

CHAPTER

7

**Post-acute care:
Increasing the equity of
Medicare's payments
within each setting**

R E C O M M E N D A T I O N

- 7** The Congress should direct the Secretary to begin to base Medicare payments to post-acute care (PAC) providers on a blend of each sector's setting-specific relative weights and the unified PAC prospective payment system's relative weights in fiscal year 2019.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

Post-acute care: Increasing the equity of Medicare's payments within each setting

Chapter summary

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries after an acute care hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). In 2016, fee-for-service (FFS) Medicare program spending on PAC services totaled \$60 billion.

Each year, in addition to evaluating the adequacy of Medicare FFS payments, the Commission considers whether revisions to the payment systems are needed to better align program payments with the costs of treating patients with different care needs. Aligning payments and costs for all conditions increases the equity of the program's payments by minimizing the financial incentives to treat some beneficiaries over others. For years, the Commission has raised concerns that the PAC prospective payment systems (PPSs) encourage some providers to favor treating some types of patients over others (thereby impairing access for some beneficiaries), furnish therapy services unrelated to a patient's condition, engage in certain questionable coding practices, extend the length of stay so that a full payment (rather than short-stay outlier payment) is made, or engage in some combination of these strategies. The Commission has urged CMS to revise the payments systems to correct these shortcomings.

In this chapter

- Shortcomings of current PAC PPSs and challenges in improving Medicare's payments for PAC
- The Commission's work on a unified payment system for PAC
- An approach to redistribute Medicare's payments for different conditions treated within each PAC setting

In addition, the Commission has recommended either no update or lowering the level of payments in each PAC setting to more closely align them with the cost of care. But concern about the wide variation in financial performance across providers has constrained these recommendations. The Commission's update recommendations this year again signal that Medicare's aggregate payments are too high relative to the costs to treat beneficiaries.

PAC presents particular challenges in establishing accurate and equitable payments because it is not always clear whether the beneficiary requires PAC and, if so, which setting is best suited to the patient's care needs or how much care would yield the best outcome. The lack of uniform assessment tools makes it difficult to compare beneficiaries, cost of services, and outcomes of care across settings.

In 2016, in response to a congressional mandate, the Commission recommended design features of a unified payment system to be used in the four PAC settings. The Commission found that a unified PAC PPS could use readily available data to pay for a stay based on a patient's characteristics, not the site of service or the amount of therapy furnished. The design would correct current distortions in the SNF and HHA PPSs that encourage providers to furnish services of questionable value and that advantage providers that avoid medically complex patients. In June 2017, the Commission recommended that the new payment system begin to be implemented in 2021 so that inequities in the current payment systems can start to be corrected as soon as possible.

Before implementing a unified PAC PPS, CMS could begin to redistribute payments within each PAC setting by blending the current setting-specific relative weights with the unified PAC PPS relative weights. Because the resulting payments would be more closely aligned with the cost of care across all conditions, the equity of the program's payments would increase. Under this blend, each PAC setting's total payments would be kept at the recommended level while payments would be redistributed within each setting based on a provider's mix of patients, costs, and therapy practices. Blending unified PAC PPS and setting-specific relative weights before the implementation of a unified payment system would give providers even more time to adjust their practices and costs to the incentives of the new system. With closer alignment of payments and costs and the redistribution of payments across providers, policymakers could then consider establishing a level of payment that more accurately reflects the costs of care. When the PAC PPS is implemented, the relative weights of that design would be exclusively used in establishing payments for providers in the four PAC settings.

To increase the equity of payments within each setting, the Commission recommends that the Congress direct the Secretary to begin blending the relative weights of the setting-specific payment systems and the unified PAC PPS in 2019 (i.e., before the implementation of the unified PAC PPS). The recommendation would redistribute payments across patients' conditions within each setting, but would not affect the level of spending in each PAC setting.

