CHAPTER 1

Implementing a unified payment system for post-acute care

RECOMMENDATION

The Congress should direct the Secretary to:

- implement a prospective payment system for post-acute care beginning in 2021 with a three-year transition;
- lower aggregate payments by 5 percent, absent prior reductions to the level of payments;
- concurrently, begin to align setting-specific regulatory requirements; and
- periodically revise and rebase payments, as needed, to keep payments aligned with the cost of care.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

CHAPTER 1

Implementing a unified payment system for post-acute care

Chapter summary

In 2015, Medicare spending on post-acute care (PAC) services totaled $60 billion. Although the types of cases treated in the four main PAC settings (skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs)) overlap, Medicare's payments for similar patients can differ substantially, in part because Medicare uses separate prospective payment systems (PPSs) to pay for stays in each setting. There is considerable variation in the supply and use of PAC providers across the country as well as an absence of evidence-based criteria guiding decisions about which patients require PAC, which PAC setting is most appropriate for a given patient, and how much care is needed. These factors undermine clear policies to guide PAC placement decisions.

Given the overlap between PAC settings in the patients they treat, the Commission has long promoted the idea of moving to a unified PAC PPS that spans the four settings, with payments based on patient characteristics rather than the site of service. As required by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT), the Commission, in June 2016, recommended the necessary features of a PAC PPS and considered the effects on payments of moving to such a system. Using readily available data on patient characteristics (such as age, reason to treat, and comorbidities), the Commission's PAC PPS design accurately predicted the costs of stays for most patient groups, although functional assessment information—uniform

In this chapter

across settings—would further align payments with the cost of certain types of stays. This PAC PPS design is conceptually consistent with past Commission recommendations to revise the SNF and HHA PPSs.

A PAC PPS would redistribute payments among types of stays and settings. Payments would decrease for rehabilitation care unrelated to patient characteristics (for example, for patients recovering from hip surgery who receive high amounts of rehabilitation therapy services regardless of their care needs) and would increase for medically complex care (for example, for patients with comorbidities that involve multiple body systems). The redistribution of payments is consistent with those estimated by the Commission in its recommended redesigns of the PPSs for HHAs and SNFs. The equity in payments would increase across different types of patients, and the providers that treat them, because the relative profitability across types of stays would be narrower. Therefore, providers would have less incentive to admit certain types of patients over others.

The Commission supports the implementation of a PAC PPS sooner than the timetable outlined in IMPACT. On the Act's schedule of required reports on a design, it is unlikely that a new payment system would be proposed before 2024 for implementation sometime later. And while the Act requires recommendations for a design, it does not require the implementation specifically of a PAC PPS. The Commission believes that the implementation could begin as early as 2021, assuming some regulatory alignment is underway that would begin to standardize requirements across the settings. The implementation could begin with a design using readily available data and be refined when uniform assessment data become available.

This year, we return to our analysis of the PAC PPS design to explore three implementation issues. First, we examine whether the implementation should include a transition during which providers would be paid a blend of current (setting-specific) rates and a PAC PPS rate. A multiyear transition would extend the inequities in the current PPSs and delay the much-needed redistribution of payments. However, it would give providers time to adjust their costs and patient mix to the new payment system. Although the PAC PPS would change payments for many providers, the Commission concludes that, because the majority of those that would experience decreases in payments had above-average profitability, the transition period could be short.

Policymakers could allow providers the option to bypass the transition and move immediately to full PAC PPS rates. However, because providers whose payments are likely to increase under a full PAC PPS would be more likely to exercise

this early option, allowing providers to bypass the transition would likely raise aggregate spending above current levels during the transition period. This additional cost could be mitigated by lowering the level of PAC payments.

A second implementation issue is whether the Congress should consider lowering the level of total PAC payments when the PPS is implemented so that payments more closely align with the cost of stays. In aggregate, we estimate that current payments to PAC providers exceed the cost of stays by 14 percent, with some variation across the patient groups. In its March 2017 report to the Congress, the Commission discussed the high level of FFS payments relative to the costs of care in PAC and recommended lowering payments to HHAs and IRFs and freezing payments to SNFs and LTCHs. Our analyses indicate that, even if payments were lowered by 5 percent, the average payments across all stays and for the 30 clinical groups we examined would remain well above the average cost of stays.

Finally, if it mandates the implementation of a PAC PPS, the Congress should provide the Secretary with the authority to perform the ongoing maintenance that is required in any payment system to keep payments and costs aligned. Medicare's experience with major payment policy changes has shown that providers will modify their costs and practices in response to such changes, thereby enabling them to maintain profitability. The Secretary will need to make regular refinements in response to changes in costs and practices to ensure that relative payments across different types of stays remain accurate. The Secretary also would need the authority to rebase payments if costs change significantly. Without this authority, over time, aggregate program payments could be too high or too low relative to the cost of stays.

The Commission's recommendation states that a PAC PPS be implemented beginning in 2021 with a three-year transition. The aggregate level of payments should be lowered by 5 percent to more closely align payments to the cost of care. To level the playing field among providers, the Secretary would need to begin aligning the setting-specific regulations when the PPS is implemented. The Secretary would also need the authority to revise and rebase PAC PPS payments over time to keep payments aligned with the cost of care.

In its discussion of the recommendation, the Commission calls for taking the 5 percent reduction at the beginning of the transition for several reasons. First, the level of payments is high. Second, a multiyear transition would phase in the impacts of the new payment system, thereby lessening its immediate effect. Third, providers are likely to change their costs, patient mix, and practices to maintain their payments well above the cost of care. Last, providers whose payments would

increase under a PAC PPS are likely to bypass the transition and be paid full PAC PPS payments, if given the option. The Commission notes that, while this option would raise program spending during the transition, overall the proposal would reduce spending and would redistribute payments toward stays for medical conditions and away from stays with therapy services unrelated to a patient's condition. ■

Introduction

Post-acute care (PAC) providers—skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs)—offer important recuperation and rehabilitation services to Medicare beneficiaries. In 2015, Medicare fee-for-service (FFS) spending on these services totaled $60 billion. Although the types of cases treated in the four settings overlap, Medicare's payments can differ substantially, in part because Medicare uses separate prospective payment systems (PPSs) to pay for stays in each setting. Two of those PPSs (for HHAs and SNFs) encourage the provision of therapy services over medically complex care. Some of the difference in payments reflects the considerably different regulatory and statutory requirements for each setting (see online Appendix 3-B from the Commission's June 2016 report to the Congress, available at http://www.medpac.gov). At the same time, there is an absence of evidence-based criteria guiding decisions about where patients should receive PAC and how much care they should receive. The only study to compare outcomes across the settings for a broad range of clinical conditions did not find consistent differences in rates of readmission to hospitals or in improvement in mobility or self-care (Gage et al. 2012). These factors contribute to considerable variation in the supply and use of PAC providers across the country. Given the overlap between settings for treating similar patients, the Commission has long promoted the idea of moving to a unified PAC PPS that spans the four settings, with payments based on patient characteristics, not the site of service (Medicare Payment Advisory Commission 2016).

As required by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT), the Commission, in June 2016, recommended necessary features of a PAC PPS and considered the impacts of moving to such a system. A second Commission report outlining the details of a prototype design is due in 2023, after the Secretary of the Department of Health and Human Services has collected and analyzed common patient assessment information and submitted a report to the Congress in 2022 recommending a PAC PPS. On this timetable, it is unlikely that CMS will propose a PAC PPS before 2024, with implementation occurring sometime after that, assuming that the Congress has granted it the authority to do so. IMPACT does not require the Secretary to implement a PAC PPS.

In its June 2016 report to the Congress, the Commission reported that a unified PPS is feasible using readily available data and that such a system would correct distortions that are present in the setting-specific PPSs. The Commission found that an initial PAC PPS design could be based on existing administrative data and therefore could be implemented earlier than the current timetable. However, because functional assessment data would improve the accuracy of payments for some patient groups, the Secretary should incorporate this dimension into the risk adjustment method when uniform patient assessment becomes available. We also found that payments in 2013 (the year of data we used for the analysis) far exceeded the cost of care.

This year, we return to our analysis of the PAC PPS design. We begin by reviewing the key findings from our June 2016 report and then consider three aspects of implementation. First, we discuss a transition policy that would phase in the implementation over multiple years and whether providers should have the option to bypass it and immediately be paid full PAC PPS payments. Second, we assess whether the Congress should lower aggregate payments so that they are more closely aligned with the cost of care. Last, we discuss the regular maintenance and rebasing that the Secretary will need to conduct to keep payments and costs aligned.

Review of June 2016 key findings

In June 2016, we reported that a PAC PPS is within reach. It is possible to design a payment system for a uniform unit of service (a stay in a PAC setting) and to adjust payments using a uniform set of patient and stay characteristics (such as clinical conditions) that do not include the amount of service furnished to a patient. The design includes a common unit of service (a stay) and risk adjustment method based on patient characteristics and considers PAC stays with and without a prior hospitalization (consistent with the current PAC PPSs) (Table 1-1, p. 8).[1] We confirmed that a PAC PPS is feasible, but the Commission fully expects that the Secretary would consider our conclusions as a starting point for the design of a unified PAC PPS.

