A Critique of MedPAC's Post-Acute Care Prospective Payment System Prototype

Model Review and Policy Recommendations

Dobson|DaVanzo

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Model Review and Policy Recommendations

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Executive Summary

This critique examines the prototype Medicare payment system for post-acute care (PAC) developed by the Medicare Payment Advisory Commission (MedPAC) in 2016. Currently, this prototype provides a foundation for the effort led by the Centers for Medicare & Medicaid Services (CMS) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to develop a fully functioning PAC prospective payment system (PPS).

In general, this critique found three key concerns with MedPAC's prototype, which are fully discussed in the main report.

- The prototype's reliance on Post-Acute Care Payment Reform Demonstration (PAC-PRD) data. Specifically, the data are out-of-date, do not represent the current PAC field, and were collected using a flawed tool and methodology. In addition, the evaluation method MedPAC used to assess the "payment adequacy" of the prototype relied on a circular utilization of the PAC-PRD data; therefore, it may overstate the accuracy of their models.
- The prototype's complex regression-based design. The design's complexity, which is unique from other payment systems that rely on pre-established payment units, may render it administratively infeasible for PAC providers.
- The prototype could threaten patient access to care. Implementation of the PAC PPS prototype could threaten patient access to care because, while the MedPAC report indicates that prototype payments for many types of PAC patients would cover estimated costs, its reliance on questionable PAC-PRD data raises concerns as to whether this is a well-founded conclusion. Without payment accuracy, it would be difficult to ensure access to care, especially for higher acuity patients with greater resource needs.

Background

As one part of a broad package PAC reforms, the Improving Post-Acute Care Transformation (IMPACT) Act of 2014 mandated the development of a single PAC PPS

with payment based on a patient's clinical characteristics instead of care setting and therapy use. While the IMPACT Act did not authorize the implementation of a PAC PPS, it calls for a model that could be a future replacement for the stand-alone payment systems for the four PAC settings: home health (HH), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH).

The PAC PPS development mandate is to be carried out over numerous years through a collaboration of several policy-making agencies, including CMS, MedPAC and ASPE. MedPAC completed the first stage of this process by presenting a PAC PPS prototype to Congress in June 2016. Since that time, CMS and ASPE have launched the first steps of the lengthy and complex process to develop a PAC PPS – a process MedPAC staff estimate could yield a legislative proposal in 2024, at the earliest.[1]

Dobson, DaVanzo & Associates, LLC, was commissioned by the American Hospital Association (AHA) to: 1) evaluate MedPAC's prototype design and methodology; 2) identify key implementation challenge; and 3) recommend policy approaches to improve the prototype and, ultimately, the final PAC PPS proposal. The AHA commissioned this work on behalf of its more than 3,000 PAC members who, along with their patients, would undergo a significant transformation if Congress one day authorizes the implementation of a PAC PPS.

Our methodological critique and qualitative feasibility assessment of the MedPAC prototype PAC PPS are based on a careful review of several key documents, including the June 2016 MedPAC report to Congress, the accompanying Urban Institute methodology paper, and CMS' evaluation of the PAC-PRD. [2, 3, 4] The PAC-PRD was a Medicare demonstration mandated by Congress in 2005 to collect standardized PAC data from the four PAC settings in order to develop a common patient assessment instrument for PAC. Our analyses were augmented by findings from a face-to-face discussion with MedPAC and Urban Institute researchers.

Key Concerns with the Prototype

The validity of the PAC PPS prototype, and its ability to generate accurate payments, is dependent on the accuracy of the predicted costs in the three models – specifically, their alignment with "real costs." However, the prototype relies on data that are out-of-date, do not represent the current PAC field, and were collected using a flawed tool and method. This, by itself, is enough to cause concern about the payment adequacy of the model, but

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[1] Medicare Payment Advisory Commission. Public Meeting Transcript for March, 2, 2017. March, 2017.

[2] MedPAC. Report to the Congress: Medicare and the Health Care Delivery System. Chapter 3: Mandated report: Developing a unified payment system for post-acute care. June 2016.

[3] The Urban Institute. Designing a Unified Payment System for Post-Acute Care. June 2016.

[4] The Centers for Medicare and Medicaid Services. Post-Acute Care Payment Reform Demonstration: Final Report. Volume 1; Volume 2; Volume 3; Volume 4. March 2012. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

the method that MedPAC used to evaluate the accuracy of its regression-based model casts additional doubt on its conclusion that payments would be adequate to ensure access to care, particularly for patients requiring the most intensive, specialized treatment.

<u>Major Concerns With PAC-PRD Data Exist</u>. While we recognize that use of the PAC-PRD data was mandated by Congress, the prototype's substantial reliance on them is very concerning. First, for the prototype to generate payments that reflect the current cost of providing PAC services, the model's underlying cost data must align with the actual cost of care. Yet, the PAC-PRD data are extremely out-of-date: data collection began in 2008. This renders the ability of the prototype to achieve alignment between payments and costs questionable, as it is reasonable to assume that the prototype's cost data (derived from 2008-2010 Medicare claims data that matched the PAC-PRD stays) do not reflect recent cost trends.

In addition, the provider sample used for the PAC-PRD data is very small, accounting for only 0.4 percent of PAC providers and 0.1 percent of PAC stays in 2013. Specifically, it included only 107 providers and 6,409 stays across the four PAC settings.[5] The sample also does not reflect the national PAC provider distribution or capture the full array of PAC patients.[6] IRF and LTCH providers and stays were over-represented, while SNF stays were under-represented in the PAC-PRD sample, compared to the relative distribution in 2013 of all PAC stays nationally.[7]

We also are concerned that the collection of the PAC-PRD data was flawed in several respects. First, it was collected via an inadequate patient assessment instrument. Specifically, the PAC-PRD's patient assessment instrument, known as the Continuity Assessment Record and Evaluation (CARE) Tool, has been criticized for its length and its inability to capture the full resource needs of high-acuity PAC patients.[8] Another potential model limitation arises from the brief two-week time period that was used to collect the PAC-PRD resource use data, which prevented capture of a full picture of variation in staff-time and resource use that is needed to treat different types of patients across PAC settings.[9] Lastly, each of MedPAC's three models utilized PAC-PRD and other data from inconsistent timeframes. To address this concern, in part, MedPAC weighted the PAC-PRD stays to match the distribution of 2013 PAC providers. However, its methodology blended two different types of data (resource use data and patient assessment data) from two different sets of PAC providers (those in the original demonstration and those in the demonstration supplemental stage). This approach raises questions as to how

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[5] MedPAC. Mandated report. Developing a unified payment system for post-acute care. June 2016.

[6] The Centers for Medicare and Medicaid Services. Post-Acute Care Payment Reform Demonstration: Final Report. Volume 1. March 2012.

[7] MedPAC. Mandated report. Developing a unified payment system for post-acute care. June 2016.

[8] The Centers for Medicare and Medicaid Services. Post-Acute Care Payment Reform Demonstration: Final Report. Volume 1. March 2012.

[9] The Centers for Medicare and Medicaid Services. Post-Acute Care Payment Reform Demonstration: Final Report. Volume 2. March 2012.

representative the PAC-PRD data used by MedPAC are, especially as the MedPAC reports do not fully explain their methodology. As a result, we are unable to investigate how the adjusted PAC-PRD data impact the accuracy of the prototype's cost data, any diminishment of which would reduce the accuracy of payments generated by the prototype.