The recommendation to blend the relative weights in no way detracts from the Commission's concurrent recommendations to revise the SNF and HHA payment systems. Because the PAC PPS is on a longer implementation timetable, Medicare must continue to improve its setting-specific payment systems. To address the persistently high level of payments in the PAC settings, the Commission has setting-specific recommendations to lower payments in the case of HHAs and IRFs and to provide no updates to the payments for SNFs and LTCHs. The blending recommendation to redistribute payments within a setting should not interfere with the consideration of the setting's payment level either in the aggregate or for individual PAC settings. ■

Shortcomings of current PAC PPSs and challenges in improving Medicare's payments for PAC

For years, the Commission has raised concerns about the design shortcomings of the individual post-acute care (PAC) payment system designs. The designs encourage providers to favor treating some types of patients over others, furnish therapy services unrelated to a patient's condition, engage in certain questionable coding practices, extend the length of stay so that a full payment (rather than a short-stay outlier payment) is made, or engage in some combination of these strategies. Specifically, the skilled nursing facility (SNF) prospective payment system (PPS) favors treating rehabilitation over medically complex patients, encourages providers to furnish therapy unrelated to a patient's condition, and poorly targets payments for patients requiring high-cost nontherapy ancillary services (such as expensive antibiotics). The home health agency (HHA) PPS also encourages agencies to provide therapy services, provide enough visits to avoid short-stay payments, and—in select states with value-based purchasing in place—code frailty to increase payments. The inpatient rehabilitation facility (IRF) PPS appears to encourage some providers to admit certain types of patients and code clinical conditions and impairments in a way that raises payments relative to the cost of care. The long-term care hospital (LTCH) PPS encourages providers to extend the duration of stays to qualify for full payment, rather than a lesser short-stay payment. Partly reflecting differences in providers' practices, the financial performance of providers differs widely. For example, in 2016, a more than 10 percentage point difference in Medicare margins existed between for-profit and nonprofit SNFs and a 20 percentage point difference existed between for-profit and nonprofit IRFs.

Distortions encouraged by the payment systems have resulted in practice patterns that do not reflect efficient care. In contrast to traditional FFS, there is some evidence that Medicare Advantage plans and providers participating in alternative payment models (such as accountable care organizations and bundled payment initiatives) refer fewer patients to PAC, use lower cost PAC settings, and, in the case of SNFs, have shorter and less therapy-intensive stays—without appearing to harm patient outcomes (Colla et al. 2016, Dummit et al. 2016, Huckfeldt et al. 2017, McWilliams et al. 2016, Winblad et al. 2017).

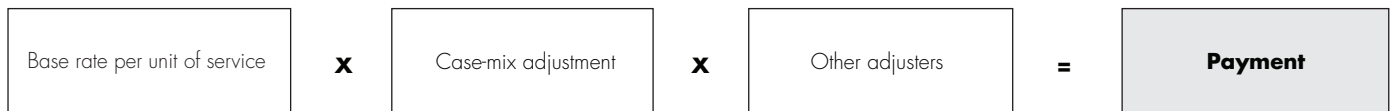
The biases of the payment systems have led the Commission to recommend changes to the PPS designs that increase the equity of payments across conditions so providers are not advantaged by admitting certain patients over others. The Commission recommended redesigns of the SNF (in 2008) and HHA payment systems (in 2011) that would base payments on patient characteristics such as diagnoses, comorbidities, and impairments, not the amount of therapy provided (Medicare Payment Advisory Commission 2011, Medicare Payment Advisory Commission 2008). The proposed changes would generally increase payments for medically complex care and decrease payments for rehabilitation care that is unrelated to a patient's characteristics. For IRFs, in 2016, the Commission recommended changes to the outlier policies as a short-term fix to better align payments with the costs of the highest acuity patients and recommended that the Secretary improve program integrity through reviewing medical records in conjunction with IRF patient assessment data and through reassessing the inter-rater reliability across IRFs to discern the accuracy of recorded patient acuity (Medicare Payment Advisory Commission 2016b).

Another persistent theme of the Commission's discussions is the level of Medicare payments to PAC providers. For most of the past 10 years, Medicare payments have been 10 percent or more above the costs to treat beneficiaries. Since 2008, the Commission has recommended either no updates to payments or a reduction in payment levels. Yet, given the wide variation in financial performance across providers, the Commission has, at times, been constrained in making recommendations that would even more closely align payments to the cost of care. The Commission's update recommendations this year again signal that Medicare continues to pay too much for PAC.

