Federal Policy Shaping Post-Acute Care

February 2018
Post-Acute Care Conference

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Overview

Context Setting
Unified PPS Updates
Impact Act Updates
- Standardized Assessment Patient Data Elements (SPADE)
- Standardized Quality Measures

What to expect for FFY 2019 Payment Rules; Balanced Budget Act of 2018; President’s Budget

Who’s Who

US Congress Passes Legislation

The US Department of Health and Human Services, including the Centers for Medicare & Medicaid Services, implements legislation through regulation and subregulatory guidance.

Established in 1997, MedPAC is an independent advisory board to Congress, made up of 17 members with health policy and clinical expertise.
Azar Confirmed as HHS Secretary

The Senate approved Alex Azar for HHS secretary by a vote of 55-43 on Jan. 24, 2018.

Background

- Served as deputy secretary of HHS under George W. Bush
- Former president of the pharmaceutical company Eli Lilly
- Has worked closely with Eric Hargan, the acting HHS secretary

Priorities include:

- Reining in drug prices
- Affordable Care Act – Obamacare markets

Congressional Calendar

House and Senate in this week

- House hearings on President’s Budget; largely moot
- Brief House recess for Presidents’ Day week

Next deadline for Congress to act is March 23 for appropriations bills

- Debt limit will not expire until March 2019, but more likely to be fall of 2019

Most of the unfinished hospital business is complete! But no rest for the weary...

- Still unfinished business: 340B Drug Payment Program and playing defense against further cuts
- Read CHA News daily for updates!

Total Budget Surplus/Deficit

FY 1965 - 2027

Source: Bipartisan Policy Center

- 2017 Tax Cut
Public Debt: The Deferred Tax

Debt held by the public – estimated to exceed 100% of economy by 2038

Source: Bipartisan Policy Center

National Health Care and Medicare Spending

Medicare is the largest single purchaser of health care in the United States.

Source: June 2017 MedPAC Report

Federal Spending Projections

Federal Spending Projected for 2027 – $6,621 billion

Source: The Congressional Budget Office, June 2017
Federal Spending as a Share of the Economy

Source: Bipartisan Policy Center

Political Theatre

- Rand Paul voted for tax bill, but opposed the continuing resolution and technically shut down the government for a few hours.
- Where was the Freedom Caucus?
- When they wake up…

Operating on Two Tracks: Current and Future

Legislative

- Impact ACT 2014
- BBA 2018 Passed 2/9/18
- President’s Budget -A Marker-
- End of the year
- What is next?

Regulatory

- FFY 2019 Rulmaking
- April
- October
- IPPS/LTCH
- IRF, SNF
- CCY 2019 Rulmaking
- July
- August
- OPPS, HHA
Driving Forces of the IMPACT Act

**Purpose:**
- Improvement of Medicare beneficiary outcomes
- Provider access to longitudinal information to facilitate coordinated care
- Enable comparable data and quality across PAC settings
- Improve hospital discharge planning
- Research

**Why the attention to Post-Acute Care?**
- Escalating costs associated with PAC
- Lack of data standards/interoperability across PAC settings
- Goal of establishing payment rates according to the individual characteristics of the patient, not the care setting

Medicare Fee-for-Service Post-Acute Expenditure

Growth in Medicare’s Fee-for-Service Post-Acute Care Expenditures has Slowed Since 2002 (2001-2015, in billions USD)
Medicare Advantage Enrollment Increasing

Percentage of Medicare Beneficiaries Enrolled in Medicare Managed Care, 1995 – 2015

Medicare Margins

Medicare Margins for Post-Acute Care Providers 2004-2015, in percentage

Timetable for a Unified 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 two years’ patient assessment data (2022) (prototype design)
- 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 Approach to Designing a Uniform PPS

- Establish a common unit (CMG, RUG like)
- Develop a common case-mix adjustment
- Predict the cost of a stay using information about the patient and the stay
  - Modeled nontherapy ancillary service costs separate from routine + therapy costs
  - Included an adjuster for HHA stays
- Predicted costs would form basis for payments