Finally, we have concerns that the prototype's reliance on the circular use of PAC-PRD data might cause an overstatement of the model's accuracy. Specifically, since the IMPACT Act mandated the use of PAC-PRD data, those data were used to estimate the resource portion of both "actual" and "predicted" costs. Further, this estimate of relative resource use from the PAC-PRD data also is based on a regression model using the same data used in the predicted cost regression model. Due to these circularity issues, we may not have a true sense of how well payments generated by the prototype align with costs.

PAC PPS's Regression-based Design Raises Concerns. The regression-based design that was used for the PAC PPS prototype raises two major concerns. First, we are concerned that complexity of the prototype's regression-based model is not administratively feasible. Specifically, we are concerned that its complexity will render PAC providers unable to reasonably estimate their payment and determine their plan of care for a given patient prior to, or within a short time after admission. Predictability and reliability are two key factors in the construction of a PPS, and providers face substantial risks when they are lacking.

PAC PPS Prototype Could Threaten Patient Access to Care. We are concerned that substantial threats to access could arise were the MedPAC PAC PPS prototype to be implemented. This is because, as discussed above, while the MedPAC report indicates that prototype payments for many types of PAC patients would cover estimated costs, its reliance on PAC-PRD data and a circular methodology for evaluating the PPS's "payment accuracy" raises questions as to whether this is a well-founded conclusion.

We are specifically concerned that the major upheaval that will result from the PPS' implementation could lead to the closure of facilities that cannot undertake such a transformative change, such as lower-margin LTCHs, IRFs that cannot bear the PAC PPS aggregate payment cuts, or smaller SNFs that struggle to meet institutional PAC Conditions of Participation. We also note that MedPAC projected the PAC PPS prototype would result in payment reductions for LTCHs and IRFs of negative 25 percent and negative 12 percent, respectively, relative to payment under the current payment systems.[10] As such, continued access to specialized services at LTCHs and IRFs may be most in jeopardy under a PAC PPS.

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[10] MedPAC. Mandated report. Developing a unified payment system for post-acute care. Page 81, Exhibit 3-6. June 2016.

In addition, the supply of health care providers is rapidly decreasing in rural areas: more rural hospitals were reported to close in 2013 than the prior 15 years combined.[11] This trend may worsen under a PAC PPS due to reduced payments and provider instability caused by the transition to a significantly different PAC model. MedPAC also did not address access for patients who need multiple types of care from several kinds of institutional PAC settings, or those where institutional PAC is preceded or followed by home-based PAC. These types of care, which can differ greatly in their scope and intensity, need to be addressed.

Finally, upstream conveners and third-party benefit administrators that have substantial incentives to reduce PAC costs under alternative payment models (APMs) are a challenge to patient access. If PAC PPS payment changes are implemented, this may incentivize even greater restriction of SNF utilization under APMs than has already occurred. Thus, substantial redistribution of payments as proposed in the PAC PPS prototype may increase the variability of PAC setting use for patients who can be treated appropriately in multiple settings rather than decrease it, counter to the intent of the model.

PAC PPS Policy Recommendations

Should CMS and ASPE decide to adopt all or part of the MedPAC prototype when building a functioning PAC PPS, they should consider the following issues and recommendations:

1. **Ensure a transparent PAC PPS development process.** Should CMS and ASPE build out the PAC PPS model, there will be great interest among stakeholders to remain informed, as well as to engage in the development process. A payment system of this complexity cannot be built in a vacuum – stakeholders have valuable knowledge and experiences which should be taken into account in any effort which will affect their daily operations and ability to remain financially stable. For example, some of MedPAC's PAC PPS analyses were not shared prior to its June 2016 report, which led to key methodology questions from stakeholders being developed only after this report was issued.

   The pending PAC PPS development process should be undertaken with maximum transparency, to enable support from the provider community. CMS and ASPE should share with stakeholders their overall plan for PAC PPS development. In addition, proactive and timely sharing of the key data and analyses to enable stakeholders to model the new payment system while under development will allow for development of external benchmarks and

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[11] Morgan, A. Rural Hospital closing at alarming rate. [Blog] May 1, 2014.

participation of analytical partners which has benefitted past efforts of this nature. This undertaking could avoid many unintended consequences.

2. **Ensure patient access to specialized PAC services.** MedPAC's June 2016 report to Congress indicates that companion policies should be developed in conjunction with a PAC PPS to ensure and monitor access to high-quality PAC care. However, the impact of the prototype model on these critical aspects of care was not thoroughly addressed by MedPAC. Moving forward, CMS and ASPE should estimate the impact of its future model on access to specialized PAC services not found in all PAC settings. This could be accomplished, in part, through payment adequacy analyses for subsets of PAC providers that primarily serve high-acuity patients and/or provide services in rural areas. It is likely that not all LTCH or IRF patients can be appropriately treated in lower-cost settings.

A major reorganization of the PAC market with a focus on reducing costs may not adequately support maintenance of high-acuity service infrastructure. In particular, we recommend that CMS and ASPE ensure payment adequacy for PAC services that:

- are more complex and costly to provide, such as ventilator weaning programs;

- require specialty clinicians, such as physiatrists, respiratory therapists or wound specialists;

- experience a drop in supply capacity due to PAC PPS redistributive payment cuts to higher-cost settings;

- are underpaid by a PAC PPS and are, therefore, not sustainable, such as the patient categories MedPAC identified as underpaid by the prototype; and/or

- are provided in rural areas already facing the pressure of dwindling health care services and professionals.

3. **Use the most currently available cost data instead of PAC-PRD cost data.** To improve the currency and accuracy of the PAC PPS model, CMS should base its PAC cost estimates entirely on the most recently available Medicare cost reports. Over time, this should be more accurate than using outdated PAC-PRD routine resource use data, which are impractical from a time and cost perspective to adequately update on an ongoing basis. It is important to note that other Medicare payment systems that have used external cost data, such as the Medicare physician fee schedule practice expense component, became outdated within a relatively short number of years, which led to the uncertain accuracy of affected CMS payment systems.

4. **Streamline the PAC PPS to achieve payment predictability.** In alignment with APM development protocols, PAC PPS development should be guided by the key principle of payment predictability.[12] The PAC PPS prototype does not achieve payment predictability since payments are calculated for each patient based on approximately 100 patient characteristics – including both clinical and non-clinical metrics. This complex approach would present operational and clinical challenges throughout an episode of care. One alternative would be a model that groups patients into clinical categories instead of the prototype's reliance on a 100-element regression model to assign payments for each patient.

5. **Streamline the PAC regulatory framework under a PAC PPS.** As discussed by MedPAC, the implementation of a PAC PPS represents an opportunity to conduct a major overhaul of PAC Medicare regulations designed to support the current siloed fee-for-service PAC delivery system. This re-engineering would affect regulations on coverage, conditions of participation, clinical operations, physical infrastructure, finances, staffing resources and other important aspects of operating a PAC facility. The new two-setting structure for PAC also would likely precipitate the need for some changes to state certificate of need laws and regulations. The appropriateness of the following types of regulations should be considered:

   - LTCH "25% Rule" and 25-day average length of stay requirement;

   - IRF "60% Rule" and three-hour rule;

   - SNF three-day stay requirement;

   - HH homebound requirement; and

   - Other policies designed to direct patients transitioning to PAC under the current, four-setting model.

