Medicare: Now and Beyond

Alyssa Keefe
California Hospital Association
Overview

- Post-Acute Care PPS Updates
- IMPACT Act Implementation Updates
  - MedPAC Recommendations
- Status of Episode Based Payment Models
- Site Neutral Payment Provisions and Next Steps
Post-Acute PPS Updates
### Post-Acute Proposed Rule

#### Updates

<table>
<thead>
<tr>
<th>Payment Setting</th>
<th>Rate Update</th>
<th>Setting-Specific Payment Adjustments</th>
<th>Wage Index</th>
<th>Pay-For-Reporting Programs</th>
<th>Other Notables</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SNF</strong>&lt;br&gt;[proposed rule]</td>
<td>+1.1%&lt;br&gt;[2.7% MB- 0.4 PPT ACA] *&lt;br&gt;-1.27% (1% cap) *1.0003&lt;br&gt;WI BN *&lt;br&gt;+ .04% BN</td>
<td>Revising and Rebasining of SNF MB to 2014 base year. ANPRM is soliciting comments on revisions to SNF methodology: replacing CMI classification model, RUG-IV, to RCS-1.</td>
<td>FFY 2018 hosp. WI</td>
<td>VBP beg FFY 2019 providing incentive payments to SNFs w/ &gt; levels of performance and penalties of up to 2% w/ &lt; performance on readmissions; proposed changes to the FFY 2020 QRP including a revised measure that address pressure ulcer changes while adding 4 function outcome measures.</td>
<td></td>
</tr>
<tr>
<td><strong>LTCH</strong>&lt;br&gt;Proposed rule</td>
<td>+2.3%&lt;br&gt;[2.8% MB- 1.15 PPT ACA] *&lt;br&gt;-0.64% (1% cap) *1.000077&lt;br&gt;WI BN *0.9672 BN as a result of SSO methodology change</td>
<td>3rd year of site neutral (SN) payment method; paid full SN rate in FFY 2018 (2yr transition blend over); Proposed 1 year delay full application of 25% PMT threshold until Oct. 2018. Changes to SSO policy.</td>
<td>FFY 2018 hosp. WI</td>
<td>Updates to Vent Measures and removal of the Potentially Preventable Readmissions Measure</td>
<td>No longer subject to a suspension on the increase of # of beds if they meet criteria. Proposes to remove MA and SN cases from ALOS calculation.</td>
</tr>
</tbody>
</table>

- All payment settings include a request to provide suggestions on ways Medicare can improve the delivery system to be more flexible and efficient.
- CMS is soliciting comments on how to include social risk factors into SNF, IRF and LTCH QRP.
- To comply with the IMPACT Act, in order to enable access to longitudinal information and to facilitate coordinated care, proposed for FFY 2020: SNFs, LTCH and IRFs to collect certain standardized patient assessment data for discharges between Oct. – Dec. 2018.
### Post-Acute Proposed Rule Updates (cont.)

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<tr>
<td><strong>IRF</strong> [proposed rule]</td>
<td>+0.81% [2.7% MB- 1.15 PPT ACA] * -0.54% (1% cap) *1.0007 WI BN * +0.9974 case mix BN</td>
<td>Loss of Rural adjustment (Final year of 3 year transition).</td>
<td>FFY 2017 hosp. WI</td>
<td># of proposed changes to the FFY 2020 QRP including removing an all-cause unplanned readmission measure, and replacing a % of residents w/ pressure ulcers that are new or worsened with a modified version “Changes in skin integrity PAC: pressure ulcer/injury.”</td>
<td>Proposes to eliminate the 25% penalty for late IRF patient assessment instrument submissions; Proposes a set of refinements to the codes used to assess a facility’s compliance with 60% Rule.</td>
</tr>
<tr>
<td><strong>IPF</strong> [proposed rule]</td>
<td>Update Notice Likely</td>
<td></td>
<td></td>
<td>Proposed measure removal factors; criteria for “topped out,” and measure retention factors.</td>
<td></td>
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- CMS is soliciting comments on how to include social risk factors into SNF, IRF and LTCH QRP.
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IMPACT Act Implementation
MedPAC Recommendations
IMPACT ACT GOALS

