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

Payment Setting	Rate Update	Setting-Specific Payment Adjustments	Wage Index	Pay-For-Reporting Programs	Other Notables
SNF [proposed rule]	**+1.1%** [2.7% MB- 0.4 PPT ACA] * -1.27% (1% cap) *1.0003 WI BN * +.04% BN	Revising and Rebasing 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.	FFY 2018 hosp. WI	VBP beg FFY 2019 providing incentive payments to SNFs w/ > levels of performance and penalties of up to 2% w/ <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.	
	+2.3% [2.8% MB- 1.15 PPT ACA] * -0.64% (1% cap) *1.000077 WI BN *0.9672 BN as a result of SSO methodology change	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.	FFY 2018 hosp. WI	**LTCH** [proposed rule]	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.

- 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.

4

Post-Acute Proposed Rule Updates (cont.)

Payment Setting	Rate Update	Setting-Specific Payment Adjustments	Wage Index	Pay-For-Reporting Programs	Other Notables
IRF [proposed rule]	**+0.81%** [2.7% MB- 1.15 PPT ACA] * -0.54% (1% cap) *1.0007 WI BN * +0.9974 case mix BN	Loss of Rural adjustment (Final year of 3 year transition).	FFY 2017 hosp. WI	# 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."	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.
IPF [proposed rule]	**Update Notice Likely**			Proposed measure removal factors; criteria for "topped out," and measure retention factors.	

- 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.

5

IMPACT Act Implementation MedPAC Recommendations

IMPACT ACT – A 3-Part Series

RTI and Abt: **Standardized Quality Measurement**

RAND and Abt: **Standardized Patient Assessment Data**

MedPAC and CMS: **Unified PAC PPS**

7

Are You on the Bus?

8

IMPACT ACT – 3-Part Series

RTI and Abt: **Standardized Quality Measurement**

RAND and Abt: **Standardized Patient Assessment Data**

MedPAC and CMS: **Unified PAC PPS**

9

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

10

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

Source: MedPAC June 2016 Report, www.medpac.gov

11

Implementation Issues

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

Source: MedPAC June 2016 Report, www.medpac.gov

12

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

Source: March 2017 MedPAC meeting transcript, www.medpac.gov

13

Stakeholder Response

- Prior to vote, AHA letter expressing concern regarding accelerated timeline
  - Noted that the prototype relies to 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

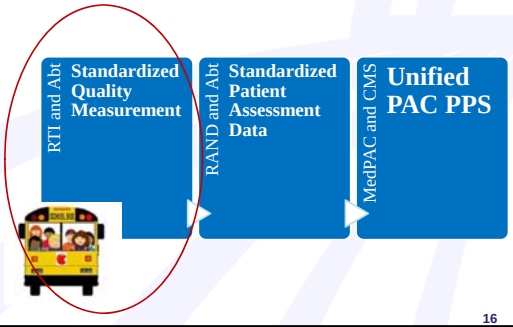
14

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.*

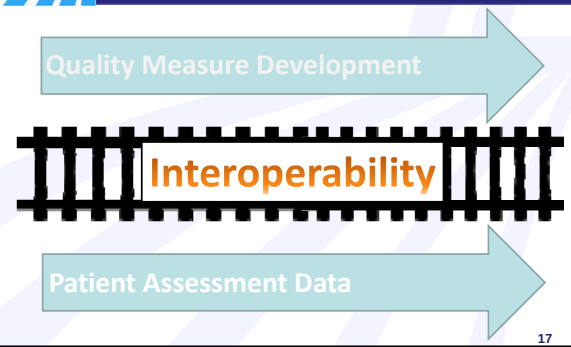
15

IMPACT ACT – 3-Part Series



16

IMPACT ACT Parallel Tracks

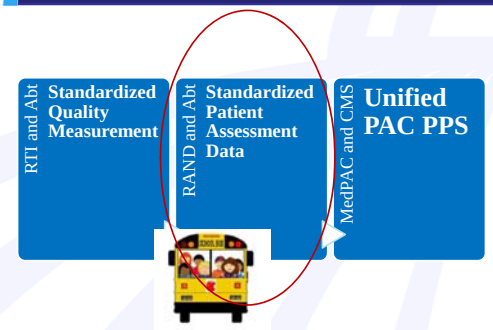


17

IMPACT Act: Measures

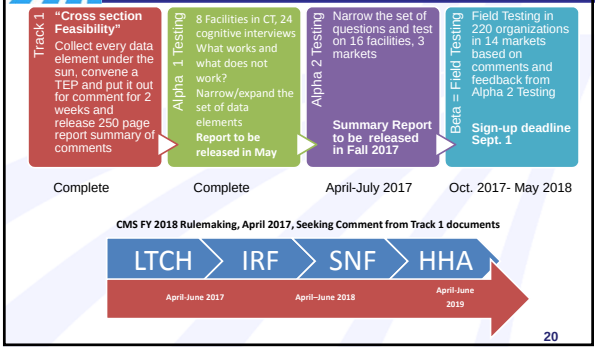
Quality Measure Domain	HHA	SNF	IRF	LTCH
Functional Status	1/1/2019	10/1/2016	10/1/2016	10/1/2018
Skin Integrity	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Medication Reconciliation	1/1/2017	10/1/2018	10/1/2018	10/1/2018
Incidence Major Falls	1/1/2019	10/1/2016	10/1/2016	10/1/2016
Transfer of Health Information	1/1/2019	10/1/2018	10/1/2018	10/1/2018
Resource Use & Other Measures 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

