Evaluating an episode-based payment system for post-acute care

Carol Carter

March 8, 2019

MEDPAC

Current post-acute care (PAC) landscape

- Medicare FFS spending totaled almost $60 billion in 2017
- Many similar patients are treated in four settings (HHA, SNF, IRF, and LTCH)
- Payments can differ substantially, in part because each setting uses its own PPS
- Limited evidence to guide patient placements
- Setting-specific patient assessments and outcome measures that cannot be compared
- FFS payments for PAC are high relative to cost of care, which also distorts MA and ACO benchmarks

Note: Home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), long-term care hospital (LTCH)

Mandated report on the design features of a unified PAC prospective payment system (2016)

- Recommended design features based on 8.9 million PAC stays in 2013
  - Uniform unit of service—a stay
  - Base rate adjusted using patient and stay characteristics
  - Adjust payments for home health episodes
  - Include short-stay and high-cost outlier policies
- Accurate payments would be established for most of the 40+ patient groups we evaluated

PAC PPS: Estimated impacts compared to current policy

- Payments would be redistributed across patient conditions
- Equity of payments across conditions would increase
  - Differences in profitability across conditions would be more uniform
  - Less incentive to selectively admit beneficiaries with certain conditions and avoid others
- Payments would be redistributed across providers based on their patient mix
  - Payments would be based on the average cost across the four settings
  - Payments would decrease for high-cost providers that treat patients similar to those treated in lower-cost settings

Since the mandated report, the Commission has discussed other PAC PPS issues

- Begin to redistribute payments ***within*** each setting prior to implementation by blending PAC PPS and setting-specific payments
- Align regulatory requirements across settings
- Align payments with costs
  - Lower payments by 5%
  - Revise and rebase PPS as needed
- Payments for sequential PAC stays that led to examining an episode-based design

Why consider an episode-based PAC PPS design?

- A stay-based PPS does not dampen the FFS incentives for volume or encourage providers to offer a continuum of care
- An episode-based design encourages providers to deliver an efficient mix of PAC and to offer a continuum of care
  - By lowering the number of transitions between providers, it could improve care coordination for beneficiaries

Stay-based versus episode-based design

Methodology

- Uses the same approach as a stay-based design: establish payments based on patient and stay characteristics
- Updated results using 2017 PAC stays
  - HHA adjuster given the much lower costs of this setting
  - Separate models for routine + therapy services and nontherapy ancillary services (e.g., drugs)
  - PAC PPS payments are budget neutral to 2017 payments
  - Routine costs estimated from cost reports and claims
- Created episodes from PAC stays within 7 days of each other
- Focused on solo and pairs of PAC stays (69% of PAC stays)

Patient characteristics considered in establishing payments

- Age and disability status
- Primary reason for treatment
- Comorbidities and risk score
- Medical complexity (severity of illness, number of different body system diagnoses, ICU + CCU days for those with a prior hospital stay)
- Cognitive status
- Other disabilities—severe wounds, bowel incontinence, difficulty swallowing

Note: Intensive care unit (ICU), coronary care unit (CCU)

Compared with current policy, episode-based payments would be more accurate and equitable for patient groups

Group	Ratio of current payments to actual costs	Ratio of PAC PPS payments to actual costs
All stays	**1.12**	**1.12**
Multiple body systems	1.08	1.14
Severely ill (severity level=4)	1.08	1.13
Respiratory medical	1.10	1.12
Severe wound	1.01	1.13
Most frail	1.09	1.13
Cardiovascular medical	1.12	1.11
Orthopedic surgical	1.12	1.12
Orthopedic medical	1.20	1.11

Payments assume budget neutrality. Episodes include first and second "standard" stays of any episode.
Results are preliminary and subject to change.
Source: The Urban Institute analysis of 2017 PAC stays.

Episode-based payments would result in large under- and over-payments depending on episode length

Group	Ratio of current payments to actual costs	Ratio of PAC PPS payments to actual costs
All stays	**1.12**	**1.12**
Episodes with only home health care	1.21	1.12
Short	1.80	2.48
Medium	1.30	1.28
Long	1.03	0.72
Episodes with only institutional PAC	1.09	1.12
Short	1.01	2.07
Medium	1.05	1.32
Long	1.14	0.76

Payments assume budget neutrality. Episodes include first and second “standard” stays of any episode. Payments assume budget neutrality. Results are preliminary and subject to change.
Source: The Urban Institute analysis of 2017 PAC stays.

A single outlier policy would not correct under- and over-payments

- Compared to separate outlier pools, under a single outlier policy:
  - Fewer home health episodes, even long ones, would qualify for outlier payments
  - More I-PAC episodes, especially long ones, would qualify
- Payment accuracy would improve but over- and under-payments would remain

	Short episodes	Long episodes
Home health only episodes	2.48	0.72
I-PAC only episodes	2.07	0.82

* Separate 5% pools for home health-only episodes, episodes with only I-PAC, and episodes with a mix were compared to a single 5% pool.
Note: Institutional PAC (I-PAC). Episodes include first and second "standard" stays of any episode.
Payments assume budget neutrality. Results are preliminary and subject to change.
Source: The Urban Institute analysis of 2017 PAC stays.

If past behavior is any guide, profitability could shape provider responses to episode-based payment

Per episode profitability of the average-risk patient		
	Home health only episodes	I-PAC only episodes
All episodes	$473	$2,129
Short	2,315	11,644
Long	-2,015	-11,452

Provider would have an incentive to:

- Keep episodes short
- Avoid patients likely to need extended care
- Withhold costly care within the episode
- Decide to transfer or continue to treat based on financial considerations

Results are preliminary and subject to change.
Source: The Urban Institute analysis of 2017 PAC stays.

Comparison of stay- and episode-based design

Aspect	Stay-based design	Episode-based design
Payment accuracy	• Accurate for most patient groups	• Accurate for most patient groups; less accurate for short or long episodes
Patient selection	• Less likely	• More likely
Stinting on care	• Less likely	• More likely
Unnecessary volume	• More likely	• Less likely
Care coordination	• More handoffs	• Fewer handoffs
Implementation and administration	• Easier	• More complicated

Conclusions

- Current policy results in inaccurate and inequitable payments
- Commission evaluated stay-based and episode-based designs
  - Compared with current policy, both designs would establish more accurate and equitable payments, but each has strengths and weaknesses
- Stay-based design would extend undesirable FFS incentives but less likely to result in patient selection and stinting
- Episode-based design has features that are attractive in theory but could result in unintended adverse consequences (e.g., patient selection, withholding of care, basing decisions to transfer or extend care on financial considerations)

Discussion question

- Should CMS pursue a stay-based design or an episode-based design?