Medicare Payment Advisory Commission Public Meeting Summary
March 3, 2016

On March 3, 2016 the Medicare Payment Advisory Commission (MedPAC) held its final public meeting to discuss components of a conceptual model for a unified cross-setting post-acute care (PAC) payment system. No concerns were raised by Commissioners, and the final report, due to the U.S. Department of Health and Human Services (DHHS), appears to be on track for an April 7-8 final Commission vote. During the April discussion, the entire conceptual model will be voted on in whole, rather than by components. The final report then will be sent to DHHS in June 2016. The Commission slides are available to view here.

Background
The MedPAC report is the first of three PAC payment reform reports statutorily mandated by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. The initial MedPAC report is intended to lay the foundation for more detailed DHHS work on the development of a unified PAC, cross-setting payment system.

In response to the June 2016 report, DHHS is required to submit a second IMPACT Act-mandated report based upon the initial MedPAC report to Congress regarding alternative models for a PAC provider payment system. The DHHS report, which would be much more detailed, must include:

- Recommendations on, and a technical prototype of, a PAC prospective payment system that would
  o Base payments on individual characteristics of the patient as opposed to the PAC setting;
  o Account for clinical appropriateness of items and services provided and the beneficiary outcomes;
  o Incorporate standardized patient assessment data received under prior sections of the IMPACT Act; and
  o Further clinical integration.

- Recommendations on which Medicare fee-for-service regulations for PAC payment systems should be altered.

- An analysis of the impact of the recommended payment system on beneficiary cost-sharing, access to care, and choice of setting.

- A projection of any potential reduction in expenditures that may be attributable to the application of the recommended payment system.
- A review of the value of subsection (d) hospitals collecting and reporting to the Secretary standardized patient assessment data for inpatient hospital services furnished by such a hospital to Medicare beneficiaries.

The second report must be submitted no later than two years after DHHS has collected two years of PAC quality and resource measurement data, approximately by 2022. The third and final report is due to Congress no later than the first June 30 following DHHS’ 2022 report. The final report, likely due in 2023, must include recommendations and a technical prototype for a PAC prospective payment system with sufficient detail to address the required elements, above.

**MedPAC Proposal**

During the March 3 session, MedPAC staff reviewed the current policy which is composed for four separate, setting-specific payment systems (e.g., IRF, LTACH, SNF, HH) which pay based upon patient characteristics. Specifically, the concept is intended to address concerns with the existing prospective payment systems (PPS) by encouraging therapy and nursing care based upon patient characteristics.

Initially, payments would remain setting specific but all would pay based upon episodes of care within the setting and for a period of time following discharge from the setting or, in the instance of home health, following the end of care delivery. In the long-term, a unified PAC PPS would span the four settings, remain based upon patient characteristics and continue to make refinements to policies intended to address current PPS challenges and would include a “glide path” to move from setting specific payments to a unified, cross-setting system.

In the presentation, MedPAC staff revisited previous payment system components:

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New components discussed during the March 3 meeting were outlier policies, level of payments, feasibility of the concept, and additional detail on a transition policy, regulatory relief, and possible inclusion of a third party PAC manager. MedPAC Staff also summarized their overall findings in preparation for the April final report and vote.

**Outlier Policies**

First, MedPAC envisions a five percent *high cost outlier* (HCO) policy paid at 80 percent above a fixed loss amount. Initially, a separate HCO pool would be established for each provider type. The HCO pool would be funded by a five percent reduction in base rates and the remaining amount of costs over the fixed loss amount would be covered by providers. MedPAC envisions phasing down the size of the HCO, therefore increasing rates in a budget neutral manner over during implementation of the payment system (see transition policy, below). MedPAC believes that with experience providers would become more efficient and deliver more effective care and, therefore, be less reliant upon the HCO pool. In its analysis, MedPAC’s findings indicate that the reduction in base rates to fund the HCO would be neutral among settings when balanced against risk adjustment for higher cost patients.
Second, MedPAC proposes to include a short-stay outlier policy. Under this proposal providers would receive a per diem payment for stays under a yet-to-be defined length of stay by episode with the first day paid at the episode per diem rate plus an additional 20% of costs. Currently, all PAC settings except SNF have a short stay outlier policy. Of note, the data displayed by MedPAC for the ratio of payments to costs with the short stay policy are pool. Therefore, the numbers display the lower end of the range. This would need to be refined by DHHS in subsequent work to ensure providers are adequately compensated.

**Level of Payments Relative to Costs**

MedPAC staff indicated that in aggregate payments exceeded costs by 19 percent in 2013. Presenting staff then outlined a series of issues must be addressed in order to better align costs with payments both with in implementation and post-implementation when the PAC PPS is recalibrated. MedPAC staff indicated that DHHS should implement past Commission recommendations for adjusting payments to the existing PPS (e.g., for SNFs this would mean a four percent reduction and, later rebasing). MedPAC also envision implementation of a definition of an efficient provider and consideration of geographic spending. Finally, while discussed in earlier sessions at *companion policies* (see November meeting slides) but related to payment levels, MedPAC also envisions attaching at least two value-based purchasing measures to payment. First, a rehospitalization measure which would cover the stay or period of care plus the thirty following days. In latter discussion, MedPAC Commissioners suggested extending the rehospitalization measurement window to 60 or 90 days. Second, MedPAC contemplates a Medicare Spending Per Beneficiary (MSPB) by provider type and episode type which also would extend 30 days post-discharge or period of care.

