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PAC Reform Response

August 19, 2013

August 19, 2012

The Honorable Max Baucus
Chairman
Senate Finance Committee
U.S. Senate
Washington, D.C. 20510

The Honorable Dave Camp
Chairman
House Committee on Ways & Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Orrin G. Hatch
Ranking Member
Senate Finance Committee
U.S. Senate
Washington, D.C. 20510

The Honorable Sander M. Levin
Ranking Member
House Committee on Ways & Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Members of the House Committee on Ways & Means Leadership and the Senate Finance Committee Leadership:

On behalf of the American Health Care Association (AHCA), I am pleased to submit our responses to a June 19, 2013, letter transmitted jointly by the U.S. Senate Finance Committee and the U.S. House of Representatives Ways and Means Committee requesting information and ideas on the types of long-term post-acute care (PAC) reforms “that will help advance the goal of improving patient quality of care, improving care transitions, while rationalizing payment systems and improving program efficiency.”

PAC is a critical component of our nation’s array of health care services. Medicare-financed PAC increasingly is becoming a key tool in reducing the length of hospital stays, providing critical services to growing numbers of older adults with multiple chronic conditions. These services optimize their recovery and foster a return to their homes and communities.

AHCA recognizes the importance of these services for the people and families we serve, as well as the importance of identifying efficiencies to address Medicare budgetary pressure. In collaboration with our membership, we have crafted a thorough response to your thoughtful inquiry. We hope the enclosed information is helpful, and we look forward to further dialogue with you. To schedule time for a discussion on this important topic, please contact my executive assistant, Carole Jones, at cjones@ahca.org or 202-898-6324.



Sincerely,

Governor Mark Parkinson
President & CEO

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Executive Summary

Today’s health care financing system is broken. Misaligned incentives embedded in the fee-for-service reimbursement model encourage higher utilization of services without a clear focus on quality, resulting in higher overall spending without a correlated improvement in outcomes. AHCA believes that we can move the system toward value-based reimbursement with the implementation of thoughtful policies that offer more than just decreasing provider payment rates.

To that point, AHCA stands ready to provide policy solutions that gradually build upon incentives for providers, which in turn further improve care of their patients while containing costs. Various approaches outlined in our response, such as pay-for-performance initiatives, are embedded in current policy. Others, such as bundled payments, are still being tested and evaluated for their potential benefits. AHCA supports many of the various policy ideas that have been included in existing budget proposals, such as those suggested by MedPAC and the Bipartisan Policy Center. *Table 1* below summarizes AHCA’s position on these various policy ideas and lists additional solutions described later in this document.

Table 1. *Comparison of PAC Reform Policy Options*

Policy Idea	MedPAC	BPC	Simpson -Bowles	FY 14 President’s Budget	AHCA Supports
PAC Market Basket Cuts	X	--	X	X	--
PAC Quality Metrics Uniform Assessment Tool	--	--	--	--	X
Value-based Purchasing	--	--	--	--	X*
SNF Readmissions	X	--	--	X	X
Bundled Payment	X	X	--	X	X*
Site Neutral Payment Beneficiary Protections	X	--	X	X	X

* *AHCA supports the concept, but further research is necessary.*

AHCA does not support further cuts to the annual market basket update as a long-term solution to today’s health care finance problems. Applying arbitrary, sequester-like cuts to provider rates will only stall the process of moving toward a value-based health care payment and delivery system. Steep cuts to provider rates stifle innovation, restrict capacity to adapt to new payment environments, and hinder efforts to modernize through implementation of health information technology (HIT) and person-centered care models. Furthermore, we maintain that the skilled nursing profession simply cannot absorb further reductions to already-thin operating margins.

On July 1st AHCA submitted a letter to the Committees explaining our concern with the PAC Medicare Margin reported in the initial request (see *Appendix A*). We reiterate here that the average Medicare margin reported for skilled nursing facilities (SNFs) in 2010

was between 22 to 24 percent. This data is inapplicable and should not be referenced in reform policy discussions. The actual average SNF Medicare margin is closer to 10 percent, and the average *total* SNF operating margin is calculated to be between 1-3 percent¹.

We have outlined a series of solutions in this response that we believe give post-acute providers the tools and incentives to allow them to succeed in a new payment environment. Success is defined by improved patient outcomes and achieving efficiencies for Medicare. In the body of the document, we discuss these solutions in more detail and have responded to the questions to which we are best positioned to provide meaningful input. Below are summaries of the policy positions that AHCA believes can assist the system in having greater value-based reimbursement:

1. AHCA supports the use of quality measures based on outcomes in payment models for the post-acute care setting.

To incentivize improvement, quality measures for PAC settings must reflect the primary goals and objectives of care. Currently, the quality measures used on the Centers for Medicare and Medicaid Service's (CMS) Nursing Home Compare and Five Star rating system are inadequate as they do not reflect the primary purpose and goals PAC services. In this document we do not discuss the basic principles to which any PAC quality metric must adhere, but we do propose specific metrics for the Committees' consideration. AHCA has undertaken efforts to develop a set of PAC-specific outcome measures that better reflect the goals and purposes of SNF Medicare Part A services than are currently in use. AHCA recommends the adoption of the following set of outcome measures for SNF setting:

- 30-day all-cause risk adjusted hospital readmission from SNF;
- Risk-adjusted discharge to community;
- Improvement in mobility;
- Improvement in self-care;
- Improvement in speech; and
- Consumer satisfaction & willingness to recommend SNF to another person.

