

MEMORANDUM

To: ACRM

From: Peter Thomas & Megan La Suer

Date: April 30, 2019

Re: Update: MedPAC Episode-Based Payment Model for Post-Acute Care

At the last Medicare Payment Advisory Commission (MedPAC) meeting in March, the Commission continued the discussion of implementing a unified payment system for post-acute care (PAC) using an episode-based payment model. MedPAC, the independent legislative branch agency that provides Congress with analysis and policy advice on the Medicare program, began discussing the possibility of a unified payment system for PAC in 2015, and published a mandated report in June of 2016 analyzing the effects of moving to a “stay”-based payment model. In 2017, MedPAC sought to improve the stay-based payment model and began to develop and analyze the viability of an episode-based payment model.

This memorandum is based on an analysis of the MedPAC transcript of the discussion they had in the March meeting. It presents an overview of the stay-based and episode-based models. It also includes recommendations presented by MedPAC for transitioning to a PAC unified payment system. The important take-away of this debate is that MedPAC Commissioners appear to be taking a pause in their deliberation of designing a unified PAC payment system. They will publish a chapter on their work on this issue in the June, 2019 MedPAC report, but it appears that designing a unified, equitable, and appropriate PAC payment system is a bit more challenging than they may have expected.

Current Post-Acute Care Landscape

Medicare pays for post-acute care services—including inpatient rehabilitation hospitals and units, skilled nursing facilities, long-term acute care hospitals, and home health agencies—using separate prospective payment systems for each setting. MedPAC believes these payment “silos” lead to inefficiency in the provision of post-acute care. Currently, there are significant variations in the services covered and incentives in those payment systems, and significant variation in the supply and use of PAC providers across the country. Medicare spending per capita varies more for PAC than for other Medicare services and Medicare fee-for-service payments totaled \$60 billion in 2017, according to MedPAC.

Stay-Based PAC Payment Model

As mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT), MedPAC issued a [report](#) in June 2016 on a potential design for a unified payment system for PAC. The report examined the possibility of implementing a stay-based payment model across all four PAC settings. Under this model, payments are based on the average cost of stays and are risk-adjusted based on patient characteristics, such as age or comorbidities. The model also included a home health

modifier to account for the lower cost of care for these services. MedPAC found that payments under a stay-based PAC unified system would be redistributed across providers based on the mix of patients they treat, decreasing payments for providers in high-cost settings who are treating patients that could be treated in lower-cost settings. Furthermore, the stay-based model would not significantly reduce fee-for-service incentives for volume, MedPAC found, nor would it encourage providers to offer a continuum of care that would reduce patient transitions from one PAC setting to another.

Episode-Based PAC Payment Model

In 2017, MedPAC began looking at an episode-based PAC model where a single payment would be made for the combination of stays that make up the patients' entire episode of care. By basing payment on the entire episode of care, patients would benefit by hopefully reducing the number of transitions the patient may experience over the course of their PAC stay. The stay-based model was also updated by using 2017 data to reflect current costs and utilization. The features of the episode-based model are similar to the stay-based model and include:

- Home health care adjusters to reflect the lower cost of care in that setting;
- Separate models to establish payments for routine care, therapy care, and non-therapy ancillary services;
- Payments were budget neutral to 2017 payments; and
- Routine cost estimates were based on readily available cost reports and claims information, no longer relying on data from CMS's post-acute-care demonstration.

Episodes were constructed from individual PAC stays that were within seven days of each other. The design initially focused on solo stays and pairs of stays, which comprise over two-thirds of PAC stays. Similar to the stay-based model, the episodic model factored in the difference in the cost of treating a variety of patients by adjusting payments based on patient characteristics. The patient characteristics that MedPAC focused on include: age and disability, primary reason for treatment, patient comorbidities, medical complexity, cognitive status, and other disabilities such as severe wounds, bowel incontinence, or difficulty swallowing.

Key Findings

- Redistribution of Costs

When compared to the current payment policy, MedPAC found that episode-based payments would be more accurate and equitable for patient groups. The episode-based approach would redistribute the payments from episodes of rehabilitative care that are high-cost and potentially unnecessary, to episodes that are more medically complex. As payments are redistributed and profitability is reduced for certain episodes, providers would have less financial incentive to selectively admit patients for unnecessary PAC episodes.

- Over-Payments and Under-Payments

When looking at payments and costs for episodes of different lengths, MedPAC found that there would be considerably more overpayments and underpayments under an episode-based model. Such a model would exacerbate the current payment-to-cost ratio because payments would be based on the average

costs across all lengths of episodes (i.e., short, medium, and long). The model resulted in shorter PAC episodes doubling in cost, whereas longer PAC episodes were about three-quarters of their current costs. MedPAC also tested a single outlier pool to account for the differences in cost between home health care and institutional PAC, but concluded that not even this method would correct for the over- and underpayments associated with length of stay.

Implications

When compared to the current fee-for-service payment system, the episode-based model is less likely to result in unnecessary episodes and produces fewer incentives for providers to generate additional PAC volume. However, during the meeting, MedPAC staff and MedPAC Commissioners expressed their concerns about implementing an episode-based model. MedPAC predicted that an episode-based payment design, with such large differences in profitability between short and long episodes, could create incentives for providers to furnish shorter episodes over longer ones. The strong financial incentive to keep PAC episodes short could also potentially lead to premature discharges. This model could also incentivize providers to avoid patients who would need extended care and/or withhold more costly services during that episode, MedPAC concluded.

While both the episode-based and stay-based payment models would unify the four separate payment systems for PAC, MedPAC seemed to favor the stay-based model. Although the stay-based model could increase the number of unnecessary PAC services and result in more transitions between providers, the model presents fewer incentives for cherry-picking patients and withholding costly services as compared to the episode-based model. MedPAC staff indicated that they would revisit the episode-based model in the future; however, they also acknowledged that it would not be feasible to implement such a payment model at this time.

MedPAC staff indicated that the episode-based PAC unified payment model would be addressed in its June Report to Congress.

MedPAC's presentation of the results of the episode-based payment model can be found [here](#).