- Does not require implementation—does not include an implementation date

Note: PAC (post-acute care), PPS (prospective payment system), ASPE (Assistant Secretary for Planning and Evaluation)

Why the interest in a unified payment system for post-acute care?

Overlapping patients in different settings

Separate PPSs resulted in different payment rates for similar patients

Unified payment system would base payments on patient and stay characteristics

Shortcomings in HHA, SNF, and LTCH payment systems

SNF and HHA PPSs encouraged unnecessary therapy; LTCHs encouraged to admit low-acuity patients

CMS made substantial changes to these PPSs

Note: PPS (prospective payment system), HHA (home health agency), SNF (skilled nursing facility), LTCH (long-term care hospital)

Conclusions about the design of a PAC PPS

- In separate studies, MedPAC and CMS/ASPE demonstrated that a unified payment system was feasible
  - Could establish accurate payments
  - Could result in relatively uniform profitability
- CMS/ASPE prototype would be a good starting point for a design
  - Consistent with the Commission's preferred features
  - However, it adjusts the payment amount by setting, thus undermining the design's uniformity

Note: PAC (post-acute care), PPS (prospective payment system), ASPE (Assistant Secretary for Planning and Evaluation)

Further considerations for refining a PAC PPS design

Prioritize uniformity vs. accuracy	• Accept less accuracy for uniform design features • Limit deviations from uniform elements to those needed to avoid access problems or that would otherwise create large distortions in payments
Re-evaluate payment adjusters	• Assess theoretical reason for payment adjustments: Should Medicare pay for the differences in costs? • Assess empirical evidence: Is the adjustment related to the predicted cost of care?
Assess incentives	• Would the design encourage the efficient provision of care? • Would the design discourage patient selection?

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

Additional PAC PPS implementation decisions

Transition policy

- Should a PAC PPS be phased in?
- For how long?

Level of payments

- Should total payments under a PAC PPS equal current payments?

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

Transition policy rationale

- A transition would
  - Avoid payment shocks
  - Give providers time to adjust their costs and practices
  - Delay redistributions of payments
- During a transition, payments would be a blend of current (setting-specific) PPS and PAC PPS payments

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

Estimated changes in payments suggest the need for a transition

- Our modeling indicates impacts on providers' payments would vary widely across providers
- Magnitude of impacts depends on the details of the design

Change in payments*	Share of PAC providers
Decreases of 10% or more	21%
Increases of 10% or more	33%

*Results are for a design that adjusts payments to home health agencies (and not to other providers.) Results are preliminary and subject to change.

Note: PAC (post-acute care)

Evidence from MedPAC's modeling suggests a transition could be short

- Changes in providers' payments would generally be inversely related to their current profitability
  - Of the providers whose payments would decrease by at least 10%, the majority (58%) were relatively profitable (PCRs > 1.1)
  - Of the providers whose payments would increase by at least 10%, the majority (57%) were relatively unprofitable (PCRs < 0.90)

Note: PCR (payment-to-cost ratio). Results are for a payment system design that adjusts payments to home health agencies (and not to other providers.) Profitability was measured using a ratio of payments to costs. Results are preliminary and subject to change.

