



Advising the Congress on Medicare issues

Mandated report: Developing a unified payment system for post-acute care

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Objectives of a PAC PPS

- Current policy:
 - 4 separate, setting-specific payment systems
 - Different payments for similar patients
 - SNF and HHA PPSs encourage therapy unrelated to patient care needs
- A unified PAC PPS would
 - Span the 4 settings
 - Correct some shortcomings of the PPSs
 - Base payments on patient characteristics

Previous sessions on the PAC PPS

- In September
 - Approach to the mandate
 - Results modeling stays in CMS's PAC demonstration
- In November
 - Possible complementary policies to counter volume incentives
 - Readmission policy, value-based purchasing, third-party PAC benefit manager
 - Waive certain setting-specific regulations and move toward a common set of conditions of participation

Today and future sessions

- Today's meeting
 - Results of analysis of PAC stays in 2013
 - Consider need for certain payment adjusters
 - Estimate impacts on payments
- March discussion topics
 - Payment adjuster for low-volume, isolated providers
 - High-cost outlier policy
 - Level of payments
- April
 - Finalize report

Overview of mandate and approach

Mandate

Methodology

Purpose

1.

Evaluate and recommend features of a PAC PPS using data from the PAC-PRD

“Full” model (**model 1**) uses data from PAC-PRD sample to predict the relative costs of PAC-PRD stays

Use unique data in the PAC-PRD to test feasibility of PAC PPS

2.

Consider the impact of implementing a unified PAC PPS

- “Administrative” model (**model 2**) predicts relative costs of PAC-PRD stays
- Compare the accuracy of models using same stays
- If equally accurate, use “administrative” model to estimate impacts with all 2013 PAC stays (**model 3**)

- Assess the accuracy of administrative model (without the unique data) that could be used on a large sample of stays
- Estimate impacts using a large sample of stays

Comparison of the models used to evaluate a PAC PPS and estimate impacts

| Factors included in models | Full model (1) | Administrative model (2) | Administrative model (3) |
|----------------------------|----------------------|--------------------------|--------------------------|
| Patient age | X | X | X |
| Diagnoses | X | X | X |
| Impairments | X | Proxies | Proxies |
| Functional status | X | No | No |
| Cognitive status | X | Proxies | Proxies |
| Routine costs | X | X | Estimated |
| Analytic sample | PAC-PRD stays | | 2013 stays |
| PAC stays | 6,409 | 6,409 | 8.9 million |
| PAC providers | 107 | 107 | 24,953 |

Patient groups examined to evaluate the model results

Clinical groups

- Based on MS-DRG

Impairment and severity

- Functional status
- Cognitively impaired
- Frailty
- Severity
- Chronically critically ill

Other groups:

- High therapy
- Low therapy
- Community-admitted
- Disabled
- Dual-eligible
- Very old
- ESRD

Compared with full model, administrative model can establish accurate relative costs of stays

- Using the same PAC-PRD stays, the full and administrative models:
 - Predicted very similar relative costs of stays for most groups
 - Explained similar shares of the variation in costs across stays (60% vs 57%)
- Conclusions: Administrative data can be used to:
 - Establish accurate relative weights for most groups
 - Estimate impacts of PAC-PPS using 2013 stays

2013 PAC stays: Administrative model would establish accurate relative weights for most patient groups

- Average predicted costs \approx average actual costs
 - Almost all clinical groups
 - Frailty groups
 - Severely ill group
 - Multiple body system diagnoses group
 - Community admissions
 - Disabled, dual-eligible, ESRD, and very old groups
 - Most rural groups
 - Stays treated in teaching IRFs

Results are preliminary and subject to change.
Source: The Urban Institute analysis of 2013 PAC stays.

Groups where average predicted costs deviate from average actual costs

- Differences that were expected:

- Low therapy share of costs
- High therapy share of costs

Actual costs reflect current therapy practices & PPS incentives

- Stays treated in IRFs
- Stays treated in LTCHs

Similar stays are treated in lower-cost settings

Groups where average predicted costs deviate from average actual costs *continued*

- Differences that may warrant payment adjustment
 - Unusually short stays—*to prevent large overpayments*
 - High-cost outliers—*to protect providers from large losses*
- Differences that may warrant further study
 - Low volume, isolated providers—*to ensure access*
 - Extremely sick patients— *to ensure access*

Estimates of impacts

- Assume budget neutrality
- Do not reflect policy changes since 2013
- Do not assume changes in provider behavior
- Estimates should be considered as directional and relative, not as point estimates

Across stays, a PAC PPS would narrow differences between payments and costs

| Group | Ratio current payments to actual costs | Ratio of PAC PPS payments to actual costs |
|------------------------|--|---|
| All stays | 1.18 | 1.18 |
| Multiple body systems | 1.03 | 1.18 |
| Severely ill (SOI=4) | 1.05 | 1.18 |
| Respiratory medical | 1.08 | 1.20 |
| Severe wound | 1.09 | 1.15 |
| Most frail | 1.14 | 1.18 |
| Cardiovascular medical | 1.19 | 1.19 |
| Orthopedic surgical | 1.24 | 1.19 |
| Orthopedic medical | 1.28 | 1.20 |

A PAC PPS is estimated to shift payments across stays

Payment increases:

- Ventilator care
- Severe wound care
- Hematology
- Respiratory medical
- Chronically critically ill
- Multiple body system diagnoses
- Low therapy
- ESRD

Payment decreases:

- Neurology medical (non-stroke)
- Orthopedic
- Least frail
- High therapy
- Community admits

Results assume budget neutrality. Results are preliminary and subject to change. Source: The Urban Institute analysis of 2013 PAC stays.

Estimated changes in payments by provider type and setting

Payment increases:

- SNFs
- Hospital-based
- Nonprofit

Why?

- *Payments reflect patient characteristics, medically complex care*

Payment decreases:

- IRFs and LTCHs
- Freestanding
- For-profit

Why?

- *Payments decrease for stays with therapy services unrelated to patient characteristics*
- *Many types of stays treated in higher-cost settings are also treated in lower-cost settings*

Summary of estimated impacts of a PAC PPS

- Shift payments from rehabilitation care to medical care
- Narrow the profitability by type of case
- Decrease the incentive to selectively admit certain types of patients
- Raise payments to providers that treat medically complex patients
- Lower payments to providers whose costs and service mix are unrelated to care needs

Impacts on an individual provider will reflect many factors

- Mix of patients treated
- The setting's current PPS design and incentives
- Provider's practice patterns
 - Services provided that are unrelated to a patient's care needs
- Ability to reduce costs to match payments

Conclusions

- A PAC PPS is feasible and would break down the silos between settings
- Payments would be based on patient characteristics, not the setting
 - Correct some of the shortcomings of current PPSs
- A unified PPS would:
 - Dampen incentives to selectively admit some types of patients over others

Implications of our findings for the design of a unified PAC PPS

- Administrative data could form the basis of a PAC PPS
 - Functional assessment data are needed to calibrate payments for certain types of patients
- Payments for stays in HHAs will need to be aligned with this setting's lower costs
- Payment adjusters
 - Short-stay policy is likely to be needed
 - A broad rural adjustment and an IRF teaching adjustment did not appear to be needed, but low-volume isolated providers may need protection

Implications of our findings for the design of a PAC PPS *continued*

- A high-cost outlier policy will help ensure beneficiary access to care and protect providers from large losses
- A transition will give providers time to adjust their costs and protect beneficiary access
- Risk-adjustment factors can be refined over time
- Relative weights should be recalibrated regularly
- Need to consider the level of payments

Discussion topics

- Questions
- Comments