In addition to providers' financial incentives created by the PPS's current designs, specific concerns about PAC have framed the Commission's discussions of the need to reform the way Medicare pays for this care. There are few evidence-based guidelines for PAC, so it is not always clear when PAC is needed, where care is best provided, how much care is required, or when more care is likely to result in better outcomes. PAC placement decisions often reflect nonclinical factors, such as local practice patterns, PAC availability in a market, the proximity to a beneficiary's home, patient and family preferences, and financial relationships between the referring hospital

**FIGURE
7-1**

Simplified design of a prospective payment system



and the PAC provider—but not necessarily where the patient would receive the best care. Given these factors, it is not surprising that per capita Medicare spending varies more for PAC than for any other service (Medicare Payment Advisory Commission 2017b). Across the four PAC settings, Medicare requires providers to use different patient assessment tools, which undermines the program’s ability to compare on a risk-adjusted basis the patients admitted, the cost of care, and the outcomes patients achieve. Finally, though similar beneficiaries can be treated in the four settings, Medicare uses separate payment systems for each that can result in considerably different payments for comparable conditions. These factors led the Congress to include mandated studies of a unified payment system in the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT).

The Commission’s work on a unified payment system for PAC

In response to IMPACT’s mandate, in June 2016, the Commission recommended features of a unified payment system and estimated the effects of moving to such a system (Medicare Payment Advisory Commission 2016a). After concluding that readily available data could accurately predict the cost of most types of conditions, the Commission evaluated a design using 8.9 million PAC stays in 2013 (see text box on the Commission’s work on the design of a PAC PPS, pp. 197–198).

Consistent with Medicare’s FFS PPSs (Figure 7-1), the Commission’s design would effectively establish a base rate that is adjusted up or down based on the patient’s care needs (the case-mix adjuster). The case-mix adjuster is a relative weight that, when multiplied by the base

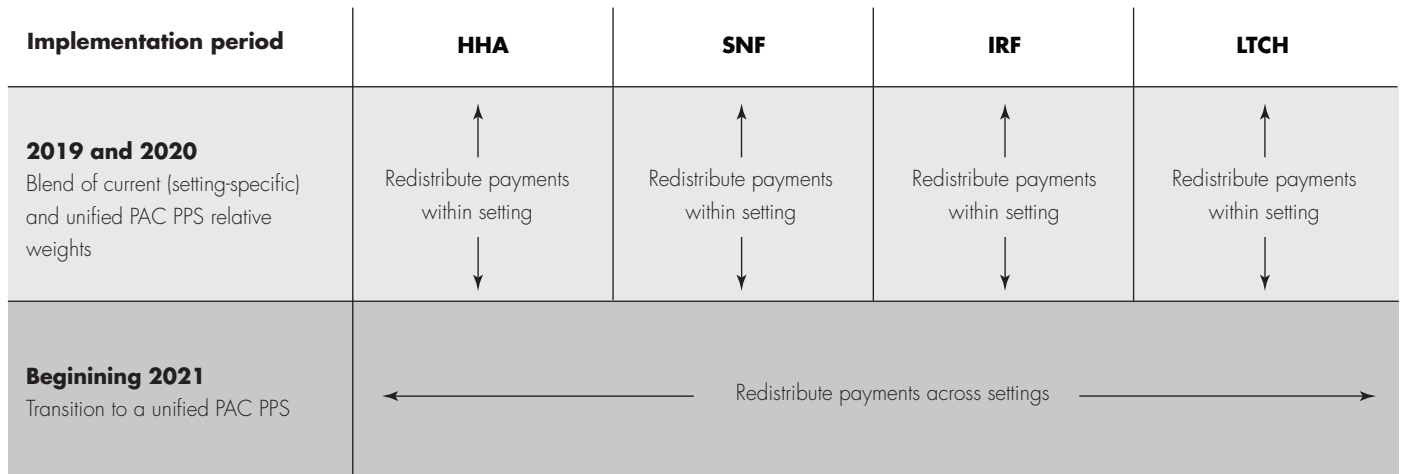
rate, lowers or raises the payment to reflect the stay’s relative costliness. Other broad adjusters (such as a disproportionate share adjustment for stays treated by providers with a high share of low-income patients) could be considered for all stays if there is empirical justification for them. A PPS often includes outlier policies that adjust payments for stays with exceptionally low or high costs.

