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MedPAC Submits June Report To Congress With Chapter on Unified Post-Acute Care Payment System

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The Medicare Payment Advisory Commission (MedPAC) released its June 2016 *Report to the Congress: Medicare and the Health Care Delivery System*. MedPAC also issued a related news release and fact sheet. The report examines a variety of Medicare payment system issues. The report includes MedPAC's analyses of the following issues: Medicare drug spending in its broader context; Medicare Part B drug and oncology payment policy issues; improving the Medicare Part D prescription drug program; using competitive pricing to set beneficiary premiums in Medicare; Medicare's new framework for paying clinicians; developing a unified payment system for post-acute care; improving efficiency and preserving access to emergency care in rural areas; telehealth services and the Medicare program; and issues affecting dual-eligible beneficiaries.

Chapter 3 is the chapter on developing a unified payment system for post-acute care (PAC). The Improving Post-Acute Care Transformation Act of 2014 (IMPACT) requires MedPAC to develop a prototype for a unified prospective payment system (PPS) that spans the four major PAC settings – long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and home health agencies (HHAs). In this preliminary report, MedPAC is required to recommend the framework of a unified PAC PPS and consider the impact of moving to such a payment system. The IMPACT Act also requires the Secretary of HHS to collect and analyze common patient assessment data and submit a report to Congress with recommendations for a PAC PPS that establishes payment rates according to individual characteristics instead of treatment setting. The Secretary's report is expected in 2022, after which MedPAC must submit a second report, due in 2023, outlining the details of a "technical prototype" design for a PAC PPS.

Consistent with MedPAC's discussions during prior meetings, MedPAC concluded that it is feasible to develop a common unit of payment for PAC services, with patient and stay characteristics forming the basis of risk adjustment. Available administrative data can accurately predict the costs (and establish payments) for most patient groups, but patient assessment data collected using a common assessment tool would increase the accuracy for certain types of stays. Payments would be aligned for stays in HHAs to reflect lower costs. Separate models would establish payments for (1) routine and therapy services, and (2) non-therapy ancillary services (*e.g.,*

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drugs). As before, MedPAC concluded that payment adjusters are needed for high-cost outliers (to protect providers from large losses and ensure access for beneficiaries) and unusually short stays (to prevent large overpayments).

The following is a more detailed discussion of MedPAC's recommendations for a unified PAC PPS.

Impact of a PAC PPS. MedPAC estimated that a PAC PPS would redistribute payments among types of stays and from higher cost settings and providers to lower cost settings and providers. MedPAC stated its belief that high-cost providers will lower their costs to match the PAC PPS payments, and all providers will change their coding practices to record patient diagnoses more completely.

MedPAC's analysis assumed that the PAC PPS would be implemented initially on a budget-neutral basis, with total estimated payments set equal to actual payments made for all PAC services in 2013. Importantly, the estimates do not reflect policy changes made since 2013, such as the enactment of LTCH patient criteria for qualified stays and site neutral payment for non-qualified stays. The estimates also do not assume any changes in provider behavior. For example, MedPAC noted that LTCHs would likely change their patient mix and costs of stays, but did not factor such potential changes into the estimates.

A comparison of payments made under the proposed PAC PPS to payments made in 2013 indicated that a PAC PPS would increase payments for many of the medical and patient impairment and severity groups, while lowering payments for stays in the patient groups where physical rehabilitation care is a large component of care. In general, the difference is caused by basing payments on patient characteristics rather than on the amount of therapy, which may be unrelated to care needs. MedPAC noted, however, that the model would not lower payments indiscriminately for rehabilitation care.

For the medically complex group, payments under the PAC PPS would increase between 4 and 9 percent for three groups (multiple body-system diagnoses, severely ill, and chronically critically ill (CCI)). The largest decrease of 11% was for the "highest acuity" group, essentially an outlier group. MedPAC acknowledged that the average payment under a PAC PPS would fall for cases treated in LTCHs. In contrast, payments for ventilator stays (predominantly in LTCHs) would increase 7%, reflecting the costliness of this care that is not reduced by stays treated in lower cost settings.

MedPAC concluded that under a PAC PPS, estimated payments to IRFs and LTCHs would decrease by 12% and 25%, respectively, because the stay costs of lower cost settings treating many of the same types of patients would be included in setting the payment. Compared with all LTCH stays, the reduction for LTCH-qualifying stays would be smaller – a decrease of 17% instead of 25% – because this subcategory overlaps less with similar stays treated in other settings. Again, this is based on 2013 payments, before LTCH patient criteria and site neutral payment went into effect.

Regulatory Requirements. MedPAC considered setting-specific regulations that might be waived when the PAC PPS is implemented, to give providers more flexibility to offer services that span the PAC continuum of care. These waivers fall into two categories – (1) near term, to be implemented

concurrent with the PAC PPS implementation; and (2) longer term, through a "core" set of conditions of participation for all PAC providers and a limited set of additional requirements for providers that opt to treat patients who require specialized care.

Near term regulatory changes that might be implemented concurrently with the start of the PAC PPS could include waiver of the following policies: the intensive rehabilitation therapy requirement for IRFs; the 60 percent rule for IRFs; the frequency of physician visits and on-duty presence of physicians in IRFs; and the greater-than-25-day average length of stay requirement for LTCHs. The Secretary also could consider standardizing the rules for therapy coverage across the four settings.

Longer term regulatory changes may include establishing a single set of conditions of participation for institutional PAC providers. MedPAC believes a common set of regulatory requirements "would ensure a baseline level of competency while allowing providers the flexibility to adjust their mix of services and staffing to meet patients' needs." In addition to the common set of regulations, MedPAC stated that CMS could develop specific requirements for providers opting to treat patients with highly specialized needs.