2. AHCA supports the use of common assessments, such as the CARE² tool, to collect standardized information across different settings.

Neither the assessment tools currently in use nor the CARE tool are perfect. However, the use of standard clinical metrics is extremely important both to patient care and to evaluation of quality across settings. Therefore, clinical conditions that are being measured across multiple provider settings should use the same assessments tools and frequency to ensure uniform data collection. Components of the CARE tool developed by

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¹ Total SNF margins include reimbursement from all payers, including Medicare, Medicaid and private payers.

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² The Continuity Assessment Record and Evaluation (CARE) Tool will measure the health and functional status of Medicare acute discharges and measure changes in severity and other outcomes for Medicare PAC patients.

CMS may meet this minimum requirement for developing standard quality measures across different provider settings. There are unique patient-care issues and requirements in each setting that will warrant the need to have unique comprehensive assessment tools. Therefore, as we explain in detail in this section, we support adding standard assessment items and scales from the CARE tool to the existing assessment tools.

3. AHCA proposes a set of recommendations for the Committees' consideration with regard to implementing a value-based purchasing (VBP) program for PAC.

AHCA recognizes the potential gains to the health care system through VBP; it is a widely heralded concept supported early on from organizations such as the Institute of Medicine (IOM) and the Medicare Payment Advisory Commission (MedPAC). However, evidence of the impact of such programs remains questionable. AHCA recommends the following steps be taken in order to develop a sound, viable PAC VBP program:

- Congress mandate that CMS provide an analysis of the successes and failures associated with the nursing home VBP demonstration. This report needs to clarify whether VBP should be applied to a single PAC setting or across settings.
- CMS needs to evaluate which payment models would be most appropriate in a VBP system to include consideration of bonus payments versus penalties and explore the potential benefits of transitioning to an entirely new payment system such as bundled payments.
- Efforts should be made to design a VBP system that utilizes a reward system rather than penalties only. The very prospect of penalties can cause failure to positively engage providers, crippling the system from the onset. Furthermore, only applying penalties works against innovation, depriving providers of badly needed funds to improve their internal functions.
- Congress should direct CMS to work on the development of a VBP model by actively engaging providers in the design and implementation processes.

4. AHCA supports linking hospital readmission rates with reimbursement based on setting specific measures as soon as possible.

AHCA has developed a legislative proposal to reduce hospital readmissions from SNFs that guarantees \$2 billion in savings to the Medicare program over the ten-year budget window. As we explain later in this section, our proposed policy works by establishing a dual-sided bonus/penalty model which differs from the current penalty-only readmissions model used by the hospitals. AHCA believes that a penalty-only approach would not be an effective way to significantly reduce hospital readmissions from SNFs. Our proposed legislation guarantees savings by setting a savings target which, if not achieved, distributes penalties across the lowest 40 percent of SNF performers. If SNFs collectively meet the savings target, those savings are counted and no SNFs are penalized. Again, AHCA does not support a penalty-only program such as the Hospital Readmissions Reduction Program (HRRP).

In this section we explain why our approach is preferred to other established approaches. Furthermore, we elaborate on lessons learned from the Nursing Home VBP Demonstration to help explain the drawbacks to a penalty-only approach. And finally, we discuss how to think about SNF-hospital readmissions in the context of other delivery system reforms.

5. AHCA believes that the concept of post-acute bundled payments has the potential to reduce costs and improve quality of care, but CMS must be given time to evaluate the results of its bundled payment demonstration and consider alternative models before policy makers consider a national, mandatory bundled payment system.

Our members' experiences in the Center for Medicare and Medicaid innovation's (CMMI) Bundled Payments for Care Improvement (BPCI) demonstration have taught us that implementing a bundled payment system is extremely complex. Previous prospective payment systems such as the IPPS, OPSS, and SNF systems were based on many years of research, and did not involve prospective payment across the boundaries of different provider systems and periods of time longer than a single day or stay. For several years, AHCA has been conducting research and analysis related to PAC bundled payment, which only has begun to scratch the surface capturing the complexity of issues to be addressed. We have developed a framework to help policymakers think through key considerations in designing PAC bundled payment policy. Our conclusions include:

- AHCA has reservations regarding a bundled payment system that is completely controlled and initiated by hospitals. An ideal bundled payment system will include post-acute-initiated bundles that are not defined by MS-DRGs;
- AHCA believes that the optimum workable bundled payment model will utilize "virtual" bundles. This means that episodes will be given a target price, those target prices will be risk adjusted appropriately, bonuses/losses will be paid retroactively, and providers will not be required to develop the insurance-like administrative systems to process claims and pay other providers;
- Alternatives to CMMI's BPCI demonstration must be considered. AHCA research will soon propose several potential post-acute bundled payment episodes that could encompass a majority of all SNF patients;
- Existing population-based and acute care risk adjustment methodologies, such as that used in Medicare Advantage or for the inpatient prospective payment system, are not sufficient to explain cost variation among post-acute patients, and inadequate risk mitigation will result in inadvertent access to care problems for higher risk complex patients; and
- Policymakers must consider how existing regulations and enforcement mechanisms – including survey inspections, medical review processes, arbitrary caps and fraud/waste/abuse rules - function as barriers to providers' development of partnering across sectors to achieve the coordination of care intended by a bundled payment model.