The design for the unified payment system uses a uniform unit of service and a common risk adjustment method that includes patient and stay characteristics (e.g., the patient’s primary reason for treatment and comorbidities). Payments would reflect the average cost of stays across the four settings based on characteristics of the patient and the stay, not the setting.¹ The Commission’s analyses concluded that two outlier policies were needed—one for unusually short stays and another for unusually high-cost stays. Because the design could be implemented relatively quickly and would correct existing biases and shortcomings of the PPSs, the Commission concluded that a unified PAC PPS could be implemented sooner than contemplated by IMPACT. In June 2017, the Commission recommended that a unified PAC PPS be implemented beginning in 2021 (Medicare Payment Advisory Commission 2017a).

The Commission evaluated the impact of the design and focused on over 30 different patient groups, including 22 clinical groups, 3 definitions of patient severity, and various demographic groups. The equity in payments across clinical conditions and the providers that treat them would increase because the relative profitability across conditions would be narrower compared with current payments (Medicare Payment Advisory Commission 2016a). The relative profitability becomes more uniform because the unified PAC PPS design would decrease payments for rehabilitation care unrelated to a patient’s characteristics and increase payments for medically

**FIGURE
7-2**

Blending unified PAC PPS relative weights with current payment system weights would redistribute payments within each setting



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).

complex patients. As a result, providers would have less incentive to admit certain patients over others. The shift in payments and increases in payment equity are consistent with the rationale for the Commission’s recommendations to revise the individual PAC PPSs.

An approach to redistribute Medicare’s payments for different conditions treated within each PAC setting

A unified PAC PPS would correct disparities in payments across settings and patient conditions by eliminating key shortcomings in the individual PPS designs and narrowing the relative profitability across conditions. Compared with the current payment systems, the unified PAC PPS increases the relative weights for medically complex care and lowers them for rehabilitation care that is unrelated to a patient’s condition. With more closely aligned payments and costs for all conditions, the design would help ensure access for all beneficiaries. The Commission recommended that a unified PAC PPS be phased in beginning in 2021, with a three-year transition period during which payments would be calculated using a blend of unified PAC PPS and setting-specific base

rates. Although a transition would give providers time to adjust their costs and mix of patients, it would extend the inequities of the existing PAC payment systems and delay the much needed (and long overdue) redistribution of payments across case types.

One way to accelerate the redistribution of payments for different conditions treated at an individual PAC setting would be to base payments partly on the relative weights (the case-mix adjuster) established by the unified PAC PPS. Aggregate payments to each setting would remain consistent with the Commission’s update recommendation for each setting, but payments for each PAC setting would be redistributed based in part on the relative weights of the unified PAC PPS (Figure 7-2). Shifts in payments across a setting’s providers would reflect a provider’s mix of patients, how a provider’s costs compared with the average, and a provider’s coding and therapy practices. The redistribution would dampen the incentive to prefer to treat certain conditions over others. By basing at least part of the payment on the unified PAC PPS’s relative weights, payments would begin to be redistributed in the direction intended under the unified PAC PPS.

A simple example illustrates how the redistribution of payments for an individual PAC setting occurs when a blend of the relative weights is used to establish payments.

**TABLE
7-1**

An example of two conditions to illustrate how changes in relative weights under a unified PAC PPS would redistribute payments across conditions within a setting

	Current PPS (Setting specific)	Unified PAC PPS	Blend
Relative weights			
Orthopedic medical	1.2	0.9	1.1
Medically complex	0.8	1.1	0.9
Payments (base rate = \$6,000)			
Orthopedic medical	\$7,200 (6,000 × 1.2)	\$5,400 (6,000 × 0.9)	\$6,600 (6,000 × 1.1)
Medically complex	\$4,800 (6,000 × 0.8)	\$6,600 (6,000 × 1.1)	\$5,400 (6,000 × 0.9)
Total payments to the provider	\$12,000	\$12,000	\$12,000

Note: PAC (post-acute care), PPS (prospective payment system). The example uses a blend of 67 percent current PPS weights and 33 percent unified PAC PPS weights.

