Implementing a unified payment system for post-acute care

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MEDPAC

Comparison of current policy and PAC PPS

- Current policy:
  - Four separate, setting-specific payment systems
  - Different payments for similar patients
  - HHA and SNF PPSs favor treating certain some types of stays over others
- A PAC PPS would:
  - Use a uniform PPS in the four PAC settings
  - Base payments on patient characteristics
  - Dampen incentives to treat some types of cases over others

Timetable for a PAC PPS considered in the IMPACT Act of 2014

- MedPAC report June 2016
  - Recommend features of a PAC PPS and estimate impacts
- Collection of uniform patient assessment information beginning October 2018
- Subsequent reports:
  - Secretary recommends PPS to the Congress using 2 years' assessment data (2022)
  - MedPAC report on a prototype design (2023)
- On this timetable, it is unlikely PAC PPS would be proposed before 2024

MedPAC's key conclusions and design features of a PAC PPS in June 2016 report

Conclusion:

- PAC PPS was feasible and could be implemented sooner than current timetable

Design features:

- Common unit of service (stay or HHA episode)
- Common risk adjustment method
- Two payments for each stay (routine + therapy, NTA)
- Adjustment for home health episodes
- Short-stay and high-cost outlier policies
- Uniform application of payment adjusters

Review: Impacts of a PAC PPS on payments

- Increases the equity of payments across stays
  - Average payments would increase: medical stays and medically complex stays
  - Average payments would decrease: stays with services unrelated to patient condition and stays treated in high-cost settings and high-cost providers
- Dampens the incentive to selectively admit certain types of patients
- The average payment would be well above the average cost of stays

Review: Other topics covered in June 2016 report

- Possible changes to regulatory requirements to “level the playing field” between settings
- Companion policies to adopt concurrently
- Need to monitor provider responses

Implementation issues

- Transition to PAC PPS rates
- Level of aggregate PAC payments
- Periodic refinements to the payment system

Updated analysis to reflect projected 2017 costs and payments

- To evaluate the need for a transition and the level of aggregate payments, we updated our analysis of 8.9 million 2013 PAC stays
- Confirmed:
  - Models accurately predict the average cost of most of 30+ patient groups
  - Equity of payments across groups increases under a PAC PPS
  - Estimated level of payments is high: 14% above costs

Results are preliminary and subject to change.

Evaluate the need for a transition

- Transition would blend setting-specific PPS and PAC PPS rates over multiple years
  - Example: 3 year transition
    - 1st year: 1/3 PAC PPS rate; 2/3 setting-specific rate
    - 2nd year: 2/3 PAC PPS rate; 1/3 setting-specific rate
    - 3rd year: 100% PAC PPS rates
- Delays redistribution but gives providers time to adjust their costs and practices
- Transition would dampen the changes in average payments in early years. Illustration:

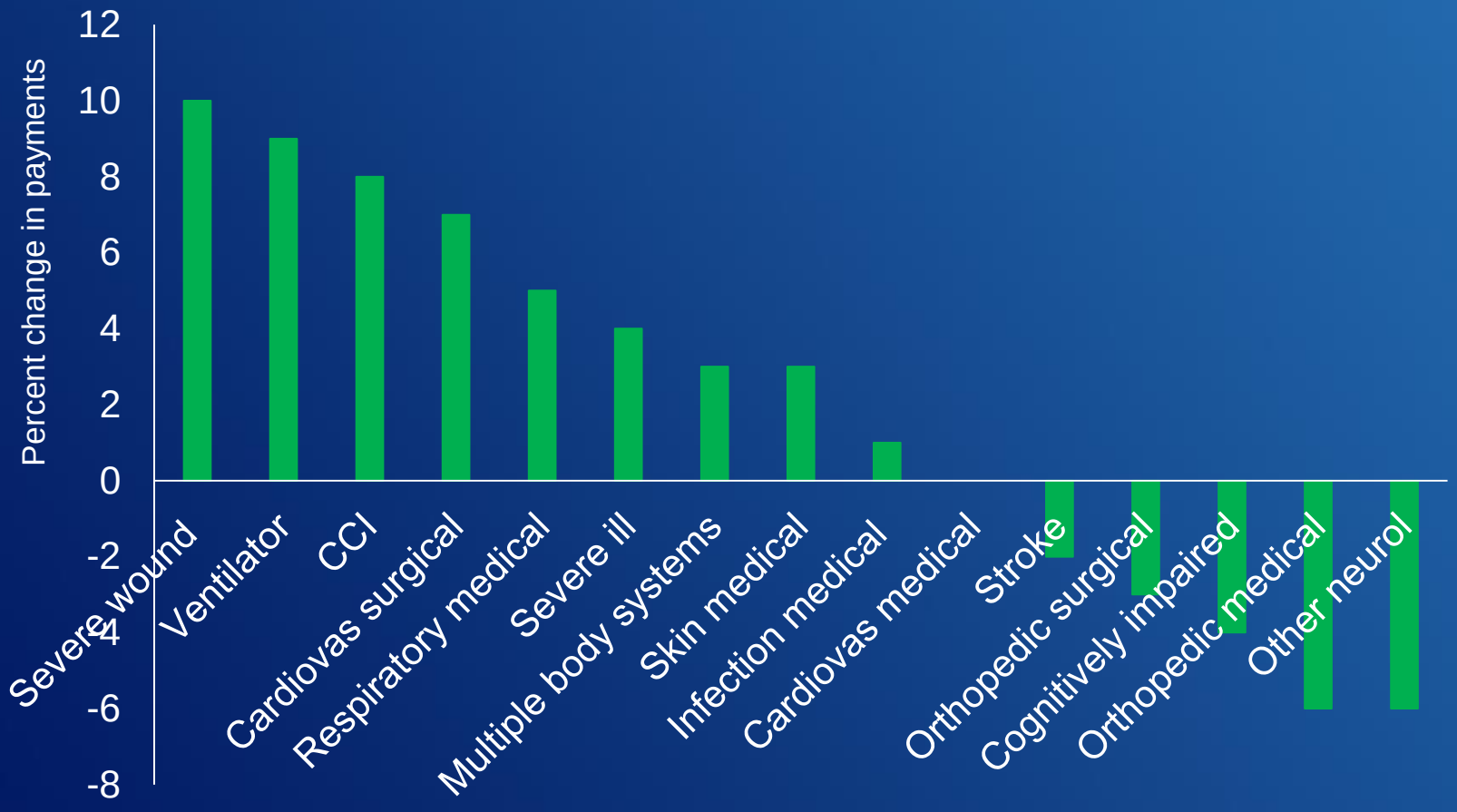
	First year	Fully implemented
Orthopedic medical	-2%	-6%
Severely ill	2%	6%

Results are preliminary and subject to change.

Analyses to help evaluate the need for a transition

- Size of the average impacts across patient groups and the distribution of impacts across stays within each group
- Relationship between changes in payments and relative profitability

Percent change in average payments under fully implemented PAC PPS for select conditions



2013 PAC stays, with payments and costs updated to 2017.
Data are preliminary and subject to change.

Changes in providers' payments are generally inversely related to their current profitability

Change in average payments	
Large increase (> 25%)	• Majority (58%) of providers have below-average PCR
Large decrease (> -25%)	• Over 2/3 have above-average PCR
Relative profitability	
High (> 25% above setting mean)	• Payments would decrease for over 2/3 of providers
Low (> 25% below setting mean)	• Payments would increase for most (88%) providers

Profitability is measured as the ratio of payments to costs (PCR). Results are preliminary and subject to change.

Option to bypass the transition

- Should providers be given the option to move directly to fully implemented PAC PPS rates?
- Providers whose payments will increase would be more likely to elect this option
- In early years of a transition, this will raise aggregate spending

Options for establishing the level of total PAC PPS payments

- Estimated current (2017) ratio of payments to costs = 1.14
- Implementation of a PAC PPS does not have to be budget neutral
- As part of the transition, could establish a level of payments that is lower than current spending

Examples of the impact of lowering payments on payment-to-cost ratios

- 2% reduction: payment-to-cost ratio=1.12
- 4% reduction: payment-to-cost ratio=1.10
- Even with a 4% reduction in payments, payments would remain higher than costs for all of the clinical and patient severity groups

Results are preliminary and subject to change.

Periodic refinements to the PAC PPS and rebase payments as needed

- In response to payment changes, practice patterns and costs may change
- Refinements of the PPS include
  - Revising the case-mix groups and their relative weights
  - Rebasing payments if the costs of care change
- The Secretary will need the authority to refine and rebase payments

Discussion topics

- Need for a transition
- Level of payments
- Secretary needs the authority to refine PAC PPS and rebase payments