On June 15, 2016, the Medicare Payment Advisory Commission (MedPAC) released its June Medicare and the Health Care Delivery System report to Congress. The overarching goal of the prototype proposal is to arrive at a single patient characteristic-based payment system. The existing site-specific payment systems would be phased out.

**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 a more detailed U.S. Department of Health and Human Services (DHHS) unified cross-setting post-acute care (U-PAC) 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:
  - Base payments on individual characteristics of the patient as opposed to the PAC setting.
  - Account for clinical appropriateness of items and services provided and the beneficiary outcomes.
  - Incorporate standardized patient assessment data received under prior sections of the IMPACT Act.
  - Further clinical integration.

- Recommendations on which Medicare fee-for-service (FFS) 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 believes the U-PAC system could be implemented by 2025.

**MedPAC Proposal**

In the report, MedPAC indicates the new system will pay based upon patient characteristics. Specifically, the concept is intended to address concerns with the existing prospective payment systems (PPS) which are believed to incentivize therapy and underfund nursing care for SNFs.

When fully implemented, as envisioned by MedPAC, U-PAC PPS would span the four settings and be based upon patient characteristics. This is a change from the initial discussion which would not have included home health. Home health is part of the final proposal. Key design features are displayed in the table below.

### Major Payment Design Features

<table>
<thead>
<tr>
<th>DESIGN FEATURE</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMMON UNIT OF SERVICE (E.G., STAY)</strong></td>
<td>Common unit of service which avoids unnecessary days or visits</td>
</tr>
<tr>
<td><strong>COMMON RISK ADJUSTMENT USING ADMINISTRATIVE DATA ON PATIENT CHARACTERISTICS</strong></td>
<td>Points out that a common functional assessment could support risk adjustment</td>
</tr>
<tr>
<td><strong>HIGH COST OUTLIER POLICY</strong></td>
<td>Intended to pay for services outside of or beyond episode costs. Other PAC providers have such a policy, now. SNF does not</td>
</tr>
<tr>
<td><strong>SHORT-STAY OUTLIER POLICY</strong></td>
<td>Intended to prevent overpayments but also should address interrupted stays</td>
</tr>
<tr>
<td><strong>VALUE-BASED PURCHASING</strong></td>
<td>Would add more value-based purchasing to existing SNF rehospitalization program</td>
</tr>
</tbody>
</table>

Source: MedPAC, Report to Congress, June 2016, Table 3-1, page 64.

Of note, the Commission modeling shows a significant redistribution of payments among PAC provider types. Under a unified system, MedPAC “expect(s) payments would be redistributed across individual providers and PAC settings based upon mix of patients treated, the provider’s therapy practice, and existing cost structure. SNFs are projected to experience an eight percent increase in payments under the new system.

**Other Report Highlights**

The report chapter on IMPACT Act payment reform echoes much of the final April discussion:

1. **Accelerate Development and Implementation.** MedPAC emphasizes the need to accelerate U-PAC development. MedPAC indicates that the available administrative data is reliable enough to make recommended changes to the current PPS, including SNF-recommended changes, and still arrive at a final U-PAC proposal sooner than 2023. In fact, MedPAC replicated an earlier
study, called the PAC-PRD, using the complete data set of PAC claims from federal fiscal year 2013. Therefore, the Commission believes it has validated implementation of U-PAC and implementation based only upon administrative data. Additionally, beginning in 2017, MedPAC annually will discuss in its reports strategies for accelerating U-PAC or implementing components of U-PAC sooner.

2. **Value-Based Purchasing.** Value-based purchasing (VBP) is discussed as one of an array of companion policies aimed at “dampening [fee-for-service] FFS incentives.” MedPAC discussed readmissions and Medicare Spending Per Beneficiary measures, both of which are IMPACT Act quality reporting measures. The Commission also notes that change in function, community discharge and care coordination could be added as part of value-based purchasing policy.

3. **Regulatory Requirement Changes.** As noted above, the goal of the MedPAC prototype payment system is to replace the existing site or provider type specific payment systems with a single patient characteristic-based payment system. MedPAC staff further elaborated upon new regulatory changes that might be implemented to support a patient characteristic-based PPS. In the short term, MedPAC indicated waiving Inpatient Rehabilitation (IRF) requirements, such as therapy and physician hours, included in their site neutral proposal. Staff also noted short term waivers for Long-Term Acute Care Hospitals, specifically staff noted waiving the 25-day average-length-of-stay (ALOS) requirement. In the long-term, site or provider specific conditions (or for skilled nursing centers, requirements) of participation would be eliminated. Rather, MedPAC envisions Requirements of Participation associated with delivering care to specific types of patients in keeping with a patient characteristic-based payment system. Of note, MedPAC stops short of recommending elimination of the three-day stay. Instead, the report simply notes that in 2015, the Commission recommended allowing up to two observation stay days count towards the three-day stay.

4. **Transition to U-PAC.** MedPAC highlighted key transition implementation issues, including: a) level of payment relative to cost; b) period needed to transition from setting-based payments to U-PAC PPS; and c) the feasibility of implementing U-PAC sooner based upon administrative data and refining U-PAC when patient assessment information becomes available. The Commission also discussed how transitions to the new system could be accelerated using administrative data.

5. **Third Party PAC Benefit Manager.** The notion of a third party post-acute care benefit manager is discussed. The Commission did not discuss the concept in April. The report discusses several possible third party PAC benefit manager iterations highlighting existing Centers for Medicare and Medicaid Innovations models but also discussing the many pros and cons associated with including a third party PAC benefit manager.