   In developing the policy framework surrounding a PAC PPS, CMS should consider removing legacy PAC regulations that may affect payment equity while balancing this with a regulatory framework that protects important aspects of each PAC setting. Completely doing away with the regulations that distinguish PAC settings during a PAC PPS transition may lead to a restructuring of the PAC marketplace in such a way that patient access to certain types of care could become more limited, if accessible at all. That is, a balanced approach is likely a better policy wherein some product differentiation across facility types is allowed and paid for.

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[12] American Medical Association. A Guide to Physician-Focused Alternative Payment Models.

6. **Anticipate the impact of APMs on a PAC PPS.** Marketplace changes fostered by APMs such as bundled payment or accountable care organizations are bringing substantial changes in the mix and type of PAC utilization. For example, under APMs, current revenue centers such as individual PAC stays become cost centers to a broader episode or payment bundle. A PAC PPS would pay SNFs more, where, under APMs, SNFs are being paid less, both through fewer days paid per episode and through fewer SNF stays as more community care is delivered. These types of contracts need to be considered as fee-for-service payments are blended with APM global or population-based payments. Such changes bring both opportunity and uncertainty to the PAC field. The addition of a PAC PPS to such markets would add another layer of complexity to these transformations. It is unclear how the PAC PPS, a fee-for-service model that pays on volume, would mesh with value-based APMs paying on a population basis. CMS and ASPE should anticipate how these distinct and unaligned models might merge in order to mitigate resulting patient access threats and provider instability.

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Critique of the MedPAC PAC PPS

This critique examines the prototype Medicare payment system for post-acute care (PAC) developed by the Medicare Payment Advisory Commission (MedPAC) in 2016. Currently, this prototype provides a foundation for the effort led by the Centers for Medicare & Medicaid Services (CMS) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to develop a fully functioning PAC prospective payment system (PPS).

In general, this critique found several concerns with MedPAC's prototype, which are fully discussed in the main report. The three key concerns are:

- The prototype's reliance on Post-Acute Care Payment Reform Demonstration (PAC-PRD) data. Specifically, the data are out-of-date, do not represent the current PAC field, and were collected using a flawed tool and method.
- The prototype's complex regression-based design. First, its complexity may render it administratively infeasible for PAC providers. In addition, the evaluation method MedPAC used for determining the "payment adequacy" of the prototype was circular and not appropriate for a regression-based payment system, and may overstate the accuracy of their models.
- The prototype could threaten patient access to care. This is because, as discussed above, while the MedPAC report indicates that prototype payments for many types of PAC patients would cover estimated costs, its reliance on PAC-PRD data and a circular methodology for evaluating the PPS's "payment accuracy" raises questions as to whether this is a well-founded conclusion.

We also make six policy recommendations that would help ensure that a PAC PPS payment model is administratively feasible, preserves access to medically necessary services, and generates adequate payments for the full spectrum of services across PAC settings:

1. Ensure a transparent PAC PPS development process;
2. Ensure patient access to specialized PAC services;
3. Use the most currently-available cost data instead of the PAC-PRD data;
4. Streamline the PAC PPS to achieve payment predictability;
5. Streamline the PAC regulatory framework under a PAC PPS; and
6. Anticipate the impact of alternative payment models (APMs) on a PAC PPS.

Background

The Improving Post-Acute Care Transformation (IMPACT) Act of 2014 mandated various PAC payment reforms and research activities. A major provision is the development of a single PAC PPS that pays for services based on a patient's clinical characteristics instead of care setting and therapy use. The PAC PPS is intended to replace the current stand-alone prospective payment systems for each of the four PAC settings: home health (HH), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH).

The PAC PPS development mandate is to be carried out over numerous years through a collaboration of several policy-making agencies, including CMS, MedPAC and ASPE. The first stage of this effort was completed with MedPAC's June 2016 report to Congress, which presented the prototype of a PAC PPS. Since then, CMS has begun to develop a functioning PAC PPS – a stage expected by MedPAC staff in March of 2017 to conclude at the earliest in 2024. Implementation of a PAC PPS was not authorized by the IMPACT Act, however, and would require the enactment of separate legislation from Congress.

Dobson, DaVanzo & Associates, LLC was commissioned by the American Hospital Association (AHA) to:

1. evaluate MedPAC's prototype design and methodology;

2. identify key implementation challenges; and

3. recommend policy approaches to improve the prototype and, ultimately, the final PAC PPS proposal.

Our qualitative methodological critique and qualitative feasibility assessment of the MedPAC prototype PAC PPS are based on a careful review of several key documents, including the June 2016 MedPAC Report to Congress, the accompanying Urban Institute methodology paper, and CMS's evaluation of the PAC-PRD, which is discussed below.[13, 14, 15] Our analyses were augmented by findings from a face-to-face discussions with MedPAC and Urban Institute researchers.

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[13] MedPAC. Report to the Congress: Medicare and the Health Care Delivery System. Chapter 3: Mandated report: Developing a unified payment system for post-acute care. June 2016.

[14] The Urban Institute. Designing a Unified Payment System for Post-Acute Care. June 2016.

[15] The Centers for Medicare and Medicaid Services. Post-Acute Care Payment Reform Demonstration: Final Report. Volume 1; Volume 2; Volume 3; Volume 4. March 2012. https://www.cms.gov/Research-Statistics-Data-and-

Overview of the PAC PPS Prototype

MedPAC designed a PAC PPS prototype to address policymakers' concern that Medicare pays different prices for the portion of the PAC patient mix that is similar and treated in more than one type of PAC setting. Given this concern, the prototype model would assign payment based on a large set of patient characteristics that feed into calculations based on a regression model. Under the prototype, the PAC infrastructure would shift to, and payments would align with, a two-setting model that includes institutional and home-based PAC providers.

MedPAC's Methodology for Designing the PAC PPS Prototype

To design the PAC PPS prototype, MedPAC developed and evaluated three models through a four-step process.

