Implementing a unified payment system for post-acute care

Carol Carter
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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’s report using 2 years’ assessment data (2022)
  - MedPAC report on a prototype design (2023)
- Unlikely that a PAC PPS would be proposed before 2024 for implementation sometime after that
- The IMPACT Act does not require implementation of a PAC PPS
Why implement a unified PAC PPS?

- Creates a uniform payment system for similar patients treated in any PAC setting
- Bases payments on patient characteristics, not where patients are treated
- Eliminates biases in the current HHA and SNF PPSs that favor treating some conditions over others
MedPAC’s key conclusions and design features of a PAC PPS in June 2016 report

Conclusions:
- PAC PPS was feasible and could be implemented sooner than outlined in IMPACT Act
- Include functional assessment data into the risk adjustment when these data become available
- Begin to align regulatory requirements

Design features:
- Common unit of service and risk adjustment method
- Adjust payments for home health episodes
- Include short-stay and high-cost outlier policies
Implementation issues

- Transition to PAC PPS
- Level of aggregate PAC payments
- The need to make periodic refinements to the PPS
Likely impacts of a PAC PPS

- Updated the costs and payments for 2013 PAC stays to 2017
- Estimated average payment per stay is 14% higher than the average cost
- Confirmed our estimated impacts:
  - Payments would be redistributed across stays
    - From stays with high amounts of therapy unrelated to a patient’s condition to medical stays
  - Equity of payments would increase
    - Smaller disparities in relative profitability across different types of stays
Transition to a PAC PPS

- Blends setting-specific PPS and PAC PPS rates over multiple years
- Dampens the changes in average payments during the phase-in period
  - Delays redistribution and extends the current inequities in SNF and HHA PPSs
  - Gives providers time to adjust their costs and practices
- Size and variation in the changes in payments suggest the need for a transition
- Transition could be relatively short
  - Providers whose payments would be lowered are more likely to have above-average profits, and vice versa

Results are preliminary and subject to change.
Option to bypass the transition and move directly to PAC PPS payments

- Providers whose payments will increase under a PAC PPS are likely to elect this option
- Differing opinions about a transition
  - Pro: Quicker shift to payments that reflect patient characteristics; more equitable payments across stays
  - Con: Raise total spending during transition
- Could lower level of spending to counter this increase
Level of aggregate PAC PPS payments

- Average PAC payment estimated to be 14% higher than the average cost of care
- Consistent with previous MedPAC recommendations, the level of payments should be lowered
- Modeled reductions of 2 to 5%
- Average payments would be 9-12% higher than the average cost of stays
Even with a 5% reduction to payments, the average payment would remain higher than the average cost of stays

<table>
<thead>
<tr>
<th>Clinical group</th>
<th>2% reduction</th>
<th>5% reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>All stays</td>
<td>1.12</td>
<td>1.09</td>
</tr>
<tr>
<td>Cardiovascular medical</td>
<td>1.13</td>
<td>1.09</td>
</tr>
<tr>
<td>Orthopedic medical</td>
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<td>1.09</td>
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<tr>
<td>Orthopedic surgical</td>
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<td>1.08</td>
</tr>
<tr>
<td>Respiratory medical</td>
<td>1.12</td>
<td>1.09</td>
</tr>
<tr>
<td>Other neurology medical</td>
<td>1.13</td>
<td>1.10</td>
</tr>
<tr>
<td>Serious mental illness</td>
<td>1.12</td>
<td>1.09</td>
</tr>
<tr>
<td>Severe wounds</td>
<td>1.13</td>
<td>1.09</td>
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<tr>
<td>Multiple body systems</td>
<td>1.12</td>
<td>1.08</td>
</tr>
<tr>
<td>Chronically critically ill</td>
<td>1.12</td>
<td>1.08</td>
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</tbody>
</table>

Results are preliminary and subject to change.
Periodic refinements to the PAC PPS and rebase payments

- As with prior payment policy changes, providers will change their costs, patient mix, and practice patterns to maintain or increase their profitability

- Refinements to the PPS:
  - Revise the relative payments across stays
  - Rebase payments if the costs of care change

- Periodic refinements are part of the ongoing maintenance of any PPS
Conclusions

- A PAC PPS could be implemented as soon as 2021
- Functional assessment data should be incorporated into the risk-adjustment method when it becomes available
- The implementation should include a short transition
- The level of PAC spending should be lowered
- Concurrently, the Secretary will need to begin to align setting-specific regulatory requirements
- The Secretary will need the authority to revise and rebase payments