MedPAC Continues to Refine Its Proposed Unified Post-Acute Payment Model and is Supportive of CMS' SNF PDPM Proposed Rule July 2018

MedPAC's Congressional mandate is to advise Congress on payments to health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, and to analyze access to care, quality of care, and other issues affecting Medicare. Two reports—issued in March and June each year—are the primary vehicles for Commission recommendations to Congress. In addition to annual reports and occasional reports on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the Department of Health and Human Services, testimony, and briefings for congressional staff.

CMS by comparison has a very different responsibility from that of MedPAC's. It must generate the regulations implementing Medicare legislation, generate the guidance implementing the regulations, and administer and monitor the actual Medicare provider programs.

MedPAC and CMS have never been far apart in their analyses of the weaknesses in the SNF PPS RUGs payment system. But CMS' pace in reforming SNF payment within CMS' statutory authority has never been fast enough for MedPAC. MedPAC's patience was sorely tried at what it seemed to feel was CMS foot dragging.

MedPAC and CMS now appear to be converging on the task of reforming post-acute care. CMS in ANPRM, unveiling RCS-1, and again in the proposed rule for its SNF PDPM model acknowledged not only its own research but also that of MedPAC and GAO. MedPAC has indicated that the work of CMS in SNF case-mix reform will provide a strong contribution to the design and success of a unified post-acute care payment model.

Below we report on MedPAC's *Comment Letter* to CMS on the PDPM that reflects overall MedPAC satisfaction with CMS' PDPM.[1] We then update readers on MedPAC's continued work on the unified post-acute PPS published in the March and June 2018 Reports.

MedPAC Comment Letter to CMS on the PDPM, CMS' Proposed SNF PPS Case-mix System Reform

On June 15, 2018, MedPAC provided CMS with comments on CMS' proposed PDPM.[2]
Chairman Francis J. Crosson, on behalf of MedPAC, stated that the Commission was pleased that this year's proposed rule included a redesign of the case-mix classification system and applauded CMS's efforts to simplify and refine the design it proposed last year.

He expressed the judgement that this year's proposed design and the estimated impacts were consistent with the Commission's own proposal for the SNF PPS and the unified PAC PPS. The Commission supports the implementation of the redesigned SNF case-mix system even as it urges the Congress to move as quickly as possible toward a unified PAC PPS.

These statements are very welcome. At times the relationship of the two models to one another was not clear and MedPAC's patience was sorely tried at what it felt was CMS foot dragging.
The Chairman, however, did express disappointment that CMS plans to delay implementing the proposed changes until fiscal year 2020. He opined that such a delay seemed unnecessary given that the design was similar to the design CMS proposed last year (RCS-1), which was developed with the assistance of numerous technical expert panels and accompanied by extensive supportive documentation. Further, providers should already be well aware of the key design features of the proposal, rendering, as it were, the delay unnecessary.

He concluded that the postponement would delay the much-needed redistribution of payments away from therapy-driven care and toward medically complex care.

In addition, Dr. Crosson disagreed with CMS' budget neutrality policy. He made it very clear that the level of program payments for SNF care was too high relative to the cost to treat beneficiaries and added that the Commission had recommended payment freezes and payment reductions each year over the past decade.

Lastly, the Commission supported the combined limit on concurrent and group therapy and the collection of the information to monitor compliance with the limitation is requirement.

MedPAC Unified Post-Acute PPS

As mandated by the Congress, the Commission in June 2016 evaluated a prototype design and concluded that it was feasible to design a unified PAC PPS that spans the four settings and bases payments on patient characteristics.

In 2017, the Commission focused on several implementation issues, including the need for a transition to this new payment system, the level at which to set payments when the system is implemented, and the need for continued monitoring and periodic refinements over time to keep payments aligned with the cost of care.

In the June 2017 Report, the Commission recommended that a unified PAC PPS be implemented beginning in 2021 with a three-year transition and a corresponding alignment of setting specific regulatory requirements.

March 2018 Report -- Blended Rates[3]

In March 2018 Report, MedPAC introduced a further refinement. It recommended that the Congress should direct the Secretary to begin to base Medicare payments to post-acute care (PAC) providers on a blend of each sector's setting-specific relative weights and the unified PAC prospective payment system's relative weights in fiscal year 2019. One example of the blending would be to phase in the PAC PPS relative weights over two years (2019 and 2020). In 2021, when the Commission had recommended that the implementation of the PAC PPS begin, the relative weights of the unified PAC PPS would be used entirely to establish payments.

