The Washington Perspective on Post-Acute Care Progress

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California Hospital Association
Agenda

- 2016 Federal legislative and regulatory updates
- Upcoming changes in Conditions of Participation for PAC providers
- Next steps in IMPACT Act implementation
- Get ready — CJR April 1
- Discussion/questions
Senate Legislative Activity

• Senate Finance Committee Workgroup on Improving Chronic Care
  – Expansion/Coordination of Medicare Advantage Benefits; Independence at Home Demonstration
  – CHA comments submitted in January
  – SFC Revisions expected in March
    • Chairman’s mark and committee discussion
• S. 2108 Preserving Access to Post-Acute Hospital Act
  – 2 additional years of relief from the full implementation of the 25% rule for LTCHs

House Ways and Means Committee

• Bipartisan workgroup addressing Stark
  – CHA submitted comments in January
  – Next Steps — TBD
• HR 3298 — Medicare Post-Acute Care Value Based Purchasing (VBP) Act of 2015
  – Establishes VBP program for LTCHs, SNF, HHA, IRFs
  – Based on Medicare Spending Per Beneficiary Measure
  – 3% of payments at risk for FY 2019, increasing to 8% by 2025
  – Sunsets existing SNF VBP Program in 2026
2016 Federal Regulatory Outlook

Stay Connected: CHA Regulatory Tracker
www.calhospital.org/regulatorytracker

- Regulation Summaries
- Member Call Information and Recordings
- CHA comment letters
- Key implementation dates
- Links to resource pages

CMS Final Rules Expected*

- Currently at OMB (final clearance) — Release is imminent
  - Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care (CoPs)
  - Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers (CoPs)
  - Fire Safety Requirements for Certain Health Care Facilities (CoPs)

*This is not an exhaustive list of pending rules. Visit www.calhospital.org/regulatorytracker
CMS Final Rules Expected* (cont.)

- **Expected in late April**
  - FFY 2017 Inpatient Prospective Payment System for Acute Care and Long-Term Care Hospital Prospective Payment System
  - FFY 2017 Skilled Nursing Facility PPS
  - FFY 2017 Inpatient Rehabilitation Facility PPS
- **Expected early July**
  - CY 2017 Home Health PPS
- **By the end of 2016**
  - Discharge Planning CoPs
  - LTC CoPs

*This is not an exhaustive list of pending rules. Visit www.calhospital.org/regulatorytracker

FFS Payment Rules

- Continued implementation of IMPACT Act
  - Quality Measure Implementation: Medication Reconciliation, Resource Use, PPR, Discharge to Community
- Continued refinements to PPS
  - LTCH Site Neutral Provisions
  - HHA Rebasing
  - SNF VBP
  - Hospice QRP
- FY April rules finalized in Aug. — effective date Oct. 1
- CY July rules finalized in Nov. — effective date Jan. 1
Conditions of Participation

- Multi-year effort to revise the CoPs across all settings, began in 2011
- Most CoP Rules will be finalized in 2016, effective dates are still unknown
- Once a CoP is finalized, CMS must also update the State Operations Manual
  - Provide state surveyor guidance/training
  - This may take up to a year

IMPACT Act Implementation

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

- Bipartisan bill passed Sept. 18, 2014 and signed into law by President Obama Oct. 6, 2014
- Requires Standardized and Interoperable Patient Assessment Data that will enable:
  - Data Element uniformity
  - Quality care and improved outcomes
  - Comparison of quality and data across post-acute care (PAC) settings
  - Improved discharge planning
  - Exchangeability of data
  - Coordinated care

Quality Measure Timelines

IMPACT Act requires PAC providers to report standardized assessment data for the following Quality Measure Domains by the following dates:

<table>
<thead>
<tr>
<th>Quality Measure Domains</th>
<th>LTCH</th>
<th>IRF</th>
<th>SNF</th>
<th>HH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional status/cognitive function</td>
<td>10/1/18</td>
<td>10/1/16</td>
<td>10/1/16</td>
<td>1/1/19</td>
</tr>
<tr>
<td>Skin integrity</td>
<td>10/1/16</td>
<td>10/1/16</td>
<td>10/1/16</td>
<td>1/1/17</td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td>10/1/18</td>
<td>10/1/18</td>
<td>10/1/18</td>
<td>1/1/17</td>
</tr>
<tr>
<td>Incidence of major falls</td>
<td>10/1/16</td>
<td>10/1/16</td>
<td>10/1/16</td>
<td>1/1/19</td>
</tr>
<tr>
<td>Communicating the existence of and providing for the transfer of health information and care preferences</td>
<td>10/1/18</td>
<td>10/1/18</td>
<td>10/1/18</td>
<td>1/1/19</td>
</tr>
<tr>
<td>Resource Use ( (MSPB, PPR) )</td>
<td>10/1/16</td>
<td>10/1/16</td>
<td>10/1/16</td>
<td>1/1/17</td>
</tr>
</tbody>
</table>

