MedPAC Calls it a Wrap!!
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On January 11/12, 2017, MedPAC met its overarching legislative mandate to assess the payment adequacy and update payments for a broad array of provider categories including hospital inpatient, hospital outpatient, physician and other health professional services, post-acute care providers, including SNFs, etc. The assessment activity took place over 2017 and was finalized on January 11/12, 2018. The findings and recommendations will be published in MedPAC's March 2018 Report to Congress.

In addition, at the January 11/12 meeting, MedPAC staff also made its final formal presentation and recommendation regarding the development of a unified post-acute care payment model mandated by Congress. [1] The model had been presented and discussed at prior MedPAC meetings and was finalized for the January 11/12 meeting. The model and recommendation for adoption, with one important change that surfaced in November, was accepted by the Commission and will be published in MedPAC's March 2018 Report to Congress. What follows is a description of the SNF payment update and MedPAC's recommendation for a unified Post-Acute Payment model (PAC PPS)

MedPAC's 2018 Recommendation for SNF Payment in FY 2019

MedPAC provided the following overview of the sector based on 2016 data:

- 15,000 SNFs
- 2.3 million FFS stays
- 4% of beneficiaries used SNF services
- Medicare FFS spending: $29.1 Billion

The Commission utilized its longstanding indicators of payment adequacy to assess the adequacy of SNF payments:

- Access: Supply is steady, admissions and days declined
- Quality of care: Mixed performance
- Access to capital: Adequate
- Medicare margin in 2016: 11.4%
- Efficient providers: 18.2%
- Marginal profit: 19.6%
- Projected Medicare margin in 2018: 9%

Staff made the following recommendations which were approved by the Commission. Congress should:

- Eliminate the market basket update for skilled nursing facilities for fiscal years 2019 and 2020;

- Direct the Secretary to implement a redesigned prospective payment system (PPS) in FY 2019 (i.e., the proposed Resident Classification System Version 1 (RCS-1); and
- Direct the Secretary to report to the Congress on the impacts of the revised PPS and make any additional adjustments to payments needed to more closely align payments with costs in FY 2021

As a reminder, MedPAC has been recommending elimination of the market basket (inflation factor) for many years. The market basket is set in statute and it would indeed take action by Congress to eliminate it. Congress has never done this. However, MedPAC's influence is nevertheless very strong and can be seen with respect to many payment issues across all provider sectors and in CMS' acknowledgment of MedPAC's thinking in CMS reworking of the RUG system.

MedPAC's Recommendation for the Unified Post-Acute Payment Model (PAC PPS)

MedPAC produced the unified post-acute payment model (PAC PPS) Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. The IMPACT Act 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. However, the Act did not mandate implementation of the system.

MedPAC met its legislative mandate and produced a PPS PAC model. In the July 2016 MedPAC report to Congress the Commission recommended that the Congress d direct the Secretary to implement the prospective payment system for post-acute care **beginning in 2021 with a three-year transition during which providers would be paid a blend of current setting –specific rates and a PAC PPS rate.**

To make matters even more complicated Med PAC changed its mind on the PPS PAC timetable. MedPAC wants to hasten implementation of the unified post-acute care model **and start the post-acute transition beginning in FY 2019.**

In the November MedPAC meeting, the staff presented a variation on the unified system that prior to implementing the PAC PPS would use a blend of the setting-specific and unified PAC PPS relative rates to establish payment. Within **each setting** payments would be distributed across conditions. The blending would take place in **2019 and 2020** and transition to unified PAC PPS would begin in 2021.

The draft recommendation MedPAC considered during their December meeting states that Congress should direct HHS to begin to base Medicare pay to post-acute care providers on a blend of the setting specific relative weights and unified post-acute care prospective payment system relative weights in fiscal year (FY) 2019. MedPAC staff suggested that a blended system could be used in 2019 and 2020 until a transition to a unified post-acute care pay system begins in 2021.

The question arises: how does the proposal of CMS (RCS-1) and the MedPAC PPS PAC model relate to each other? How will CMS implement its own RCS-1 for FY 2019 while trying to prepare for the PPS PAC model slated to start in blended form in FY 2019? Are they compatible or on a collision course? MedPAC first addressed that question in its Comment Letter on CMS' notice on RCS-1 when the target implementation year was still 2021. The question pertained to the 2021 target year.

> 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 Medicare. 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.[2]

When the target implementation year for blending was changed to 2019, a Commissioner again posed the question as to whether it was "feasible time-wise for CMS to implement the PAC PPS beginning in 2019?" The response was that analytically it was feasible but administratively it may not be. MedPAC has PAC PPS relative weights ready to go, but CMS would have to comply with the Administrative Procedures Act going through, for example, a notice and comment period. The Commissioner noted that that could take a year.

The Finale

Thus, SNFs head into FY 2019 with a "reform" of the SNF PPS on the part of CMS, RCS-1. They also head into FY 2019 with the question of Congress' reaction to the MedPAC unified post-acute care payment model created at the behest of Congress.

Congress may not act on it anytime soon but like every subject that MedPAC addresses and analyses, the information and analysis provided by MedPAC on all the aspects of care provided by the post-acute providers will have an impact; issues such as the similarities of rehabilitation patients across the post-acute spectrum and wide discrepancies in payment for treatment of patients with similar characteristics.

MedPAC's analysis, backed by voluminous data, could well figure, for example, into the actions of the hospitals, managed care providers, bundled care entities, ACOs etc.

Starting now in 2018 MedPAC will embark on its agenda for the MedPAC March 2019 Report to Congress.

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[1] Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

[2] *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