MedPAC also recommended that the Medicare program consider a standard cost-sharing requirement when beneficiaries use any PAC service. MedPAC addressed beneficiaries using IRFs and LTCHs, who incur Part A deductibles if they are admitted directly from the community. Although most Medigap plans cover the Part A deductible, at least one plan does not. MedPAC concluded that beneficiaries without supplemental policies might avoid LTCHs or transfer out of that setting if their stays exceed 60 days, since additional cost sharing begins on day 61 of the LTCH stay. Standardized cost-sharing would allow beneficiaries to select a provider and setting based on the care they would expect to receive, rather than based on any financial implications of their choice.

Implementation Issues. While MedPAC noted that the PAC industry has been "highly responsive to policy changes," it continued to recommend tempering the initial impact of the PAC PPS by implementing a transition period for moving toward a new payment system. However, MedPAC again noted that a unified PAC PPS could be implemented sooner than is currently legislated, by using administrative data to predict the cost of most clinical groups of stays and making refinements over time when patient assessment data becomes available through the new IMPACT Act measures. Currently, the Secretary must use two years of uniform patient assessment data to design a PAC PPS, and the data will not begin to be collected until October 2018. A unified system is unlikely to be proposed before 2024 based on that timetable.

The June report estimates that payments to PAC providers in 2013 were 19 percent higher than the cost of stays. MedPAC recommends that payment rates for PAC providers need to come down, and a transition policy should consider when and how large the rebasing should be. Ultimately, MedPAC believes Medicare needs to move toward integrated payment and delivery systems, such as episode-based payments.

Companion Policies. As discussed previously, MedPAC recommended certain companion policies when implementing a PAC PPS to dampen the fee-for-service incentives that generate serial PAC stays and stinting on care. Specifically, MedPAC recommended implementing a value-based purchasing (VBP) policy to tie payments to measures of quality and resource use. Tying payments to outcomes would protect beneficiaries against providers' stinting on services. Tying payments to resource use would prevent unnecessary service use, including serial PAC stays. Quality measures could include risk-adjusted rates of potentially avoidable readmissions and community discharge and changes in function.

MedPAC also recommended a readmission policy for all PAC providers to prevent unnecessary hospital readmissions. This companion policy is intended to prevent providers from stinting on care. MedPAC pointed out that the 30-day readmission rates for certain types of LTCH patients are currently lower than other settings. Given the potential regulatory changes made concurrent with a PAC PPS, MedPAC stated that LTCHs may have more incentive to discharge patients earlier, potentially increasing readmissions. Its proposed readmission policy is intended to dampen any financial incentive for providers to underprovide care.

MedPAC suggested that CMS might consider outsourcing the management of PAC services to a third party. It discussed the possibility of a benefit manager who could receive a separate payment to manage PAC services or, accepting more risk, could be financially responsible for the costs of PAC services in a given market. Although beneficiaries would retain freedom of choice, MedPAC acknowledged that a risk-sharing third-party manager would have a financial incentive to steer patients toward the lowest cost appropriate setting. Also, a number of MedPAC commissioners expressed reservations about third party managers at recent meetings. However, MedPAC believes that a benefit manager could facilitate patients' decisions about where to get PAC and guide patients to high-quality providers. The June report notes that Kindred Healthcare recently launched a national referral service staffed by nurses to provide consumers with PAC resources, including referrals and insurance coverage information. It further noted that Kindred plans to develop a PAC benefit management model to manage specific patient populations on behalf of payers and health system entities like accountable care organizations (ACOs).

Monitoring Provider Responses. After implementing a unified PAC PPS, MedPAC stated that the Secretary will need to establish a monitoring program to detect inappropriate provider responses, such as patient selection, stinting on care that may lower quality and outcomes, unnecessary PAC stays, and delays in care that shift, but do not lower, program spending. To monitor quality, MedPAC advised that the Secretary should track potentially avoidable readmission rates, potentially avoidable complication rates, changes in patient function during the PAC stay, and beneficiary experience. To assess care coordination, the Secretary could monitor rates of potentially avoidable emergency department visits and rates of observation stays, as well as the number of days between discharge from the hospital and follow-up care with a physician or other clinician. The Secretary also should monitor changes in the rates of PAC use, the mix of patients across settings, and changes in PAC lengths of stay. As indicators of the adequacy of Medicare's payments, MedPAC advised the Secretary to track Medicare margins, cost growth, and a

count of "efficient" providers (*i.e.,* providers that are relatively low cost and high quality).

Next Steps. MedPAC recognized that it still needs to do more work with respect to the need for payment adjusters in the following areas: to examine the need for an adjustment for low-volume, isolated providers; to confirm the need for an adjustment for providers treating high shares of low-income patients; and **to define and adjust for medically complex patients.** In addition, MedPAC directed the Secretary to consider the following policy considerations in implementing and maintaining a PAC PPS: the definition of a stay; the transition period (both the number of years and how to blend old and new payments); the level of payments; and periodic refinements to maintain the accuracy of payments.

About Us

The Law Offices of Jason M. Healy PLLC is a Washington, D.C. based law firm serving national and local clients. We focus primarily on legal issues affecting health care providers and welfare benefit plans. We help health care providers and their trade associations understand Medicare and Medicaid laws and regulations, and address compliance matters. We also represent health care providers in reimbursement audits, appeals, litigation, and transactions. We help sponsors of welfare benefit plans understand and comply with federal and state laws and prepare plan documents. Located in Washington, DC, just minutes from the Department of Health and Human Services, Congressional offices, and the White House, we are well positioned to provide legal support for advocacy efforts. Our Principal, Jason M. Healy, is a health care lawyer with over 16 years of experience with the array of legal issues facing health care providers.