MedPAC June 2016 and 2017 Reports
on the Implementation of Post-Acute Care Unified Payment

For nearly a dozen years, MedPAC has worked extensively on post-acute care (PAC) payment reform -- pushing for closer alignment of costs and payments, more equitable payments across different types of patients, and outcomes-based quality measures (with payment tied to performance).

However, MedPAC has observed that while there has been some progress on the quality and value-based purchasing fronts, over the years, it saw few corrections to the known shortcomings of the SNF prospective payment system (PPS), and that payments remained high relative to the costs of treating beneficiaries.[1] As a result, according to MedPAC, the inequities in payment have continued to encourage patient selection and to advantage some providers over others.

Thus, the Commission has continued to provide over time both **update** recommendations and **revision** recommendations – revision of individual provider sector payment systems. The Commission explained its goals in making payment recommendations as follows:

- The yearly ***update*** recommendations, individual for all provider sectors -- aimed to ensure that payments are adequate so that beneficiary access is preserved while taxpayers and the long-run sustainability of the program are protected.[2]
- The other set of recommendations to *revise the payment systems -- for selected providers* – has been intended to match program payments to the costs of treating patients with different care needs. MedPAC hopes that such targeting increases the equity of the program's payments so that providers have little financial incentive to treat some beneficiaries over others. With regard to MedPAC's SNF specific revision, it too was published in the March 2017 MedPAC Report and reviewed by *LTC Pharmacy News in March.* [3]

MedPAC over time has thus provided recommendations for **both** updates for the SNF PPS system itself **and** the revision of SNF PPS. But it has gone dramatically further. It has provided for the development of a unified post-acute payment system.

The proposed unified PAC PPS encompasses SNFs, Inpatient Rehab Facilities (IRFs), Long Term Care Hospitals (LTCHs) and Home Health Agencies (HHAs). This newsletter focuses on SNFs and the recommended unified post-acute payment system from the prospective of SNFs.

We ask the question: can a revised SNF PPS and unified post-acute payment system be successfully implemented merely three years apart even with a PAC PPS three year transition period? MedPAC seems to think that they can. CMS and MedPAC activity discussed below is captured in the chart on the last page of this newsletter.

1. MedPAC Recommendation for Reform/Revision of the SNF PPS

As far back as 2008, the Commission recommended key revisions to the SNF that would base payments on the clinical, functional, and demographic characteristics of patients, not on the amount of therapy furnished. The revised designs were intended to rebalance payments between therapy cases and medically complex cases, which would shift payments from the relatively more profitable (typically for-

[1] March 2017 Report to the Congress: Medicare Payment Policy, Chapter 7, p. 185 at http://www.medpac.gov/-documents-/reports

[2] With regard to MedPAC's SNF update recommendations, they were published in the March 2017 MedPAC Report. March 2017 Report to the Congress: Medicare Payment Policy, Executive Summary and Chapter 7 at http://www.medpac.gov/-documents-/reports They were reviewed by *LTC Pharmacy News in March 2017.*

[3] LTC Pharmacy News, March 2017.

profit and freestanding facilities) to the relatively less profitable (typically nonprofit and hospital-based) providers.

To review for a moment -- as we outlined in the April edition of *LTC Pharmacy News* -- MedPAC in its March 2017 Report opined about the C*ommission's increasing frustration* with the lack of statutory or regulatory action to lower the level of payments and revise the SNF payment system. MedPAC provided much detail on the negatives of not heeding MedPAC's recommendations. For example, it noted that the cost to the program of not implementing the Commission's update recommendations would be substantial and the cost of past inaction was also considerable. The Commission had also repeatedly recommended that the payment system for SNFs be revised to base payments on patient characteristics, not the amount of service furnished.

2. CMS Produces a Revised SNF PPS

Finally, MedPAC's frustration should be at an end – at least for now. CMS has stepped up to the plate! After years of its own research, consideration of MedPAC's research, and the work of CMS' contractor, Acumen, which had started in 2013,CMS did produce the long awaited proposed revision. In the Advance Notice of Proposed Rulemaking of April 27, 2017, CMS showcased the result of its research and outreach to post-acute providers, laid out the details of the revision, and indicated 2019 implementation of the proposed revision. [4]