6. AHCA supports post-acute site-neutral payment reform, and we have developed a patient-focused payment model that would reduce spending on post-acute care while facilitating the movement toward a more rational system of PAC payment and delivery.

We are fully aligned with site-neutral principles that have been espoused by CMS, MedPAC, Simpson-Bowles, and the President. Our plan, outlined in this document, supports true equality of payments for appropriate conditions with no differentiation. As we will describe, our solution has the potential to reduce federal spending by approximately \$15-20 billion over the 10-year budget window.

Under our solution, patients will be grouped by clinical condition and severity of illness using a single assessment tool where payment for patients within each group will be the same regardless of where the patient is being treated. The payment rates for each category would cover the expected costs of providing the appropriate type, duration, and mix of services. A single Medicare payment would be made to each PAC provider to cover the services provided to the patient.

7. AHCA proposes a set of recommendations for the Committees to consider in any discussion involving a shift away from fee-for-service payment.

AHCA outlines key considerations that are common to any shift away from fee-for-service payment, whether toward value-based purchasing, bundled payments, or some other model. In order for PAC providers to succeed in this new environment of care delivery and payment, transition and execution must be done thoughtfully. AHCA recommends the following to help ensure that PAC providers succeed and ensure access to such services in this new environment:

- Recommendation #1: Include a meaningful transition period in any legislation moving toward new care and payment delivery model;
- Recommendation #2: Relax the current regulator and program integrity environment to allow providers to engage in innovative delivery reform; and
- Recommendation #3: Promote provider engagement in any design and planning of new reform models.

8. In conclusion, AHCA outlines a series of proposals designed to protect beneficiaries from both increased cost burdens and declines in access to care during a period of heavy transition to new care delivery and payment reforms.

In this section, AHCA outlines four policy proposals that succeed in driving down overall health care costs without passing those savings down to consumers in any negative way. Those policies align around changes to the current cost-sharing structures within Medicare, to reimbursement policies for bad debt, to payments for therapy services, and to solving the growing problem with observation stays.

- AHCA supports policy options for **cost sharing** that call for a single annual deductible that would apply to the combined Part A and B Medicare benefit, a uniform percentage coinsurance policy that would apply to all A and B services, and “stop loss” limits that would cap the total amount of cost sharing to which a beneficiary would be subject to in each benefit year.
- AHCA cautions against further reductions to Medicare **bad debt** reimbursement. As we will outline in this document, such reductions are poor policy options because: (1) the use of post-acute services is increasing with the aging population; (2) the options for providers to look to states for bad debt reimbursement are dwindling; and (3) beneficiaries do not have as easy access to third-party insurance alternatives as in days past.
- AHCA maintains that beneficiary access to needed **therapy services** must not be limited by arbitrary caps in reimbursement. AHCA supports the continuation of the therapy cap exceptions process as part of any payment reform policy, and we oppose any policy that further restricts access to therapy.

- AHCA seeks to protect beneficiary access to necessary skilled nursing services by proposing legislation which would count the number of days a patient is under **observation status** toward the mandated three-day inpatient stay requirement to qualify for a Medicare-covered SNF stay.

Preface – Context for SNF-Delivered PAC

As the nation’s largest association of long term and post-acute care providers, the American Health Care Association (AHCA) represents a diverse group of approximately 12,000 providers that care for patients across the health care spectrum. AHCA represents two-thirds of all for-profit facilities, one third of not-for-profit facilities and nearly half of government facilities in the country. Our members are committed to a quality-driven, innovative and efficient health care system that meets the needs and preferences of the individuals in our care.

Post-Acute Care Supply and Demand

Medicare is the U.S. federal health insurance program for people aged 65 or older, people younger than 65 with disabilities, and people of any age with end-stage renal disease. The risk of developing a chronic condition or multiple chronic conditions increases with age. The older population – persons aged 65 years or older – numbered 39.6 million in 2010 (the latest year for which data is available). They represented 12.9 percent of the U.S. population, about one in every eight Americans. By 2030, there will be about 72.1 million older persons, more than twice their number in 2000. People 65-plus represented 12.4 percent of the population in the year 2000, but are expected to grow to 19 percent of the population by 2030.³

These absolute numbers are only one factor increasing Medicare budgetary pressure and driving the need for post-acute care reform. Recent research indicates that more than 21 million Medicare fee-for-service beneficiaries had two or more chronic conditions in 2010, and more than 11 million had four or more.⁴ Multiple chronic conditions increase the risks for poor outcomes, such as mortality and functional limitations (see below), as well as the risk of high- cost services such as hospitalizations and emergency room visits.⁵ Furthermore, use of post-acute care increases as the number of chronic conditions

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³ Administration on Aging – Aging Statistics. DOI: http://www.aoa.gov/AoARoot/Aging_Statistics/index.aspx

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⁴ Lochner KA, Cox CS. Prevalence of Multiple Chronic Conditions Among Medicare Beneficiaries, United States, 2010. *Prev Chronic Dis* 2013;10:120137. DOI: <http://dx.doi.org/10.5888/pcd10.120137>.