Under this design, payments to HHAs would be adjusted to reflect this setting's considerably lower costs.[2] This adjustment would need to be set so that it does not interfere with clinical decision making; that is, it would neither financially encourage nor discourage the use

TABLE 1–1 **Commission's key recommended design features of a PAC PPS**

Design feature
• A common unit of service (e.g., institutional stay or home health stay)
• A common method of risk adjustment that relies on administrative data on patient characteristics and incorporates functional status as these data become available
• Two payment models (one for routine and therapy services, another one for nontherapy ancillary services) to reflect differences in benefits across settings; sum of the two payments establish the total payment amount for the stay
• Adjustment of payments for home health stays to prevent considerable overpayment
• A high-cost outlier policy to protect providers from incurring large losses and help ensure beneficiary access to care
• A short-stay outlier policy to prevent large overpayments for unusually short stays
• Uniform application of any payment adjusters across all providers

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

Source: Medicare Payment Advisory Commission 2016.

of home health care. The design would need to include two outlier policies: one for unusually short stays and one for unusually high-cost stays. To help compensate for inaccurate payments for high-cost stays during the transition period, the design could include a large outlier pool that would get smaller over time as assessment data and refinements were incorporated into the PAC PPS.

We found that models could accurately predict the average costs of most stays.[3] We "stress tested" the models by examining the accuracy of predicted costs for more than 30 different patient groups, including 4 definitions of medically complex stays. For patient groups with predicted costs that differed substantially from the stays' actual costs, current practices (such as the provision of therapy services unrelated to patient characteristics) or the cost structures of high-cost settings explained the results.

We compared the accuracy of designs with and without functional assessment data and confirmed that designs using readily available administrative data were accurate for most of the patient groups. However, patient assessment data would increase the accuracy of payments for certain types of stays (for example, patients with low or high functional status). The Commission noted that the Secretary could implement a PAC PPS sooner than the time frames outlined in IMPACT, by beginning with a design that does not rely on patient assessment data and refining the payment system over time as those data become available. Providers are required to begin collecting certain uniform patient assessment information (including functional status) in October 2018 for institutional PAC providers and in January 2019 for HHAs, with other items to be added later.

Payment implications of a PAC PPS

We estimated the payment implications of a PAC PPS, assuming no changes in provider behavior. A PAC PPS would redistribute payments among types of stays and settings and correct some of the distortions in current payment systems. Payments would decrease for rehabilitation care unrelated to patient characteristics (for example, for patients recovering from hip surgery who receive high amounts of rehabilitation therapy services regardless of their clinical condition) and increase for medically complex care (for example, patients with comorbidities that involve multiple body systems). The equity in payments across different types of patients, and across the providers that treat them, would increase because the relative profitability across types of stays would be narrower. Therefore, providers would have less incentive to admit certain types of patients over others. The shifts in payments and the increases in the equity of payments across types of stays would be consistent with the goals of the Commission's recommendations to revise the SNF and HHA PPSs.

Many of the various types of PAC stays are treated in all four settings, so payments based on the average cost

across settings would be considerably lower than current payments for the high-cost (and lower volume) settings, namely LTCHs and IRFs, while payments would be higher for the lower cost SNF setting. Because the objective of a PAC PPS is to base payments on patient characteristics, not setting, a redistribution of payments would be expected. A high-cost outlier policy and a multiyear transition would give providers time to adjust their costs and practice patterns to match the PAC PPS payments.

The Commission found that the average level of payment for PAC was considerably higher than the average cost of stays. Our impact analyses assumed that the PAC PPS was implemented on a budget-neutral basis (i.e., that the level of payments in aggregate would be the same as the current level). However, the Commission noted that the Secretary would need to consider lowering aggregate spending to more closely align Medicare's payments with providers' costs. Lowering aggregate spending on PAC would be consistent with the Commission's recommendations for many years regarding updates to FFS payments to SNFs, HHAs, IRFs, and LTCHs.

If past provider responses to other changes in payment policy are any guide, we would expect providers to change their costs and mix of patients in reaction to a PAC PPS. If they did, the impact on providers' payments would differ from our estimates. Over time, a PAC PPS would need to be updated to incorporate changes in practice, mix of patients, and absolute and relative costs of stays. Because Medicare's payment reforms—including accountable care organizations, bundled payment initiatives, the joint replacement demonstration, cardiac bundles, and Medicare Advantage plans—are based on the FFS payment model, a PAC PPS would influence payments under these alternative payment models. Reciprocally, these payment alternatives would likely influence FFS practices by, for example, encouraging shorter SNF stays and shifts in placement to lower cost PAC settings. When possible, some patients currently treated in IRFs and LTCHs would be shifted to SNFs, while some patients currently treated in SNFs would be discharged to home health care, without compromising patient outcomes. The lower costs associated with these shifts and shorter stays would be incorporated into the PAC PPS as payments are periodically recalibrated.

Conforming regulatory requirements

When Medicare begins to pay PAC providers under a single payment system, it will need to give providers more flexibility to offer services that span the PAC continuum of care. If certain regulations are waived or modified, providers can change their cost structures to more closely align them with PAC PPS payments. A more flexible structure would give providers the option to consolidate separate PAC operations into a single, larger institutional PAC unit to achieve greater economies of scale. Likewise, low-occupancy hospitals or PAC providers would have the flexibility to convert unused capacity to become an institutional PAC provider serving a broader mix of patients. Either scenario could create a higher volume of patients in one location that might encourage greater physician presence if the dispersion of PAC patients across multiple locations discourages physicians from conducting rounds on them.

The Commission discussed a two-part strategy to even out the different regulatory requirements across settings. In the near term, the Secretary could waive or modify select setting-specific requirements, such as the 25-day length of stay requirement for LTCHs and the 60 percent rule and intensive therapy requirements for IRFs. The Secretary currently has this authority for some setting-specific requirements (such as requiring intensive therapy for IRF patients) but would need to be granted the authority for others (such as the 25-day length of stay requirement for LTCHs). Note that revised regulatory requirements could, in some cases, result in more stringent requirements that raise the cost of care for some providers. For example, PAC providers could be required to have a registered nurse available 24 hours a day, 7 days a week—a level that is higher than the current 8-hour per day requirement for SNFs.

The Commission has proposed that, over the longer term, a common core set of conditions of participation be developed for all PAC providers, with additional requirements specified for providers that opt to treat patients who require specialized resources. Requirements would thus shift from being based on setting to being defined by the care needs of different types of patients. For example, additional requirements could be specified for patients requiring ventilator care, intensive rehabilitation therapy, and care management for severe wounds.

The effect of waiving requirements could be limited by state licensure, certificate of need, or other regulations that providers must meet. For example, providers that are certified for both Medicaid and Medicare and located in states with minimum staffing requirements for nursing homes would have less flexibility to change their staffing mix (and the accompanying costs) compared with

providers in other states. Because Medicare does not have the authority to change state requirements, providers would continue to meet state requirements, just as they do now when state and federal requirements differ.

The Commission also noted that, as Medicare moves toward uniform payment for PAC, the program would need to standardize its cost-sharing requirements, which currently vary by setting. This standardization would result in more rational PAC use for those beneficiaries who select a PAC setting based at least in part on cost-sharing requirements. Over the coming year, the Commission will examine this issue.

Companion policies to dampen FFS incentives

The Commission also discussed companion policies to dampen the underlying incentives of FFS payment design—that is, incentives to generate unnecessary volume or provide low-quality care if it is less costly. Companion policies include a readmission policy to prevent unnecessary hospital readmissions and a value-based purchasing program to protect beneficiaries against stinting and the program against unnecessary services. In addition to these policies, CMS would need to monitor provider behavior to detect inappropriate responses, including stinting on care that could result in poor outcomes; selecting patients who are likely to be relatively more profitable; generating unnecessary PAC stays; and delaying care that shifts, but does not lower, program spending. As unintended consequences are documented, the Secretary would need to revise the PAC PPS accordingly.

Options for transitioning to a PAC PPS

Given the accuracy of payments using readily available data, the Commission urges the implementation of a PAC PPS sooner than outlined in IMPACT. Policymakers will need to consider whether to include a transition policy that phases in the new PAC PPS over multiple years. A transition would extend the current inequities of the HHA and SNF PPSs and delay the redistribution of payments toward medical and medically complex cases (and away from stays with therapy services that appear unrelated to patients' characteristics). However, it would give providers time to adjust their costs and mix of patients. The Commission's impact analyses showing substantial changes in payment for many PAC stays and providers suggest the need for a transition. However, because, in general, providers that would incur the largest decreases in payments under the PAC PPS are also currently the most profitable, the Commission concludes that the transition should be short. By blending current and "new" payments, a transition would dampen the effects of the new payment system during the phase-in period. Policymakers could consider allowing providers the choice to bypass the transition altogether and move directly to full PAC PPS payments.

Year to begin the implementation

Our analyses indicate that the initial design of a PAC PPS could be based on administrative data, with refinements to the risk adjustment method to incorporate the uniform functional data when they become available. Under such a design, the Commission believes the Secretary could implement a PAC PPS as early as 2021, assuming some regulatory alignment is underway. The start date of a PAC PPS would depend on whether and how quickly the Secretary could waive or modify certain regulatory requirements now in place that raise the costs of care in some settings. To help compensate for inaccurate payments for high-cost stays during the transition period, the initial design could include a large pool of funds to pay for high-cost outlier cases, with the size of the pool decreasing over time as refinements improve the new PPS's accuracy. A high-cost outlier policy would help moderate the financial impacts of the new PPS on providers, especially as high-cost providers modify their cost structures and mix of patients.

Before implementation, the Secretary must complete a list of activities that is, admittedly, long but we believe achievable since CMS has deep experience with prior payment systems that have required identical actions. These activities include:

- Develop and validate the design of the payment system—such as its case-mix groupings, payment adjusters, and outlier policies. To expedite this process, the Secretary could begin using the Commission's work as a readily implementable starting point in identifying factors that should be considered in a case-mix system and other aspects of the PPS design. The Secretary may wish to use a more recent year of PAC stays in establishing the base year and PPS design.

- Identify (1) the regulatory and statutory requirements that need to be aligned before the beginning of the

transition and (2) begin to develop a common set of requirements for all PAC providers and additional requirements for providers opting to treat patients with special care needs.

