MEMORANDUM

To: ATRA

From: Peter Thomas and Leif Brierley

Date: October 12, 2018

Re: Summary of MedPAC Meeting: Episode-Based Payments and Outcome Measures under a Unified Payment System for Post-Acute Care

On October 5, 2018, the Medicare Payment Advisory Commission (MedPAC), an independent legislative branch agency that provides Congress with analysis and policy advice on the Medicare program, held a meeting that included a session titled Episode-Based Payments and Outcome Measures under a Unified Payment System for Post-Acute Care. MedPAC staffers Carol Carter and Ledia Tabor presented on this topic using the associated slide deck, which can be found here.

The presentation provided an overview of an episode-based unified post-acute care (PAC) prospective payment system (PPS) and two uniform outcome measures that MedPAC is considering adopting. The presentation set the stage for a future presentation, slated for spring 2019, on the results of MedPAC’s modeling of an episode-based PAC PPS system and the two outcome measures that would be applied across all four PAC settings. The Commissioners offered questions and feedback on the presentation and staff’s thinking on these design elements of a future uniform PAC PPS.

Overview of the Presentation

MedPAC staff used the presentation to provide historical context of MedPAC’s work on a uniform PAC PPS and the related elements of such a system. Throughout the first several slides of the presentation, MedPAC staff summarized the PAC landscape and the previous recommendations made by the Commission on PAC, and highlighted several estimated impacts and implementation issues that could occur upon implementation of a uniform PAC PPS. These slides set the stage for the next section of the presentation, which provided an overview of MedPAC’s initial thinking on the design of an episode-based PAC PPS.

According to the presentation, MedPAC envisions an episode-based PAC PPS in which providers would be paid for a sequence of PAC stays. The single payment for the episode would, in their view, encourage institutional PAC providers to offer a continuum of care and provide an efficient mix of PAC settings, reduce the number of transitions between settings for beneficiaries, and could help lower program spending and costs to beneficiaries. MedPAC plans to evaluate their episode-based payment model based on 2017 data across individual PAC stays,
creating episodes from stays that are within seven days of each other. MedPAC will compare episode and stay-based payments as part of its evaluation of the model.

Next, MedPAC staff described several new uniform outcome measures they plan on evaluating. The presentation included background on requirements for such uniform outcome measures, including that they evaluate provider performance to allow direct comparison of rates across providers. MedPAC intends for the uniform outcome measures to help tie provider performance to payment under a new uniform PAC PPS. MedPAC staff then walked through several uniform measures that the Commission has considered in previous cycles, including MSPB-PAC (Medicare Spending per Beneficiary), and readmissions measures. Both measures had their own shortcomings which were highlighted in the presentation. MSPB-PAC data varied considerably across providers, and results for small providers lacked accuracy due to small sample sizes, necessitating pooling of data. Readmissions data did not include community admissions or the majority of home health stays, and found wide variation in readmission rates across providers.

To adjust for these differences, MedPAC staff outlined two new uniform outcome measures that they will consider. Those include combined admissions and readmissions rates and a discharge to community measure. The combined admissions and readmissions measure would include LTCHs, as well as observation stays in the definition of hospitalization. The discharge to community measure would seek to capitalize on what MedPAC believes is the primary goal of the majority of PAC patients: return to home and stay at home. The measure would gauge how successfully providers discharge beneficiaries home with no planned readmissions or mortality within 31 days of discharge. MedPAC plans to report back on the development of these measures in the spring of 2019.

Questions from Commissioners
Commissioner Bruce Pyenson asked about the ability for providers in PAC settings to choose low-cost patients in a PAC value-based purchasing (VBP) model. MedPAC staff said that in any PPS, a provider would have incentives to avoid some patients, but that the PAC PPS has been designed to include some indicators to signal patient costs. The answer did not quite match the question.

Commissioner Pyenson followed up and asked if mortality could be used as a uniform quality measure. MedPAC staff said they would defer to the Commission, but that they think mortality is captured in the discharge to community measure they will be exploring.

Commissioner Kathy Buto pointed out that PAC stays can be long enough that there can be differences between two episodes, making them hard to align in an episode. MedPAC staff said they plan to use PAC stays within seven days to try and account for this potential issue.

Vice Chairman Jon Christianson asked about the discharge to community measure, inquiring if data from a discharge planner would be required to determine the beneficiary’s situation, especially to find out if they have a home to be discharged to. MedPAC staff indicated the measure would be claims based, so there would be no way to account for individual beneficiaries’ circumstances. However, they do plan to risk adjust the measure and include factors such as age and severity of illness.
Commissioner Pat Wang expressed concern that home health providers might have less of an ability to prevent readmissions. She also noted that for discharge to community, sometimes a safe discharge for a particular patient is not to home, but to permanent placement in a nursing home. She asked how that important point would be accounted for, and MedPAC staff indicated that the measure will be set up to account for state-assisted discharges, and would not count individuals that cannot be safely discharged home.

