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*Medicare*

## Medicare Panel Calls for More Help for Rural Hospitals (1)

Congress should provide more support to rural hospital emergency departments, including exploring new payment models to support outpatient-only hospitals, a panel of Medicare advisers said.

Part of this solution would include allowing isolated rural stand-alone emergency departments (meaning more than 35 miles from another emergency department) to bill standard outpatient prospective payment system facility fees, according to the Medicare Payment Advisory Commission (MedPAC). The panel made the recommendation to cut the risk of emergency department services disappearing from rural areas.

Freestanding emergency departments ''may have a role in maintaining access in rural areas,'' Jim Mathews, executive director of MedPAC, said in a call with reporters June 15.

These recommendations, which were approved unanimously by the 17 members of the commission, were the only recommendations made in the June 15 report. MedPAC advises Congress on health-care policy and produces reports twice a year, in March and June.

The report did, however, make conclusions about the usefulness of some Medicare programs and discuss potential ways to improve others.

Joanna Hiatt Kim, vice president of payment policy at the American Hospital Association, lauded the recommendation on rural emergency departments.

''We support MedPAC's recommendation to allow isolated rural hospitals to convert to stand-alone EDs, which will help ensure continued access to essential health services in vulnerable rural communities,'' Hiatt Kim told Bloomberg Law in an email June 15.

''We continue to urge the commission to expand this recommendation to include EDs in vulnerable urban communities as well,'' she said.

**Hospital Readmissions** MedPAC found that the Hospital Readmissions Reduction Program contributed to a decline in preventable readmission rates since the program's introduction in 2010. The program did so without causing a material increase in emergency department visits or mortality rates and saved Medicare about $2 billion each year.

Congress added a financial incentive to reduce hospital readmissions in 2010: a 3 percent reduction in Medicare payment rates for hospitals with above-average readmission rates.

The program's goal was to relieve Medicare beneficiaries of having to return to the hospital and decrease the cost for which taxpayers were responsible.

Prior to 2010, the rate of readmissions was fairly constant at around 17.7 percent. After the program's introduction, it decreased to 15.8 percent in 2016.

The decline in readmissions was greatest for the three conditions that were initially addressed by the program: acute myocardial infarction, heart failure, and pneumonia.

MedPAC suggested that this program could be improved by expanding it to cover all conditions and reducing the penalty for each excess readmission.

**Post-Acute Care** MedPAC has made post-acute care a priority within this report, taking up the issues of payment and provider quality.

The commission discussed the need to define when one phase of post-acute care ends and the next begins in situations of sequential stays. Post-acute care can occur at skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.

Sequential stays become an issue in billing because the cost of a stay can vary depending on where it falls within the sequence of post-acute care provider stays. Without defining each phase of care, a provider would get one payment for the total stay, which gives them a financial disincentive to treat patients with evolving care needs.

Each type of post-acute care provider currently uses a separate payment system at a total cost of $60 billion in 2016. In the commission's June 2017 report, the commission recommended a unified payment system to increase the accuracy of payments for sequential stays.

The prototype of the unified payment system did not include a way to appropriately pay a provider that cared for a range of post-acute care services.

The adjustment for home health payments will be ''critical,'' Thomas Threlkeld, deputy director of policy and communications at the National Association for Home Care & Hospice, told Bloomberg Law June 15. ''How these things are done will really matter.''

In the next year, the commission plans to explore the possibility of a single payment for all post-acute care during an episode of care. The panel also plans to look into how to help beneficiaries identify better quality post-acute care providers.

Eighty-five percent of patients who used a post-acute care provider after hospitalization had a higher quality provider available to them within a 15 mile radius than the one they used.

''Obviously, we have no problem with encouraging Medicare beneficiaries to seek out high-quality post-

acute care providers,'' Threlkeld said. ''We'll have to see what the implementation is.''

**Hospital Quality Incentives** Four quality-based payment systems currently exist to improve patient care. The report addresses the concern that four systems create unneeded complexity in the Medicare program and that some of the programs rate providers relative to one another instead of based on performance targets.

The Medicare panel suggested a model where one payment system distributes payment adjustments to hospitals that are organized into groups that serve similar populations. The program would combine measures of mortality, readmissions, patient experience, and Medicare spending per beneficiary.

''There is a lot of redundancy among these programs and administrative complexity,'' MedPAC's Mathews said. The program MedPAC recommended would be based on administrative data that hospitals already submit and would have no additional burden for hospitals.

The program would organize hospitals into 10 peer groups based on their share of patients enrolled in both Medicare and Medicaid. Half of the hospital groups would get a negative payment adjustment based on their performance and the other half would get a positive adjustment.

This program would take the socioeconomic status of patients into account through payment adjustments on the back end, Mathews said. ''This approach treats hospitals that have a disproportionate share of low-income patients much more equitably than current systems do,'' Mathews said.

**ACOs** MedPAC's report also addressed how accountable care organizations that take on two-sided risk appear to save more money than ACOs that don't assume any downside risk. The Medicare ACOs were created to tamp down spending growth and improve the quality of care in fee-for-service Medicare by making health-care providers such as doctors responsible for costs and quality of care.

In a two-sided risk model for an ACO, the health-care providers can lose or receive extra funding based on their performance. The report concluded that ACOs with this model may have been saving 1 to 2 percent more than indicated by their performance.

MedPAC discussed ways to bring longevity to two-sided risk ACOs, including using equitable benchmarks to encourage long-term participation. The panel also discussed how hospitals may want to participate in these types of ACOs because the savings come from reduction in use of post-acute care and not inpatient care.

The commission also discussed how participation in two-sided ACOs could be encouraged by giving clinicians a 5 percent bonus on all their physician fee schedule payments instead of basing that bonus on exceeding a threshold.

The National Association of ACOs (NAACOS) appreciates MedPAC's ''recognition that Medicare ACOs save more money for Medicare than what is reflected in basic evaluations of performance compared to CMS manufactured benchmarks,'' Allison Brennan, vice president of policy for NAACOS, told Bloomberg Law June 15.

**Medical Equipment** MedPAC also said it plans to look into how to improve payment policies for durable medical equipment, prosthetics, orthotics, and supplies that are not part of a current competitive bidding program.

The panel said products that are part of the competitive bids program have lower costs, so MedPAC suggested moving additional products—such as back braces, orthotic braces, ventilators, and catheters—into the program.

MedPAC also looked at policies to encourage the development of highly integrated plans for so-called ''dual-eligible'' beneficiaries who qualify for both Medicare and Medicaid.

The panel suggested that Congress limit how often those beneficiaries can change their coverage, limit enrollment in Medicare Advantage dual-eligible special needs plans, and expand the use of passive enrollment (the automatic enrollment of beneficiaries in Medicare-Medicaid plans).

The report looked at potential tools to prevent the use of low-value care, including expanding prior authorization, increasing cost sharing, and establishing new payment models.

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