The component parts of the prototype's analytic design are displayed in Exhibit 1. Columns reflect the model development and evaluation process:

1. "actual" costs;
2. predicted costs;
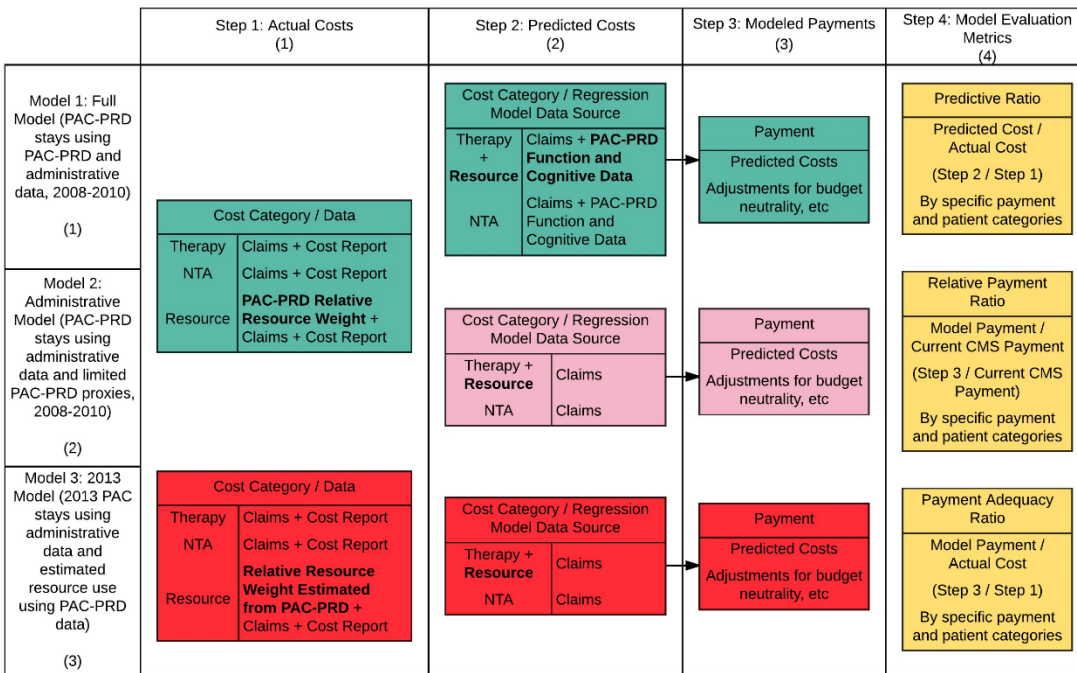3. modeled PAC PPS payments; and
4. model evaluation metrics.

Rows reflect three separate models:

1. Model 1 using the PAC-PRD data (for stays in 2008-2010) along with administrative data for those stays;
2. Model 2, for the same PAC-PRD stays used in Model 1, and using a limited set of proxies for the PAC-PRD variables; and
3. Model 3 for all 2013 PAC stays using the administrative model, along with relative resource use estimated from the PAC-PRD data.

The "cells" within the Exhibit indicate how cost components (therapy, nontherapy ancillary (NTA), resource use) are built from the various data sources (administrative data, Medicare cost reports, PAC-PRD data).

Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

Exhibit 1: Overview of MedPAC PAC PPS Model Relationships[16]

Source: Dobson | DaVanzo Analysis of Urban Institute PAC PPS Design Report

Exhibit 1 shows that the four steps of MedPAC prototype development and evaluation (columns) and the three models are all tied together by PAC-PRD resource use data, since all estimates are based to some extent on the PAC-PRD data. Bold text shows where the model uses PAC-PRD data, or estimates of PAC-PRD data, either for relative resource use (weights) or for patient functional status and cognitive impairment.

The foundation for MedPAC's prototype site-neutral prospective payment model, as shown across the columns of Exhibit 1, rests on the following four-step process:

Step 1: Establish "actual" costs from claims, Medicare cost reports, and estimated routine resource usage. These "actual" costs were used in each of the three models as the basis for cost estimates based on patient characteristics.

– Therapy and nontherapy ancillary (NTA) costs were derived from charges taken from administrative claims data and then multiplied by the relevant facility's cost-to-charge ratio from the Medicare cost reports.
– Routine resource costs (such as nursing time) were estimated by multiplying each facility's average length of stay, average daily payment rate, and the ratio of the resource use for an episode over the average

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[16] Regressions for Model 1 use a combination of claims and PAC-PRD data for patient and disease characteristics including cognitive impairment and functional status. Regressions for Models 2 and 3 use claims data for patient and disease characteristics with claims-based proxies for cognitive function and functional status.

resource use for that facility (measured using PAC-PRD data as available, but estimated otherwise).

Step 2: Predict costs using regression models based on patient characteristics. These regression models used the "actual" costs established in Step 1 as the dependent variable with patient characteristics as the independent variables.

– MedPAC used patient diagnosis and demographic information from claims along with functional status and cognitive impairment assessments from the PAC-PRD data to predict costs.

– Where PAC-PRD data were unavailable, functional status was estimated from claims information and cognitive impairment was removed from the model.

Step 3: Assign budget-neutral payments based on Step 2 predicted costs.

– Model payments were then determined from costs predicted from patient characteristics.

– To test redistributive payment impacts, the model was set to maintain the same total payment amount as the current payment system (i.e., budget-neutral) for a given set of claims. However, it should be noted that, during the April 2017 Commissioners meeting, MedPAC finalized a recommendation to set PAC PPS payments at 5 percent less than the overall budget-neutral level, which may produce prohibitive losses for LTCHs and IRFs.

Step 4: Assess the accuracy of predicted costs from Step 2, the impact of the payments assigned in Step 3, and the adequacy of the payments assigned in Step 3.

– Model costs and payments were evaluated via simple ratios in three ways:

1. The accuracy of estimated costs was assessed through a predictive ratio by dividing predicted costs (Step 2 outputs) by "actual" costs (Step 1 outputs) to show the predictive accuracy for different patient and provider groups;

2. The relative payment impact of the PAC PPS was assessed through a relative payment ratio by dividing PAC PPS model payments (Step 3 outputs) by current CMS case payments for groups of patients and providers; and

3. The adequacy of payments was assessed through a payment adequacy ratio by dividing PAC PPS model payments (Step 3 outputs) by "actual" costs (Step 1 outputs) for groups of patients and providers.

– The MedPAC predictive ratio evaluation approach (using the Step 4 model evaluation metrics) may not be entirely valid for the prototype model (as described below) and assertions that the model predicts PAC stay costs accurately and provides adequate payments need to be carefully considered.

Each of the four steps was performed for each of the three models culminating in the payment model prototype. Each of the three models was necessary to both satisfy the IMPACT Act mandate for inclusion of PAC-PRD data, as well as to step away from these data and bring the estimation approach to bear on a more recent series of PAC stays, and thus be applicable for future stays.

- **Model 1**[17] was constructed using administrative data, as well as PAC-PRD data, for provider resource use and patient functional status and cognitive impairment. It includes the matched PAC-PRD cases only, which were a small sample of stays between the years 2008-2010. Model 1 was the test by which MedPAC could understand whether it was possible to predict the costs of a PAC stay with patient characteristic information. MedPAC evaluated the results of this model and reported the output to be "accurate" and payments to be similar to actual CMS payments for the stay.

- **Model 2**[18] was constructed primarily using administrative data. This model contained the same stays as Model 1 (2008-2010) and was used to understand whether it was feasible to reproduce the results of the "full" model without complete reliance on PAC-PRD patient characteristic data. MedPAC found that this approach yielded similarly "accurate" payments as Model 1.

- **Model 3**[19] used administrative data for all 2013 PAC stays. It also used aspects of the PAC-PRD data to estimate relative resource use[20] within facilities. Though MedPAC once again found the model to produce "accurate" payments, we have concerns about their conclusion for two reasons, which are outlined in further detail below: 1) Model 3 payments rely on an estimate of resource costs indirectly based on PAC-PRD data; and 2) the evaluation structure is not necessarily valid under the specific circumstances of Model 3 (e.g., the predictive ratio output may be biased to show that payments are more accurate than they really are).