- Identify measures to monitor and develop the systems that will track provider performance. Sample measures are described in Table 1-7 (p. 24).
- Revise and test the claims processing and other systems to pay providers, monitor quality, and track beneficiary cost sharing.
- Consider provider input through the Secretary's rule-making process.

Definition and rationale for a transition

A transition policy blends current policy payments with payments under a new policy, weighting current payments more heavily in the early years and new payments more heavily in later years, until current payments are phased out. The blending of current and new payments would temper the impact of the PAC PPS in the early years. Policymakers would need to decide the number of years over which to blend old and new payments and how to weight the blend of payments in each year. For example, a three-year transition could consider a one-third blend of new PAC PPS rates during the first year, a two-thirds PAC PPS blend during the second year, and full PAC PPS rates beginning the third year.

A transition begins the much-needed shift of payments toward medically complex care and away from therapy-based care that may be unrelated to a patient's condition. Further, by moving to a new payment system gradually in one-year increments, a transition would likely make it easier to gain provider support. In addition, a transition period would give providers time to adjust their costs and mix of patients, thereby protecting themselves from large payment reductions that could impede some beneficiaries' access to care. SNFs would transition from a day-based PPS to stay-based payments, thereby aligning their unit of service with that of other PAC providers. The high level of aggregate payments dampens the concern that payment reductions will affect access or threaten many providers' financial viability. However, a transition would extend the current inequities of the current HHA and SNF payment systems, thereby delaying the narrowing of differences in profitability across different types of stays. A long transition could run the risk that industry pressure would further delay or halt entirely the implementation of the new payment system.

Wide range in the effects of a fully implemented PAC PPS on payments suggests the need for a transition

To consider the need for a transition, we updated the results included in our June 2016 report based on 8.9 million PAC stays in 2013; the updated results reflect changes in costs and payments between 2013 and 2017 (see online Appendix 1-A, available at http://www.medpac.gov, for a description of the methodology). This update provides a more accurate picture of the need for a transition and the current misalignment between payments and costs. The estimated costs and payments in 2017 for these PAC stays are the starting point for all analyses included in this chapter. Consistent with past analyses, we have not modeled provider responses to the PAC PPS. Although changes in the mix of patients and cost per stay are likely, the analyses presented do not attempt to simulate the size of such changes or their likely effects. The analyses of the transition assume aggregate payments remain the same (the section on the level of payments, page 20, estimates the impacts of various reductions to total payments).

We confirmed that the model accurately predicts the costs of most of the more than 30 patient-stay groups we examined, including medically complex groups (Wissoker 2017). Differences in the relative profitability of PAC payments across patient groups would narrow considerably under a PAC PPS, so providers would have less incentive than they do now to admit some types of patients over others. A PAC PPS would redistribute payments from stays that include high amounts of therapy care not predicted by patients' clinical characteristics (for example, orthopedic stays with unusually high amounts of therapy care) to medical stays (such as severe wound or ventilator care). However, the design would not lower payments indiscriminately for rehabilitation care. Payments would be above average for patients with clinical characteristics and impairments indicating higher than average care needs. The resulting redistribution of payments would be consistent with the Commission's recommended changes to the SNF and HHA PPSs (Medicare Payment Advisory Commission 2011, Medicare Payment Advisory Commission 2008).

Policymakers can evaluate the need for a transition by considering the estimated impact of the PAC PPS on different conditions and types of providers. The effects of

TABLE 1–2

A fully implemented PAC PPS would affect payments differently by types of stay and setting, based on 2013 PAC stays' payments and costs updated to 2017 (continued next page)

Reporting group	Percent change in payments between PAC PPS payments and current payments	Ratio of average payment under a PAC PPS to average cost of stays	Percent of stays	Mix of stays by setting			
				HHA	SNF	IRF	LTCH
All stays	0%	1.14	100%	69%	25%	4%	2%
Cardiovascular medical	0	1.15	14	81	17	1	0
Orthopedic medical	–6	1.15	10	83	15	2	0
Orthopedic surgical	–3	1.14	10	44	44	12	0
Respiratory medical	5	1.15	9	62	34	2	2
Other neurology medical	–6	1.15	8	80	17	3	0
Serious mental illness	0	1.15	5	57	36	4	3
Severe wound	10	1.15	5	71	15	4	10
Skin medical	3	1.14	4	87	12	1	0
Cardiovascular surgical	7	1.14	3	53	36	10	2
Infection medical	1	1.14	3	35	57	4	4
Stroke	–2	1.13	2	30	41	28	1
Hematology medical	4	1.11	2	80	18	1	0
Ventilator	9	1.17	<1	6	14	1	79
Least frail	–4	1.15	7	92	8	0	0
Most frail	1	1.13	11	38	49	9	4
Cognitively impaired	–4	1.14	20	57	38	3	2
Multiple body system diagnoses	3	1.14	5	0	76	10	14
Chronically critically ill	8	1.14	5	31	46	10	13
Severely ill (SOI = Level 4)	6	1.13	4	0	71	12	17

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), SOI (severity of illness), I–PAC (intitutional post-acute care), ESRD (end-stage renal disease). Percent of stays do not total 100 percent because many of the groups overlap.
"Other neurology medical" excludes stroke. "Serious mental illness" includes beneficiaries with schizophrenia, bipolar disorders, or severe depression. Patients' level of frailty was determined using a frailty index. "Multiple body system diagnoses" includes patients treated in I–PAC with diagnoses involving five or more body systems. "Chronically critically ill" stays include patients who spent eight or more days in an intensive care unit during the preceding hospital stay or were on a ventilator in the PAC setting. "Severely ill" stays include patients treated in I–PAC who were categorized as SOI Level 4 during the immediately preceding hospital stay (or simulated for patients admitted from the community). "Lowest therapy costs" and "highest therapy costs" refer to those stays in the lowest and highest quartile, respectively, of therapy costs as a share of total stay costs. For home health stays, the low group includes only stays with no therapy. Institutional PAC includes SNFs, IRFs, and LTCHs. "LTCH-qualifying" stays are those that would meet the patient-specific criteria to qualify for LTCH PPS payments.

Source: Analysis of 8.9 million 2013 PAC stays with costs and payments updated to 2017 (Wissoker 2017).

a fully implemented PAC PPS on payments would vary considerably across the condition groups and providers we examined, even if aggregate PAC PPS payments were set equal to aggregate payments under current policy (i.e., even if, on net, there were no change in total payments) (Table 1-2).[4] For example, across the clinical conditions we examined, payment changes under a PAC PPS would range from a 10 percent increase for severe wound cases to a 6 percent decrease for orthopedic medical stays and for other neurology medical stays (excluding stroke).

We expected and found that payments for stays with low and high shares of therapy costs would change considerably under a PAC PPS. For patients who receive high amounts of therapy, payments would decline substantially because the amount of therapy (and the associated costs) furnished during many HHA and SNF

TABLE 1–2

A fully implemented PAC PPS would affect payments differently by types of stay and setting, based on 2013 PAC stays' payments and costs updated to 2017 (continued)

Reporting group	Percent change in payments between PAC PPS payments and current payments	Ratio of average payment under a PAC PPS to average cost of stays	Percent of stays	Mix of stays by setting			
				HHA	SNF	IRF	LTCH
No therapy costs for HHA stays	25	1.94	29	100	0	0	0
Lowest therapy costs for I–PAC stays	18	1.11	8	0	68	13	19
Highest therapy costs for HHA stays	–24	0.83	17	100	0	0	0
Highest therapy costs for I–PAC stays	–16	1.11	8	0	94	6	0
Community admitted	–4	1.16	50	94	5	1	0
Stays with prior hospital stay	1	1.14	50	44	46	7	3
Disabled	1	1.15	26	72	22	4	2
Dual eligible	–3	1.14	32	71	24	3	2
ESRD	2	1.14	4	62	30	5	4
Very old (age 85+ years)	–2	1.14	30	67	29	3	1
HHA	–1	1.16	69				
SNF	7	1.22	25				
IRF	–15	1.00	4				
LTCH: All stays	–15	0.89	2				
LTCH-qualifying stays	–9	0.95	1				
Nonprofit	9	1.09	22	65	26	9	1
For profit	–3	1.17	75	70	25	3	2
Hospital based	11	0.94	11	64	15	20	0
Freestanding	–1	1.18	89	69	27	2	2
Urban	–1	1.14	84	69	25	5	2
Rural	3	1.15	16	69	29	2	0
Frontier	10	1.13	<1	71	28	0	0

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), SOI (severity of illness), I–PAC (intitutional post-acute care), ESRD (end-stage renal disease). Percent of stays do not total 100 percent because many of the groups overlap.
"Other neurology medical" excludes stroke. "Serious mental illness" includes beneficiaries with schizophrenia, bipolar disorders, or severe depression. Patients' level of frailty was determined using a frailty index. "Multiple body system diagnoses" includes patients treated in I–PAC with diagnoses involving five or more body systems. "Chronically critically ill" stays include patients who spent eight or more days in an intensive care unit during the preceding hospital stay or were on a ventilator in the PAC setting. "Severely ill" stays include patients treated in I–PAC who were categorized as SOI Level 4 during the immediately preceding hospital stay (or simulated for patients admitted from the community). "Lowest therapy costs" and "highest therapy costs" refer to those stays in the lowest and highest quartile, respectively, of therapy costs as a share of total stay costs. For home health stays, the low group includes only stays with no therapy. Institutional PAC includes SNFs, IRFs, and LTCHs. "LTCH-qualifying" stays are those that would meet the patient-specific criteria to qualify for LTCH PPS payments.