Evaluate the Need for Additional Payment Adjusters

Results support an adjustment for:
- Unusually short stays
- High-cost outliers

Results did not support an adjustment for:
- Rural location
- IRF teaching

Further study
- High shares of low-income patients
- Highest acuity patients

Estimates of Impacts

- Assumed budget neutrality
- Did not consider changes in provider behavior
- MedPAC clearly states their estimates indicate the direction of impacts
- Used PAC PRD data and 2013 claims data for two separate models to develop the PPS and estimate payments
A PAC PPS Would Redistribute Payments Across Stays

Payments would:
- Increase for medical and medically complex stays
- Decrease for rehabilitation care unrelated to a patient’s characteristics

A PAC PPS would result in more uniform profitability across different types of stays
- Would decrease incentive to prefer to treat certain patients over others

Source: MedPAC, September 2017, Presentation to state hospital association executives

Average Payments under PAC PPS

Estimated percent change in average payments under a PAC PPS for select conditions

Analysis based on 8.9 million 2013 PAC stays, with payments and costs updated to 2017. The estimates are for a fully implemented PAC PPS.

Source: MedPAC, September 2017, Presentation to state hospital association executives

PAC PPS Would Redistribute Payments Across Settings and Providers

Payments would increase for:
- SNFs (7%)
- Hospital-based (11%)
- Nonprofit (9%)
- Rural (3%)
- Frontier (10%)

Payments would decrease for:
- IRFs and LTCHs (-15%)
- Freestanding (-1%)
- For-profit (-3%)
- Urban (-1%)

Analysis based on 8.9 million 2013 PAC stays, with payments and costs updated to 2017. The estimates are for a fully implemented PAC PPS.

Source: MedPAC, September 2017, Presentation to state hospital association executives
### MedPAC’s Key Conclusions & Design Features 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

Source: MedPAC June 2016 Report

### Implementation: Commission Recommendation (March 2017)

- Begin implementation in **2021** with a 3-year transition
- Incorporate functional assessment into the risk adjustment when it becomes available
- **Lower the aggregate level of payments by 5% absent prior reductions**
- Concurrently, **begin to align setting-specific regulatory requirements**
- Periodically revise and rebase payments to keep payments aligned with costs of care

Source: MedPAC, September 2017, Presentation to state hospital association executives

### Stakeholder Response

- Following June 2016 report, MedPAC continued discussions related to implementation
- 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
Align Regulatory Requirements for Providers

- With payments based on patient characteristics, setting-specific regulations are less important
- Near-term: begin alignment of regulations
  - Give providers flexibility to treat a broad mix of patients
- Longer-term: condition-based requirements
  - A common core set of requirements that define a baseline competency
  - Additional requirements for providers opting to treat patients with highly specialized needs

2018 MedPAC Recommendations

Begin to base Medicare payments to all four PAC settings on a blend of the current setting-specific relative weights for each payment system and a new unified post-acute care prospective payment system beginning in 2019.

Redistribution would begin to:
- Correct the known biases of current PPSs
- Increase the equity of payments across conditions
- Give providers more time to adjust to changes needed to be successful under PAC PPS
- Support recommendations that better align payments to the cost of care

Transition: Two-Year Blend

<table>
<thead>
<tr>
<th>Implementation Period</th>
<th>HHA</th>
<th>SNF</th>
<th>LTCH</th>
<th>IRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blend setting-specific and Unified PPS relative weights for FFY 2019 and 2020</td>
<td></td>
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</tr>
<tr>
<td>Redistribute payments within the setting</td>
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<td>Redistribute payments within the setting</td>
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<td></td>
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<tr>
<td>Transition to a unified PPS in FFY 2021</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Redistribute payments across settings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MedPAC Recommendations

- Calling for accelerated change and move to Unified PPS faster
- Technically unclear how blending would work; more detail expected in March 2018 report to Congress
- Congressional action required before action can take place
  - 5% reduction in payments to all PAC providers is attractive to Congress
- Much more work to do regarding streamlining regulatory burden

Next Steps in Unified PPS

Legislation requires subsequent reports due:

- Secretary’s report using 2 years’ patient assessment data (2022) (prototype design)
- MedPAC report on a prototype design (2023)

Assumes Patient Assessment Data to inform prototypes will begin data collection by…