- Passed by Congress on Bipartisan basis - October 2014
- Improve Medicare beneficiary outcomes
- Facilitate comparable data and quality across PAC settings
- Support provider access to longitudinal information to facilitate coordinated care
- Develop payment models based on patient characteristics
IMPACT ACT – A 3-Part Series

1. RTI and Abt: Standardized Quality Measurement
2. RAND and Abt: Standardized Patient Assessment Data
3. MedPAC and CMS: Unified PAC PPS
“Before I write my name on the board, I’ll need to know how you’re planning to use that data.”
Are You on the Bus?
IMPACT ACT – 3-Part Series

RTI and Abt: Standardized Quality Measurement

RAND and Abt: Standardized Patient Assessment Data

MedPAC and CMS: Unified PAC PPS
Timetable for a PAC PPS Considered in the IMPACT Act of 2014

- MedPAC report June 2016
  - Recommend features of a PAC PPS and estimate impacts
- Collection of uniform patient assessment information beginning October 2018 will inform subsequent reports
- Subsequent reports due:
  - Secretary’s report using 2 years’ patient assessment data (2022)
  - MedPAC report on a prototype design (2023)
- Unlikely that a PAC PPS would be proposed before 2024 for implementation sometime after that
- The IMPACT Act does not require implementation of a PAC PPS
Conclusions:

- PAC PPS was feasible and could be implemented sooner than outlined in IMPACT Act
- Include functional assessment data into the risk adjustment when these data become available
- Begin to align regulatory requirements

Design Features:

- Common unit of service and risk adjustment method
- Adjust payments for home health episodes
- Include short-stay and high-cost outlier policies

Implementation Issues

- Transition to PAC PPS
- Level of aggregate PAC payments
- The need to make periodic refinements to the PPS

March 2017 Recommendation

- Congress should direct the Secretary to implement a prospective payment system for post-acute care beginning in **2021 with a 3-year transition**; **lower aggregate payments by 5%**, absent prior reduction to the level of payments; **concurrently, begin to align setting-specific regulatory requirements**, and periodically revise and rebase payments as needed, to keep payments aligned with the cost of care.
- Unanimous Yes Vote, discussion forthcoming in June 2017 report.
- Future work: Regulatory alignment.

Stakeholder Response

- Prior to vote, AHA letter expressing concern regarding accelerated timeline
  - Noted that the prototype relies too much on empirical evidence (regression analysis)
  - Hugely complex as compared to other PPS
  - Took CMS 3 years to complete SNF rebasing, timeline is not achievable
- Final recommendation reflects some of the AHA criticisms, e.g., COP changes and other regulatory changes to set the stage
Mr. Thomas: *I think this can work. We just can’t change the payment model, though. We have to change the regulatory issues to allow people to move...*

Dr. Samitt: *I just wonder if there are other areas of similar thinking where we’re not seeing the right care in the right place at the right cost ... Pre-acute, urgent care, etc....*

Mr. Thomas: *I hope there would be flexibility to create models or pilots between now and 2021 because this is a massive change for the industry ... We can’t underestimate the major impact it is going to have.*

All: *Enthusiastic YES — Great Work Staff.*
IMPACT ACT – 3-Part Series

RTI and Abt
Standardized Quality Measurement

RAND and Abt
Standardized Patient Assessment Data

MedPAC and CMS
Unified PAC PPS
IMPACT ACT Parallel Tracks

Quality Measure Development

Interoperability

Patient Assessment Data
## IMPACT Act: Measures

<table>
<thead>
<tr>
<th>Quality Measure Domain</th>
<th>HHA</th>
<th>SNF</th>
<th>IRF</th>
<th>LTCH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Functional Status</strong></td>
<td>1/1/2019</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2018</td>
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<tr>
<td><strong>Skin Integrity</strong></td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
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<tr>
<td><strong>Medication Reconciliation</strong></td>
<td>1/1/2017</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
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</tr>
<tr>
<td><strong>Incidence Major Falls</strong></td>
<td>1/1/2019</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
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<tr>
<td><strong>Transfer of Health Information</strong></td>
<td>1/1/2019</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
</tr>
<tr>
<td><strong>Resource Use &amp; Other Measures Domain</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Spending Per Beneficiary</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Discharge to Community</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
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<tr>
<td>Potentially Preventable Hospital Readmissions</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
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IMPACT ACT – 3-Part Series