Consider a provider that treats two patients, one with an orthopedic medical condition (such as nonsurgical medical treatment for hip fracture) and another requiring medically complex care (Table 7-1). Under the unified PAC PPS, the relative weight for orthopedic medical conditions would decline and the relative weight for medically complex conditions would increase. In this example, the relative weight for the orthopedic medical case decreases from 1.2 to 0.9 (and the resulting payment

decreases from \$7,200 to \$5,400). The relative weight for the medically complex case increases from 0.8 to 1.1, resulting in payments increasing from \$4,800 to \$6,600. Though the total payments to the provider remain the same (\$12,000), payments across the two types of conditions are redistributed. Before the implementation of the unified PAC PPS, a blend of the unified PAC PPS and setting-specific relative weights would begin to shift payments across conditions.

**TABLE
7-2**

Blending current PPS and PAC PPS relative weights and base payments for PAC providers before and during the transition to a unified prospective payment system

Year	Relative weights		Base payments	
	Current PPS (Setting specific)	Unified PAC PPS	Current PPS (Setting specific)	Unified PAC PPS
2019	67%	33%	100%	0%
2020	33	67	100	0
2021	0	100	67	33
2022	0	100	33	67
2023	0	100	0	100

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

Source: MedPAC analysis.

Per the Commission’s recommendation, the unifying of payments *across* settings would not begin until 2021, with the start of a three-year transition to a PAC PPS. At that point, payments begin to be redistributed across settings using a blend of the setting-specific base payment and the unified PAC PPS base payment.

Before the unified PAC PPS is fully implemented, CMS could use a blend of the unified PAC PPS *relative weights* and setting-specific *relative weights* to calculate payments, while keeping total payments to each setting at the recommended level (Table 7-2). Over time, the blend would shift from having the setting-specific relative weights “count more” than the unified PAC PPS relative weights in 2019 to having the relative weights of the unified PAC PPS count more in 2020. But within each setting, aggregate payments would remain at the recommended level. CMS would apply a budget-neutrality factor to keep payments within a setting at the recommended level, which would prevent payments from shifting between the settings before the PAC PPS is implemented. Starting in 2021, the relative weights would be based entirely on the unified PAC PPS weights and the three-year transition to the unified PAC PPS would begin using the new system’s base rates.

During the transition to a fully implemented PAC PPS (2021 to 2023), the base payment would be a blend of the setting-specific *base rate* and the unified PAC PPS *base rate* (and using the unified PAC PPS relative weights). In the early years, each setting’s base rate would count more and the unified PAC PPS base rates would count less. In the later years, the unified PAC PPS base rates would count more until they are used exclusively to pay PAC providers. For example, in the first year of the transition, the payment for a stay treated in an IRF would be a blend of the IRF base rate times the unified PAC PPS relative weight and the PAC PPS base rate times the unified PAC PPS relative weight. Using the PAC PPS base rate to establish payments would result in the redistributions *across* settings, with larger shifts occurring as the “weight” of the PAC PPS base rate increases until it is used exclusively to establish payments in each PAC setting.

We estimated the effects of blended relative weights for the years before the implementation of the unified PAC PPS (2019 and 2020) using a 67:33 blend of current setting-specific relative weights and unified PAC PPS relative weights in 2019 and a 33:67 blend in 2020, while keeping payments at the current level of spending. We did not model any provider responses to the proposed changes.