The measure domains provided in the Act are not exhaustive.
Measures Development Timeline

<table>
<thead>
<tr>
<th>IMPACT Measure Domain</th>
<th>Technical Expert Panels</th>
<th>Public Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Reconciliation</td>
<td>July 2015</td>
<td>September 2015</td>
</tr>
<tr>
<td>Discharge to Community</td>
<td>August 2015</td>
<td>November 2015</td>
</tr>
<tr>
<td>All-Condition Risk-Adjusted Potentially Preventable Hospital Readmission Rates</td>
<td>August 2015</td>
<td>November 2015</td>
</tr>
<tr>
<td>Total Estimated Medicare Spending Per Beneficiary</td>
<td>October 2015</td>
<td>January 2016</td>
</tr>
</tbody>
</table>

CHA Member Engagement

- CHA members reviewed measures
  - Discharge to community, medication reconciliation and potentially preventable readmissions
- CHA comments available at www.calhospital.org
- CHA participation in the NQF Process
  - CHA member participation at MAP
- CMS/CHA dialogue continues
  - Draw on experience of CA providers in PAC PRD
- All of the measures will likely be in the FFS Payment rules this spring, data collection will begin as early as Jan. 1, 2017
IMPACT ACT: Standardized Patient Assessment Data

• Requirements for reporting assessment data:
  – Providers must submit standardized assessment data through PAC assessment instruments under applicable reporting provisions
  – The data must be submitted with respect to admission and discharge for each patient, or more frequently as required

Use of Standardized Assessment data no later than:

- SNF: Oct. 1, 2018
- IRF: Oct. 1, 2018
- LTCH: Oct. 1, 2018
- HHA: Jan. 1, 2019

IMPACT ACT: Standardized Patient Assessment Data (cont.)

• Data categories:
  – Functional status
  – Cognitive function and mental status
  – Special services, treatments, and interventions
  – Medical conditions and co-morbidities
  – Impairments
  – Other categories required by the Secretary
PAC Assessment Domain Standardized Data: Stakeholder Opportunities

- Consensus Development
  - Focus Groups: 5 focus groups including consumers (Los Angeles)
  - Site Visits/Case Studies: Inform testing, training
  - Technical Experts Panels (TEPs): TBD
- Provider Testing
  - Recruitment: TBD
  - Alpha/beta testing: spring/fall 2016
- Anticipate FY/CY 2018 rulemaking cycles
  - Public display of draft item sets
  - To be incorporated into existing tools and be interoperable
CHA Member Engagement

- TEP opportunities in 2016
- Review of measures and payment rules during Center forum discussions — May
- Review measure specifications now and ask questions of CMS
- Ready yourself for new measures, new data requirements
  - All require resources
  - Participate in training when made available

Parallel Tracks

- Quality Measure Development
- Interoperability
- Patient Assessment Data
Interoperability

Data Follows the Person

- Long Term and Post Acute Care (LTPAC): SNF/NF, IRF, HHA, LTCH
- Acute Care/Critical Access Hospitals (CAH)
- Other Providers (e.g., pharmacies, dentists...)
- Emergency Medical Services (EMS)
- Long Term Services and Support (LTSS)
- Home and Community Care Based Services (HCBS)
- Assisted Living Facilities (ALF)

Person

Family, Member/Caregiver
### Overview of Mandate and Approach

<table>
<thead>
<tr>
<th>Mandate</th>
<th>Methodology</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Evaluate and recommend features of a PAC PPS using data from the PAC-PRD</td>
<td>“Full” model <em>(model 1)</em> uses data from PAC-PRD sample to predict the relative costs of PAC-PRD stays</td>
<td>Use unique data in the PAC-PRD to test feasibility of PAC PPS</td>
</tr>
<tr>
<td>2 Consider the impact of implementing a unified PAC PPS</td>
<td>● “Administrative” model <em>(model 2)</em> predicts relative costs of PAC-PRD stays</td>
<td>● Assess the accuracy of administrative model (without the unique data) that could be used on a large sample of stays</td>
</tr>
<tr>
<td></td>
<td>● Compare the accuracy of models using same stays</td>
<td>● Estimate impacts using a large sample of stays.</td>
</tr>
<tr>
<td></td>
<td>● If equally accurate, use “administrative” model to estimate impacts with all 2013 PAC stays <em>(model 3)</em></td>
<td></td>
</tr>
</tbody>
</table>


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### A PAC PPS is estimated to shift payments across stays

#### Payment Increases:
- Ventilator care
- Severe wound care
- Hematology
- Respiratory medical
- Chronically critically ill
- Multiple body system diagnoses
- Low therapy
- ESRD