Source: Analysis of 8.9 million 2013 PAC stays with costs and payments updated to 2017 (Wissoker 2017).

stays under the current PPS designs is unrelated to a patient's clinical conditions. Conversely, payments for stays with low therapy costs (for example, medical cases with multiple comorbidities) would increase substantially because the PAC PPS would base payments on the clinical conditions and complexity of the patient. Over time, under a PAC PPS, we would expect providers to change their therapy practices to match patients' characteristics.

As we expected, the impact on the high-cost settings (IRFs and LTCHs) would be large because most providers in these settings treat the types of cases that are also admitted

TABLE 1–3

Distribution of the changes in payments under a fully implemented PAC PPS, based on 2013 PAC stays' payments and costs updated to 2017 (continued next page)

	Decrease in payment			About the same	Increase in payment		
Stay or provider group	**>25%**	**10% to 25%**	**1% to 10%**	**−1% to +1%**	**1% to 10%**	**10% to 25%**	**>25%**
Reporting groups: Stays							
All stays (*N* = 8.9 million)	20%	12%	8%	2%	8%	12%	39%
Cardiovascular medical	16	10	9	2	10	15	38
Orthopedic medical	25	15	7	1	6	10	34
Orthopedic surgical	25	17	8	2	7	8	32
Respiratory medical	18	10	7	2	8	12	42
Other neurology medical	25	13	7	2	7	12	36
Serious mental illness	20	10	6	1	7	11	45
Severe wound	10	8	5	1	6	13	56
Skin medical	13	9	8	2	13	20	34
Cardiovascular surgical	16	11	7	2	8	12	43
Infection medical	22	10	6	1	6	9	46
Stroke	21	13	7	2	6	9	42
Hematology medical	13	10	8	2	8	13	45
Ventilator	18	17	8	2	6	8	41
Least frail	20	15	10	2	9	13	30
Most frail	21	11	6	1	6	9	44
Cognitively impaired	23	11	7	2	7	11	40
Multiple body system diagnoses	24	10	5	1	4	6	50
Chronically critically ill	18	11	6	1	6	9	47
Severely ill (SOI = Level 4)	22	10	5	1	5	6	51

Note: PAC (post-acute care), PPS (prospective payment system), SOI (severity of illness), HHA (home health agency), I–PAC (institutional–post-acute care), ESRD (end-stage renal disease), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital). The percentages in each row may not sum to 100 because of rounding. The stay-level reporting groups show the distribution of the change in payments for the stays in the each group. The provider-level analysis shows the distribution of the change in the average payment for the providers in the group.
"Other neurology medical" excludes stroke. "Serious mental illness" includes beneficiaries with schizophrenia, bipolar disorders, or severe depression. Patients' level of frailty was determined using a frailty index. "Multiple body system diagnoses" includes patients treated in I–PAC with diagnoses involving five or more body systems. "Chronically critically ill" stays include patients who spent eight or more days in an intensive care unit during the preceding hospital stay or were on a ventilator in the PAC setting. "Severely ill" stays include patients treated in I–PAC who were categorized as SOI Level 4 during the immediately preceding hospital stay (or simulated for patients admitted from the community). "Lowest therapy costs" and "highest therapy costs" refer to those stays in the lowest and highest quartile, respectively, of therapy costs as a share of total stay costs. For home health stays, the low group includes only stays with no therapy. Institutional PAC includes SNFs, IRFs, and LTCHs. The provider reporting groups include providers with at least 20 stays.

Source: Analysis of 8.9 million 2013 PAC stays with costs and payments updated to 2017 (Wissoker 2017).

to lower cost (and higher volume) settings. Payments to IRFs and LTCHs would decrease by 15 percent, while payments to SNFs would increase 7 percent.[5] On average, nonprofit, hospital-based, and frontier providers would experience fairly large increases in payments (9 percent, 11 percent, and 10 percent, respectively), while for-profit, freestanding, and urban providers would experience small decreases. The magnitude of these changes, especially for LTCHs and IRFs, suggests that a transition is desirable.

We also found that if a PAC PPS were implemented to maintain aggregate PAC payments at the current level, the level of PAC payments would remain well above the cost of stays. We estimate that the average PAC PPS payment would be 14 percent higher than the current average cost of PAC stays.

The predicted redistribution of payments *within* each type of stay and provider category further supports

TABLE 1–3

Distribution of the changes in payments under a fully implemented PAC PPS, based on 2013 PAC stays' payments and costs updated to 2017 (continued)

	Decrease in payment			About the same	Increase in payment		
Stay or provider group	**>25%**	**10% to 25%**	**1% to 10%**	**–1% to +1%**	**1% to 10%**	**10% to 25%**	**>25%**
No therapy costs for HHA stays	2%	3%	6%	2%	11%	20%	56%
Lowest therapy costs for I–PAC stays	16	7	4	1	3	5	64
Highest therapy costs for HHA stays	47	25	10	2	6	5	5
Highest therapy costs for I–PAC stays	33	11	6	1	5	8	35
Community admitted	19	12	8	2	9	14	36
Stays with prior hospital stay	21	12	7	2	7	10	42
Disabled	18	11	8	2	8	13	40
Dual eligible	20	11	7	2	8	12	40
ESRD	19	11	8	2	8	11	41
Very old (age 85+ years)	21	12	7	2	8	12	39
Reporting groups: Providers							
All providers (*N* = 24,225)	7	19	18	4	17	19	16
HHA	6	16	20	5	22	22	9
SNF	7	18	15	4	15	18	23
IRF	9	55	28	3	5	1	0
LTCH	12	53	24	2	8	1	0
Nonprofit	2	14	14	3	16	20	29
For profit	8	21	19	4	18	18	12
Hospital based	2	19	15	3	13	17	31
Freestanding	7	19	18	4	17	19	15
Urban	7	20	19	4	17	19	15
Rural	6	18	15	4	17	20	21
Frontier	7	11	9	2	16	18	35

Note: PAC (post-acute care), PPS (prospective payment system), SOI (severity of illness), HHA (home health agency), I–PAC (institutional–post-acute care), ESRD (end-stage renal disease), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital). The percentages in each row may not sum to 100 because of rounding. The stay-level reporting groups show the distribution of the change in payments for the stays in the each group. The provider-level analysis shows the distribution of the change in the average payment for the providers in the group.
"Other neurology medical" excludes stroke. "Serious mental illness" includes beneficiaries with schizophrenia, bipolar disorders, or severe depression. Patients' level of frailty was determined using a frailty index. "Multiple body system diagnoses" includes patients treated in I–PAC with diagnoses involving five or more body systems. "Chronically critically ill" stays include patients who spent eight or more days in an intensive care unit during the preceding hospital stay or were on a ventilator in the PAC setting. "Severely ill" stays include patients treated in I–PAC who were categorized as SOI Level 4 during the immediately preceding hospital stay (or simulated for patients admitted from the community). "Lowest therapy costs" and "highest therapy costs" refer to those stays in the lowest and highest quartile, respectively, of therapy costs as a share of total stay costs. For home health stays, the low group includes only stays with no therapy. Institutional PAC includes SNFs, IRFs, and LTCHs. The provider reporting groups include providers with at least 20 stays.

Source: Analysis of 8.9 million 2013 PAC stays with costs and payments updated to 2017 (Wissoker 2017).

incorporating a transition period into the implementation of a PAC PPS. Within each reporting group, there would be considerable variation in the payment changes that result from a PAC PPS (Table 1-3). Although aggregate payments across all stays would remain unchanged (assuming implementation to be budget neutral), we estimate that payments would decrease by more than 25 percent for one-fifth of stays and would increase by

TABLE 1–4

For many providers, changes in payments would be inversely related to current relative Medicare profitability

Relative profitability	Provider count	Decrease in average payment >25%	Decrease in average payment 10% to 25%	Decrease in average payment 1% to 10%	About the same −1% to +1%	Increase in average payment 1% to 10%	Increase in average payment 10% to 25%	Increase in average payment >25%
Below average								
<0.75 (lowest)	2,720	4	100	189	45	357	715	1,310
0.75 to 0.90	4,586	91	533	762	189	910	1,127	974
About average								
(0.9 to 1.1)	10,105	402	2,086	2,078	465	1,902	1,879	1,293
Above average								
1.1 to 1.25	4,265	497	1,248	861	186	679	518	276
>1.25 (highest)	2,549	620	737	410	70	295	315	102
Provider count	24,225	1,614	4,704	4,300	955	4,143	4,554	3,955

Note: Relative profitability is a ratio of the provider's profitability (the ratio of the provider's average payment under current policy to the average stay cost) to the setting's average profitability. Ratios below 1.0 indicate below-average profitability; ratios above 1.0 indicate above-average profitability. Only providers with at least 20 stays were included in the analysis (*N* = 24,225).

Source: Analysis of 8.9 million 2013 post-acute care stays with costs and payments updated to 2017 (Wissoker 2017).

more than 25 percent for over one-third (39 percent) of stays. Analysis of the estimated payment changes reveals a wide range even for types of stays that would, on average, experience modest change in payments. For example, though we estimate that the average payment for cardiovascular medical stays would not change (as shown in Table 1-2, pp. 12–13), payments for over half of these stays would decrease or increase by more than 25 percent.

The estimated distribution of changes reflects in part the settings where patients are treated. Almost one-third of stays were treated in settings that we estimated would experience sizable changes in payments: There would be a 7 percent increase in average payments for stays treated in SNFs and a 15 percent reduction for stays treated in IRFs and LTCHs, as shown in Table 1-2 (pp. 12–13). Thus, even for types of stays that would experience a large average increase in payment—such as the ventilator group, which would see a 9 percent increase—payments would decrease for many stays (43 percent), in part because the majority of these patients were treated in LTCHs. Similarly, the average payment for severe wound stays would increase 10 percent (Table 1-2) and for more than half of these stays (56 percent), payments would increase by more than 25 percent. Yet, even for this group, 18 percent of severe wound stays would see payments fall by 10 percent or more (Table 1-3). This difference would occur because a sizable share (14 percent) of severe wound stays was treated in IRFs and LTCHs, where payments on average are estimated to decrease (Table 1-2, pp. 12–13).