RTI and Abt: Standardized Quality Measurement

RAND and Abt: Standardized Patient Assessment Data

MedPAC and CMS: Unified PAC PPS
Domains for Patient Assessment Data (Admission and Discharge)

- Function (e.g., self care and mobility)
- Cognitive function (e.g., express & understand ideas; mental status, such as depression and dementia)
- Special services, treatments & interventions (e.g., need for ventilator, dialysis, chemotherapy, and total parenteral nutrition)
- Medical conditions and co-morbidities (e.g., diabetes, heart failure, and pressure ulcers)
- Impairments (e.g., incontinence; impaired ability to hear, see, or swallow)
Current Assessment Tools

4 Different Settings, 4 Different Assessment Tools

• Skilled Nursing Facilities (SNF) Minimum Data Set (MDS)
• Home Health Agencies (HHA) Outcome and Assessment Information Set (OASIS)
• Inpatient Rehabilitation Facilities (IRF) IRF Patient Assessment Instrument (IRF-PAI)
• Long Term Care Hospitals (LTCH) LTCH CARE Data Set (LCDS)

Overlapping domains and purposes, but specific items measuring common domains differ across settings
GOAL: Uniform Data Collection

GG0160. Functional Mobility
(Complete during the 3-day assessment period.)

Code the patient’s usual performance using the 6-point scale below.

<table>
<thead>
<tr>
<th>CODING:</th>
<th>Enter Codes in Boxes</th>
<th>( A ). Roll left and right: The ability to roll from lying on back to left and right side, and roll back to back.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td></td>
<td>( B ). Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.</td>
</tr>
<tr>
<td>Quality of Performance</td>
<td></td>
<td>( C ). Lying to Sitting on Side of Bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.</td>
</tr>
</tbody>
</table>

06. Independent - Patient completes the activity by him/herself with no assistance from a helper.

05. Setup or clean-up assistance - Helper SETS UP or cleans UP; patient completes activity. Helper assists only prior to or following the activity.

04. Supervision or touching assistance - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

01. Dependent - Helper does ALL of the effort. Patient does none of the effort to complete the task.

07. Patient refused

09. Not applicable

If activity was not attempted, code:

88. Not attempted due to medical condition or safety concerns

Data Element & Response Code

Care Planning/Decision Support

QI

Quality Reporting

Payment

Care Transitions
Standardized Patient Assessment Data Process

**Track 1**
“Cross section Feasibility”
Collect every data element under the sun, convene a TEP and put it out for comment for 2 weeks and release 250 page report summary of comments

**Alpha 1 Testing**
8 Facilities in CT, 24 cognitive interviews
What works and what does not work?
Narrow/expand the set of data elements
Report to be released in May

**Alpha 2 Testing**
Narrow the set of questions and test on 16 facilities, 3 markets

**Beta = Field Testing**
Field Testing in 220 organizations in 14 markets based on comments and feedback from Alpha 2 Testing

**Summary Report to be released in Fall 2017**

**Sign-up deadline Sept. 1**

**CMS FY 2018 Rulemaking, April 2017, Seeking Comment from Track 1 documents**

- **LTCH**
  - April-June 2017

- **IRF**
  - April-June 2018

- **SNF**
  - April-June 2019

- **HHA**
  - April-July 2017

- **Complete**
  - Complete
  - April-July 2017
  - Oct. 2017- May 2018
Beta Design

- National sample will include:
  - 210 PAC facilities from 14 geographic/metropolitan areas
  - 28 IRFs, 28 LTCHs, 84 SNFs, and 70 HHAs
  - An average of 2 IRFs, 2 LTCHs, 6 SNFs, and 5 HHAs per PAC market

- Providers will be randomly selected to participate
- Patients/residents will be enrolled upon admission
- Design will include admission and discharge assessments
- Subset of patients/residents will be double-assessed by research and facility staff (as in Alpha test) to evaluate reliability
Beta Test Market Areas

14 geographic/metropolitan areas for Beta include:

- Boston, MA
- Harrisburg, PA
- Philadelphia, PA
- Fort Lauderdale, FL
- Durham, NC
- Chicago, IL
- Nashville, TN
- Kansas City, MO
- St. Louis, MO
- Dallas, TX
- Houston, TX
- Phoenix, AZ
- Los Angeles, CA
- San Diego, CA
Beta Recruitment Timeframe