**Feasibility of a PAC PPS**

MedPAC staff affirmed their initial findings that a unified PAC PPS is feasible indicating that key features would need to include a common unit of payment with risk adjustment. Risk adjustment is considered critical to ensure the highest cost Medicare beneficiaries have adequate access to care. Payments would be based upon patient characteristics which also would be used to risk adjust. Additionally for home health, payment would need to be aligned with the lower costs typically found in home health. Finally, MedPAC envisions separate models to establish payments for routine plus therapy services and non-therapy ancillary services (e.g., drugs). In its analysis, MedPAC evaluated 40-plus patient groups of stays which included 22 clinical groups. Administrative data would be used to develop payments with risk adjustment. However, MedPAC noted challenges with modeling payments for the highest acuity stays noting the DHHS would need to explore this area in more detail.

As part of the feasibility analysis, MedPAC staff once again highlighted the need for outlier policies. Staff also noted while they found no need for a “broad rural or frontier adjuster” they did believe more exploration would be needed for certain providers. Specifically, MedPAC staff indicated that for low volume, isolated providers a three percent enhancement might be needed as well as a seven percent enhancement for frontier providers. MedPAC does not envision any payment adjusters for IRFs which also have teaching programs nor does it believe there is a need for adjustments associated with large numbers of low income patients. In the discussion portion of the session, Commissioners asked that MedPAC staff further explore the potential need for providers with more low income patients and note that DHHS also should explore this area in their report.

**Transition Policy**

MedPAC staff noted the need to develop a plan to transition level of payments to costs. In the June report, MedPAC will note that DHHS should explore how long the transition from the current PPS should...
be to full implementation of the new PPS. Staff also presented the notion of allowing providers to bypass the transition period and go directly to the new payment system. In this section, MedPAC staff also highlighted the notion of phasing down the HCO from five percent to a lower figure, such as two percent. As part of transition and possible HCO phase down, MedPAC also envisions periodic refinements or recalibrations to “keep payments aligned with costs.”

**Regulatory Requirements**
As discussed in the November meeting, MedPAC staff reiterated the notion of regulatory simplification among PAC providers to allow PAC providers to use beds for various types of patients now classified by setting type (e.g., an IRF patient, a SNF patient, etc.) rather than by patient characteristics. In the short-term, MedPAC envisions waiving certain types of setting specific requirements. In the long-term, MedPAC envisions DHHS developing a set of core requirements for all providers with additional requirements for providers treating patients with highly specialized needs.

**Third Party PAC Manager**
Also discussed in the context of a companion policy (see November slides), MedPAC again raised the idea of a third party PAC benefit manager. In discussion, Commissioners, as in November, raised a number of questions and concerns about inclusion of such an entity or entities in the payment system concept. Commissioners asked that this topic be moved from the executive summary of the report to the body with a more extensive discussion included pros and cons of including a third party.

**Impacts on PAC PPS Payments**
In general MedPAC findings indicate higher average payments for patients whose stay are medical or medically complex. At the same time, they envision payments to decrease for stays which hinge upon rehabilitation unrelated to patient condition and they envision lower cost settings receiving lower payments except when admitting higher cost patients. The overall impacts would be a shift of payments from rehabilitation to medical care and “reduced variation in profitability as well as less incentives to selectively admit.”

**Commissioner Discussion**
Most Commissioners during the discussion period expressed support for the information in the report to Congress. Several Commissioners, including Ms. Naylor and Dr. Coombs, expressed support for risk adjustment and refinements for high acuity patients, with Dr. Coombs emphasizing the importance of LTACHs for patients with high resource needs. David Nerenz of the Henry Ford Health System stated the short-stay outlier policy should distinguish between positive and negative short stays. Ms. Naylor and Dr. Coombs also agreed that a 60- or 90-day readmissions policy, rather than a 30-day readmissions policy, should be considered. Ms. Naylor called for further consideration of changes to improve beneficiary cost-sharing, and urged the Commission staff to discuss in the final report both the benefits and drawbacks of using a third party benefits administrator. Dr. Hall of the University of Rochester School of Medicine stated that further analysis should be conducted to examine the impact of the proposed changes on community and other specialized providers.

Of note, many Commissioners pointed out that the report should include a discussion of how DHHS could accelerate development and implementation of the unified PAC PPS using the Center for Medicare and Medicaid Innovation (CMMI) demonstration authority. Mr. Thomas suggested the Centers for Medicare & Medicaid Services (CMS) consider conducting a demonstration to evaluate the impact of a unified PAC PPS; however, Dr. Rita Redberg of UCSF, School of Medicine expressed concern that a demonstration would likely attract early adopters and would not provide useful information on the impact of the payment changes across providers. Others pointed out that CMMI could use an approach...
analogous to the mandatory Comprehensive Care for Joint Replacement (CJR) demonstration to address such selection bias. Mr. Thomas also called for a faster payment transition to create value for patients and improve innovation in PAC care. His comments were echoed by Ms. Buto and Dr. Hoadley who suggested including elements of the unified payment concept be included in MedPAC’s annual recommendations report. Dr. Crosson asked the Commissioners if any would have difficulty supporting the report when finalized for the April meeting; none of the Commissioners expressed concern about supporting the final report.

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