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[17] MedPAC and the Urban Institute refer to this as the "full" model.

[18] MedPAC and the Urban Institute refer to this as the administrative only model.

[19] MedPAC and the Urban Institute refer to this as the 2013 model.

[20] In the PAC PPS prototype, relative resource use is the ratio of stay resource use to the average resource use of all stays seen at a facility for a specified period.

Key Concerns with the PAC PPS Prototype

The validity of the PAC PPS prototype, and its ability to generate accurate payments, is dependent on the accuracy of the predicted costs in the three models – specifically, their alignment with "real costs." However, the prototype relies on data that are out-of-date, do not represent the current PAC field, and were collected using a flawed tool and method. This, by itself, is enough to cause concern about the payment adequacy of the model. However, the method that MedPAC used to evaluate the accuracy of its regression-based model casts additional doubts on its conclusion that payments would be adequate to ensure access to care, particularly for patients requiring the most intensive, specialized treatment.

A. **Major Concerns with the Use of PAC-PRD Data Exist**

While we recognize that use of these data was mandated by Congress, the prototype's substantial reliance on PAC-PRD data is very concerning. As highlighted in Exhibit 1, each of MedPAC's three models use PAC-PRD data:

Model 1 used PAC-PRD Data for:
  • Patient functional status
  • Patient cognitive impairment
  • Provider resource use[21]

Model 2 used PAC-PRD data for:
  • Provider resource use

Model 3 used estimates of PAC-PRD data:
  • A regression model using the same variables as the predicted cost model (Step 2 above) was used to predict PAC-PRD resource use based on patient characteristics. These estimates were then used to estimate Step 1 for Model 3

The prototype's reliance on the PAC-PRD data elicits the following concerns, each of which is described in more detail below:

  • The data are extremely outdated and do not reflect the current state of PAC patient care.

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[21] The specific costs and stay-level routine resource expenditures collected for the resource use component were used along with CARE assessment data and charge information from the claims data to predict resource use in the four PAC settings in the prototype PAC PPS model. The basic measure of resource use is the weighted sum of total staff time per individual patient. Total staff time includes all direct care staff and support staff directly involved in the care of specific patients. CMS stated that these data were weighted to reflect each staff member's national wage rate by occupation and licensure level.

> **PAC-PRD Background**
>
> CMS conducted the PAC-PRD starting in 2008, as mandated by the Deficit Reduction Act of 2005. This demonstration yielded standardized data for the four PAC settings in these domains:
>
> 1. medical status/clinical complexity;
> 2. functional status;
> 3. cognitive status; and
> 4. social support factors.
>
> These data were collected using a common patient assessment instrument, known as the Continuity Assessment Record and Evaluation (CARE) Tool, and real-time audits of the resources used per patient. PAC-PRD data have been used by policy-makers as they are the only standardized data that cross the four PAC settings.

- The data sample is not representative of the PAC field – both in size and distribution of provider types.
- The data collection was flawed – the tool itself, as well as the collection process.

PAC-PRD Cost Data Out of Date. For the prototype to generate payments that reflect the current cost of providing PAC services, the model's underlying cost data must align with the actual cost of care. The ability of the prototype to achieve this alignment is questionable, however, as it is reasonable to assume that the prototype's cost data (derived from 2008-2010 Medicare claims data that matched the PAC-PRD stays) do not reflect recent cost trends. Since the PAC-PRD era, PAC costs have changed due to a host of statutory and regulatory changes, which include, but are not limited to, the calendar year (CY) 2014 through 2017 rebasing of the HH payment system, the introduction of LTCH site-neutral payment implementation in 2015, the implementation of revised coverage criteria for IRFs, and the implementation of APMs in many markets. For example, the link between patient characteristics, as captured within the PAC-PRD data, and the cost of PAC service delivery will not likely hold over time, particularly with the ongoing spread of value-based payment and APMs. Further, to periodically update the PAC-PRD cost data would be highly unwieldy and expensive, as discussed more below. We also note that the prototype's reliance on these static data raise questions about how policymakers would update the system in the future.

PAC-PRD Provider Sample Very Small and Not Representative of Current Distribution of PAC Providers. The provider sample used for the PAC-PRD data is very small, accounting for only 0.4 percent of PAC providers and 0.1 percent of PAC stays in 2013. Specifically, as shown in Exhibit 2, the PAC-PRD sample included only 107 providers and 6,409 stays across the four PAC settings.[22]

Exhibit 2: Comparing Sample Size between PAC-PRD and Claims Data

Sample Size	Matched PAC-PRD Sample (2008-2010)	Sample Size of Claims Data (2013)	PAC-PRD Sample as % of Claims Data
Number of PAC Stays	6,409	8.9 million	0.1%
Number of Providers	107	24,953	0.4%

Source: MedPAC. Developing a unified payment system for post-acute care. June 2016.

In addition, the sample does not reflect the national PAC provider distribution or capture the full array of PAC patients.[23] Per Exhibit 3, IRF and LTCH providers and stays were over-represented, while SNF and HHA providers and stays were under-represented in the

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[22] MedPAC. Mandated report. Developing a unified payment system for post-acute care. June 2016.

[23] The Centers for Medicare and Medicaid Services. Post-Acute Care Payment Reform Demonstration: Final Report. Volume 1. March 2012.

PAC-PRD sample, compared to the 2013 national distributions. [24] The sample representativeness is further weakened by the likelihood of selection bias, as provider participation in the PAC-PRD was voluntary. These limitations make the generalizability of inferences made using the PAC-PRD data open to question, as they could negatively affect the resulting PPS, the accuracy of its payments and future replication work. While MedPAC acknowledged the issue of limited representativeness of PAC-PRD data in its June 2016 report,[25] we are forced to conclude that **the PAC-PRD data reflect only the patient care provided by participating providers, which accounted for only 0.4 percent of all PAC providers.**

Exhibit 3: Comparing Sample Distributions between PAC-PRD and Claims Data

PAC-PRD Stays	Sample Distribution	National Distribution
HHAs	60%	70%
SNFs	12%	25%
IRFs	17%	4%
LTCHs	11%	2%

PAC-PRD Providers	Sample Distribution	National Distribution
HHAs	38%	43%
SNFs	26%	52%
IRFs	22%	4%
LTCHs	13%	1%

Source: MedPAC. Developing a unified payment system for post-acute care. June 2016.

PAC-PRD Data Gathered Using Flawed Data Collection. The collection of the PAC-PRD data was flawed in several respects. First, it was collected via an inadequate patient assessment instrument. Specifically, the PAC-PRD's patient assessment instrument, known as the CARE Tool, has been criticized for its length and its inability to capture the full resource needs of high-acuity PAC patients.[26]The CARE Tool takes approximately 30 minutes to complete for healthier patients, but up to 60 minutes or longer for the more severely ill patients receiving hospital-level care in LTCHs and IRFs.[27] In addition, these two settings were under-sampled in MedPAC's work, perhaps compounding the underestimation of high-resource need patients. Thus, the CARE Tool data, as with all data severity measurement systems, are likely "compressed" where high-cost cases are under-

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[24] MedPAC. Mandated report. Developing a unified payment system for post-acute care. June 2016.