IMPACT ACT – 3-Part Series



19

Standardized Patient Assessment Data Process



20

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

21

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**

22

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

23

Updates to Patient Assessment Tools proposed for April or Oct. 1, 2018

Proposed IRF-PAI (Oct. 1, 2018)
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Proposed-IRF-PAI-Version-20-Effective-October-1-2018.pdf

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Proposed-IRF-PAI-Versions-15-and-20-Change-Tables.pdf

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

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Proposed-LTCH-CARE-Data-Set-V-400-Effective-April-1-2018.zip

Proposed MDS (Oct. 1, 2018)
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Proposed-Specifications-for-SNF-QRP-Quality-Measures-and-Standardized-Data-Elements-Effective-10-1-18.pdf

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Proposed-MDS-30-V1160-Change-Table.pdf

24

IMPACT Act Implementation

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

25

Managing Complex Change

Vision	+ Skills	+ Incentives	+ Resources	+ Action Plan	=	Change
[ ]	+ Skills	+ Incentives	+ Resources	+ Action Plan	=	Confusion
Vision	+ [ ]	+ Incentives	+ Resources	+ Action Plan	=	Anxiety
Vision	+ Skills	+ [ ]	+ Resources	+ Action Plan	=	Resistance
Vision	+ Skills	+ Incentives	+ [ ]	+ Action Plan	=	Frustration
Vision	+ Skills	+ Incentives	+ Resources	+ [ ]	=	False Starts

Adapted from Knoster, T., Villa R., & Thousand, J. (2000). A framework for thinking about systems change. In R. villa & J. Thousand (Eds.), Restructuring for caring and effective education: Piecing the puzzle together (pp. 93-128). Baltimore: Paul H. Brookes Publishing Co.

Episode-Based Payment Program Updates

What's Happening in EPMs

BPCI
- 2-year extension, possibility of 2.0 (MACRA)
- "Education cycle" (staff change, evolving understanding, changing rules)

CJR
- Hospitals only
- Mandated nature driving change in BPCI
- Precedence issues
- EPM rule add remaining hip/femur fractures

OCM
- Physician practices only
- Risk stratification critical

CAD
- Mandatory?
- Hospitals only?
- Complex Target methodology

28

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

29

CJR Program

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

30

Reconciliation – Struggles

- 2 quarters
- Change in standardization
- Small changes in spend = large change in NPRA
  - Implications for true-up in 2018

31

Claims Lag: True-ups

Spend increase of 1%

- Targets are fixed prior to performance period
- Claims continue to accrue for episodes

- **This is why you need to reserve!**

DRG	Performance Period Episode Count (a)	Performance Period Episode Target (b)	Total Performance Target $ (a*b)	Total Actual Performance $ (c)	Reconciliation Amount ([a*b]-c)
470 w/o Fracture	100	$24,000	$2,400,000	$2,222,000	$178,000
470 w/o Fracture	10	$40,000	$400,000	$555,500	($155,500)
Hospital A Total	110		$2,800,000	$2,777,500	$22,500

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…

33

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?

34

Site Neutral Payment Updates

CY 2017 OPPS Final Rule

- 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

36

CY 2017 OPPS Final Rule (cont.)

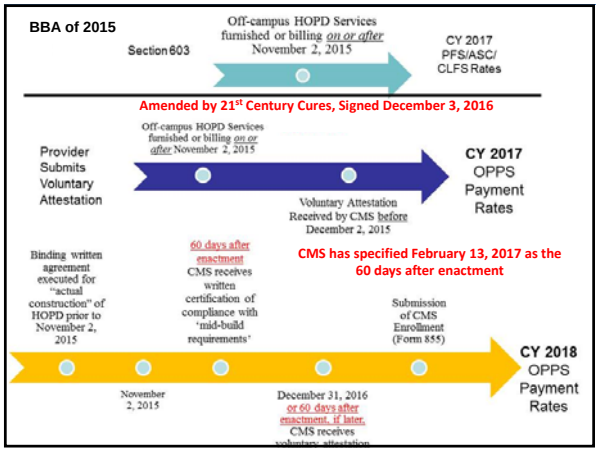
- Other finalized items
  - OPPS payment policies like packaging and C-APCs will apply
  - Paying hospitals directly will enable them to show non-excepted PBD expense & revenue on cost reports and maintain 340B eligibility
  - CMS stated it does not have the statutory authority to allow additional exceptions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

37

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"

38



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

40

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?

41

Summary of Billing & Payment Mechanisms

Location of Outpatient Service	Hospital Claim	Professional Fee (PF) Claim	Payment Systems
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

42

Questions?

Text (703) 340-9850

Thank you

Alyssa Keefe
Vice President, Federal Regulatory Affairs
California Hospital Association
(202) 488-4688
akeefe@calhospital.org

44