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⁵ Chronic Conditions Among Medicare Beneficiaries – Chartbook: 2012 Edition. Centers for Medicare and Medicaid Services. DOI: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf>

increases.⁶ Such post-acute care is critical to preventable re-hospitalizations, a major, national healthcare savings effort, and ensuring successful transitions to home and community.

At the same time, the total number of nursing facilities and the total number of beds has essentially remained static over the past five years at approximately 15,700 facilities and 1.7 million total beds. Overall, 69 percent of skilled nursing facilities (SNFs) serve urban communities, while only 31 percent are located in rural areas.

The number of Medicare-certified beds also has remained essentially unchanged over the last six years, but the number of Medicaid-only certified beds has declined by 44 percent. This trend likely represents the payment levels associated with Medicare and Medicaid programs. MedPAC's annual reports have consistently shown positive Medicare margins for SNFs. However, it is important to note that the MedPAC 2011 average Medicare margin for SNFs, 22-24 percent, is an anomaly. Our more typical Medicare margin is in the range of 10 percent.

Our combined Medicare-Medicaid margins, however, now barely register in the 1-3 percent range, and for some providers, could be negative.⁷ Specifically, Medicare cross-subsidization of Medicaid historically has played an important role in sustaining nursing center care. However, with recent Medicare rate reductions (i.e., productivity reduction, sequestration) this program can no longer fully subsidize the widening gap between the costs of care and Medicaid payments for such care.

The projected average Medicaid shortfall for 2012 of \$22.34 per Medicaid patient day is 14.3 percent higher than the preceding year's projected shortfall of \$19.55. Using Medicare margin data and 2012 projected Medicaid shortfall data, Eljay projects a combined Medicare/Medicaid shortfall that exceeds \$2.51 billion for the current year or, expressed as a margin percentage across these two programs, a negative 2.8 percent (-2.8 percent) of revenue.⁸ Thus, the declining trend in Medicaid-only beds is of little surprise. Static numbers of Medicare-certified beds and declining number of Medicaid-licensed beds raise questions about out-year supply and its capacity to meet the needs of a growing older adult population with increasingly complex multiple chronic conditions.

Shift from Long Term Care to Short-Term Rehabilitation

Today's SNFs care for two distinct populations. Facilities have long been known for providing care to individuals who need long term care because they can no longer live independently at home or in assisted living. However, in recent years, there has been a shift in the types of individuals served in this setting. Now, the majority of individuals served in SNFs are those who need rehabilitation or skilled nursing care to complete their

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⁶ Ibid.

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⁷ Medicare Payment Advisory Commission 2013 Report to Congress.

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⁸ Eljay, LLC (December 2012) A Report on Shortfalls in Medicaid Funding for Nursing Center Care.

Prepared for the American Health Care Association. DUI:

http://www.ahcancal.org/research_data/funding/Documents/2012%20Report%20on%20Shortfalls%20in%20Medicaid%20Funding%20for%20Nursing%20Home%20Care.pdf

course of care following an acute illness. Of the 3.7 million individuals who received care in a nursing facility in 2009, only 854,000 resided in the facility for at least a year. Of the remaining 2.9 million, 80 percent were admitted for short-term rehabilitation and covered by Medicare. Individuals with short-term admissions are much younger and less likely to have dementia compared to long-stay individuals. As a result of this shift, both the range of services provided by SNFs and the acuity of illness of persons served has significantly increased over time.

Chronic medical conditions are present in at least one-quarter to one-third of all individuals receiving skilled nursing care, with most of these individuals living with multiple chronic conditions. The average case-mix index (a measure of severity of illness) has increased in nursing facilities each year. Therefore, nursing centers are well positioned to play a key role in efforts associated with reduced hospital lengths of stay, avoidable hospitalizations through the provision of higher intensity skilled care, and aiding in successful transitions to home and community via high quality, effective rehabilitation services.

At the same time, AHCA members continue to be the leading providers of care and services for the nearly one million individuals who do reside in nursing facilities for the long term. For the majority of these individuals, Medicaid is the principal payer for their care. Compared to non-members, AHCA members serve a greater percentage of Medicaid beneficiaries – people with very low incomes and minimal assets.

Approximately 65 percent of the residents in AHCA-member facilities rely on Medicaid as the principal payer for their care, compared to 61 percent of residents in non-member facilities. Only 20 percent of individuals in member facilities pay for their care out-of-pocket, compared to 24 percent in non-member facilities.

Reimbursement and Delivery System Trends

The historic method of purchasing SNF care using fee-for-service payment structures rewards providers with higher costs and higher volume, regardless of the quality of outcomes. However, in recent years, reimbursement trends across health care settings for both Medicare and Medicaid have begun to shift from payments based on volume and type of services provided to payments based on outcomes and quality. Payment methods intended to foster specific provider behaviors and better outcomes are often referred to as pay-for-performance or value-based purchasing (VBP) arrangements.

