FOCUS ON MedPAC

There are three major players in the Medicare post acute payment reform environment: The Congress, the Medicare Payment Assessment Commission, known as MedPAC, and CMS. Congress passes the applicable law(s); MedPAC advises on what it believes the governing law on Medicare payment models should be and responds to specific Congressional requests such at that provided in the IMPACT ACT. CMS implements the law and regulates the affected post-acute providers. This all perhaps sounds so smooth and easily workable but in reality has proven to be anything but.

These entities establish their own timetables and policy approaches which do not always appear to coincide and can reflect varying goals. However, there is one unifying principle that undergirds their work and that is the shared belief that Medicare payment for post acute care should be based on patient characteristics – not on the volume of services provided. This is a compelling principle.

With respect to SNFs, potential reform of the SNF PPS system guts an established payment model, based on clinician judgment, provided by CMS itself in 1998 after years of testing in demonstrations. The current payment system reflects the availability of and comprehension of whatever data was available in the late 1990s and the best that CMS could do with that data -- and has been in place for 19 years.

The new approach calls, at a minimum, for a restructuring of the components that go into the establishment of the reimbursement rate. This is a huge challenge, but MedPAC has thought for a long time that it is doable and has persisted in advocating for revision. It did so again with renewed fervor in its latest March Report for 2017.

MedPAC

MedPAC is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. MedPAC's impact on policy making is complicated but real!! The primary vehicles for MedPAC's recommendations are two reports, one issued by MedPAC in March updating MedPAC Medicare payment recommendations for the following fiscal year. The other is issued in in June each year addressing various refinements to Medicare payments systems and broader changes in health care delivery and the market for health care servcies. **We focus on the latest March 2017 Report.**

The March MedPAC Report 2017

The Commission has two goals in making payment recommendations.[1] The update recommendations aim to ensure that payments are adequate so that beneficiary access is preserved while taxpayers and the long-run sustainability of the program are protected. The recommendations to revise the payment systems aim to match program payments to the costs of treating patients with different care needs.

To examine the adequacy of Medicare's payments, MedPAC analyzed beneficiaries' access to care, quality of care, provider access to capital, and Medicare payments in relation to providers' costs to treat Medicare beneficiaries. The data on these key measures, as reported by MedPAC, indicated to the Commission that Medicare payments to SNFs are adequate as follows:

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

- ***Beneficiaries' access to care***—Access to SNF services remains adequate for most beneficiaries.[2]

- ***Quality of care—***Between 2014 and 2015, the community discharge rate and the rates of hospital readmissions (during SNF stay and within 30 days after discharge) improved. The functional change measures were essentially unchanged.

- ***Providers' access to capital***— Access to capital was adequate in 2016 but getting tighter and is expected to remain so in 2017. Lending wariness reflects broad changes in post-acute care, **not** the adequacy of Medicare's payments. Medicare is regarded as a preferred payer of SNF services.

- ***Medicare payments and providers' costs—***In 2015, the average Medicare margin was 12.6 percent—the 16th year in a row that the average was above 10 percent. Margins continued to vary greatly across facilities, reflecting differences in costs and shortcomings in the SNF prospective payment system (PPS) that favor treating rehabilitation patients over medically complex patients. The marginal profit, a measure of the relative attractiveness of treating Medicare beneficiaries, was at least 20.4 percent. The projected Medicare margin for 2017 is 10.6 percent.

Based on these factors, MedPAC recommended that:[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.

- In 2020, the Secretary should report to the Congress on the impacts of the reformed PPS and make any additional adjustments s to payments needed to more closely align payments with the costs of efficient providers.

Note that the recommendations call for **both** lower payments and a revised PPS design. MedPAC does not want payments increased for 2018 and 2019 while a revised PPS is implemented. With the projected Medicare margin at 10.6 percent in 2017, MedPAC emphasizes that Medicare payments appear to be more than adequate to accommodate SNF cost growth without updates in 2018 and 2019.

With revision, the recommendation also requires that the PPS be revised to increase the equity in payments for different types of stays. Under a revised design, payments would increase for medically complex stays and decrease for stays that include intensive therapy that is unrelated to a patient's care needs. [4] Long Term Care pharmacies might wish to carefully follow the development of the reformed SNF PPS. Long term care facilities will be striving to provide high quality care for patients needing intensive medical care. Pharmacy may be playing an enhanced role in such a system.