At the provider level, the distribution of payment changes would not be as wide as at the stay level because payment changes at the stay level would be averaged across all of a provider's stays, thereby offsetting some of the increases and decreases for individual stays. For example, though our analysis found that 20 percent of PAC stays would experience payment decreases of more than 25 percent, we estimate that a much smaller share (7 percent) of providers would experience payments decreases of that magnitude (Table 1-3, pp. 14–15). The majority of providers would experience more moderate changes in payments. Nevertheless, the distribution of the changes further supports the need for a transition to full implementation of the PAC PPS.

Estimated changes in payments would be inversely related to current provider profitability, suggesting viability of a short transition

The relationship between payment changes and provider profitability also informs the decision to include a transition and how long it should be. Two findings argue for a transition of short duration. First, the providers predicted to experience the largest payment reductions have relatively high profitability. Those providers' current profits would allow them to absorb at least some of the payment reductions while remaining profitable. Second, average payments are expected to increase the most for relatively low-profit providers, so it would be desirable to move quickly to the PAC PPS, with a short transition (or none at all).

To explore the relationship between payments and profitability under the PAC PPS, we measured current relative profitability using the ratio of the provider's average current payment (under its setting's PPS) to its average per stay costs and compared the facility's payment-to-cost ratio (PCR) with the average PCR for that setting. For example, we compared each IRF's PCR with the average PCR for all IRFs to control for the different cost structures across settings.

In general, we found that expected payment changes under a PAC PPS were inversely related to providers' relative profitability (Table 1-4). Of the 2,720 providers with well-below-average profitability (a PCR that was more than 25 percent below the setting average), most (2,382) would experience increases in their average payment, and almost half (1,310) would experience payment increases of at least 25 percent. Fewer than 300 providers with low profitability (11 percent) would experience decreases in their average payment. Only four providers with well-below-average profitability would experience large (greater than 25 percent) reductions in their average payment.

Low-profitability providers that would experience large payment increases were disproportionately nonprofit and had lower therapy costs as a share of the stay's total cost. These results suggest that many providers would not need a long transition to a PAC PPS.

Conversely, of the 2,549 providers with well-above-average profitability (a PCR that was more than 25 percent higher than the setting average), the majority (1,767) would experience reductions in their average payment, and almost one-quarter (620) would have payment reductions of more than 25 percent. High-profitability providers that would experience large decreases in their average payments had high therapy costs as a share of total stay costs. Four percent (102) of providers with high PCRs would see large increases (greater than 25 percent) in payments.

We also looked at relative profitability for providers experiencing the largest changes in payment. Among providers expected to experience payment increases of 25 percent or more, more than half had below-average profitability; one-third had the lowest relative profitability (relative PCR of less than 0.75). Among providers expected to experience payment decreases of more than 25 percent, more than two-thirds had above-average profitability; 38 percent had the highest relative profitability (relative PCR of greater than 1.25). The PAC PPS would thus shift payments from high-profitability providers (disproportionately for profit and freestanding) to low-profitability providers (disproportionately nonprofit and hospital based), in part reflecting their mix of patients and current therapy practices. A long transition would delay this redistribution, thus perpetuating current payment system inequities.

PAC PPS payment changes would be moderated during a transition

By blending current setting-specific payments with those under a PAC PPS, a transition would dampen the immediate impact of a full PAC PPS. Changes in the distribution of payments—the shift of payments to medically complex care from therapy-driven care—would be phased in over the transition period.

We illustrate the moderated impact on providers during a three-year transition and show payments during the first year based on a one-third blend of PAC PPS payments and a two-thirds blend of current payments (Table 1-5, pp. 18–19). Compared with the impact of full PAC PPS payments, the change in payments would be proportionally smaller during the first year of the transition. For example, under full PAC PPS implementation versus first year of transition: stays with severe wounds would experience a 10 percent payment increase versus a 3 percent payment increase; orthopedic medical stays would experience a 6 percent payment reduction in payments versus a 2 percent payment reduction.

Similarly, a transition would dampen the initial effects of the PAC PPS on IRFs and LTCHs, which would experience a 5 percent reduction in payments in the first year, compared with a 15 percent reduction under a fully implemented PAC PPS (Table 1-5, pp. 18–19). A multiyear

TABLE 1–5

A three-year transition would reduce the first-year impact of a PAC PPS, based on 2013 PAC stays' payments and costs updated to 2017 (continued next page)

Reporting groups	Current policy: Ratio of average payment to average cost of stays	Impact of full PAC PPS		First year impact of a 3-year transition (33% PAC PPS)	
		Percent change in payment from current payments	Ratio of average payment to average cost of stays	Percent change in payment from current payments	Ratio of average payment to average cost of stays
All stays	1.14	0%	1.14	0%	1.14
Cardiovascular medical	1.15	0	1.15	0	1.15
Orthopedic medical	1.22	–6	1.15	–2	1.20
Orthopedic surgical	1.18	–3	1.14	–1	1.17
Respiratory medical	1.09	5	1.15	2	1.11
Other neurology medical	1.22	–6	1.15	–2	1.20
Serious mental illness	1.14	0	1.15	0	1.14
Severe wound	1.05	10	1.15	3	1.08
Skin medical	1.11	3	1.14	1	1.12
Cardiovascular surgical	1.06	7	1.14	2	1.09
Infection medical	1.13	1	1.14	0	1.13
Stroke	1.15	–2	1.13	–1	1.14
Hematology medical	1.07	4	1.11	1	1.08
Ventilator	1.07	9	1.17	3	1.10
Least frail	1.20	–4	1.15	–1	1.18
Most frail	1.12	1	1.13	0	1.12
Cognitively impaired	1.19	–4	1.14	–1	1.17
Multiple body system diagnoses	1.10	3	1.14	1	1.11
Chronically critically ill	1.06	8	1.14	3	1.09
Severely ill (SOI = Level 4)	1.07	6	1.13	2	1.09

Note: PAC (post-acute care), PPS (prospective payment system), SOI (severity of illness), HHA (home health agency), I–PAC (institutional–post-acute care), ESRD (end-stage renal disease), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital). The impact of the first year was modeled using a blend of one-third PAC PPS payments and two-thirds setting-specific PPS payments.
"Other neurology medical" excludes stroke. "Serious mental illness" includes beneficiaries with schizophrenia, bipolar disorders, or severe depression. Patients' level of frailty was determined using a frailty index. "Multiple body system diagnoses" includes patients treated in I–PAC with diagnoses involving five or more body systems. "Chronically critically ill" stays include patients who spent eight or more days in an intensive care unit during the preceding hospital stay or were on a ventilator in the PAC setting. "Severely ill" stays include patients treated in I–PAC who were categorized as SOI Level 4 during the immediately preceding hospital stay (or simulated for patients admitted from the community). "Lowest therapy costs" and "highest therapy costs" refer to those stays in the lowest and highest quartile, respectively, of therapy costs as a share of total stay costs. For home health stays, the low group includes only stays with no therapy. Institutional PAC includes SNFs, IRFs, and LTCHs. LTCH-qualifying stays are those that would meet the patient-specific criteria to qualify for LTCH PPS payments.

Source: Analysis of 8.9 million 2013 PAC stays with costs and payments updated to 2017 (Wissoker 2017).

transition would therefore give high-cost providers time to restructure their costs and practices, but it would also delay redistributing payments to medical stays.

A transition would also temper the *distribution* of increases and decreases in payments during a transition. Using the same three-year example, many fewer stays and providers would experience large changes in payments (data not shown). During the first year, no stays would experience reductions of 25 percent or more (compared with 20 percent of stays under the full PAC PPS rates). We see similar moderation in the impact of a transition on providers. In the first year of a three-year transition,

TABLE 1–5

A three-year transition would reduce the first-year impact of a PAC PPS, based on 2013 PAC stays' payments and costs updated to 2017 (continued)

Reporting groups	Current policy: Ratio of average payment to average cost of stays	Impact of full PAC PPS		First year impact of a 3-year transition (33% PAC PPS)	
		Percent change in payment from current payments	Ratio of average payment to average cost of stays	Percent change in payment from current payments	Ratio of average payment to average cost of stays
No therapy costs for HHA stays	1.55	25	1.94	8	1.68
Lowest therapy costs for I–PAC stays	0.94	18	1.11	6	0.99
Highest therapy costs for HHA stays	1.09	–24	0.83	–8	1.00
Highest therapy costs for I–PAC stays	1.32	–16	1.11	–5	1.25
Community admitted	1.21	–4	1.16	–1	1.19
Stays with prior hospital stay	1.12	1	1.14	0	1.13
Disabled	1.13	1	1.15	0	1.14
Dual eligible	1.17	–3	1.14	–1	1.16
ESRD	1.12	2	1.14	1	1.13
Very old (age 85+ years)	1.17	–2	1.14	–1	1.16
HHA	1.17	–1	1.16	0	1.16
SNF	1.14	7	1.22	2	1.17
IRF	1.18	–15	1.00	–5	1.12
LTCH: All stays	1.05	–15	0.89	–5	1.00
LTCH-qualifying stays	1.05	–9	0.95	–3	1.01
Nonprofit	1.00	9	1.09	3	1.03
For profit	1.20	–3	1.17	–1	1.19
Hospital based	0.85	11	0.94	4	0.88
Freestanding	1.19	–1	1.18	0	1.19
Urban	1.15	–1	1.14	0	1.15
Rural	1.11	3	1.15	1	1.12
Frontier	1.03	10	1.13	3	1.06

Note: PAC (post-acute care), PPS (prospective payment system), SOI (severity of illness), HHA (home health agency), I–PAC (institutional–post-acute care), ESRD (end-stage renal disease), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital). The impact of the first year was modeled using a blend of one-third PAC PPS payments and two-thirds setting-specific PPS payments.
"Other neurology medical" excludes stroke. "Serious mental illness" includes beneficiaries with schizophrenia, bipolar disorders, or severe depression. Patients' level of frailty was determined using a frailty index. "Multiple body system diagnoses" includes patients treated in I–PAC with diagnoses involving five or more body systems. "Chronically critically ill" stays include patients who spent eight or more days in an intensive care unit during the preceding hospital stay or were on a ventilator in the PAC setting. "Severely ill" stays include patients treated in I–PAC who were categorized as SOI Level 4 during the immediately preceding hospital stay (or simulated for patients admitted from the community). "Lowest therapy costs" and "highest therapy costs" refer to those stays in the lowest and highest quartile, respectively, of therapy costs as a share of total stay costs. For home health stays, the low group includes only stays with no therapy. Institutional PAC includes SNFs, IRFs, and LTCHs. LTCH-qualifying stays are those that would meet the patient-specific criteria to qualify for LTCH PPS payments.