- Assume 1 year to do analysis and write a report
- 2 years’ data collection
- 2022 – 2023 = Standardized data collection beginning 2019?
  - FFY 2019 and 2020 rulemaking to revise patient assessment tools?
  - Beta test underway, driving toward this timeline

AHA Study of MedPAC Proposal

- September 2017, AHA letter to Administrator Verma and Assistant Secretary for Planning and Evaluation
- Critique of MedPAC analysis; study by Dobson DaVanzo
- Key findings:
  - Data used is old (PAC PRD) and does not account for recent legislative changes to PPS systems
  - Regression design is complex, incorporating 100 patient characteristics
  - The estimated shifts and payment jeopardize access
AHA Study of MedPAC Proposal

Recommendations to CMS and ASPE
- Ensure a transparent development process
- Ensure patient access to specialized PAC services
- Use currently available data
- Streamline PAC PPS to achieve predictability (data collection at different times is inherent in SPADE)
- Streamline the regulatory framework
- Anticipate and prepare for alternative payment models
- Urge HHS to reject MedPAC prototype, and not rely on it

IMPACT ACT – A Three-Part Series

Requirements for Standardized Assessment Data

IMPACT Act added new section 1899(B) to Title XVIII of the Social Security Act (SSA)

PAC providers must report:
- Standardized assessment data
- Data on quality measures
- Data on resource use and other measures

The data must be standardized and interoperable to allow for the:
- Exchange of data using common standards and definitions
- Facilitation of care coordination
- Improvement of Medicare beneficiary outcomes

PAC assessment instruments must be modified to:
- Enable the submission of standardized data
- Compare data across all applicable providers
Standardized Patient Assessment Data Element (SPADE) Process

**“Cross section feasibility”**
- Collect every data element under the sun, convene a TEP and pull out for comment for 2 weeks and release 250-page report summary of comments
- Narrow the set of 24 complex interviews into 16 facilities, 3 markets
- Field testing in 220 organizations in 14 markets based on comments and feedback from Alpha 2 Testing
- Still recruiting

**Track 1**
- “Cross section feasibility”
- Collect every data element under the sun, convene a TEP and pull out for comment for 2 weeks and release 250-page report summary of comments
- Narrow the set of 24 complex interviews into 16 facilities, 3 markets
- Field testing in 220 organizations in 14 markets based on comments and feedback from Alpha 2 Testing
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Law requires standardized patient assessment data be collected; non reporters subject to 2% reduction in payment

Updates to Patient Assessment Tools Proposed in April for Oct. 1, 2018

**Proposed IRF-PAI (Oct. 1, 2018)**

**Proposed CARE Tool (LTCH) (April 1, 2018)**
- CMS.gov/medicare/quality-initiatives-patient-assessment-instruments/ltc-quality-reporting/downloads/Proposed-LTCH-CARE-Data-Set-Version-4-00-Change-Table-Effective-April-1-2018.zip

**Proposed MDS (Oct. 1, 2018) (SNF)**

FY 2018 IRF, SNF & IPPS/LTCH PPS Final Rules

**FY 2018 IRF, SNF & IPPS/LTCH PPS Final Rules**

**FY 2019 IRF, SNF and LTCH QRFs:** Data elements used to calculate current quality measure, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and replacement measure beginning FY 2020, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, will satisfy the submission of standardized patient assessment data in satisfaction of the category Medical Conditions and Comorbidities.

**FY 2020 IRF, SNF, and LTCH QRFs:** Data elements used to calculate quality measure, Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #0631), will also satisfy the submission of standardized patient assessment data in satisfaction of the category Functional Status.
CMS did not finalize proposals on the implementation of the following SPADE categories:

- Cognitive Function & Mental Status
- Special Services, Treatments & Interventions
- Impairments

Primary reasons for not finalizing remaining categories:

- To be responsive to stakeholders’ comments that the addition of standardized data elements “are too much, too soon”
- To enable greater “recovery” for providers between major releases as expressed
- To allow for additional reliability and validity testing in some areas, including testing on time points used in data collection, as commenters requested
- To allow more time with stakeholders and TEPs to build additional consensus on elements

**Beta Patient/Resident Participants**

Beneficiaries selected will be Medicare only or dually eligible (Medicare-Medicaid) that are admitted to participating providers during the field period.