Within each setting, aggregate payments remain the same, but payments would be redistributed considerably across patient conditions. The broad effects on different conditions would be similar across the four settings and illustrate the findings previously reported (Medicare Payment Advisory Commission 2017a, Medicare Payment Advisory Commission 2016a). Payments within each setting would increase for patients who are medically complex, including those who are chronically critically ill; patients with the highest level of severity; patients with comorbidities that involve multiple body systems; and patients who require severe wound care or ventilator care. For conditions that typically involve the provision of therapy services unrelated to a patient’s condition, payments would decrease for the majority of stays. The redistribution in payments is likely to make providers less reluctant to admit medically complex patients, thereby increasing those beneficiaries’ access to PAC.

For each PAC setting, the magnitude of the effects by condition would vary because the new system’s relative weights are based on the average cost of stays across the four settings, and these differ from each setting’s relative weights. In addition, the volume of a condition can be low for an individual PAC setting, so the effects for a particular condition will be driven by the costs of the stays in the other PAC settings. Further, the incentives of the current PPSs and the provider behavior they have encouraged differ by setting. Thus, for example, the effects for conditions that may involve the overprovision of therapy services are likely to vary by setting. In contrast, the effects are far more uniform for medically complex conditions.

The effects of redistributed payments on providers within a setting are relevant to the update discussion. Across providers, average payments would be redistributed based on the mix of patients a provider treats, how a provider’s costs compare with the average, and whether the provider typically furnishes rehabilitation therapy that is unrelated to their patients’ conditions (and not based on the provider’s characteristics, *per se*). Across each setting’s providers, the effects would be consistent by ownership (for profit vs. nonprofit) and type (hospital based vs. freestanding). Average payments would increase for nonprofit providers and hospital-based providers and decrease for for-profit facilities and freestanding providers (Table 7-3, p. 196). To be clear, these changes in payments reflect the mix of patients treated by these providers and their therapy practices, not the provider characteristics themselves. The redistributions would have the effect of

**TABLE
7-3**

Estimated change in payments in 2019 and 2020 using a blend of unified PAC PPS and current (setting-specific) relative weights

Reporting category	Share of facilities	Percent change from 2017 payments			
		HHA (69% of stays)	SNF (26% of stays)	IRF (4% of stays)	LTCH (2% of stays)
2019 (67% setting-specific relative weights : 33% unified PAC PPS relative weights)					
All stays	100%	0%	0%	0%	0%
For profit	75	-0.7	-1.6	-0.9	-0.4
Nonprofit	25	2.3	6.0	0.9	2.1
Hospital based	11	4.1	28.0	1.0	N/A
Freestanding	89	-0.4	-1.0	-1.1	N/A
Urban	84	-0.4	0.0	0.2	0.1
Rural	16	2.0	-0.1	-2.1	-1.8
2020 (33% setting-specific relative weights : 67% unified PAC PPS relative weights)					
All stays	100%	0%	0%	0%	0%
For profit	75	-1.4	-3.2	-1.9	-0.8
Nonprofit	25	4.7	11.8	2.0	4.4
Hospital based	11	8.2	55	2.1	N/A
Freestanding	89	-0.8	-2.0	-2.3	N/A
Urban	84	-0.7	0.0	0.4	0.2
Rural	16	4.0	-0.2	-4.4	-3.8

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), N/A (not applicable). All LTCHs are considered freestanding. The analysis does not consider any provider responses to the proposed policy.

Source: MedPAC analysis based on impacts of a unified PAC PPS estimated by the Urban Institute for MedPAC (Wissoker 2017).

raising payments to low-margin providers and lowering payments to high-margin providers.

Blending the unified PAC PPS and setting-specific relative weights has three benefits. First, it would start to correct the inequities of the current PPSs, which create financial incentives for providers to favor treating certain conditions over others because the relative profitability of different conditions would narrow. Second, it would give providers even more time to adjust their practices to payments based on patient characteristics rather than the amount of rehabilitation services furnished or coding practices. Providers would have a financial incentive to change their therapy practices and align their costs with the blended payment even sooner than the full implementation of the unified PAC PPS because the changes encouraged by

blended payments would be consistent with those that will be required to be successful under the new payment system. During the blending period, providers and CMS could learn important lessons applicable to the unified PAC PPS's implementation. Last, because payments would be redistributed across conditions and the providers that treat them, policymakers would be less constrained in reducing payments to a level more closely aligned with the costs of care.