[25] MedPAC. Report to the Congress: Medicare and the Health Care Delivery System. Chapter 3: Mandated report: Developing a unified payment system for post-acute care. Chapter 3. Page 66. June 2016.

[26] The Centers for Medicare and Medicaid Services. Post-Acute Care Payment Reform Demonstration: Final Report. Volume 1. March 2012.

[27] The Centers for Medicare and Medicaid Services. Post-Acute Care Payment Reform Demonstration: Final Report. Volume 1. March 2012.

costed and low-cost ones are over-costed – a challenge that must be addressed for a PAC PPS to generate accurate payments for such patients.

Another potential model limitation arises from the brief two-week time period that was used to collect the PAC-PRD resource use data. This brevity prevented the capturing of a full picture of variation in staff-time and resource use that is needed to treat different types of patients across PAC settings.[28] Such a limitation is especially concerning given that many PAC patients are long-stay patients. Since the data only provide brief snapshots of resource use at different times, and since some providers collected only one to two rounds of resource use data and may not have had adequate experience to report data in a consistent way, the insights from these data can be called into question.[29]

Finally, as shown in Exhibit 1, each of MedPAC's three models utilized PAC-PRD and other data from inconsistent timeframes. To address this concern, in part, MedPAC weighted the PAC-PRD stays to match the distribution of 2013 PAC providers. However, their methodology blended two different types of data (resource use data and patient assessment data) from two different sets of PAC providers (those in the original demonstration and those in the demonstration supplemental stage). This approach raises questions as to how representative the PAC-PRD data used by MedPAC are, especially as the MedPAC reports do not fully explain their methodology. As a result, we are unable to investigate how the adjusted PAC-PRD data impact the accuracy of the prototype's cost data, any diminishment of which would reduce the accuracy of payments generated by the prototype.

Circular Use of Data. In addition, we have concerns that prototype's reliance on the circular use of PAC-PRD data might cause an overstatement of the model's accuracy, and subsequently, we may not have a true sense of how well payments generated by the model align with costs. Typically, when building a regression-based payment system, such as the Inpatient Psychiatric Facility PPS, actual costs are calculated independently (e.g., wholly from the Medicare cost report and claims data); then, predicted costs are estimated in the regression model, using actual costs as the dependent variable and patient and/or facility characteristics as independent variables. However, the prototype design lacks this standard element of independence between "actual" costs, predicted costs, and payments. Specifically, since the IMPACT Act mandated the use of PAC-PRD data, those data were used to estimate the resource portion of both "actual" and "predicted" costs, while the cost report and claims data were used to calculate therapy and nontherapy ancillary costs (as shown in Exhibit 1). This estimate of relative resource use from the PAC-PRD data also is based on a regression model using the same data used in the predicted cost regression model. Further, we have concerns that the evaluation method MedPAC used for determining the "payment adequacy" of the

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[28] The Centers for Medicare and Medicaid Services. Post-Acute Care Payment Reform Demonstration: Final Report. Volume 2. March 2012.

[29] The Centers for Medicare and Medicaid Services. Post-Acute Care Payment Reform Demonstration: Final Report. Volume 2. March 2012.

prototype was not appropriate for their regression-based approach. Due to these circularity issues, we may not have a true sense of how well payments generated by the prototype align with costs.

B. PAC PPS's Regression-based Design Raises Concerns

The regression-based design that was used for the PAC PPS prototype raises two major concerns. First, we are concerned that complexity of the prototype's regression-based model is not administratively feasible. Specifically, we are concerned that its complexity will render PAC providers unable to reasonably estimate their payment and determine their plan of care for a given patient prior to, or within a short time after admission. This is because, under MedPAC's design, the PAC payment is based on approximately 100 patient characteristic variables. In addition, at least some variables that are needed to estimate payments are unlikely to be complete until well after post-acute care admission. Predictability and reliability are two key factors in the construction of a PPS, and providers face substantial risks when they are lacking.

In comparison, other non-PAC payment systems such as the inpatient hospital PPS, the IPF PPS, etc. rely on a patient classification system, and are predictable, reliable and non-complex. In fact, the IPF PPS's regression-based approach, which uses the Medicare Severity-Diagnosis Related Group (MS-DRG) classification system, uses a limited set of independent variables, including the MS-DRGs, to create payment adjustments that make it relatively simple for providers to estimate their payments. The PAC payment systems also use some form of patient classification system and CMS should consider incorporating such a system that can be used across PAC settings, as discussed in more detail below.

C. PAC PPS Prototype Could Threaten Patient Access to Care

In its June 2016 report to Congress, MedPAC notes that PAC access issues could arise if PAC PPS payments for particular types of cases are set too low. It indicates that outcomes monitoring should be implemented to identify access risks, such as tracking lengths of stay for referring hospitals to identify cases that might be difficult to place in PAC and, as a result, remain longer in a referring hospital. We concur that substantial threats to PAC access could arise. This is because, as discussed above, while the MedPAC report indicates that prototype payments for many types of PAC patients would cover estimated costs, its reliance on PAC-PRD data and a circular methodology for evaluating the PPS's payment accuracy raises questions as to whether this is a well-founded conclusion. This reliance on PAC-PRD data limits the confidence with which we can, at this time, predict which specific PAC patients would face access challenges. However, some concerns are clear. For example, the transition from a four-setting framework to a two-setting framework will likely cause major upheaval for certain providers, which could then lead to the closure of facilities that cannot undertake such a transformative change, such as lower-margin LTCHs, IRFs that cannot bear the PAC

PPS aggregate payment cuts, or smaller SNFs that struggle to meet institutional PAC conditions of participation. Such closures would obviously reduce patients' access to these PAC services. In addition, we are concerned about access to:

- Specialized PAC Services. MedPAC projected the PAC PPS prototype would result in payment reductions for LTCHs and IRFs of negative 25 percent and negative 12 percent, respectively, relative to payment under the current PPSs.[30] As such, continued access to specialized services at LTCHs and IRFs may be most in jeopardy under a PAC PPS. Both settings offer specialized programs led by clinical personnel not found in SNFs and HHAs. While the LTCH and IRF patient mix include some overlap with the mix found in SNFs and HHAs, stringent admissions and treatment criteria yield LTCH and IRF patient populations that are discrete in their need for hospital-level care. In addition, the LTCH population has far greater levels of intensive care unit utilization in the prior hospital stay and, not surprisingly, far greater proportions of patients with extreme or major severity of illness. Further, IRFs provide specialized programs for medically complex patients, such as brain injury and spinal cord injury patients. The sustainability of these specialized programs may be particularly vulnerable under the anticipated prototype cuts.

- PAC Services in Rural Areas. In general, the supply of health care providers is rapidly decreasing in rural areas: more rural hospitals were reported to close in 2013 than the prior 15 years combined.[31] This trend may worsen under a PAC PPS due to reduced payments and provider instability caused by the transition to a significantly different PAC model. As a useful reference point, CMS's evaluation of the BPCI initiative for Models 2-4 found that many rural hospitals do not yet have experience with episode-based payment – meaning they may be less prepared to undertake any major change.

