Post-Acute PPS Updates

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 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 Notations</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF (proposed)</td>
<td>+4.9%</td>
<td>+1.1%</td>
<td>Wage Index</td>
<td>FFY 2018</td>
<td>The language in the proposed rule for the increase in wage index appears to be incorrect.</td>
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<td></td>
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<td>-1.27% (1% cap)</td>
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<td>+0.4%</td>
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<tr>
<td>LTCH (proposed)</td>
<td>+2.3%</td>
<td>+0.9974 case mix BN</td>
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<td>FFY 2017</td>
<td>Proposes to eliminate the 25% penalty for late IRF patient assessment instrument submissions.</td>
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<td>-0.64% (1% cap)</td>
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<td>+0.9672 BN as a result of SSO methodology change</td>
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<tr>
<td>IRF (proposed)</td>
<td>+0.81%</td>
<td>+0.81%</td>
<td></td>
<td>FFY 2017</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>
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<td>-0.54% (1% cap)</td>
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<tr>
<td>IPF (proposed)</td>
<td>Update Notice Likely</td>
<td>Proposed measure removal factors; criteria for &quot;topped out&quot; and measure reinsertion factors</td>
<td></td>
<td>FFY 2018</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>
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• 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.)

IMPACT Act Implementation MedPAC Recommendations
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

MedPAC’s Key Conclusions and Design Features of a PAC PPS in June 2016 Report

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

Commissioner Comments

- 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
HHS 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>
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</thead>
<tbody>
<tr>
<td>Functional Status</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>Skin Integrity</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>Medication Reconciliation</td>
<td>1/1/2017</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
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<tr>
<td>Incidence Major Falls</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>Transfer of Health Information</td>
<td>1/1/2019</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
</tr>
<tr>
<td>Resource Use &amp; Other Measures Domain</td>
<td>HHA</td>
<td>SNF</td>
<td>IRF</td>
<td>LTCH</td>
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<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>
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<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>
</tbody>
</table>
IMPACT ACT – 3-Part Series

RTI and Abt
Standardized Quality Measurement

RAND and Abt
Standardized Patient Assessment Data

MedPAC and CMS
Unified PAC PPS

Standardized Patient Assessment Data Process

Cross section feasibility
Collected every data element under the sun, convened a TEP and put it out in 12 weeks and released a 250 page report summary of comments.

Facilities in CT, 24 cognitive interviews. What works and what does not work? Narrow/expand the set of data elements.

Summary Report to be released in Fall 2017

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

LTCH IRF SNF HHA

Beta Design

- National sample will include:
  - 210 PAC facilities from 14 geographics/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)

Proposed MDS (Oct. 1, 2018)
IMPACT Act Implementation

“Before I write my name on the board, I’ll need to know how you’re planning to use that data.”

Managing Complex Change

- Vision
- Skills
- Incentives
- Resources
- Action Plan

= Change
= Confusion
= Anxiety
= Resistance
= Frustration
= False Starts

Episode-Based Payment Program Updates
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
- Precedence issues
- EPM rule add remaining hip/femur fractures
- Physician practices only
- Risk stratification critical
- Mandatory?
- Hospitals only?
- Complex Target methodology

CMS Delay in EPMs

- 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

CJR Program

- Data Feeds
  - Rerun of baselines
  - Standardization of fields
  - Dropping of BPCI episodes
- Progress to date
- First Reconciliation began April 25
Reconciliation — Struggles

- 2 quarters
- Change in standardization
- Small changes in spend = large change in NPRA
  - 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></th>
<th>Performance Period Episode Count</th>
<th>Performance Period Episode Target</th>
<th>Total Performance Period EP Target</th>
<th>Total Actual Performance Period EP</th>
<th>Reconciliation Amount</th>
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</thead>
<tbody>
<tr>
<td>Fracture</td>
<td>160</td>
<td>$24,000</td>
<td>$2,322,000</td>
<td>$2,222,000</td>
<td>$100,000</td>
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<tr>
<td>Non-Fracture</td>
<td>12</td>
<td>$400,000</td>
<td>$93,500</td>
<td></td>
<td>($155,500)</td>
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<tr>
<td><strong>Total</strong></td>
<td>172</td>
<td>$28,000</td>
<td>$2,315,500</td>
<td>$2,277,500</td>
<td>$35,000</td>
</tr>
</tbody>
</table>

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?

Site Neutral Payment Updates

- 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

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 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

Non-Excepted PBD — “Interim Final” Payment System

- Site of Service Specific — form of MPFS applied only to HOPD services billed with modifier -PN
- Payment rate = 50% of OPPS payments and includes all OPPS packaging policies
- No “fee schedule” will be published, rather the OPPS I/OCE logic uses modifier -PN as the last step in payment processing to determine payment at 50% for every separately payable line on the claim having modifier -PN
- Will CMS finalize payment method in July CY 2018 OPPS Proposed 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>
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<tbody>
<tr>
<td>Off-campus PBD</td>
<td>No modifier</td>
<td>POS = 22</td>
<td>OPPS for hospital • MPFS facility RVUs for PF</td>
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<td>Off-campus excepted PBD</td>
<td>Modifier PO</td>
<td>POS = 19</td>
<td>OPPS for hospital • MPFS facility RVUs for PF</td>
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<td>Off-campus non-excepted PBD</td>
<td>Modifier PN</td>
<td>POS = 19</td>
<td>Special “MPFS” rate of 50% of OPPS for hospital • MPFS facility RVUs for PF</td>
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<td>Freestanding physician office practice</td>
<td>NA - no hospital claim</td>
<td>POS = 11</td>
<td>NA for hospital • MPFS at non-facility RVUs for PF</td>
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</tbody>
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Questions?
Text (703) 340-9850

Thank you

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