Within each setting, using a blend of the setting-specific relative weights and the unified PAC PPS relative weights would redistribute payments across conditions, with payments increasing for medically complex stays and decreasing for stays that currently receive rehabilitation therapy that is unrelated to a patient's clinical condition.

Lastly, the redistribution of payments would narrow the differences in relative profitability across patients with different care needs and, based on a provider's mix of stays and therapy practices, redistribute payments across providers. Redistributed payments would encourage providers to begin making the changes needed to be successful under a unified PAC PPS.

MedPAC June 2018 Report -- Sequential Stays[4]

In 2018, MedPAC considered another refinement to the unified PAC PPS that would increase the accuracy of payment for cases that involve a course of PAC care—that is, sequential stays. (See June 2018 Report Chapter 4). MedPAC defines sequential stays for its research purposes as PAC stays within seven days of each other. MedPAC explains that there are two main payment issues related to sequential stays.

The first has to do with the way the cost of a stay can vary, depending on where it falls in a sequence of PAC stays. The second involves how to identify, for payment purposes, distinct phases of care for a PAC provider that treats a patient "in place" as care needs evolve rather than refers the patient to another PAC provider. MedPAC points out that under the unified PAC PPS, such providers would be financially disadvantaged unless the payment system included a way to trigger payments for different phases of care.

MedPAC considered various ways to address the issues but emphasized Medicare making a single payment for all post-acute care provided during an "episode" of PAC. MedPAC made it clear that it would continue to explore episode-based payments for PAC, but that CMS should proceed with implementing a stay-based unified PAC PPS.

MedPAC June 2018 Report -- Encouraging Medicare Beneficiaries To Use Higher Quality Post-Acute Care Providers[5]

MedPAC also reported its work on the need to increase the use of higher quality PAC providers. We discussed this subject when MedPAC first reviewed it in public session on September 7, 2017 and we refer readers to the November 2017 LTC Pharmacy Newsletter for our analysis.[6]
MedPAC research had showed that beneficiaries were by-and-large not using higher-quality-post-acute care providers. The MedPAC staff thesis was that steps should be taken to improve beneficiary choice. MedPAC Commissioners were in agreement, but their discussion reflected the myriad problems in attempting to rectify the situation given the fact that defining and measuring quality itself is far from clear and cogent.

A major part of the problem is that hospital discharge planning is hampered by statute and regulations that limit their ability to be proactive in helping patients chose a high quality post-acute provider. Discharge planning is a hospital responsibility required by the BBA. The BBA requires hospitals to provide beneficiaries with a list with a list of nearby SNFs and home health agencies, but the list is not required to have quality information.

In addition, Medicare statute provides that hospitals may not recommend providers.

The IMPACT ACT created new requirements that hospitals use quality data during the discharge planning process and provide it to beneficiaries, but this new requirement has not been implemented as yet. Medicare does not require the use of quality measures in discharge planning, and, confirmed by MedPAC, the efforts required by the IMPACT Act appear to have no certain implementation date.

MedPAC concludes that helping beneficiaries to identify better quality PAC providers should be a goal in a reformed discharge planning process, and authorizing hospital discharge planners to recommend specific higher quality PAC providers would further this goal.

Conclusion

CMS, as we have reported these last two years, has developed a model that focuses on payment based on patient characteristics and the needs of the patients. More accurate reimbursement for non-therapy ancillaries, especially that of drugs, is a strong aspect of PDPM. SNF payment based on PDPM will be an integral part of the post-acute unified system. We recommend again that LTC pharmacy pay attention to both the CMS and MedPAC reforms to assure that the component of non-therapy ancillaries is strong in both. The PDPM Final Rule must by statute be issued before August 1.[7]

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[1] *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program* in the Federal Register, vol. 83, no. 89, p. 21018 (May 8, 2018). (Includes proposal to replace RUG IV with a new case-mix classification system, Patient Driven Payment Model (PDPM) for Fiscal year 2020.

2. MedPAC Comments on CMS SNF Proposed Rule For FYI 2019 with PDPM for FY 2020. http://www.medpac.gov/docs/default-source/publications/06152018__fy19medpac_snf_pps_nprm_comment_sec.pdf?sfvrsn=0

[3] MedPAC *March 2018 Report to Congress,* http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0

[4] MedPAC *June Report 2018* to Congress, http://www.medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_sec.pdf?sfvrsn=0

5. Id at Chapter 5.

[6] *LTC Newsletter,* http://www.ltcpharmacynews.com/docs/PDF%20Docs/Keeping%20an%20Eye%20on%20MedPAC_ESmith.pdf

[7] 4432(a) of the BBA, section 1888(e)(4)(H). https://www.law.cornell.edu/uscode/text/42/1395yy