- Mailings to be sent out in late April, early May 2017 to invite providers to participate in Beta
- Recruitment outreach calls from Abt Associates team members will closely follow mailings
- Recruitment target of 210 facilities must be obtained by Sept. 1, 2017
- Field period runs from Oct. 2017 – May 2018
- Debrief activities will be ongoing but summarized in early Summer 2018
Updates to Patient Assessment Tools proposed for April or Oct. 1, 2018

Proposed IRF-PAI (Oct. 1, 2018)


Proposed CARE Tool (LTCH) (April 1, 2018)
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Proposed-LTCH-CARE-Data-Set-Version-4-00-Change-Table-Effective-April-.pdf


Proposed MDS (Oct. 1, 2018)

Implications for Hospitals

- If providing PAC services; more information being collected than ever before
  - Will require additional IT infrastructure, personnel, and ongoing training
  - Data collection will continue to evolve over time
  - Time of enormous change
  - PAC providers will need time to develop efficiencies and patient workflows, leading to potential upstream impacts on patient transitions to PAC
  - May see changes in care transition patterns with PAC providers as they begin to understand implications going forward
What’s Happening in EPMs

- 2-year extension, possibility of 2.0 (MACRA)
- “Education cycle” (staff change, evolving understanding, changing rules)
- Hospitals only
- Mandated nature driving change in BPCI
- EPM rule add remaining hip/femur fractures
- Physician practices only
- Risk stratification critical
- Mandatory
- Hospitals only
- Complex Target methodology
CMS issued Final Rules on May 20, 2017 to further delay the start date for the Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model to Jan. 1, 2018.

This also delays the effective date for certain changes to the Comprehensive Joint Replacement (CJR) Model to align CJR with the EPMs to Jan. 1, 2018; CJR provisions in the original EPM final rule are also effective as of May 20, 2017.

CHA comments at www.calhospital.org/cha-news-article/cha-submits-comments-delay-cardiac-epms-cjr-model-expansion
Reconciliation — Struggles

- Reconciliation began in April, Deadline to appeal is June
- Change in standardization methodology
- First of two reconciliations
  - Implications for true-up in 2018
### Claims Lag: True-ups

- Targets are fixed prior to performance period
- Claims continue to accrue for episodes
- This is why you need to reserve!

<table>
<thead>
<tr>
<th>DRG</th>
<th>Performance Period Episode Count (a)</th>
<th>Performance Period Episode Target $ (b)</th>
<th>Total Performance Target $ (a*b)</th>
<th>Total Actual Performance $ (c)</th>
<th>Reconciliation Amount $ ([a*b]-c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>470 w/o fracture</td>
<td>100</td>
<td>$24,000</td>
<td>$2,400,000</td>
<td>$2,200,000</td>
<td>$200,000</td>
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<tr>
<td>479 w/o fracture</td>
<td>10</td>
<td>$40,000</td>
<td>$400,000</td>
<td>$550,000</td>
<td>-$150,000</td>
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<tr>
<td>Hospital A Total</td>
<td>110</td>
<td>$24,455</td>
<td>$2,800,000</td>
<td>$2,750,000</td>
<td>$50,000</td>
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<td>$24,000</td>
<td>$2,400,000</td>
<td>$2,222,000</td>
<td>$178,000</td>
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<tr>
<td>470 w/o Fracture</td>
<td>10</td>
<td>$40,000</td>
<td>$400,000</td>
<td>$555,500</td>
<td>($155,500)</td>
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<tr>
<td>Hospital A Total</td>
<td>110</td>
<td>$24,455</td>
<td>$2,800,000</td>
<td>$2,777,500</td>
<td>$22,500</td>
</tr>
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**Spend increase of 1%**

**Savings cut in half!**
Common Strategies

- Pre-op optimization and expectation-setting
- Longer inpatient LOS
- Increase discharge to home
- Developing post-acute networks
- Strategic use of current PAC staff — IRF and SNF following the patient into the community
- Gainsharing

Success REQUIRES Physician champions...
Real-Time Management vs. Strategy Review

- **Real-time management**
  - Identify at scheduling
  - Coordinate with discharge planners
  - Monitor patient progress through 90 days

- **Strategy Review**
  - What was my strategy?
  - Did I follow it?
  - Did it have the expected impact?