In its Comments to CMS, MedPAC lauded the proposed revision and offered various technical recommendations. Dr. Crosson wrote "The redesigns redirect payment away from therapy care that is unrelated to a patient's characteristics and towards medically complex care. With this redistribution, there will be less financial advantage to treating some types of patients over others and beneficiaries with complex medical conditions should experience fewer delays in getting placed in a SNF."[5]

3. MedPAC Post -Acute Prospective Payment Reform
A Post-Acute Unified Payment System

MedPAC's reporting of its work on a unified post-acute payment system was provided in two consecutive MedPAC June Reports. And one cannot be discussed without the other. In the June 2016 Report, MedPAC provided a very comprehensive and detailed exposition and analysis of its research leading it to its conclusion that a unified post-acute payment system was possible. In the June 2017 Report, MedPAC laid out implementation issues and recommendations to address them.

a. MedPAC June 2016 Report

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 required the Commission 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, inpatient rehabilitation facilities, and long-term care hospitals. The Commission was required to recommend features of a unified PAC PPS and consider the impact of moving to such a payment system. [6]

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[4] The ANPRM was subsequently published in the Federal Register at 82 Federal Register 20980, May 4, 2017. See https://www.gpo.gov/fdsys/pkg/FR-2017-05-04/pdf/2017-08519.pdf
See also LTC Pharmacy News May, 2017 for review of ANPRM.

[5] *Comment Letter, CMS-1686-ANPRM,* 82 Federal Register 20980, May 4, 2017 from Francis J. Crosson, MD, Chairman of MedPAC, to Seema Verma, MPH, Administrator, CMS, June 21, 2017, at http://www.medpac.gov/docs/default-source/comment-letters/06212017_2018medpac_snf_anprm_comment_sec.pdf?sfvrsn=0

[6] See Section 2(b) (1) of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT.) Congress did not mandate a PAC PPS.

In June 2016, as required by the Congress, the Commission outlined the key design features of a unified payment system to span the four PAC settings (Medicare Payment Advisory Commission 2016). Underpinning this work is the recognition that many similar patients are treated across the four settings . Like the recommended design for a SNF PPS, the unified PAC payment system bases payments on patient characteristics, not services furnished, and would redirect program payments toward medically complex patients and away from patients who receive therapy services unrelated to their care needs.

The Commission set out the necessary features of a PAC PPS and considered the effects on payments of moving to such a system. These included: Commission's

- Using available data on patient characteristics, the Commission's PAC PPS design predicts the costs of stays for a broad range of conditions;
- The PAC PPS would redistribute payments across patient conditions. Payments would decrease for rehabilitation care unrelated to patient needs and increase for medically complex care;
- Equity in payments would increase, and providers would have less incentive to selectively admit certain types of patients over others;
- The Commission's research found 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 of the patient groups MedPAC examined, but patient assessment data collected using a common assessment tool would increase the accuracy for certain types of stays;
- Policymakers will also need to consider the level of PAC payments. The Commission estimates that, in 2013, PAC payments were 19 percent higher than the cost of stays.

b. MedPAC June 2017 Report

In the June 2017 Report, MedPAC reiterated a recommendation for unified prospective payment system (PPS) for post-acute care (PAC). And it returned to its analysis of the PAC PPS design to explore three implementation issues.

First, it examined whether the implementation should include a transition during which providers would be paid a blend of current (setting-specific) rates and a PAC PPS rate. It concluded that a multiyear transition would extend the inequities in the current PPSs and delay the much-needed redistribution of payments. However, it would give providers time to adjust their costs and patient mix to the new payment system.

A second implementation issue is whether the Congress should consider lowering the level of total PAC payments when the PPS is implemented so that payments more closely align with the cost of stays. In aggregate, MedPAC estimated that the current payments to PAC providers exceed the cost of stays by 14 percent, with some variation across the patient groups. MedPAC's analyses indicate that, even if payments were lowered by 5 percent, the average payments across all stays and for the 30 clinical groups we examined would remain well above the average cost of stays.

Third and finally, if it mandates the implementation of a PAC PPS, MedPAC recommends that Congress should provide the Secretary with the authority to perform the ongoing maintenance that is required in any payment system to keep payments and costs aligned. The Secretary will need to make regular refinements in response to changes in costs and practices and would also need the authority **to rebase payments** if costs change significantly. In summary, the Commission recommended that the Congress should direct the Secretary to:

- Implement a prospective payment system for post-acute care beginning in 2021 with a **three-year transition;**

- Lower aggregate payments by 5 percent, absent prior reductions to the level of payments;
- Concurrently, begin to align setting-specific regulatory requirements; and
- Periodically revise and rebase payments, as needed, to keep payments aligned with the cost of care.