In an effort to provide additional resources to SNFs and further emphasize quality care for Medicaid beneficiaries, many states are exploring VBP programs. In 2013, 12 states with AHCA affiliates were operating under these arrangements. So far, states have tested a variety of approaches to VBP with mixed results.

Both Medicare and Medicaid managed care are rapidly replacing traditional fee-for-service arrangements as the dominant payment and service delivery systems. Many states with existing managed care programs are aggressively pursuing managed long term care expansions. Eleven states were operating some form of Medicaid managed long term care statewide or regionally in 2011. By 2014, approximately 28 states will have some form of Medicaid managed long term care. However, it is unclear at this point if and how managed care will incorporate VBP models.

Additionally, the *Patient Protection and Affordable Care Act* (ACA) established three national efforts with implications for nursing centers: Accountable Care Organizations

(ACOs), bundled payments and Medicare-Medicaid integration efforts. All three seek to facilitate and encourage coordinated and integrated care and reward providers who improve quality while lowering cost. However, these efforts still are unfolding and little detail is available on how or whether these efforts will impact Medicare spending or create quality incentives for skilled nursing centers.

Renewed Focus on Quality

People who receive care in SNFs and their families have increasingly higher expectations for the quality of services provided. They are rightfully demanding excellent outcomes and maximum value. SNFs are well on their way to transforming their operations to meet the quality and value demands of their customers and of government payers. Through improvements in a majority of quality measures, declines in citations, increases in staffing levels and improvements in customer satisfaction rates, SNFs have demonstrated their commitment to improving quality of care.

This commitment has been accelerated by new collaborative efforts of the profession in partnership with government and other stakeholders. The Advancing Excellence in America's Nursing Homes (AE) campaign brings together a variety of the profession's stakeholders to activate and support SNFs as they improve their performance in key clinical and organizational areas. Through AHCA's software tool LTC Trend TrackerSM, independent and small regional providers now have easy access to the kinds of key quality and operational information needed to examine and benchmark performance that were previously only available to larger skilled nursing chains. Additionally, AHCA is driving quality improvement through the AHCA/NCAL Quality Awards Program, which establishes criteria and pathways and provides peer recognition for providers on their journey toward performance excellence.

Finally, earlier in 2012, AHCA/NCAL launched the Quality Initiative, a member-wide challenge to meet specific, measurable targets:

- ***Safely Reduce Hospital Readmissions:*** By March 2015, reduce the number of hospital readmissions within 30 days during a SNF stay by 15 percent.
- ***Increase Staff Stability:*** By March 2015, reduce turnover among nursing staff (RN, LPN/LVN, CNA) by 15 percent.
- ***Increase Customer Satisfaction:*** By March 2015, increase the percentage of customers who would recommend the facility to others up to 90 percent.
- ***Safely Reduce the Off-Label Use of Antipsychotics:*** By December 2012, reduce the off-label use of antipsychotic drugs by 15 percent.

Taken together, the Quality Initiative offers the potential to improve dramatically outcomes and satisfaction for hundreds of thousands of individuals in long term and post-acute care, while simultaneously reducing health care costs.

Medicare and Medicaid budgetary pressure will continue to drive policymakers and skilled nursing care providers to explore payment methodologies that offer the promise of greater accountability and efficiency. By continuing to expand their capacity to effectively manage, measure, and monitor specific areas of care, providers will be better equipped to meet beneficiary needs and work toward payment system reforms that produce efficiencies and ensure access.

Responses to Joint Committee Post-Acute Care (PAC) Inquires

In the section below, AHCA provides responses to the nine question areas (e.g., quality, assessment tools, value-based purchasing, reducing hospital admissions, bundled payments, site neutral payments, questions raised by alternatives to fee-for-service (FFS) payment, budgetary implications, and beneficiary protections and issues).

We have responded to each area of inquiry with the exception of budgetary impacts. Our budget comments are embedded in the other eight response sections. In brief, our responses reflect the following high-level observations and recommendations on post-acute care reform:

- ***Quality*** – AHCA supports the use of quality measures based on outcomes in payment models for PAC settings. Additionally, AHCA has underway an array of quality measurement efforts.
- ***Assessment Tools*** – AHCA supports the use of common assessments, such as the CARE tool, to collect standardized information across different settings. Such common assessment tools will be important for site-neutral concepts.
- ***Value Based Purchasing*** – AHCA presents a series of principles for policy makers to consider in the development of PAC value-based purchasing (VBP). As we outline in this section, certain steps must be taken before CMS considers an expansion of VBP in post-acute settings.
- ***Reduced Hospital Readmissions*** – AHCA supports linking hospital readmission rates with reimbursement based on setting specific measures as soon as possible. We have a readmissions proposal.
- ***Bundled Payments*** – AHCA presents a series of policy options that must be included in any PAC bundled payment model if it is to be successful. While AHCA recognizes that the goal of bundled payments is to reduce costs while maintaining quality, we do not believe enough evidence exists to support that as fact. CMS must be given appropriate time to evaluate the results of its bundled payment demonstration before policy makers consider a national, mandatory

bundled payment system. In this section we also describe our ongoing research efforts to develop and propose an alternative PAC bundled payment approach for the Committees' consideration.