Commissioner Dana Gelb Safran noted functional status was an important piece that the Commission wants included, but was not mentioned in the presentation. She also asked if the staff had considered using the health outcomes survey measure from Medicare Advantage. MedPAC staff indicated that the November 2018 presentation on PAC would address functional measures in PAC.

Commissioner Warner Thomas asked where the staff sees instances of patients using the entire PAC system and its services, and where most patients end up. Staff replied that results from alternative payment models indicate that when patients can go home following PAC, they do, so episode-based payment design should account for that. Commissioner Thomas followed up by asking further what the staff’s view was on the shifting that could occur under a uniform PAC PPS – he seemed to believe that the incentives in this model would potentially lead to less use of certain types of settings, and that home health care would be less intensive. Staff said they hope that there are more institutional PAC providers as a result. They indicated that offering step-down care would be valuable to help decrease the transitions a patient would need to endure. They indicated that the fewer transitions a patient has to go through between PAC settings, the better for that patient’s outcomes.

**Discussion**

Commissioner Brian DeBusk opened the discussion with wide-ranging comments that complimented the staff on their model, which he thinks will address high costs, misaligned incentives, and quality measures. He indicated he thinks the uniform payment model is similar to site neutral payment policies. He likes the idea of reducing transitions between PAC settings. He hopes the episode-based payment work continues. He likes the MSPB-PAC measure, thinks it is consistent methodologically with the other settings. Commissioner DeBusk hopes that the staff explores peer grouping within measures before adjusting for factors such as age, gender, and race. Regarding the two specific measures considered, he believes the combined readmission measure is promising, and the discharge to community measure is on the right track.

Commissioner Pyenson said that he thought it would be useful for the Commission to consider grouping providers for evaluation, similar to what was done with the Merit-Based Incentive Payment System (MIPS).

Commissioner Buto indicated she believes that episode-based payment has the potential to bring home health into the overall PAC system, since it is different than institutional PAC care. She thinks that the uniform PAC PPS will lead to consolidation of providers, which could be a good thing in terms of enhancing care coordination, or it could be a bad thing.
Commissioner Thomas believes that a unified PAC PPS makes a lot of sense. He said that they need to think about having the right incentives for more complex patients so that it is attractive for providers to accept more complex patients. Similar considerations should be given for lower acuity patients as well. He then pointed out that home health providers have a wide variety of performance, and he encouraged the staff to create a model of an efficient provider. He pointed out concerns that home health providers will see more acute patients on the front end, and therefore may need different capabilities to work with those patients. One thought he had was to reduce regulatory burden around PAC use, similar to what accountable care organizations (ACOs) have been able to do. Finally, regarding skilled nursing, Commissioner Thomas indicated that he believes the economic model for them does not work, and that lower acuity stays need to be reimbursed the right way.

Vice Chairman Christianson also supported the direction of this work. He said he believes the discharge to home quality measure sounds nice, but is not a good measure for all beneficiaries. He indicated that some beneficiaries would be hurt when discharged to the community, especially when the community doesn’t provide them with a home. He asked the staff to keep thinking about different options here.

Commissioner Wang also supported the direction of the work, especially the payment episodes component. Regarding the quality metrics, she shared the concerns of Vice Chairman Christianson, saying it is too black and white to assume discharge to community is the safest patient outcome. Different states vary on what supports may be available at home, and she contended that the Commission should not count on that support. Sometimes patients should not go home, because it is less safe. Additionally, once a patient is at home, there is not much a PAC provider can do to account for their care.

Commissioner Jonathan Jaffrey noted that distribution of payment within a PAC under the proposed system could add significant administrative burden to those organizations. PAC settings may be hurt if they are expected to be able to adequately distribute lump sum payments or other episode-based payments, especially given the challenges of administering such a system.

Commissioner Gelb Safran is very supportive of the direction of this activity, and thinks it creates accountability on the PAC side. She believes quality measurement in PAC is lagging behind, and that this work will help push it forward. Functional status measures, and a timeframe around them, will be important. She also mused whether the Commission should develop a functional status measure on the hospital side.

Commissioner Jonathan Perlin highlighted the challenges of anti-kickback rules, the Stark Law, and other regulations that make it hard to discharge patients to settings that a provider may know is good. Similar to Commissioner Thomas, he pointed to how those rules have been waived in ACO and bundled payment contexts as a potential model for PAC settings. He agrees that home health settings will see more levels of acuity as well, despite home health being the hardest setting for a patient to get into. Commissioner Buto asked more about the Stark Law issue, and Commissioner Perlin indicated that physicians in the same group practice are being precluded from having conversations about coordinating care with group members in other settings.
Commissioner Wang reminded the Commission that there are a number of reasons why those self-referral laws are in place, and that any changes to them need to be done carefully because, unfortunately, there are bad actors in the system who could exploit these well-intended changes.

Commissioner Perlin noted that perhaps discharge planners that are not affiliated with a medical group could be good, disinterested assistants in facilitating helpful transitions between settings.

Commissioner Thomas agrees with Commissioner Perlin, and with Commissioner Wang, saying that hospitals typically have the information on the best settings to send a patient to but are often unable to act on it.