Source: Analysis of 8.9 million 2013 PAC stays with costs and payments updated to 2017 (Wissoker 2017).

no provider would experience decreases of 25 percent or more (compared with 7 percent of providers under a fully implemented PAC PPS), while 3 percent of providers would experience increases of 25 percent or more (compared with 16 percent of providers under a fully implemented PAC PPS). Under a transition, the payment changes would be more moderate: Most providers (84 percent) would have increases or decreases of 10 percent or less (compared with 39 percent of providers under a fully implemented PAC PPS).

Allowing providers to bypass the transition

Policymakers may want to consider giving providers the option to bypass the transition and move directly to full PAC PPS rates. Experience with the implementation of the setting-specific PPSs suggests that many providers whose payments would increase under the PAC PPS would elect to do so if given the option. The implementation of the SNF, IRF, and LTCH PPSs included multiyear transitions with blended rates but allowed providers to bypass the transition and receive full PPS rates, which many providers did.[6]

Allowing providers to bypass the transition would have benefits and drawbacks. A key advantage of allowing providers to bypass the transition is the quicker shift to a payment system that will base payments on patient care needs and be more equitable across different types of stays and providers. One indicator of how many providers might opt to bypass the transition is the share of providers whose payments would increase substantially. We estimate that average payments would increase by at least 10 percent for about 35 percent of providers (Table 1-3, pp. 14–15). One reason to allow "early adopters" is to create momentum for the new payment system and make it less likely to delay full implementation. The key disadvantage of the bypass option is that it will raise total spending during the transition. Providers that expect their payments to increase under the PAC PPS will likely opt to bypass the transition, while those that expect their payments to decline will not. Some policymakers may question why program spending has to increase to implement a more equitable payment system. The Secretary could mitigate this added cost by lowering the aggregate level of spending as part of the transition.

Because the impact of the PAC PPS will vary considerably across settings and providers, we expect providers' interest in bypassing the transition will differ substantially. Many providers in lower cost settings (HHAs and SNFs) are likely to experience increases in their payments under a PAC PPS and may be interested in transitioning quickly to a full PAC PPS payment. In addition, in discussions with the Commission's staff, administrators of some integrated systems have indicated their interest in moving quickly to a PAC PPS so they have a uniform set of payment rules and incentives and greater flexibility in the mix of patients their providers treat. Conversely, high-cost providers (for example, many IRFs and LTCHs) are likely to face lower payments under a PAC PPS. Many of them will likely prefer to adhere to the transition schedule, gaining extra time to restructure their costs and payments.

A transition would require CMS to maintain parallel payment systems, during which CMS would calculate rates under the "old" setting-specific system and under the "new" system; CMS would then apply a blend of the two to arrive at the final payment. This approach is typically taken by CMS when transitioning from one payment system to another (for example, the implementation of the IRF PPS and the implementation of site-neutral payments for LTCHs). Because both systems would use administratively available data that are currently submitted to CMS, providers would not be required to collect and submit new data.

Assessing the level of aggregate payment

In implementing a PAC PPS, the Secretary will need to evaluate the level of aggregate payments. The analyses conducted thus far have assumed that the PAC PPS would be implemented to be budget neutral relative to the current level of aggregate PAC payments. However, this approach would maintain average payments that we estimate would be 14 percent higher than the average costs of care in 2017. The Commission has repeatedly recommended reductions or freezes to payments to PAC providers to bring Medicare's payments in closer alignment with providers' costs. This year, the Commission recommended that the Congress lower payments to HHAs and IRFs by 5 percent and freeze payment rates for SNFs and LTCHs (Medicare Payment Advisory Commission 2017). The Commission's payment update recommendations made in March 2017 would result in about a 2 percent reduction in aggregate spending, lowering program spending by about $1.2 billion.

If the Congress has not made setting-specific payment reductions by the time the Secretary implements the PAC PPS, the Congress should lower payments to align them with the cost of stays, consistent with the Commission's recommendations regarding payment updates to PAC providers. This policy is separate from the need for the Secretary to have the authority to rebase payments periodically. Lowering the initial level of payments would bring payments more in line with the current cost of stays, while the authority to rebase payments acknowledges that

changes in the costs of care may warrant future payment realignment.

We modeled several reductions to overall payments, ranging from 2 percent to 5 percent, and compared the resulting average payments with the average cost of PAC stays. All scenarios assume no changes in providers' costs or practices. However, experience with other payment policy changes suggests that, under a PAC PPS, many providers are likely to lower their costs and change the mix of their patients relatively quickly. The limited evidence comparing PAC use by beneficiaries in accountable care organizations and Medicare Advantage with PAC use by beneficiaries in FFS Medicare may offer some insights into the type of changes providers may make. Although the incentives differ, alternative payment models appear to prompt shorter and less therapy-intensive stays and increase the use of relatively lower cost PAC settings (Colla et al. 2016, Huckfeldt et al. 2017, McWilliams et al. 2016). Because the PAC PPS would narrow the differences in payments across settings, it would dampen the incentive to shift where patients are treated, but the incentive to lower costs would remain.

Under all of the options we modeled, average payments would remain higher than the average cost of all stays and higher than the average cost for most of the patient groups (Table 1-6, pp. 22–23). For example, if payments were lowered by 5 percent, the average payment for all stays would remain 9 percent higher than the average cost of stays and between 8 percent and 9 percent higher for most of the patient groups. As we reported in June 2016, compared with current policy, the ratios of payments to costs across the various patient groups would be much narrower, so providers would have less incentive to admit certain types of patients over others.

The ratios of payments to costs are less than 1.0 for the higher cost providers (such as IRFs, LTCHs, and hospital-based providers) because the PAC PPS considers the costs of the lower cost providers and lower cost settings in determining the payments across all stays with similar characteristics. By averaging the costs of all similar stays (regardless of setting), the payments made to the high-cost settings and high-cost providers are lowered. Under the PAC PPS, payments would be below the cost of stays for HHA stays with high therapy costs (even before reductions to the aggregate level of payment are considered), most likely because payments would be based on patient characteristics, in contrast to current HHA costs that include the provision of therapy services that are of questionable value. This finding is an expected result of a PAC PPS based on patient characteristics rather than the amount of care furnished to a patient. If a patient had clinical characteristics and impairments indicating above-average care needs, payments for the stay would be above average.

A transition would temper the impact of the changes in payments under a PAC PPS, but these changes could be further moderated by taking the reduction in increments throughout the transition. Given that PAC payments are relatively high and there may be a transition to full PAC PPS rates, the Commission supports taking the reduction in one action at the beginning of implementation. This approach makes it less likely that reductions are halted partway through the transition, before the full realignment of payment to the costs of care.

The Secretary would consider the aggregate reduction separately from each year's update; providers would continue to receive payment updates, as appropriate, during the transition. After full implementation, the Secretary would need to evaluate whether further alignment of payments with costs was warranted. Continued monitoring of beneficiary access, provider performance, and Medicare margins would provide indicators of the need for future refinements.

Periodic refinements needed to maintain the accuracy of the PAC PPS

Under a new PAC PPS, practice patterns will change as high-cost providers lower their costs and all providers evaluate and possibly shift their mix of patients and services furnished. These changes could compromise the quality of care furnished and, if payments are inaccurate, beneficiaries' access to care. The Secretary must carefully monitor provider behavior, including the level of quality furnished, the types of stays admitted, and the adequacy of payments. If aberrant patterns or unintended provider responses occur, the Secretary will need to make revisions to counter this behavior. As with any payment system, the Secretary would need to revise and rebase the PAC PPS, when warranted, to maintain the accuracy of payments over time.