MedPAC further 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."[5] This admission of frustration is new to MedPAC's March reporting but not surprising given the years of

[2] Ibid. Chapter 8, p.198.
[3] Ibid. Chapter 8, p.196
[4] Ibid. Chapter 8, p.220
[5] Ibid. Chapter 8, p.199

recommendations that appeared to be implemented neither by CMS nor the Congress. 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 is substantial. Across the four PAC settings, if this year's recommendations are implemented, we estimate that FFS program spending will be reduced by more than $30 billion over the next 10 years. [6]

- …the cost of past inaction was also considerable. Had the 2008 recommendations to eliminate the updates to payments for HHAs and SNFs been implemented, MedPAC estimated that FFS spending between 2009 and 2016 would have been $11 billion lower without affecting access.

- The Commission had also repeatedly recommended that the payment systems for SNFs and HHAs be revised to base payments on patient characteristics, not the amount of service furnished. Implementing these recommendations would have narrowed the differences in financial performance across providers within each setting while preserving the profitability of the SNF and HHA sectors.

- Further, because FFS payments are the basis of payments under alternative payment models (such as accountable care organizations and bundled payment initiatives) and are used to establish MA benchmarks, reducing post-acute payment rates would also reduce the level of spending in those models.

Moreover, the Commission was emphatic that a two-year horizon to implement a revised design was feasible. [7] It added that the Commission first recommended a revised design in 2008 and since then has continued to develop and communicate alternative design features that redirect payments toward medically complex care. [8]

Looking Ahead

The question is: where is everybody on all of this? MedPAC says a revised design is feasible within a two year horizon. But the entity to make it feasible and bring it home is CMS. What does CMS think? There is no doubt that CMS has in some sense embraced MedPAC's concerns and has also decided on reform based on its own examination of the reimbursement data over the years which it shared with providers. We might pause here to note that CMS in the 10 or so years has done a fair amount to improve various aspects of the SNF PPS system and it has done so within its statutory powers. CMS is clear that it intends to develop a revised payment model that is implementable without requiring additional statutory authority.[9]

[6] Ibid Executive Summary, p. xvi.
[7] Ibid, Chapter 8, p.221.
[8] Ibid. See Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2009, Medicare Payment Advisory Commission 2008, Medicare Payment Advisory Commission and The Urban Institute 2015.
[9] Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2017, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and SNF Payment Models Research, 81 Federal Register 51970, at 52048, August 5, 2016.

In the February LTC Pharmacy News, we updated you on the current status of the CMS work on reforming the SNF PPS: The bottom line on the CMS side is that the agency is indeed working hard on researching the components of an alternative payment approach.

To the best of our knowledge, CMS has sent the proposed annual SNF PPS update rule to the Office of Management and Budget for review. If OMB has no changes, it will send it back to CMS and OK its issuance. That could come any day now.

The "update" proposed rule is the vehicle that CMS will use to unveil the SNF payment modifications. We may be out on a limb but we doubt we doubt that the agency will provide a proposed rule with the new system to be effective for FY 2018. We think rather that it might take the opportunity to "present" and discuss proposed changes, ask for comment, and aim for FY 2019 implementation.

Our "guesstimate" is based in part on CMS' own words in the SNF Update Final Rule for FY 2017. CMS had received comments to the effect that CMS should hasten the implementation of the SNF reform and should load on various adjustments that it, CMS, had not considered. CMS' response was clear. It said in effect that the undertaking was complex and would take time to get right.

> We .. would note that reform of a system which covers such a wide range of services and such a diverse population of beneficiaries requires time to be completed correctly. We are moving as expeditiously as possible, ensuring that we allow sufficient time for requesting and considering public comments.[10]

While this response was made in 2016, a review of the CMS presentation material and reports on the work of the four Technical Expert Panels convened by CMS and its contractor, Acumen LTD, panels to date suggests that much remains to be done.[11] We will know with certainty when we see the upcoming SNF PPS proposed rule .

When the SNF PPS Update Proposed rule is issued, we will review and provide a report. In addition, MedPAC has been working on its plan for a unified post-acute care payment system pursuant to the mandate of the IMPACT Act. That system was first unveiled in the MedPAC July Report of 2016 and will be reported on again in MedPAC's June Report for 2017. Again we will provide a summary of the post-acute section of the report and our analysis of its implications for long term care.

[10] SNF PPS Update Final Rule for FY 2016. 81 Federal Register 51970 at 52049. August 5, 2016.

[11] CMS has provided an excellent one page overview of the various phases of the Acumen SNF PPS research and provided citations for all the relevant reports. See: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html