<table>
<thead>
<tr>
<th>PAC setting</th>
<th>Target number of patients per facility</th>
<th>Target number of facilities</th>
<th>Target number of admission assessments</th>
<th>Target number of discharge assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTCH</td>
<td>30</td>
<td>26</td>
<td>840</td>
<td>579</td>
</tr>
<tr>
<td>IRF</td>
<td>30</td>
<td>26</td>
<td>840</td>
<td>772</td>
</tr>
<tr>
<td>SNF</td>
<td>25</td>
<td>84</td>
<td>2100</td>
<td>1,491</td>
</tr>
<tr>
<td>HHIA</td>
<td>25</td>
<td>70</td>
<td>1,750</td>
<td>1,103</td>
</tr>
<tr>
<td>TOTAL</td>
<td>---</td>
<td>210</td>
<td>5,530</td>
<td>4,035</td>
</tr>
</tbody>
</table>

**Beta Data Collection**

- Completed electronically on handheld tablets provided to the facilities
- Protocol includes patient interviews, patient observation and record review items
- A subset of assessments will be coded by both facility staff and a project research nurse to evaluate inter-rater reliability
- Research nurses will also conduct repeat assessments on a subset of patients to identify optimal lookback for items
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 Participants

Beneficiaries selected will be Medicare only or dually eligible (Medicare-Medicaid) that are admitted to participating providers during the field period.

<table>
<thead>
<tr>
<th>PAC Setting</th>
<th>Target number of patients per facility/agency</th>
<th>Target number of facilities/agencies</th>
<th>Facilities/agencies recruited as of 11/29 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTCH</td>
<td>30</td>
<td>28</td>
<td>26</td>
</tr>
<tr>
<td>IRF</td>
<td>30</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
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<td>25</td>
<td>84</td>
<td>67</td>
</tr>
<tr>
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<td>25</td>
<td>70</td>
<td>51</td>
</tr>
<tr>
<td>TOTAL</td>
<td>--</td>
<td>210</td>
<td>172</td>
</tr>
</tbody>
</table>

 CMS Website for Beta Test Info

- CHA requested transparency in Beta Testing
- Additional information will be posted
**Stakeholder Engagement Activities**

- In the first half of 2018, CMS and RAND will engage associations and providers to hear concerns and ideas for data element standardization
  - Conference presentations, one-on-one interviews with purposive sample of organizations and providers
  - RAND will hold targeted webinars in mid-2018 on special populations
  - CMS and RAND will host a mini-conference on Data Element Standardization in PAC in late 2018 to discuss findings of testing and stakeholder engagement activities, answer questions and hear feedback on candidate data elements
  - Mini-conference will provide opportunity for open discussion of candidate data elements with CMS leadership
  - CHA encourages member participation in stakeholder engagement

**IMPACT ACT – A Three-Part Series**

- **Standardized Quality Measurement**
- **Standardized Patient Assessment Data**
- **Unified PAC PPS**
- **Rulemaking, Measure Development, NQF, and Measures Application Process**
- **Beta Test and Stakeholder Engagement**
- **Congressional Action needed prior to implementation**
Meaningful Measures Objectives

Meaningful Measures focus everyone’s efforts on the same quality areas and lend specificity, which can help:

- Address high impact measure areas that safeguard public health
- Patient-centered and meaningful to patients
- Outcome-based where possible
- Relevant for and meaningful to providers
- Minimize level of burden for providers
  - Remove measures where performance is already very high and that are low value
- Significant opportunity for improvement
- Address measure needs for population-based payment through alternative payment models
- Align across programs and/or with other payers (Medicaid, commercial payers)

Meaningful Measures

Meaningful Measure Areas:
• Care is Personalized and Aligned with Patient’s Goals
• End of Life Care according to Preferences
• Patient’s Experience and Functional Outcomes

Meaningful Measure Areas:
• Appropriate Use of Healthcare
• Patient-focused Episode of Care
• Risk Adjusted Total Cost of Care

Make Care Safer by Reducing Harm Caused in the Delivery of Care

Meaningful Measure Areas:
• Healthcare-Associated Infections
• Preventable Healthcare Harm