- Downside risk has started
Next steps

- New administration has not made clear its priorities for CMMI
- Current rule at OMB is pending on EPMs, unclear its content (Delay, make voluntary, increase waivers??)
- Hospitals continue to prepare for episode based payment in the acute care setting
- Little is known about impact on hospitals, continue evaluation and monitoring
Site Neutral Payment Updates
Amended by 21st Century Cures, Signed December 3, 2016

BBA of 2015

Section 603

Off-campus HOPD Services furnished or billing on or after November 2, 2015

Cy 2017 PFS/ASC/CLFS Rates

Voluntary Attestation

Received by CMS before December 2, 2015

Voluntary Attestation

60 days after enactment

CMS receives written certification of compliance with ‘mid-build requirements’

Submission of CMS Enrollment (Form 855)

Cy 2018 OPPS Payment Rates

60 days after enactment

or 60 days after enactment, if later

CMS receives voluntary attestation

Cy 2017 OPPS Payment Rates

CMS has specified February 13, 2017 as the 60 days after enactment
21st Century Cures Act

- Enacted into law on Dec. 13, 2016
- Sections 16001 and 16002 amend section 1833(t)(21) of the Social Security Act (the Act) and provide additional criteria by which off-campus departments of a provider can be excepted from application of Section 603
  - Section 16001: Continuing Medicare payment under HOPD prospective payment system for services furnished by mid-build off-campus outpatient departments of providers
  - Section 16002: Treatment of cancer hospitals in off-campus outpatient department of a provider policy
- CMS released guidance titled, “Note Regarding Implementation of Sections 16001 and 16002 of the 21st Century Cures Act”
CMS did NOT finalize much of what it proposed as result of the comments received:

- NO limits on service expansion in excepted locations but CMS intends to monitor volume & mix of services provided at excepted PBDs, but CMS states they will monitor service changes at excepted locations
- NO change in billing from the UB-04 to the CMS 1500
- Payment NOT being made to the physician so no need for hospitals to enter into agreements with physicians or change their structures to receive payment
- Payments NOT being made using the MPFS rates but instead an interim final decision taken to set the “MPFS” payment at 50% of the OPPS rate
Other finalized items

- OPPS payment policies like packaging and C-APCs will apply
- Paying hospitals directly will enable them to show non-excepted PBD expense & revenue on cost reports and maintain 340B eligibility
- CMS stated it does not have the statutory authority to allow additional exceptions to Section 603 and that would have to occur through legislative, hence the Cures Act
CMS Guidance on Exceptions Requests

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Subregulatory-Guidance-Section-603-Bipartisan-Budget-Act-Relocation.pdf

- CMS Region IX has granted seismic relocation requests for provider-based hospital outpatient departments in California

- If you believe you need an exception, please contact CHA so that we can assist

- CHA is unaware of any hospital that has requested or been granted an exception for any other circumstance as described in the final rule
## Summary of Billing & Payment Mechanisms

<table>
<thead>
<tr>
<th>Location of Outpatient Service</th>
<th>Hospital Claim</th>
<th>Professional Fee (PF) Claim</th>
<th>Payment Systems</th>
</tr>
</thead>
</table>
| On-campus PBD                 | No modifier   | POS = 22                   | • OPPS for hospital  
• MPFS facility RVUs for PF |
| Off-campus excepted PBD       | Modifier PO   | POS = 19                   | • OPPS for hospital  
• MPFS facility RVUs for PF |
| Off-campus non-excepted PBD   | Modifier PN   | POS = 19                   | • Special “MPFS” rate of 50% of OPPS for hospital  
• MPFS facility RVUs for PF |
| Freestanding physician office practice | NA - no hospital claim | POS = 11                   | • NA for hospital  
• MPFS at non-facility RVUs for PF |
Next Steps

- CY 2018 OPPS Rule will be released in July
- Will CMS continue 50% of OPPS rates for no excepted off campus HOPDs?
- Will CMS develop an alternative payment methodology? If so what?
- [www.calhospital.org/regulatorytracker](http://www.calhospital.org/regulatorytracker)
  - Rule Analysis and Summaries, Member Forum invitations and recordings, comment letters
  - Stay Connected!
Questions?

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