One way to accomplish the blending of the relative weights (in 2019 and 2020) would be for CMS to calculate the payment for each stay two ways—under the current setting-specific PPS, using those relative weights, and under the unified PAC PPS, using that design's relative weights—and blend the two, using a mix of the two that

Design of a PAC PPS and the development of PAC PPS relative weights

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 required the Commission to use data from CMS's Post-Acute Care Payment Reform Demonstration (PAC-PRD) to evaluate and recommend features of a unified PAC prospective payment system (PPS) and to estimate the impacts of moving from setting-specific PPSs to a unified payment system (see MedPAC's June 2016 report to the Congress, available at <http://medpac.gov/docs/default-source/reports/chapter-3-mandated-report-developing-a-unified-payment-system-for-post-acute-care-june-2016-report-.pdf?sfvrsn=0>). Because participation in the PAC-PRD was voluntary and its sample of providers and stays was small and not representative, the Commission took a two-part approach to complete this work. First, we tested the feasibility of basing payments for stays (defined as a stay for patients treated in skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals and as a home health episode for care furnished by home health agencies) on patient and stay characteristics using the PAC-PRD data. Payments would be based on the predicted costs of stays. The factors used to predict the actual cost of stays included beneficiary characteristics (e.g., age, disability); the primary reason for treatment; comorbidities; cognitive status; patient impairments (e.g., difficulty swallowing, bowel incontinence); measures of patient severity; and

the use of special treatments (e.g., ventilator care). The actual costs of stays were estimated using Medicare cost reports and claims data and include all Medicare-allowed costs, using patient and stay characteristics.

The models accurately predicted the actual cost of stays for most of the many patient groups we examined. Models using only readily available administrative data were almost as accurate as models that used the unique data collected by the PAC-PRD. The Commission concluded that a PAC PPS design for a uniform unit of service (a stay) and using a common set of case-mix adjusters was feasible and administrative data could be used to establish accurate payments.

The second phase of the work estimated the impacts of moving to a PAC PPS. To complete this work, we used 8.9 million stays (including those for beneficiaries admitted from the community) for home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals in 2013, the most recent year of data when the work was undertaken. The models predicting the actual cost of stays in 2013 were refined and re-estimated using routinely and uniformly collected information across the four settings. The factors used to predict the costs and their relative importance (the coefficients) were

(continued next page)

changes over time. In the early years of the blending, the current payments would have less weight each year, and the "new" payments would have more weight until the new payments made up 100 percent of the payment. For example, in a two-year transition, the setting-specific weights (and payment) could make up two-thirds of the payment for a stay in the first year and one-third of the payment in the second year. Since payments to LTCHs, HHAs, and IRFs are based on a discharge or episode, implementing this change would be relatively straightforward. Because the SNF payments are required to be per diem, the Secretary would need to convert the stay-based unified PAC PPS payment to a per diem payment.

The blending of payments under the current and "new" set of relative weights (and running parallel payment systems) is common practice when changes to a PPS are phased in. The statutory language for each setting's PPS varies in specificity and the latitude the Secretary has regarding case-mix adjusters. To circumnavigate any ambiguities regarding this authority, the Commission's recommendation is directed to the Congress. That said, the Commission acknowledges that CMS may require additional resources to implement this approach. However, it is important to maintain momentum toward a unified PAC PPS to improve equity of payment and access for medically complex beneficiaries. Blending relative

Design of a PAC PPS and the development of PAC PPS relative weights (cont.)

published in 2016 and can be found at <http://medpac.gov/docs/default-source/contractor-reports/designing-a-unified-prospective-payment-system-for-postacute-care.pdf?sfvrsn=0>. These factors could be used to establish the relative weights in a unified PAC PPS. The actual costs of stays were estimated using Medicare cost reports and claims data and include all Medicare-allowed costs, using patient and stay characteristics. The models predicting the costs of 2013 PAC stays were accurate for most of the more than 40 patient groups we examined.

