MedPAC Addresses A Key Element in the Uniform PAC PPS Uniform PAC PPS Outcome Measures

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The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 required the Medicare Payment Assessment Commission (MedPAC) to develop a prototype for a unified prospective payment system that spans the four post-acute care (PAC) settings -- skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). The Commission was required to recommend features of a unified PAC PPS and consider the impact of moving to such a payment system.

MedPAC started publication of its work on the PAC PPS in the MedPAC June 2016 Report to Congress. [1] Since then, as pointed out by Carol Carter, MedPAC Principal Policy Analyst, the Commission has continued to work on several implementation issues, including the level of payments and the need for a transition to the new payment system, an approach that would begin to increase the equity of payments prior to implementing a PAC PPS, paying for sequential PAC stays, and aligning setting-specific regulatory requirements.[2]

LTC Pharmacy News has reported on MedPAC's ongoing development of the system.[3] The latest development was unveiled in the MedPAC public meeting on April 5, 2018. Ms. Carter briefed the Commission on the staff's work on an additional crucial component of the system -- that of uniform outcome measures for post-acute care. MedPAC highlighted its findings for three cross setting measures as proof of concept: readmissions during the PAC stay, readmissions during the 30 days after discharge, and a measure of resource. [4]

Why Uniform Outcome Measures?

Ms. Carter explained that with a unified payment system, uniform outcome measures are needed to compare provider performance across PAC settings and was able to report that the staff had started to develop them. There are three reasons to develop uniform PAC outcome measures. [5]

- First, there is overlap in the beneficiaries treated in different settings. Uniform measures are needed to compare the care furnished in the different settings. Uniform measures allow the program, providers, and beneficiaries to compare outcomes across settings. The program will be able to evaluate the quality and the value of its purchases while providers and beneficiaries will be able to directly compare outcomes for different types of PAC providers.

- Second, when CMS implements a unified PAC payment system, it will be critical to monitor provider performance, including whether providers

maintain quality of care and furnish appropriate use of post-acute care and other services.

- Last, uniform outcome measures could be used in a value-based purchasing policy for all PAC providers. By tying a portion of a provider's payments to its performance on quality and resource use, providers would have an incentive to achieve good outcomes while using resources efficiently.

Three Cross Setting Outcome Measures

MedPAC highlighted its findings for three cross setting measures: readmissions during the PAC stay, readmissions during the 30 days after discharge, and a measure of resource use. The rates of readmission during PAC stays gauge the quality of care furnished during the beneficiary's entire stay while rates of readmission during the 30 days after discharge detect premature discharges and gauge how well the provider managed the transition to the next setting or home.

In MedPAC's work, for each provider, observed rates were risk-adjusted using characteristics for each stay, including age, gender, comorbidities, functional status, and cognitive status. The findings briefly were: [6]

1. *Readmissions During the PAC Stay*

MedPAC found that the risk- adjusted rates of readmission during the stay varied considerably by setting, looking either at the potentially avoidable or the all-cause rates. On average, home health agencies had the highest during-stay rates and IRFs had the lowest rates.

2. *Rates Of Readmission During The 30 Days After Discharge*

The rates were more similar across the three settings, indicating that once beneficiaries are not under the care of a provider, they are exposed to similar risk of readmission. SNFs had the highest rates, and the IRF and LTCH rates were pretty similar. Looking across all providers in the three settings, the readmission rates varied widely. Across the during-stay rates, there was almost a four-fold difference in the potentially avoidable rates comparing providers at the 90th percentile and the 10th percentiles. The all cause rates varied less, but still almost three-fold.

The Commissioners were informed that they could use the uniform PAC readmission rates in two ways. In its annual assessment of the adequacy of payments, the Commission could include these readmission rates when considering the quality of care. Also, given the fact that over the coming year staff planned to develop ideas for a PAC VBP, the readmission measures could be included in a composite score for VBP, either under current setting specific payment systems or under a PAC PPS.

3. *Provider-Level Measure of Resource Use: Medicare Spending Per Beneficiary (MSPB)*

The MSPB-PAC is a provider-level measure that captures spending during the initial PAC stay and the next 30 days. Low MSPB is considered desirable. To keep its value low, a provider has an incentive to furnish high-quality care to avoid unnecessary hospital use, make referrals to the necessary level and amount of subsequent care, ensure safe transitions, and discharge beneficiaries to providers that have low readmission rates. Discussion was especially robust regarding the MSPB measure. Commissioner Grabowski expressed concern about MSPB as a performance measure, given that it is a resource-based measure. He queried whether Medicare "…spending per beneficiary adds new information here and alongside the readmission measure? Is this a unique measure?"

Next Steps

MedPAC staff indicated that over the coming year, they plan to explore other outcome measures. Such measures could include discharge to the community or a combined measure of preventable admissions and readmissions, a risk-adjusted count of the number of days between when a beneficiary leaves her home and returns after a hospitalization and/or a PAC use. To gauge patient experience, staff could also explore an instrument to be used by all PAC providers. Some of this work may be reported on in the MedPAC June 2018 Report to Congress.

Impact for LTC Providers

No post-acute provider community is thrilled about a unified PAC PPS. Even the recommended lifting some of the regulations that the post-acute providers consider unnecessary and overkill, such as removal of the IRF coverage requirement of 3 hours of therapy a day, does not seem to alleviate their wariness. Other "obstacles" to the implementation of a unified PAC PPS include:

- Competing CMS Medicare payment reforms such as Patient Driven Payment Model (PDPM). SNF providers are looking at the FY 2019 SNF Annual Update proposed rule to determine the potential impact of this proposal. It is difficult to imagine that CMS facing the heavy lift of implementing such a reform are cheering on a unified PAC PPS. It is true that once PDPM is up and running, it may provide a sounder base for inclusion of SNF data in a unified PAC PPS, but, first, PDPM must be implemented and monitored for accuracy.

- Implementation of a uniform PAC PPS must be legislated. The IMPACT ACT did not mandate implementation of a unified PAC PPS. Sources tell us that there is no current Hill agenda for pursuing this, given the current policy and political complexities.

A Crystal Ball

If any post-acute provider intends to be in business ten years from now. – be aware. My take is that unified PAC PPS is inevitable – I give it three more years to gel. What else is inevitable is endless: massive health care system consolidation, ACOs, Medicare and Medicaid Managed Care growth, Ambulatory Surgery Centers, hospital consolidation re bringing in PAC (IRFs, SNFs, home health etc.) within the hospital corporation, innovative community health care facilities etc. It is hardly news to anyone, especially post-acute providers, that a long-term survival strategy is called for.

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[1] http://www.medpac.gov/docs/default-source/reports/june-2016-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0

[2] See http://www.medpac.gov/docs/default-source/reports/jun17_reporttocongress_sec.pdf?sfvrsn=0

[3] For example, see: http://ltcpharmacynews.com/Elise%20Smith.html?utm_source=getresponse&utm_medium=email&utm_campaign=paulwbaldwin&utm_content=LTC+Pharmacy+News

[4]See MedPAC Slide Presentation on April 5, 2018 at http://www.medpac.gov/docs/default-source/default-document-library/pac-outcome-measures-handouts.pdf?sfvrsn=0 and MedPAC Transcript at http://www.medpac.gov/docs/default-source/default-document-library/april-2018-meeting-transcript.pdf?sfvrsn=0 Pages 120-157.

[5] Ibid.

[6] Ibid.