- Services for Patients Requiring Multiple PAC Settings. MedPAC also did not address access for patients who need multiple types of care from several kinds of institutional PAC settings, or those where institutional PAC is preceded or followed by home-based PAC. These types of care, which can differ greatly in their scope and intensity, need to be addressed.

Finally, upstream conveners and third-party benefits administrators that have substantial incentives to reduce PAC costs under APMs are a challenge to patient access. This spending decrease currently occurs through substitution of lower-cost PAC for higher-cost PAC and in reduced spending within a setting (e.g., reduced length of stay in SNFs). Some markets and APMs have seen substantial PAC cost reductions through these strategies.[32] Proposed PAC payments under the prototype PAC PPS are counter to

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[30] MedPAC. Mandated report. Developing a unified payment system for post-acute care. Page 81, Exhibit 3-6. June 2016.
[31] Morgan, A. Rural Hospital closing at alarming rate. [Blog] May 1, 2014.
[32] McWilliams, J.M., et al. Changes in Postacute Care in the Medicare Shared Savings Program. JAMA Internal Medicine. April 2017.

current market movements. Under the prototype, SNF payments would be raised and IRF and LTCH payments would be cut. This would suggest more SNF and less LTCH and IRF usage. SNFs would normally expect increased prices to yield higher total payments. However, if PAC PPS payment changes are implemented, this may incentivize even greater restriction of SNF utilization under APMs that have shared responsibility for PAC costs. Thus, substantial redistribution of payments, as proposed in the PAC PPS prototype, may increase the variability of PAC setting use for patients who can be treated appropriately in multiple settings rather than decrease it, counter to the intent of the model.

Policy Recommendations

To develop a PAC PPS payment model that preserves access to medically necessary services, generates adequate payments for the full spectrum of PAC services, and is administratively feasible, we encourage CMS and ASPE to consider the following recommendations.

1. Ensure a Transparent PAC PPS Development Process

As a PAC PPS would alter the PAC provider supply and marketplace structure, and thus patient access to PAC, CMS and ASPE should provide updates to stakeholders at key stages of policy development. This includes sharing the methodology and underlying data to allow providers and their representatives to replicate and weigh in on key elements of the model while in the development stage. A transparent development process would help produce the stakeholder buy-in needed to implement the new model successfully and account for the myriad consequences, which are possible under a substantial marketplace overhaul. For instance, after the release of the MedPAC report, many methodological questions were left unanswered for stakeholders. Further, the lack of sharing of MedPAC data and methodologies has prevented stakeholders from duplicating and validating the prototype, a key aspect of having a thoroughly informed provider community able to meaningfully contribute to this highly complex undertaking.

Policymakers also should be transparent and timely in their release of details about PAC PPS proposals and related policies for how a new PAC PPS fits into the broader reform plan for PAC. Complete transparency has not been provided for prior reform efforts related to APMs and value-based payment models, which has tempered support for these efforts and caused implementation challenges, particularly for mandatory programs. We encourage CMS to release a master plan to guide providers' decision making related to a potential PAC PPS transition within the framework of the many other policy changes currently under consideration.

2. Ensure Patient Access to Specialized PAC Services

Fair and adequate payments, which preserve patient access to care, should be a guiding principle embraced throughout the conception, development, and transition to any alternative payment system or initiative. Preserving patient access may require new companion policies targeted to assuring adequate payment to rural PAC providers as

well as other appropriate companion policies or incentives to ensure access to care. In response to the access concerns raised above, CMS and ASPE should estimate the impact of this future model on access to specialized PAC, especially specialized services not found in all PAC settings. Steps should be taken to preserve services that are more vulnerable to being lost in the transition to a PAC PPS because:

- These services are more complex and costly to provide, such as ventilator weaning programs;

- They require specialty clinicians, such as physiatrists, respiratory therapists or wound specialists;

- Utilization drops due to reductions in supply capacity due to PAC PPS redistributive payment cuts to higher-cost settings;

- They are underpaid by a PAC PPS and, therefore, not sustainable, such as the patient categories MedPAC identified as underpaid by the prototype; and/or

- They are provided in rural areas already facing the pressure of dwindling health care services and professionals.

CMS and ASPE should ensure that access to care for patients is maintained, particularly for patients who are only able to receive appropriate care in a specific setting. To do so, we suggest that CMS/ASPE findings on payment adequacy for these specialized services and the following access issues be examined:

- Whether PAC PPS payments support the providers and specialized programs needed to sustain services designed for high-acuity patients and rural areas;

- Whether PAC PPS payments produce new barriers to patient choice; and

- Whether the combined impact of a PAC PPS, along with other new payment models, results in the reduction in use of higher-cost, higher-intensity services. The financial soundness of providers who serve medically complex cases needs to be considered.

In addition, as discussed in the MedPAC report, careful consideration should be given to the adjustments needed to ensure payment adequacy, and therefore access to care. Adjustments can include high-cost outliers, risk adjustment to account for treating higher-acuity patients, and the need for payment adjustments for facilities that are rural, have teaching programs, and/or treat high shares of low-income patients.

Transition Policies Must Be Carefully Crafted. Decisions about the transition to the PAC PPS – when and how to rebase payments, and whether to maintain payment system budget neutrality – are under consideration by MedPAC. While MedPAC impact analyses already show substantial cuts in payments to LTCHs and IRFs – to the point of creating negative LTCH margins and thin IRF margins on current caseloads – MedPAC recently has argued that further cuts should be made. At the April 2017 meeting,

MedPAC commissioners agreed that a PAC PPS should be implemented 5 percent below budget neutrality. Combining marked redistribution of payments away from the settings which provide care for the patients with the most severe needs while reducing total payments overall may threaten patient access to currently available services. While companion policies (such as possible changes to regulatory frameworks described below) would allow LTCHs and IRFs to serve lower acuity and lower cost patients, it is unclear if the subsequent change in patient mix (and, thus, payments) would be adequate to maintain access and the availability of high-cost, medically necessary services. CMS might consider adding adjustments to a PAC PPS, such as regional or site-specific payment additions, to preserve beneficiary access.

3. Use the Most Currently-available Cost Data instead of PAC-PRD Cost Data

CMS and ASPE are not subject to the IMPACT Act mandate that MedPAC utilize PAC-PRD data. Therefore, to ensure payment accuracy, we recommend that the pending CMS and ASPE PAC PPS model utilize cost data from Medicare cost reports and claims data, rather than the prototype's approach of utilizing PAC-PRD data. It is important to note that systems, such as the Medicare physician fee schedule, that used external data became obsolete (and produced inaccurate results) within a relatively short time. Thus, basing cost estimates entirely on the most recent complete Medicare cost report information along with claims data could improve the utility and accuracy of the model. Removing PAC-PRD from the model entirely also would eliminate the issues related to over-estimation of model payment accuracy and adequacy as this would cause the comparisons to be fully independent (as described in the above sections). Relying on cost report data would also facilitate updates to the system over time, in contrast to relying on static PAC-PRD data.