- ***Site Neutral Payments*** – AHCA supports post-acute site-neutral payment reform, and we have developed a patient-focused payment model that would reduce spending on post-acute care while facilitating the movement toward a more rational system of post-acute care payment and delivery. AHCA has a site-neutral proposal.
- ***Alternatives to FFS Payment*** – AHCA believes that policymakers must address the increasing role played by managed care models such as Medicare Advantage (MA) and Accountable Care Organizations (ACO) in any reform policy discussions. AHCA has two member-staffed work groups focused on these topics and has developed an array of areas for consideration.
- ***Beneficiary Protections*** – AHCA supports payment reform policies only if they work to protect beneficiaries from both increased cost burdens and declines in access to care.

AHCA has addressed each question area with a discussion of the topic rather than providing direct responses to each question. Our responses are organized in the following manner: a summary of our perspective, background on the issue area in the context of skilled nursing, and an AHCA position statement on the status of our work in the area in question.

Quality Metrics

Summary

AHCA supports the use of quality measures that measure outcomes in payment models for the post-acute care (PAC) setting. Measures need to be outcome based and should reflect the main reasons people receive SNF care such as improvement in function and discharge to community. Current measures used by CMS in Five Star are more heavily weighted toward structure and process measures rather than outcomes but also focus issues more relevant to long stay residents being paid for by Medicaid rather than short stay being paid for by Medicare. For example, only four quality measures currently in use are specific to care received during a person's skilled nursing facility (SNF) Part A stay (influenza vaccine, pneumonia vaccine, pain management and pressure ulcer care), none of which relate to the primary purpose for which most patients seek SNF care. We support the use of measures such as rehospitalization, discharge to community, improved function (mobility, self-care, and speech) as well as customer satisfaction, particularly responses to two questions: overall satisfaction and recommendation to others.

Background

Quality measures were first developed as quality indicators for long stay residents in skilled nursing centers to use as part of their internal quality improvement efforts. Soon after their implementation, CMS began to use them in the annual survey inspection. Over time, they began to use them more aggressively to identify individual charts to review often assuming until proven otherwise that care was deficient if the person triggered the quality indicator. Many of the quality indicators were submitted to National Quality Forum (NQF) for review, and those that were voted on by the membership, were called "quality measures" and used in a public reporting program as part of CMS's nursing home compare website. A subset of those quality measures were incorporated into a five star rating system. While this rating system was intended to help consumers select a nursing center; they were never intended to be the only piece of information. These quality measures were updated and reevaluated by NQF. Several measures from prior years did not pass review by the technical committee and others received time-limited endorsement or approval with concerns about the measure validity. The NQF only reviews measures submitted to them. As a result many areas that are important to consumers (such as improvement in function following rehab or the proportion of SNF admissions who are discharged home) but were not submitted for review. Therefore, these important topics are not collected and reported by CMS on Nursing Home Compare. Similarly, this process results in few if any measures for each of the six IOM domains for measuring quality: safety, effectiveness, equity, timeliness, patient-centeredness, and efficiency.

CMS website still recommends that consumers use additional information to the five star and quality measures. *"Information on Nursing Home Compare isn't an endorsement or advertisement for any nursing home. You may want to use a variety of resources when choosing a nursing home. Don't rely only on the nursing home's star rating to make a final decision"* (CMS Your Guide to Choosing a Nursing Home July 2013). However,

despite this warning on how to use the quality measures, others such as commercial insurers and MCOs have used them to determine participation in their networks.

Focus of quality measures

CMS currently measures the quality of care and services provided in skilled nursing facilities using the Five Star rating system and a set of NQF-endorsed quality measures derived from the Minimum Data Set (MDS) standardized assessment tool. A facility's Five Star rating is heavily weighted toward the results of periodic inspections conducted by state survey agencies on behalf of CMS to determine compliance with regulations. The state to state and region-to-region variations in the implementation of these inspections and their results are huge, which does not allow comparison between states. PAC providers other than skilled nursing facilities do not have annual State survey inspections. These limitations make this metric unreliable for use in cross-setting PAC payment models.

Currently, the quality measures used on CMS's Nursing Home Compare and Five Star rating system are also inadequate as they do not reflect the primary purpose and goals of PAC services. The Five Star and nursing home compare measures mainly focus on quality of long term services. For example, only four quality measures currently in use are specific to care received during a person's SNF Part A stay (influenza vaccine, pneumonia vaccine, pain management and pressure ulcer care). In addition, most of the measures are either structural measures of quality (e.g. compliance with regulations or staffing levels) or process measures (e.g. immunizations, or treatment for pain). While these four measures reflect important aspects of care, they do not adequately capture the outcomes that reflect the main goals or purposes of post-acute care.