Promote Effective Communication & Coordination of Care

Meaningful Measure Areas:
• Medication Management
• Admissions and Readmissions to Hospitals
• Seamless Transfer of Health Information

Promote Effective Prevention & Treatment of Chronic Disease

Meaningful Measure Areas:
• Preventive Care
• Management of Chronic Conditions
• Prevention, Treatment, and Management of Mental Health
• Prevention and Treatment of Opioid and Substance Use Disorders
• Risk Adjusted Mortality

Work with Communities to Promote Best Practices of Healthy Living

Meaningful Measure Areas:
• Equity of Care
• Community Engagement

Meaningful Measures Objectives

IMeasuring cHanges in Aging

Meaningful Measure Domains

Measure Domain | HHA | SNF | IRF | LTCH
--- | --- | --- | --- | ---
Functional status | 1/1/2019 | 10/1/2016 | 10/1/2016 | 10/1/2018
Skin integrity | 1/1/2017 | 10/1/2016 | 10/1/2016 | 10/1/2016
Medication reconciliation | 1/1/2017 | 10/1/2018 | 10/1/2018 | 10/1/2018
Incidence major falls | 1/1/2019 | 10/1/2016 | 10/1/2016 | 10/1/2016
Transfer of Health Information | 1/1/2019 | 10/1/2018 | 10/1/2018 | 10/1/2018

Measures used for Other Measuring Domains

IMeasuring cHanges in Aging


domain

Measures used for Other Measuring Domains

IMeasuring cHanges in Aging

Meaningful Measure Domains

Measure Domain | HHA | SNF | IRF | LTCH
--- | --- | --- | --- | ---
Medicare Spending Per Beneficiary | 1/1/2017 | 10/1/2016 | 10/1/2016 | 10/1/2016
Discharge to Community | 1/1/2017 | 10/1/2016 | 10/1/2016 | 10/1/2016
Potentially Preventable Hospital Readmissions | 1/1/2017 | 10/1/2016 | 10/1/2016 | 10/1/2016
Measures Under Consideration for FY 2019 – SNF QRP

CoreQ: Short Stay Discharge Measure (MUC ID: MUC17-258)

Description: The measure calculates the percentage of individuals discharged in a six-month time period from a SNF, within 100 days of admission, who are satisfied. This patient reported outcome measure is based on the CoreQ: Short Stay Discharge questionnaire that utilizes four items. The following are the four items: 1. In recommending this facility to your friends and family, how would you rate it overall? (Poor, Average, Good, Very Good, or Excellent) 2. Overall, how would you rate the staff? (Poor, Average, Good, Very Good, or Excellent) 3. How would you rate the care you receive? (Poor, Average, Good, Very Good, or Excellent) 4. How would you rate how well your discharge needs were met? (Poor, Average, Good, Very Good, or Excellent)

(Measure Specifications; Summary of NQF Endorsement Review)

- MAP Supported the Measure for SNF QRP

Next Steps

Quality Measure Development

Interoperability

Patient Assessment Data

PAC QM vs. Hospital/EP eCQM Processes

Data Collection:
- Hospitals and EPs: Clinical data entry in CEHRT (certified EHR technology) software which produces QRDA files
- Source data must be EHR-generated
- PAC Settings: Setting-specific assessment instrument completion via vendor software/free CMS software which produces XML submission files
- Source data can come from a variety of sources including an EHR, but is then abstracted into the vendor or CMS free software

Data Submission:
- Hospitals and EPs: CMS reporting portals
- PAC Settings: ASAP System

Quality Measure Reporting:
- Hospitals and EPs: Submission and measure reports via CMS portal
- PAC Settings: Submission and measure reports via CASPER Reporting System
Operating on Two Tracks: Current and Future

**Legislative**
- Impact ACT 2014
  - President's Budget - A Marker
  - BBA 2018
    - Passed 2/9/18

**Regulatory**
- FFY 2019 Rulemaking
  - April
  - October
  - IPPS/LTCH, IRF, SNF
- CCY 2019 Rulemaking
  - July
  - August
  - OPPS, HHA

End of the year
What is next?

Walk & Chew Gum at the Same Time

Congress and CMS continue to ask providers to lower costs, increase efficiencies, and transform care delivery.