#### Payment Decreases:
- Neurology medical (non-stroke)
- Orthopedic
- Least frail
- High therapy
- Community admits

Estimated changes in payment by provider type and setting

Payment Increases:
• SNFs
• Hospital-based
• Non-profit

Why?
• Payments reflect patient characteristics, medically complex care

Payment Decreases:
• IRFs and LTCHs
• Freestanding
• For-profit

Why?
• Payments decrease for stay with therapy services unrelated to patient characteristics
• Many types of stays treated in higher-cost settings are also treated in lower-cost settings

Conclusions

• A PAC PPS is feasible and would break down the silos between settings
• Payments would be based on patient characteristics, not the setting
  – Correct some of the shortcomings of current PPSs
• A unified PPS would:
  – Dampen incentives to selectively admit some types of patients over others
• Preliminary findings will be in the June 2016 report, additional report required in 2023
Current and Future State

Illustrative example of the multiple trajectories for the future state of PAC Payment in Medicare FFS

General Resources


- Comments and questions can be submitted to: PACQualityInitiatives@cms.hhs.gov
  - Copy akeefe@calhospital.org on your note to CMS
Program Basics

• Begins April 1, 2016
• 90 day episode for DRGs 469/470
  – LEJR; Hip Fractures
• This is a retrospective payment model, it is NOT a prospective bundled payment model
  – Everyone gets paid their FFS rates through the entire period of the program
• If a hospital exceeds the target price for the episode, the hospital will pay Medicare
• If the hospital comes in under the target price, and achieves the quality benchmarks, the hospital may receive a reconciliation payment
CJR — Implications for PAC

- Hospitals will be looking closely at their referral patterns and LOS in PAC

<table>
<thead>
<tr>
<th>Use Rates</th>
<th>National DRG 469 %</th>
<th>So Cal DRG 469 %</th>
<th>National DRG 470 %</th>
<th>So Cal DRG 470 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF</td>
<td>66.0%</td>
<td>64.7%</td>
<td>42.4%</td>
<td>35.5%</td>
</tr>
<tr>
<td>HH</td>
<td>36.7%</td>
<td>41.2%</td>
<td>48.4%</td>
<td>65.3%</td>
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<tr>
<td>IRF</td>
<td>19.0%</td>
<td>17.6%</td>
<td>13.5%</td>
<td>3.6%</td>
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<tr>
<td>LTCH</td>
<td>3.2%</td>
<td>0.0%</td>
<td>0.4%</td>
<td>0.0%</td>
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<tr>
<td>Readmission Rate</td>
<td>30.8%</td>
<td>20.6%</td>
<td>12.2%</td>
<td>9.0%</td>
</tr>
</tbody>
</table>

- Southern California has lower cost PAC use rates as compared to national averages
- Readmission rates are lower than the national average

Source: BDO Center for Health Care Excellence and Innovation Presentation, Jan. 2016

CJR — Implications for PAC (cont.)

SNF Ratings for Southern CA

<table>
<thead>
<tr>
<th></th>
<th>1 Star</th>
<th>2 Star</th>
<th>3 Star</th>
<th>4 Star</th>
<th>5 Star</th>
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<tr>
<td>National</td>
<td>14.9%</td>
<td>19.8%</td>
<td>18.9%</td>
<td>23.5%</td>
<td>22.8%</td>
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<tr>
<td>N=15446</td>
<td>2307</td>
<td>3057</td>
<td>2926</td>
<td>3267</td>
<td>3529</td>
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<tr>
<td>LA</td>
<td>10.3%</td>
<td>20%</td>
<td>19.1%</td>
<td>23.7%</td>
<td>26.8%</td>
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<tr>
<td>N=560</td>
<td>58</td>
<td>122</td>
<td>107</td>
<td>133</td>
<td>150</td>
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<tr>
<td>OC</td>
<td>6.5%</td>
<td>25%</td>
<td>19.7%</td>
<td>28.9%</td>
<td>23.6%</td>
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<td>N=76</td>
<td>5</td>
<td>19</td>
<td>15</td>
<td>22</td>
<td>18</td>
</tr>
<tr>
<td>MSA</td>
<td>10%</td>
<td>20.5%</td>
<td>19.2%</td>
<td>24.4%</td>
<td>26.4%</td>
</tr>
<tr>
<td>N=636</td>
<td>63</td>
<td>131</td>
<td>122</td>
<td>155</td>
<td>168*</td>
</tr>
</tbody>
</table>

Source: BDO Center for Health Care Excellence and Innovation Presentation, Jan. 2016
CMS Next Steps

• February — expected release of claims data to CJR hospitals through data portal
• March — CMS Needs assessment
  – What resources/guidance do hospitals need from CMS to be successful in the CJR program?
• Spring — forum for sharing best practices and effective strategies for implementation
Questions?

Thank you

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