The following year, the Commission conducted additional work to consider a time frame for implementing a unified PAC PPS, a transition to the new payment system, and the level of payments. For

this research, the actual costs and payments for the same 8.9 million PAC stays from 2013 were updated to reflect changes in costs and payments between 2013 to 2017 (see MedPAC's June 2017 Report to the Congress (available at http://medpac.gov/docs/default-source/contractor-reports/jun17_transitionpacpps_contractor.pdf?sfvrsn=0) and the supporting contractor report by researchers at the Urban Institute (available at http://medpac.gov/docs/default-source/reports/jun17_ch1.pdf?sfvrsn=0)). Based on this investigation, the Commission recommended that a PAC PPS be implemented sooner than contemplated in the IMPACT Act, include a three-year transition, and lower the aggregate level of PAC payments by 5 percent. ■

weights would begin the process of rebalancing payments within the individual PAC settings.

RECOMMENDATION 7

The Congress should direct the Secretary to begin to base Medicare payments to post-acute care (PAC) providers on a blend of each sector's setting-specific relative weights and the unified PAC prospective payment system's relative weights in fiscal year 2019.

RATIONALE 7

This recommendation calls for the Secretary to begin to redistribute payments within each setting by using a blend of the relative weights of a unified PAC PPS and each sector's setting-specific relative weights in 2019. One example of the blending would be to phase in the PAC PPS relative weights over two years (2019 and 2020). In 2021, when the Commission has recommended that the implementation of the PAC PPS begin, the relative weights of the unified PAC PPS would be used entirely to establish payments.

Within each setting, using a blend of the setting-specific relative weights and the unified PAC PPS relative weights would redistribute payments across conditions, with

payments increasing for medically complex stays and decreasing for stays that currently receive rehabilitation therapy that is unrelated to a patient's clinical condition. The blending would begin to correct the known biases of the HHA and SNF payment systems. The redistribution of payments will narrow the differences in relative profitability across patients with different care needs and, based on a provider's mix of stays and therapy practices, redistribute payments across providers. Redistributed payments would encourage providers to begin making the changes needed to be successful under a unified PAC PPS. It would also give providers and CMS valuable experience that would inform the implementation of the PAC PPS. In addition, redistributing payments across different provider types based on the mix of patients they treat would enable policymakers to lower PAC payments to more closely align with the costs of care.

The recommendation to blend the relative weights in no way detracts from the Commission's concurrent recommendations to revise the SNF and HHA PPSs. Since the PAC PPS is on a longer implementation timetable, CMS should continue to improve the accuracy and the equity of the setting-specific payment systems. When CMS implements the revised SNF and HHA PPSs, those

new relative weights would be used in the blending with the PAC PPS weights to establish payments for each setting. Because the directional effects of the PAC PPS and the setting-specific redesigns are the same, revising the SNF and HHA PPSs would complement the implementation of the PAC PPS by beginning to redistribute payments across conditions.

To address the persistently high level of payments, the Commission has setting-specific recommendations to lower payments in the case of HHAs and IRFs and to provide no updates to payment rates for SNFs and long-term care hospitals. The blending recommendation, which redistributes payments *within* a setting, should not interfere with the consideration of the *level* of payments. Across PAC, program payments need to be lowered.

IMPLICATIONS 7

Spending

- Relative to current law, this recommendation would not change program spending.

Beneficiary and provider

- This recommendation would begin to correct the known imbalances of the current PPSs that create incentives for providers to favor treating some beneficiaries over others. Basing payments on a blend of the unified PAC PPS relative weights and setting-specific relative weights would generally raise payments for beneficiaries with medically complex care needs. As a result, access for these beneficiaries should increase.
- Within each PAC setting, in aggregate, the recommendation would reduce the disparities in Medicare financial performance across provider types. Providers would have less incentive to admit certain types of patients and avoid others.
- The impacts on individual providers will vary based on their mix of patients, their relative costs, and their current practice patterns. These shifts reflect the mixes of patients and their practices, not their ownership or provider type per se. The recommendation would not eliminate all of the differences in Medicare margins across providers because providers' costs vary widely. ■

Endnotes

- 1 Payments to HHAs would be adjusted to reflect the considerably lower costs of this setting.

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