Quality measures for the SNF population should reflect the goals and objectives of PAC. While the goals and objectives of PAC may vary depending on each individual's condition and reason for admission; there are a common set of goals that apply to nearly all individuals who seek PAC care hope to achieve. For most individuals served in these setting, the primary goals include:

- Return to their prior living situation or the most independent and least institutional setting practical as quickly as possible
- Restore, stabilize or improve their function, particularly related to mobility, self-care (e.g. activities of daily living, or ADLs), and speech
- Treat patient's acute and chronic illnesses and avoid unplanned rehospitalizations
 - Improve their clinical condition (e.g. wound healing, post-surgical recovery, etc)
 - Complete their course of treatment for an episode of illness that requires skilled nursing care (e.g. IV medications such as antibiotics),
- Learn to manage chronic disease(s) or disability better (e.g. transitioning to successful self- administration of medications)

Principles in selecting quality measures

Regardless of how or what specific quality measures are used, we believe it is critical for the measures to adhere to several basic principles. Quality measures used in payment models must:

- reflect the primary goals of care for the population receiving care,
- be meaningful to both the consumer and the provider,

- be risk-adjusted to account for differences between facilities in patient populations and acuity (preferably by use of the more robust approach of regression modeling rather than through a set of exclusions),
- be much more heavily weighted for patient outcome measures rather than structure or process measures,
- contribute to providers' ability to achieve better outcomes (e.g. are timely and can be used in facility-level quality improvement efforts such as Quality Assurance Performance Improvement [QAPI]), and
- be readily available for use now or under development to be used in the near future.

Proposed Quality measures for SNF setting

AHCA has identified a set of PAC-specific outcome measures that better reflect the goals and purpose of SNF Part A services than those currently in use. We support the use of these measures in new payment models and public reporting. These measures include the following:

- 30-day all-cause risk adjusted rehospitalization from SNF (data source: MDS 3.0)
- Risk-adjusted discharge to community (data source: MDS 3.0)
- Improvement in mobility (data source: mobility component of the CARE tool)
- Improvement in self-care (data source: self-care component of the CARE tool)
- Improvement in speech (data source: NOMS)
- Consumer satisfaction & willingness to recommend SNF to another person (data source: instrument and data collection & reporting mechanism under development)

Several of these measures are being tested and validated for submission to National Quality Forum for endorsement. In order to be valid measures of quality, all outcome measures must be risk-adjusted in order to allow for valid comparisons of quality between facilities, especially when used for any type of accountability mechanism (e.g. value based purchasing). We believe these measures can also be readily applied across PAC settings. However, the risk adjustment variables may need to differ, given the differences in patients cared for between settings.

Gaps in current quality measures

There are five major gaps in current quality measures. The first is their failure to capture outcomes or issues that are most relevant to the goals of PAC care. Most measures currently used are structural or process of care measures rather than outcome measures. These measures may not be adequately linked to better outcomes. While publicly available outcome measures are currently not available, many are under development and should be available by 2014. AHCA recommends using the set of outcome-based quality measures recommended above. When structure or process measures are considered they should have a clear and strong link to outcomes but be given less weight than outcome measures. Second, there are few, if any, quality measures related to end-of-life care in PAC settings. AHCA recommends that Congress direct CMS to develop such measures. Third, measures based on claims have a significant lag time in their availability, may not reflect current provider practices and lack adequate clinical detail to facilitate appropriate risk-adjustment. AHCA recommends that measures should be based on clinical assessment tools such as the MDS, CARE tool or be derived from electronic medical records in order to capture critical clinical information needed in risk adjustment and

measurement specifications. Fourth, measures of care transitions that have been developed for hospital discharges need to be adapted for discharges from PAC settings. AHCA recommends that the Care Transition Measure (CTM3) measures be modified for use in other settings and added to satisfaction questionnaire to be administered to beneficiaries after discharge from each PAC setting. Fifth, data collection methods differ across settings and differ in frequency of data collection that does not allow for adequate comparisons of change over time between settings. To improve consistency of data and ability to generate comparable measures across settings, AHCA recommends the incorporation of sections from the CARE tool (e.g. self-care and mobility scales) into the various standardized clinical assessment tools currently used in the PAC settings, such as the OASIS in home health, MDS in skilled nursing, and IRF-PAI in inpatient rehabilitation facilities. Similarly, some standardization of the frequency of data collection (at minimum collected at admission and discharge) must be required across all settings to allow for appropriate comparisons. This also applies to collecting data during the hospital stay otherwise trending change over time from the hospital stay is not possible. Closing these gaps will facilitate improved comparability of measures across PAC settings and more accurately capture primary outcomes of interest and importance critical to creating positive and effective incentives for high-quality service delivery.

Assessment Tools

Summary

AHCA supports the use of common assessments by including core data-elements of the Continuity Assessment Record and Evaluation (CARE) tool in current setting specific assessment tools (e.g. MDS, OASIS and IRF-PAI) to collect standard information across different settings. The common assessments must also be collected in hospital and other settings at the same time intervals to facilitate integrated care delivery as well as the development of comparable measures across provider settings. None of these tools by themselves can be used to determine the appropriate care setting since the availability of resources, staff training and patient/family wishes are critical in determining the appropriateness of a care setting for an individual.