Do more with less.

Added quality measures
Continued refinement and rebasing
Unified PPS
Tinker with update factors for cost savings
Added items to assessment tools

When was the last time you did something like that?
### Post-Acute Final Rule Overview

<table>
<thead>
<tr>
<th>Payment Setting</th>
<th>Rule Update</th>
<th>Setting-Specific Payment Adjustments</th>
<th>Pay-For-Reporting Programs</th>
<th>Other Notables</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IRF Final Rule</strong></td>
<td>CMS estimates 0.5% increase or $75 million MACRA limits update to FFY 2019</td>
<td>Loss of Fraud adjustment (Final year of 3 year transition)</td>
<td>Finalized changes to the FFY 2020 GPR including removing an all-cause unplanned rehospitalization measure, and replacing it with a % of residents or pressure ulcers that are new or worsened with a modified version “Changes in skin integrity” (PC1, pressure ulcer/person).</td>
<td>Discusses the 20% penalty for late IRF patient assessment submissions. Finalizes rule related to the cap used to assess a facility’s compliance with 60% Rule.</td>
</tr>
<tr>
<td><strong>SNF Final Rule</strong></td>
<td>CMS estimates 1.0% increase or $370 million MACRA limits update to FFY 2019</td>
<td>Steering and reporting of SNF MB to FY 2014 base year</td>
<td>GFR beginning FY 2019 providing incentive payments to SNF and levels of performance and penalties of up to 2% on performance on readmissions. Changes to the FFY 2020 GPR including a revised measure that address pressure ulcer/injury changes while adding 4 functional outcome measures.</td>
<td>Additional renumbering sought comments on revisions to SNF methodology, replacing CMS classifications model, RUG-IV to RCS-1.</td>
</tr>
</tbody>
</table>

### Post-Acute Final Rule Updates

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<tbody>
<tr>
<td><strong>LTCH Final Rule</strong></td>
<td>CMS estimates +2.4% increase MACRA authorized 1% MB update</td>
<td>3rd year of rate neutral (SNR) payment method, paid full SN rate in FY 2018.</td>
<td>No longer subject to a suspension on the increase of all beds if they meet criteria.</td>
<td>Made modifications to short stay outlier policy.</td>
</tr>
<tr>
<td><strong>HAA Final Rule</strong></td>
<td>Net Reduction: 0.4%, -$80m, +1.0% update, per MACRA</td>
<td>NO rebasing cut; ACA-authorized cut concluded in CY 2017.</td>
<td>Did not adopt the new case mix groups for home health as proposed.</td>
<td>NO rural add-on; phased out after Dec 31, 2017.</td>
</tr>
</tbody>
</table>

### Projected Payment Updates for 2019

<table>
<thead>
<tr>
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<th>SNF</th>
<th>LTCH</th>
<th>HAA</th>
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<tbody>
<tr>
<td>Estimated Market Basket Update</td>
<td>2.8%</td>
<td>2.7%</td>
<td>2.8%</td>
<td>2.8%</td>
</tr>
<tr>
<td>ACA Cut</td>
<td>-0.75%</td>
<td>-</td>
<td>-0.75%</td>
<td>-</td>
</tr>
<tr>
<td>Productivity Reduction</td>
<td>-0.6%</td>
<td>-0.6%</td>
<td>-0.6%</td>
<td>-0.6%</td>
</tr>
<tr>
<td>Estimated Updates for FFY 2019 Prior to BBA 2018</td>
<td>1.45%</td>
<td>2.10%</td>
<td>1.45%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>
MedPAC Recommendations

Recommendations for Medicare Fee-for-Service Payment and Policy Changes for FFY and CY 2019

Skilled Nursing Facilities (SNF)
- Redesign SNF prospective payment system in 2019
- No payment update for SNFs in 2019 and 2020

Inpatient Rehabilitation Facilities (IRF)
- 5% reduction of payment update for FFY 2019

Home Health Agencies (HHA)
- Reform home health prospective payment system
- 5% reduction in payments for home health agencies in 2019
- Two year rebasing of HH payment system beginning in 2020