4. Overall Impact for SNFs

What does all this legislative and agency activity mean for SNFs? At a minimum, the environment is very challenging and a mixed bag. As we all know, SNFs are trying to embrace and work within the context and environment of a variety of expanding MCOs and innovative models from bundled payments to ACOs. And now, they face radical change in the methodology of their FFS payment: changes by regulation to the SNF PPS with a proposed implementation date of FY 2019; and possible changes by Congressional action to the overall post-acute care payment system (PAC PPS) with a proposed implementation date of 2021, albeit with a 3 year transition period.

It is not a surprise that observers have wondered how these two revision models coming so close together can work with each other. MedPAC in its comment letter to CMS on the ANPRM model tried to answer that question.

> Some observers have asked MedPAC how the revisions to a SNF PPS fit with its recommendations for a PPS to span the post-acute settings. The Commission recognizes that the implementation of a PAC PPS is likely to be years away. In the interim it is critical that the known shortcomings of the SNF PPS be corrected. Not only will fee-for-service payments be more accurate and more equitable, the improved payments will spill over into alternative payment models (such as bundled payments and accountable care organizations) and Medicare Advantage benchmarks all of which are based on FFS Medciare. Moreover the changes providers are likely to make under the new PPS (such as matching the provision of services to the care needs of patients) are consistent with those that will be encouraged by a PAC PPS. Therefore, a redesigned SNF PPS will be a good transition to a PAC PPS.[7]

Originally MedPAC suggested that 2024 was the earliest for implementing a PAC PPS – in sync with the legislative schedule of reports. Then it suggested that 2021 was a reasonable implementation year. Then in June, in Comments to CMS on the ANPRM, it stated that "The Commission recognizes that" the implementation of a PAC PPS is likely to be years away."[8] One conclusion is that MedPAC does believe that a 2021 implementation is possible but that 2021 is indeed years away, and the transition period will act as a shock absorber.

However. we wonder if the analyses provided to date suggest rather that the new CMS SNF PPS (ANPRM) be allowed to take hold for a designated period to give providers time to adjust to a new payment system. Then revisions can be made to improve the ANPRM before diving into a PAC PPS.

The nursing facility industry has historically looked favorably on a unified PAC PPS. MedPAC estimates that a PAC PPS would redistribute payments among types of stays from higher cost settings and providers to lower cost settings and providers. Facilities hope that this equates to redistribution from, let us say, IRFs to SNFs.

However such a stance may now be fraught with various problems. CMS might be forced to implement

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[7] *Comment Letter, CMS-1686-ANPRM,* from Francis J. Crosson, MD, Chairman of MedPAC, to Seema Verma, MPH, Administrator, CMS, June 21, 2017. http://www.medpac.gov/docs/default-source/comment-letters/06212017_2018medpac_snf_anprm_comment_sec.pdf?sfvrsn=0

[8] Ibid.

a unified payment system without adequate resolution of problems that arise within the revised SNF PPS. And a Congressionally mandated unified PAC PPS may have components such as "rebasing" and lower aggregate payments that could provide great concern.

SNF Payment
CMS and MedPAC

FY	CMS SNF PPS Update Rule	MedPAC SNF Update Recommendation	CMS SNF PPS Revision	MedPAC SNF Revision	MedPAC Unified Post-Acute Payment System
FY 2018	• CMS is held to an update of a 1% increase in the SNF market basket due to MACRA. • Without MACRA, the increase would have been 2.3%.	The Congress should **eliminate the payment increases** for 2018 and 2019 and direct the Secretary to revise the prospective payment system (PPS) for skilled nursing facilities.		Congress should direct the Secretary to revise the prospective payment system (PPS) for skilled nursing facilities.	
FY 2019			Revision of current RUG IV system and implementation of new system in FY 2019. • CMS to implement RCS-1 • Payments based on clinical characteristics -- a more resident centered case mix adjustment		
FY 2020					

FY 2021					MedPAC believes that a unified system could be implemented by 2021 as opposed to a legislative schedule that would put implementation toward 2024.
Current Situation	***FY 2018 Update will take place starting on October 1, 2017. Congressionally mandated.***		***Implementation should take place FY 2019 if no impediments. Changes within CMS authority.***		