Monitor provider responses to the PAC PPS

In June 2016, the Commission discussed possible measures to monitor quality, patient selection, unnecessary

TABLE 1–6

Lowering payments by 2 percent to 5 percent would still cover the average cost of stays for most patient groups (continued next page)

		Ratio of average payment to average cost of stays					
			Payments reduced under PAC PPS by:				
Reporting group	Percent of stays	Current policy	0%	2%	3%	4%	5%
All stays	100%	1.14	1.14	1.12	1.11	1.10	1.09
Cardiovascular medical	14	1.15	1.15	1.13	1.12	1.10	1.09
Orthopedic medical	10	1.22	1.15	1.13	1.11	1.10	1.09
Orthopedic surgical	10	1.18	1.14	1.12	1.11	1.10	1.08
Respiratory medical	9	1.09	1.15	1.12	1.11	1.10	1.09
Other neurology medical	8	1.22	1.15	1.13	1.12	1.11	1.10
Serious mental illness	5	1.14	1.15	1.12	1.11	1.10	1.09
Severe wound	5	1.05	1.15	1.13	1.12	1.11	1.09
Skin medical	4	1.11	1.14	1.12	1.11	1.10	1.09
Cardiovascular surgical	3	1.06	1.14	1.11	1.10	1.09	1.08
Infection medical	3	1.13	1.14	1.12	1.11	1.09	1.08
Stroke	2	1.15	1.13	1.10	1.09	1.08	1.07
Hematology medical	2	1.07	1.11	1.08	1.07	1.06	1.05
Ventilator	<1	1.07	1.17	1.15	1.13	1.12	1.11
Least frail	7	1.20	1.15	1.13	1.11	1.10	1.09
Most frail	11	1.12	1.13	1.11	1.10	1.09	1.08
Cognitively impaired	20	1.19	1.14	1.12	1.11	1.10	1.09
Multiple body system diagnoses	5	1.10	1.14	1.12	1.11	1.09	1.08
Chronically critically ill	5	1.06	1.14	1.12	1.11	1.10	1.08
Severely ill (SOI = Level 4)	4	1.07	1.13	1.11	1.10	1.09	1.08

Note: PAC (post-acute care), PPS (prospective payment system), SOI (severity of illness), HHA (home health agency), I–PAC (institutional–post-acute care), ESRD (end-stage renal disease), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital). Percent of stays does not total 100 percent because many of the groups overlap.
"Other neurology medical" excludes stroke. "Serious mental illness" includes beneficiaries with schizophrenia, bipolar disorders, or severe depression. Patients' level of frailty was determined using a frailty index. "Multiple body system diagnoses" include patients treated in I–PAC with diagnoses involving five or more body systems. "Chronically critically ill" stays include patients who spent eight or more days in an intensive care unit during the preceding hospital stay or were on a ventilator in the PAC setting. "Severely ill" stays include patients treated in I–PAC who were categorized as SOI Level 4 during the immediately preceding hospital stay (or simulated for patients admitted from the community). "Lowest therapy costs" and "highest therapy costs" refer to those stays in the lowest and highest quartile, respectively, of therapy costs as a share of total stay costs. For home health stays, the low group includes only stays with no therapy. Institutional PAC includes SNFs, IRFs, and LTCHs. LTCH-qualifying stays are those that would meet the patient-specific criteria to qualify for LTCH PPS payments.

Source: Analysis of 8.9 million 2013 PAC stays with costs and payments updated to 2017 (Wissoker 2017).

PAC use, and the adequacy of payments (Table 1-7, p. 24). Observed changes in PAC use under the new PAC PPS could reflect a change in payment incentives. Certain types of patients might be more or less preferable to admit than they were under the previous payment systems. Such changes in PAC use may be desirable or may indicate the need for payment revisions. Although the relative profitability across patient conditions will be considerably narrower than under current policy, there will continue to be some variation that could make certain types of conditions more attractive for providers to treat. As part of his ongoing evaluation, the Secretary should monitor PAC provision for these conditions and for particularly vulnerable patients, such as the sickest and frailest patients. Observed increases in the length of stay of preceding hospitalizations could reflect delays in PAC placement, which could indicate that PAC providers are reluctant to admit less profitable patients. Changes in the distribution of the lengths of PAC stays (such as a concentration of discharges just after a short-stay threshold) could indicate that revisions to the short-stay outlier policy are needed.

TABLE 1–6

Lowering payments by 2 percent to 5 percent would still cover the average cost of stays for most patient groups (continued)

		Ratio of average payment to average cost of stays					
			Payments reduced under PAC PPS by:				
Reporting group	Percent of stays	Current policy	0%	2%	3%	4%	5%
No therapy costs for HHA stays	29	1.55	1.94	1.91	1.89	1.87	1.85
Lowest therapy costs for I–PAC stays	8	0.94	1.11	1.08	1.07	1.06	1.05
Highest therapy costs for HHA stays	17	1.09	0.83	0.82	0.81	0.80	0.79
Highest therapy costs for I–PAC stays	8	1.32	1.11	1.09	1.08	1.07	1.06
Community admitted	50	1.21	1.16	1.14	1.13	1.12	1.10
Stays with prior hospital stay	50	1.12	1.14	1.12	1.10	1.09	1.08
Disabled	26	1.13	1.15	1.12	1.11	1.10	1.09
Dual eligible	32	1.17	1.14	1.12	1.11	1.10	1.09
ESRD	4	1.12	1.14	1.12	1.11	1.10	1.08
Very old (age 85+ years)	30	1.17	1.14	1.12	1.11	1.09	1.08
HHA	69	1.17	1.16	1.13	1.12	1.11	1.10
SNF	25	1.14	1.22	1.19	1.18	1.17	1.16
IRF	4	1.18	1.00	0.98	0.97	0.96	0.95
LTCH: All stays	2	1.05	0.89	0.87	0.87	0.86	0.85
LTCH-qualifying stays	1	1.05	0.95	0.93	0.92	0.91	0.90
Nonprofit	22	1.00	1.09	1.07	1.06	1.05	1.04
For profit	75	1.20	1.17	1.15	1.13	1.12	1.11
Hospital based	11	0.85	0.94	0.92	0.91	0.90	0.90
Freestanding	89	1.19	1.18	1.15	1.14	1.13	1.12
Urban	84	1.15	1.14	1.12	1.11	1.10	1.09
Rural	16	1.11	1.15	1.12	1.11	1.10	1.09
Frontier	<1	1.03	1.13	1.10	1.09	1.08	1.07

Note: PAC (post-acute care), PPS (prospective payment system), SOI (severity of illness), HHA (home health agency), I–PAC (institutional–post-acute care), ESRD (end-stage renal disease), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital). Percent of stays does not total 100 percent because many of the groups overlap.
"Other neurology medical" excludes stroke. "Serious mental illness" includes beneficiaries with schizophrenia, bipolar disorders, or severe depression. Patients' level of frailty was determined using a frailty index. "Multiple body system diagnoses" include patients treated in I–PAC with diagnoses involving five or more body systems. "Chronically critically ill" stays include patients who spent eight or more days in an intensive care unit during the preceding hospital stay or were on a ventilator in the PAC setting. "Severely ill" stays include patients treated in I–PAC who were categorized as SOI Level 4 during the immediately preceding hospital stay (or simulated for patients admitted from the community). "Lowest therapy costs" and "highest therapy costs" refer to those stays in the lowest and highest quartile, respectively, of therapy costs as a share of total stay costs. For home health stays, the low group includes only stays with no therapy. Institutional PAC includes SNFs, IRFs, and LTCHs. LTCH-qualifying stays are those that would meet the patient-specific criteria to qualify for LTCH PPS payments.

Source: Analysis of 8.9 million 2013 PAC stays with costs and payments updated to 2017 (Wissoker 2017).

Other possible provider responses will also warrant monitoring. For example, a large increase in second PAC stays following initial PAC use could indicate that providers are unbundling care—for example, IRFs could discharge a higher proportion of patients to SNFs as a way for IRFs to avoid treatment costs. Although second PAC use can be appropriate, large changes in its use could indicate unintended provider responses and would increase Medicare spending, as well as expose beneficiaries to unnecessary care transitions.

Medicare margins and cost growth are good barometers of the adequacy of Medicare's payments. When payments are more than adequate, providers have less incentive to control their costs, and cost growth may be high. However, high cost growth could also reflect providers making

TABLE 1–7 **Measures to monitor provider responses to a PAC PPS**

Dimension	Measure
Quality of care	• Potentially avoidable readmissions
	• Potentially avoidable admissions (for community admissions)
	• Changes in patient function
	• Length of PAC stay
	• Potentially avoidable complication rates
	• Potentially avoidable emergency department visits and observation stays
	• Days elapsed between discharge from PAC and follow-up appointment with a clinician
	• Beneficiary experience
Patient selection	• PAC use by condition/reason to treat
	• Mix of patients across settings and providers
	• Length of stay of preceding hospital stay
PAC use	• PAC use following a hospital stay, which could detect over- or underuse
	• Subsequent PAC use following an initial PAC stay, which could detect over- and underuse
Adequacy of payments	• Medicare margins
	• Cost growth

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

investments in staffing and equipment to treat a more complex mix of patients.

The Commission has been clear that providers should be accountable for the quality of care they furnish and for a period after discharge. The first helps protect beneficiaries from providers stinting on services if doing so lowers their costs. The second encourages providers to coordinate care with the patient's next provider (or the caregiver at home) so that the patient has a safe transition. The Commission's PAC measures of quality (and CMS's hospital readmission rates) include 30 days after discharge. Tracking measures over longer periods of time, such as 60 or 90 days, would hold providers accountable for a longer recovery period but could include events unrelated to the initial reason for PAC.

Maintain alignment of payments and costs

Experience with prior payment policy changes indicates that providers will change their costs, patient mix, and practice patterns to maintain or increase their profitability. The Secretary should therefore periodically evaluate the need to make refinements to the PAC payment system. Such refinements fall into two broad categories. The first involves revisions to the classification system—the case-mix groups and their relative weights—to help maintain the equity and accuracy of payments across different types of stays. The second involves rebasing payments to keep them aligned with the cost of stays. Both types of refinements are part of the ongoing maintenance of any PPS.

The Secretary should periodically evaluate the need to revise the PPS to help ensure that Medicare's payments capture changes in the relative costs of stays. For example, if admitting practices change, the relative and absolute costs of different types of stays may change. Further, standards of care may change, affecting the costs of some types of stays relative to others. This ongoing maintenance would include revisions to the case-mix adjustment system (such as the adding or collapsing of case-mix groups) and

the relative weights that adjust payments up or down for each type of case.