Long-Term Care Hospitals (LTCH)
- No payment update in FFY 2019

MedPAC Recommended Payment Updates for 2019

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Bipartisan Budget Act of 2018

- Funds federal government through March 23
- Lifts the debt ceiling through March 2019
- Raises non-defense budget caps by $57 billion
- Extends mandatory 2 percent Medicare sequestration cut through FY 2027 (2 additional years)
- Extends CHIP additional 4 years through FY 2027 (Saves $260 million)
- Reauthorizes community health centers, the National Health Services Corps and teaching health centers that operate GME programs through FY 2019 (+$8.042 billion)
### Key Provisions of Bipartisan Budget Act of 2018

- Eliminates Medicaid disproportionate share hospital reductions for FY 2018 and FY 2019
  - Adds $6 billion in Medicaid DSH reductions in future years (FY 2020 - $4 billion; FY 2021 - 2025 - $8 billion per year)
- Two-year extension of Medicare-dependent Hospital Program (+890 million)
- Five-year extension of payment adjustment for low-volume hospitals with modifications (+1.8 billion)
- Extends current outpatient supervision requirements for Critical Access Hospitals and other rural hospitals for calendar year 2017 (in addition to 2018 and 2019)

- Adds hospice to existing post-acute transfer policy beginning Oct. 1, 2018
  - Hospitals would be paid less upon transfer to hospice for short hospital stays (-4.895 billion)
- Extends the LTCH current blended rate applied to site-neutral cases for two years, and implements a MB reduction of 4.6% for FY 2018 thru 2026
- Sets the SNF rate update at 2.4% for FFY 2019
- Five-year extension for home health rural add-on with modifications to payment targeting (+375 million);
- Sets the home health increase to 1.4 percent in FY2020 (-3.5 billion); requires budget neutral reform of home health payment system beginning Jan. 1, 2020

### Home Health Payment Reform

- Requires CMS to undergo rulemaking to propose and finalize revised payment system by Jan. 1, 2020
  - Reduces the unit of a home health episode from 60 to 30 days
  - Requires revision to current case-mix system and elimination of the use of therapy thresholds
  - Home health payments will be revised to ensure reform is budget neutral
Therapy and DME Provisions

- Permanently repeals outpatient therapy caps beginning on Jan. 1, 2018 (+$6.47 billion)
- Continues to require modifier on claims over the current exception threshold indicating medical necessity; lowers the threshold for targeted manual medical review process to $3,000
- Offset includes reduction in payment to Part B therapy services furnished all or in part by a physical and occupational therapy assistant
- Makes permanent coverage of speech generating devices under routinely purchased durable medical equipment (+$12 million)

Additional Hospital Provisions

- Includes CHRONIC Care Act
- Expands telehealth services for home dialysis patients in Medicare Advantage plans and Accountable Care Organizations; and removes geographic restrictions to payment for telestroke services
- Allows CMS flexibility in applying less stringent meaningful use requirements
- Give CMS increased flexibility in implementing physician Quality Payment Program

Projected Payment Updates for 2019

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Things to Watch…

- FFY 2019 Rulemaking: April, October - IPPS/LTCH, IRF, SNF
- CCY 2019 Rulemaking: July, August - OPPS, HHA

● New Home Health Payment System details
● SNF refinements as seen in advanced rule making
● Implementation of various provisions and likely some we haven’t thought of yet

President's Budget

Address Excessive Payment for PAC Providers by Establishing a Unified Payment System Based on Patients’ Clinical Needs Rather than Site of Care

- For FY 2019 to FY 2023, the four primary PAC settings, including SNFs, HHAs, IRFs, and LTCHs, will receive a lower annual Medicare payment update.
- Beginning in FY 2024, this proposal implements a unified post-acute care payment system that spans these settings, with payments based on episodes of care and patient characteristics rather than the site of service.
- Rates for the provider types included in this proposal are updated on a fiscal year basis, including those whose payment systems are currently updated on a calendar year basis.
- The first year of implementation is required to be budget neutral relative to estimated payments that would otherwise have been paid in FY 2024 absent this change.

A Lot is Happening…

- Stay connected and engaged
- Actively participate in CHA Post-Acute Care Forums
  - We need your input to help shape changing health care policy
  - Change could happen sooner than you think