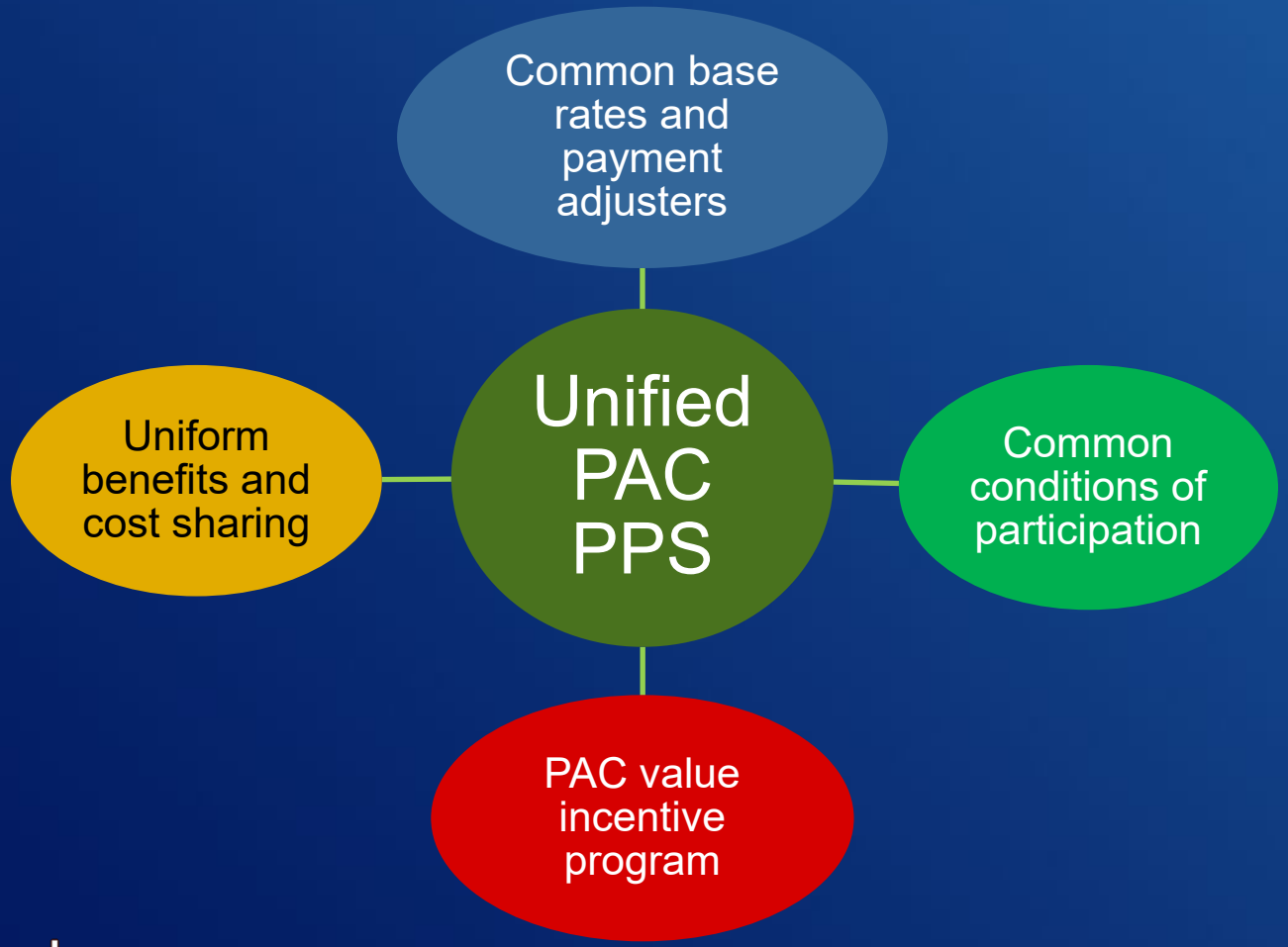
Setting the level of payments

- In 2019, aggregate payments were 14% higher than aggregate costs (payment-to-cost ratio = 1.14)
- Lowering the level of payments would help align payments to costs
- A reduction could be phased in over multiple years
- Payment-to-cost ratios under three implementation options:

No transition, no reduction to payments	No transition, 5% reduction to payments	First year of a 3-year transition, 5% reduction to payments
1.14	1.08	1.12

Results are for a payment system design that adjusts payments to home health agencies (and not to other providers.) Results are preliminary and subject to change.

Companion policies would need to accompany a PAC PPS



- Modeling has demonstrated a uniform payment system is feasible
- Necessary companion policies pose additional challenges

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

Uniform benefits and cost sharing

Current policy

- Benefits differ by setting
  - e.g., Prior hospital stay required for SNF coverage
- Cost sharing differs by setting
  - e.g., Co-payments begin on day 21 of a SNF stay, no co-payments for home health care

PAC PPS

- Benefits and cost sharing should be aligned
- Significant implications
  - For beneficiaries—e.g., Cost sharing for home health care?
  - For program spending—e.g., Elimination of prior hospital stay requirement for PAC PPS coverage?

Note: PAC (post-acute care), PPS (prospective payment system), SNF (skilled nursing facilities)

Align Conditions of Participation

Current policy

- Provider requirements and their associated costs differ by setting
  - IRFs and LTCHs: Hospital CoPs
  - SNFs: Requirements of participation
  - HHAs: Separate CoPs
  - Each set of requirements has its own cost implications for providers

PAC PPS

- Regulatory requirements would be commensurate with the acuity of patients
- Implications/challenges
  - Condition-defined CoPs would be a substantial departure from current policy
  - Could raise requirements (and costs) for some providers

Note: PAC (post-acute care), PPS (prospective payment system), CoP (Conditions of Participation)

Value incentive program

Rationale

- Tie payments to a provider's performance on outcome measures
- Dampen the incentives to generate unnecessary volume or reduce costs in ways that could harm patient care

Design elements

- Small set of measures
- Strategies to ensure reliable results
- Structure rewards and penalties with minimal "cliffs"
- Account for social risk of a provider's patient population (if needed) using peer groups
- Distribute entire provider-funded pool of dollars

Additional development work for CMS

- Measures of patient experience and accurate measures of functional status
- Define and measure social risk of a provider's patient population

Companion policies present challenges to implementing a PAC PPS

- Aligning benefits and cost sharing will involve tradeoffs that may be controversial
- Establishing a common set of Conditions of Participation would be relatively straightforward for some dimensions (e.g., patient rights, quality assurance) but complex for others (e.g., staffing levels, physician presence)
- In addition to the design elements, a value incentive program would require additional development work on measures of performance and social risk

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

Key takeaways

- A PAC PPS is feasible and could establish accurate payments
- Designing a payment system would be relatively straightforward; implementing the accompanying policies would not be
- Recent changes to the SNF, HHA, and LTCH PPSs addressed one of the reasons for a PAC PPS (to correct the shortcomings of the PPSs)
- Given the resources required to implement a PAC PPS and the companion policies, policy makers may opt to consider smaller-scale, site-neutral policies that would be simpler to implement

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