The Secretary should also have the authority to rebase payments periodically if payment changes outpace cost changes. Because coding practices are likely to change (as they typically do when new payment systems are implemented), payments are likely to increase, even when patients' resource needs remain the same. PAC providers are likely to adjust to this new payment system just as they have consistently done to other payment policy changes by changing their costs, mix of patients, and practices. With the implementation of each setting's PPS, providers relatively quickly adjusted their practices, and Medicare margins increased substantially. After the HHA PPS was implemented, HHA margins in 2003 were the highest they have ever been (23 percent). Between 1999 and 2000, the year CMS implemented the SNF PPS, SNF Medicare margins rose from 2.0 percent to 10.1 percent. Between 2001 and 2002, the year CMS implemented the IRF PPS, IRF margins increased from 1.5 percent to 10.8 percent. Between 2002 and 2003, the year the LTCH PPS was implemented, LTCH margins grew from –0.1 percent to 5.2 percent. To protect the program and taxpayers from excessively high payments relative to the cost of stays, the Secretary would need the authority to rebase payments, if necessary, to maintain the alignment of payments with the cost of stays.

Recommendation regarding the implementation of a PAC PPS

In June 2016, the Commission recommended to the Congress the design features of a PAC PPS and estimated the impact of the new system on payments. The design features include a uniform unit of service (a stay) and risk adjustment method using patient characteristics rather than the site of service or the amount of therapy a patient received, outlier payments for unusually short or unusually high-cost stays, and a downward adjustment for home health stays to reflect this setting's considerably lower cost compared with institutional PAC.

IMPACT does not require the implementation of a PAC PPS by an explicit date, but its report requirements suggest that a unified PPS would not be proposed before 2024 for implementation some time later. However, the Commission contends that a PAC PPS should be implemented sooner than contemplated by IMPACT, beginning in 2021, with a design that relies on readily available data and is revised over time to include functional status as a risk adjuster when these data become available. This implementation timetable assumes that the Secretary will have begun to waive or modify certain setting-specific regulatory requirements. Because some of the regulatory requirements are in statute, the Congress will need to grant authority to the Secretary to take these actions. Given the range in impacts, the implementation should include a transition, but because providers with the largest decreases in payments tend to be those with above-average profitability, the phase-in period should be short.

Regarding the level of payments, if the Congress has not already done so by the beginning of the implementation, the aggregate level of spending on PAC should be lowered to more closely align payments with the costs of care. Concurrently, the Secretary would need to begin to align the regulatory requirements across PAC providers so they face similar costs in furnishing care to beneficiaries. In addition, the Congress should give the Secretary the authority to periodically revise and rebase the PAC PPS to keep payments aligned with the cost of care.

RECOMMENDATION

The Congress should direct the Secretary to:

- **implement a prospective payment system for post-acute care beginning in 2021 with a three-year transition;**
- **lower aggregate payments by 5 percent, absent prior reductions to the level of payments;**
- **concurrently, begin to align setting-specific regulatory requirements; and**
- **periodically revise and rebase payments, as needed, to keep payments aligned with the cost of care.**

RATIONALE

The Commission found that payments based on a design that used currently available administrative data were accurate for most types of stays. The Commission concluded that a PAC PPS could be implemented in 2021 using administrative data and be revised over time to incorporate information on patient function into the risk adjustment of payment when these data become available.

A PAC PPS will have widely varying effects on payments for stays and on providers. Therefore, the Commission concludes that the new payment system should be

implemented with a transition that blends current setting-specific payments with PAC PPS payments. However, the transition should be relatively short because it delays the redistribution of payments toward medical and medically complex stays. Implementing a PAC PPS with a short transition balances the desire to redistribute payments quickly and the need to give high-cost providers time to modify their costs and practices. Furthermore, this recommendation puts the PAC industry on notice about the type of changes they will need to make, giving them effectively a six-year transition to fully implemented PAC PPS payments. Providers could begin to change their cost structures and therapy practices in anticipation of the changes encouraged by the PAC PPS.

The Commission recommends that when the PAC PPS is implemented, the aggregate level of PAC payments be lowered by 5 percent. This reduction assumes that the Congress has not already acted to lower PAC spending. If the Congress has already lowered the level of payments to PAC providers, it should compare the impact of those reductions with the Commission's recommendation and make additional adjustments if necessary to reach the recommended reduction.

The Secretary could give providers the option to bypass the transition and be paid full PAC PPS payments. While this option would raise program spending during the transition, it would begin to shift payments to being more equitable and based on patient characteristics compared with the current designs of the HHA and SNF payment systems.

The Commission's recommendation to lower payments is consistent with the payment update recommendations the Commission has made for many years concerning PAC providers, most recently in March 2017. Compared with these recommendations, the Commission recommends a larger reduction for two reasons. First, if providers respond to the PAC PPS as they have to previous payment system changes—by altering their mix of patients, costs, and coding—their margins could increase substantially under the PAC PPS. Second, prior experience suggests that providers whose payments will increase under the PAC PPS are likely to opt to bypass the transition and receive full PAC PPS payments. Because this possibility will raise aggregate PAC spending during the transition, a larger reduction helps mitigate the increased spending. However, even with a 5 percent reduction, the average payment would remain substantially above the average cost of stays for all stays and for the 30 patient groups we examined.

The Commission believes the reduction should be taken in one action at the beginning of the implementation because the level of PAC payments is high; there would be a transition to full PAC PPS rates; providers may have the option to bypass the transition (which would raise program spending); and providers are likely to respond by changing their patient mix, costs, and treatment practice.

The recommendation explicitly ties the implementation of a unified payment system to the start of the alignment of setting-specific regulatory requirements. Without alignment, some providers will continue to face differing regulatory requirements that may raise their costs. The Secretary will need the authority to waive or modify regulatory requirements that are in statute. Eventually, the Secretary should develop regulations that delineate a core set of requirements all providers must meet and a separate set of requirements for those providers opting to treat patients with special care needs. The Commission plans to focus on this issue over the coming year.

Finally, the Secretary must have the authority to periodically revise and rebase PAC PPS payments. Revisions to the PAC PPS (such as changes to the patient classification system and the risk adjustment method) will help ensure that Medicare's payments capture changes in the relative cost of stays. Rebasing will help ensure that the aggregate level of Medicare's payments reflects the costs of care. Throughout the implementation, the Commission will continue to monitor the level and alignment of payments with the cost of care and make recommendations as needed.

IMPLICATIONS

Spending

- The one-year spending will not change relative to current law because the recommendation does not affect payments until 2021 (or year 4). Over five years, spending will be lower by between $5 billion and $10 billion. These estimates assume no behavioral changes by providers. In addition, savings will depend in part on whether providers are allowed to bypass the transition, and if so, how many will exercise this option. Providers that expect their payments to increase under the PAC PPS may opt to bypass the transition, raising spending during the transition, while those whose payments will decrease are likely to adhere to the three-year transition. The net change will depend on how many providers opt to move directly to full PAC PPS rates.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on beneficiaries. On the contrary, payments based on patient characteristics will make providers more willing to admit and treat medical patients and medically complex patients. With a transition that phases in the impacts of the new payment system, providers will be protected from large changes in payments that otherwise could adversely affect beneficiaries.The PAC PPS will redistribute payments from high-cost settings and providers to lower cost settings and providers. Further, by basing payments on patient characteristics rather than the amount of service furnished, the new payment system will shift payments to medically complex patients and away from patients who receive high-intensity rehabilitation that appears unrelated to their clinical condition. Thus, the PAC PPS will narrow disparities in the profitability of Medicare patients and increase the equity of Medicare's payments to providers. The impact on providers will vary considerably and will depend on how quickly providers can adjust their cost structures, treatment practices, and mix of patients to align with payments under the PAC PPS. ■

Endnotes

1 A stay is defined as the days spent in a PAC provider between admission and discharge or, in the case of home health care, the end of the 60-day episode. A SNF stay followed by a HHA episode would count as two PAC stays.

2 Because the costs of HHAs are so much lower than the costs of the three institutional PAC settings, payments for stays in HHAs would need to be adjusted to avoid exceptionally high payments relative to the cost of these stays. In our analyses, we included a home-health indicator in the model predicting the cost of stays as one way to account for the very different costs in this setting. The indicator keeps the predicted cost of HHA stays aligned with their actual costs and preserves the relative differences in costs between institutional and HHA stays.

3 The cost of stays was predicted using Poisson regression models and the following patient information: age and disability status, primary reason to treat, diagnoses and comorbidities, severity, impairments, cognitive status, and use of high-cost service items (ventilator care, tracheostomy care, and continuous positive airflow pressure). We developed one model to predict the routine and therapy costs per stay and another for the nontherapy ancillary (NTA) costs per stay (such as drug costs) because the costs and payments for stays in HHAs do not include NTA services. We combined the results of the two models and compared their results with the actual costs of stays. The predicted costs would form the basis of payments under a PAC PPS. In this analysis, we assumed total payments under a PAC PPS would equal total actual payments to providers across the four settings.

4 Aggregate payments under the PAC PPS were set to be budget neutral to current *aggregate* payments, not budget neutral by setting.

5 Our estimate of the impact of the PAC PPS on LTCHs assumes that the number and types of cases admitted to LTCHs in 2017 will be the same as in 2013. However, substantial changes in LTCH payment policy, which began in fiscal year 2016, will likely alter the admission patterns, volume, and cost structures of these providers.

6 Within two years of the five-year transition to the LTCH PPS, almost all LTCHs had transitioned; most IRFs opted to bypass the two-year transition to the IRF PPS. The HHA PPS did not include a transition.

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