4. Streamline the PAC PPS to Achieve Payment Predictability

PAC PPS development should be guided by the key principle of payment predictability, as is the case with APM development protocols. [33] The PAC PPS prototype may not be able to achieve payment predictability for providers since payments are calculated using a regression that incorporates approximately 100 patient clinical and demographic characteristics. These data are collected at disparate times, many of which occur long after the patient has been discharged back to his or her community. This complex approach would present operational and clinical challenges throughout an episode of care. For example, for a general acute-care hospital stay, post-acute planning is part of the pre-hospitalization, acute stay, and discharge planning stages of care. Hospitals would struggle with accessing the 100 model data elements associated with the PAC PPS as they treat the patient and prepare for a post-acute transition. From the PAC perspective, this complex model would inhibit an understanding of PAC needs, costs and payments, which could drive up the risk of admitting patients with an unclear PAC PPS profile. To achieve payment predictability, CMS should simplify the prototype's classification system implicit in the regression models and define a simple companion

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[33] American Medical Association. A Guide to Physician-Focused Alternative Payment Models.

patient assessment tool that captures functional status and other key clinical characteristics relevant to PAC placement.

To address these concerns, we suggest that CMS and ASPE:

- Consider a model that groups patients into clinical categories instead of the prototype's reliance on a 100-element regression model to assign payments for each patient, if a clinically relevant design can be built for all PAC settings. Any alternative to the prototype's regression-based approach should be based on a clinical rationale that could be more intuitive to understand and less administratively burdensome.

- Investigate existing clinical discharge assessment tools currently being used by hospitals, which have minimal data entry requirements and, thus, low provider burden. Many acute care hospitals and PAC providers have taken the initiative to implement their own discharge planning tools to improve transitions to post-acute care and reduce readmissions; instruments such as Partners' Continuing Care's Post-Acute Leveling Tool and the Cleveland Clinic's "Six Clicks" Functional Mobility Measure[34] share the commonality that they are chart-based and reflect limited collection burden. These types of tools could be easily implemented to improve clinical consistency as well as the predictability of PAC payments.

Some additional implementation concerns were addressed by MedPAC, such as an illustrative outlier policy, but others were not addressed in the report or subsequent MedPAC meetings. The prototype effort left payment for care pathways ambiguous. Courses of care requiring the services of multiple PAC providers are not uncommon – for example, a patient may receive care at an IRF following an acute care discharge and then returns home with follow-up care provided through HH services. Payments for these cases were not modeled in the MedPAC prototype, which is a substantial omission considering that timing and sequencing of post-acute care indicates substantially different resource uses.[35]

5. Streamline the PAC Regulatory Framework under a PAC PPS

The transition to a site-neutral PAC PPS presents a unique opportunity to streamline the PAC regulatory infrastructure designed to support the current fee-for-service siloed PAC delivery system. As CMS has done when implementing APMs, the transition to a PAC PPS could be paired with a lighter regulatory load, as the current PAC admission criteria and related policies are substantial, costly to comply with, and may serve to reduce patient access to high-acuity services under the PAC PPS model. CMS and ASPE should consider MedPAC's recommendation that the prototype PAC PPS be

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[34] American Hospital Association. Private-Sector Hospital Discharge Tools. Jan 2015.

[35] Abt Associates. Medicare Home Health Prospective Payment System: Case-Mix Methodology Refinements. Overview of the Home Health Groupings Model. Nov 2016.

implemented along with waivers of setting-specific regulations that do not align with a PAC PPS structure and incentives, such as:

- LTCH "25% Rule" and 25+ day average length of stay requirement;

- IRF "60% Rule" and three-hour rule;

- SNF three-day stay requirement;

- HH homebound requirement; and

- Other policies designed to distinguish the PAC settings from one another or to direct PAC patients to a particular setting.

A more targeted and lighter regulatory framework paired with a PAC PPS would enable the reallocation of resources from administrative and compliance activities to patient care. This may effectively consolidate PAC provision from four settings to two: institutional SNF, IRF and LTCH services in one setting or one corporate structure and home-based care. Under a PAC PPS transition, CMS should seek to balance the needs for reduced regulation to allow for PAC provider changes in patient mixes to remain financially stable with the broader need to maintain access to high-acuity services, which are largely defined by the current regulatory framework. Additional payment incentives may be needed to maintain some level of uniqueness among different types of service providers in order to achieve an optimal mix of available services. A middle ground approach is likely a better policy wherein some product differentiation across facility types is allowed and paid for. Under a new PAC PPS, with its two-setting framework, Medicare conditions of participation and state certificate of need laws would also require refinements to align with the new system.

6. Anticipate the Impact of APMs on a PAC PPS

If authorized by Congress, a PAC PPS would bring transformative change to the PAC marketplace after 2024. By that time, the PAC field will likely look substantially different than it did when the IMPACT Act was enacted in 2014 and the prototype payment model developed in 2016, due to APM-driven shifts in PAC utilization and other PAC-specific regulatory changes. For example, since the passage of the IMPACT Act in 2014, the LTCH field has initiated a major transformation with the implementation of site-neutral payment. In addition, major payment system refinements are nearing completion at CMS for both the HH and SNF PPSs. PAC utilization may be further redistributed across settings, if not outright reduced under these refinements by the time Congress could consider implementing a PAC PPS.

Given the scope of these major changes, beyond a potential PAC PPS implementation, CMS and ASPE should consider the following:

> Transition gradually. A gradual PAC PPS transition would be warranted to enable providers to adapt their operations to change in payments and overall

payment philosophy under a PAC PPS, as well as the extensive regulatory changes that may accompany such a payment system. A gradual transition would avoid the problems associated with the early stages of APM activities, which continue to present conceptual and operational challenges to both policymakers and providers. [36] These challenges include unexpected effects of new or revised incentive systems such as altered patterns of care and near-term marketplace instability.

A gradual transition would also be beneficial in light of PAC providers' limited participation and experience to date in CMS's bundled payment initiatives.[37] The experience of the Bundled Payment for Care Improvement (BPCI) initiative and Accountable Care Organization (ACO) implementation have suggested that an average of approximately three years ─ with defined phase-in periods ─ could be needed for the transition from setting-specific PPS to site-neutral PAC PPS payments. A recommendation for a three-year transition was also proposed in MedPAC's meeting on March 2, 2017.[38] In addition, it is very likely that the PAC PPS initiative will need to be modified on a real-time basis with a series of midcourse corrections, to accommodate a changing policy landscape.

Clarify how a PAC PPS would fit with broader policy framework. To assist providers in their transition to a PAC PPS, CMS should communicate its PAC payment reform master plan that articulates the key reform elements, their interactions, as well as respective timelines. CMS also should communicate its view on how a PAC PPS would fit with hospital discharge processes and how patient assessments for PAC patients would be handled for the purposes of PAC placement, care planning, and payment determination. In particular, it would be helpful if CMS/ASPE elaborated on whether it plans to create patient assessment and discharge evaluations that could be used by providers across the full continuum of care.

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[36] The Lewin Group. CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 2 Evaluation and Monitoring Annual Report. Prepared for CMS. August 2016.

[37] The Center for Medicare and Medicaid Services. BPCI Model 3: Retrospective Post Acute Care Only. There were only 622 SNF participants, 81 HHAs, 9 IRFs, and no LTCHs in the Bundled Payment Care Improvement (BPCI) Model 3 Phase 2, as of January 1, 2017.[37]

[38] Medicare Payment Advisory Commission. Public Meeting Transcript for March, 2, 2017. March, 2017.