

# Implementing a unified payment system for post-acute care

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# Comparison of current policy and PAC PPS

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- 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

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- 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

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## 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

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- 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

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

# Implementation issues

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- 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

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- 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



# Evaluate the need for a transition

- Transition would blend setting-specific PPS and PAC PPS rates over multiple years
  - Example: 3 year transition
    - 1<sup>st</sup> year: 1/3 PAC PPS rate; 2/3 setting-specific rate
    - 2<sup>nd</sup> year: 2/3 PAC PPS rate; 1/3 setting-specific rate
    - 3<sup>rd</sup> 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:

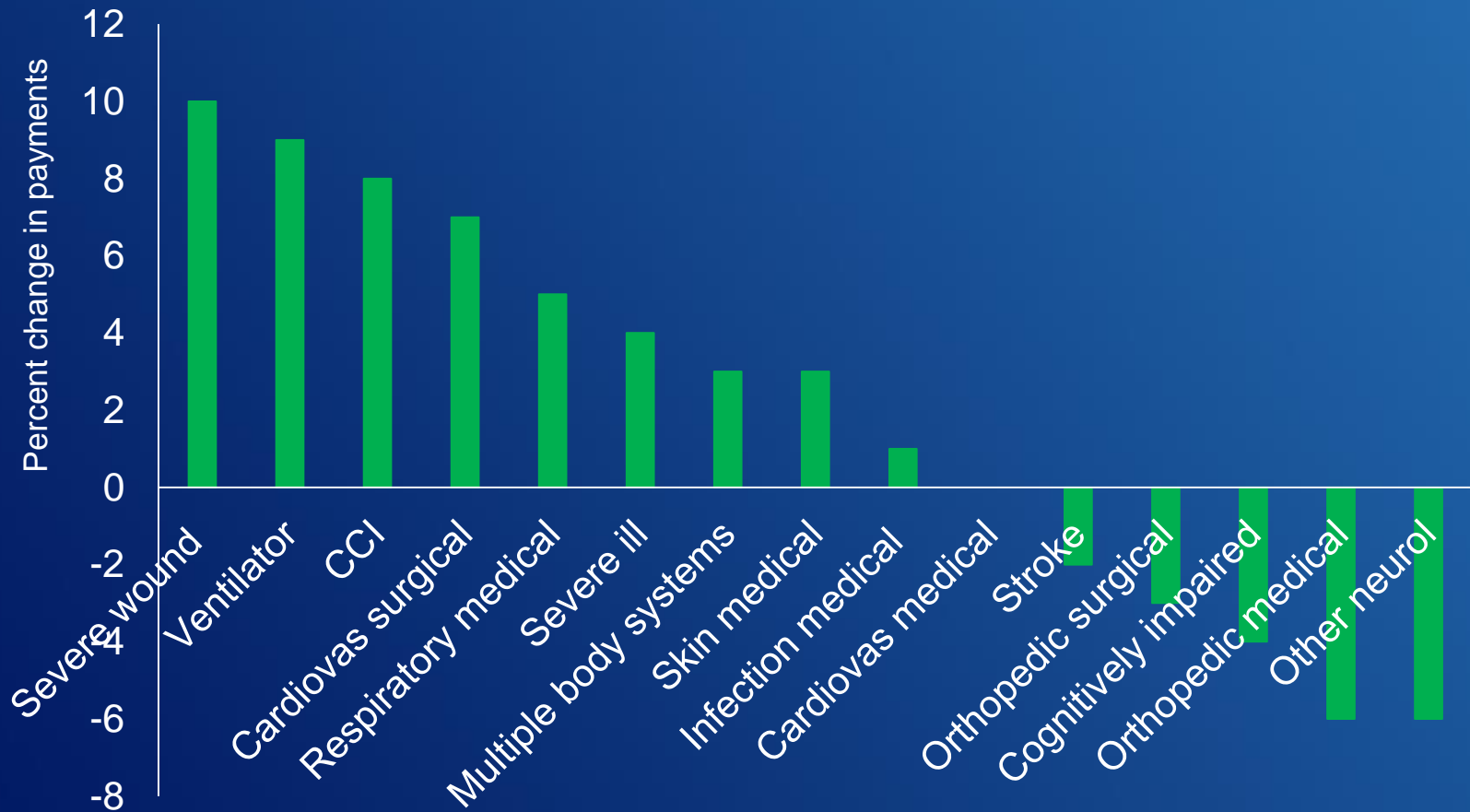
	<u>First year</u>	<u>Fully implemented</u>
Orthopedic medical	-2%	-6%
Severely ill	2%	6%

# Analyses to help evaluate the need for a transition

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- 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

<u>Change in average payments</u>	
Large increase (> 25%)	<ul style="list-style-type: none"><li>Majority (58%) of providers have below-average PCR</li></ul>
Large decrease (> -25%)	<ul style="list-style-type: none"><li>Over 2/3 have above-average PCR</li></ul>
<u>Relative profitability</u>	
High (> 25% above setting mean)	<ul style="list-style-type: none"><li>Payments would decrease for over 2/3 of providers</li></ul>
Low (> 25% below setting mean)	<ul style="list-style-type: none"><li>Payments would increase for most (88%) providers</li></ul>

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

# Option to bypass the transition

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- 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

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- 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

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- 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

# Periodic refinements to the PAC PPS and rebase payments as needed

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- 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

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