Background

It is important to remember that the MDS was principally developed as a standardized assessment tool to help with patient care delivery that was later adapted for payment. The CMS MDS manual states: *“its primary purpose as an assessment tool is used to identify resident care problems that are addressed in an individualized care plan.”* The use of common assessment tools - either within or across settings - can help clinicians better assess patient’s conditions, track their progress with the care plan and identify areas at risk that need attention. Using different assessment tools in different settings (e.g., OASIS, MDS, and IRF-PAI) would not be a concern if patients received care in just one setting. However, a large proportion of the frail elderly - the population that most often requires PAC - receive care from multiple PAC providers. Critical to any integration of care efforts across providers is the use of standard, common clinical assessments. Therefore, those clinical areas that are present and relevant to care across different settings should be assessed using similar tools. Examples of areas where common assessment would be valuable include: cognitive status, depression, ADLs, IADLs, wounds, pressure ulcer risk, incontinence, etc.

The resident assessment instrument (RAI) remains the principal component of the MDS used in skilled nursing centers. The statutory authority for the RAI is found in Section 1819(f)(6)(A-B) for Medicare, and 1919 (f)(6)(A-B) for Medicaid, of the Social Security Act (SSA), as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). These sections of the SSA require the HHS Secretary to specify an MDS of core elements for use in conducting assessments of skilled nursing center residents.

The MDS collects demographic, clinical and care delivery information. It was developed as part of OBRA-87 and implemented shortly thereafter in 1990. It has undergone a number of revisions. The most recent version (MDS 3.0) was implemented in Oct 2010. The MDS contains a number of clinical assessment scales (e.g. ADLs, dementia, depression, pressure ulcer risk assessment, etc.) It provides a standard method of assessing patients across the country in all skilled nursing centers. The information is used in clinical care; to develop each resident’s care plan, to identify individuals at risk for common geriatric conditions (e.g. falls, pressure ulcers, etc.) that trigger the facility to complete a Resident Assessment Protocol (RAP); to calculate quality indicators and

quality measures; and to determine payment for Medicare and in some states' Medicaid programs as well.

All Medicare and Medicaid certified facilities must collect information on all residents at regular intervals. For Medicare beneficiaries whose stay is being paid for under Medicare Part A, SNFs must collect the MDS 5 days, 14 days, 30, 60, and 90 days after admission (commonly referred to as SNF PPS assessments) since information is used to classify a resident into one of 66 different Resource Utilization Groups (RUGs)). RUGs are used to determine Medicare Part A payment. SNFs must also complete a discharge assessment whenever the patient leaves the SNF for any reason (such as discharged home, rehospitalized, transferred to another SNF, etc.) In addition, the MDS must be completed for any significant change in condition of the resident and with any change in amount or type of therapy services. For non-Medicare Part A stays, the facility must collect the MDS within 14 days of admission (commonly referred to as the OBRA assessment) and every 90 days thereafter as well as with any change in status and at discharge from the facility for any reason.

The amount of information varies with each collection period or assessment type, but the items, scales and ratings are always the same. Thus the information on each assessment is comparable and allows for tracking of a resident's condition over time, which would be critical when linking outcomes to payment across multiple settings. The information on the MDS is part of the official medical record and is based on assessments performed by physicians, nurses, physical therapists, occupational therapists, speech therapists, social workers, and other health professionals.

The CARE tool was developed by CMS in response to the Deficit Reduction Act of 2005. The CARE tool is a standardized patient assessment instrument providing information on clinical and other patient factors associated with costs and resource use, outcomes, discharge placement and care transitions. The CARE tool is designed to collect information at discharge from acute care hospitals and at admission and discharge from post-acute care sites such as Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs). However, the CARE tool has not been extensively pilot tested other than the initial development test by CMS. There are also plans to use it in the bundle payment demonstration. Additional data on how best to use the CARE tool are needed.

Using a standard assessment tool

According to CMS, almost one in five Medicare beneficiaries is admitted to the hospital each year. Approximately 40 percent of Medicare beneficiaries discharged from the hospital will receive post-acute care in one of four settings. According to CMS, in 2008, patients discharged to PAC services tended to go primarily to HHAs (37percent) or SNFs (42 percent) and only nine percent went to IRFs and just two percent to an LTCH. Many of those discharged to PAC used more than one service during their episode of care, particularly those discharged to SNFs and LTCHs. For example, 67 percent of those discharged to SNFs received additional PAC services.

In order for provider to deliver the best possible care across settings, not only do the PAC providers need to use the same assessment tools, but they must also be used in hospitals. Although the three CMS mandated assessments (OASIS, MDS, IRF-PAI) measure similar concepts, they use different clinical items, different assessment timeframes and disparate measurement scales to assess health, physical function, and cognitive status. This makes care coordination difficult and the development of comparable measures extremely difficult if not impossible.

Lack of coordinated assessment tools also makes it very difficult to develop payment models that compare outcomes across these different settings. Acute care hospitals and LTCHs do not have any similarly mandated assessments. When hospitals use different assessment tools, not only is it difficult to track a patient's condition as he or she moves in and out of the hospital, but communication between settings to assess the patient's condition is also compromised. As a result, the patient is less likely to receive appropriate care than when standard common clinical metrics are used. Therefore, for patient care purposes alone, AHCA supports moving to the use of standard assessment tools for common clinical conditions across all health care settings including hospitals.

Neither the assessment tools currently in use nor the CARE tool is perfect, however, as mentioned the use of standard clinical metrics across settings is extremely important both to patient care and to evaluation of quality across settings. Therefore, it is preferable to have a standard metric in place that is not quite perfect rather than to have *multiple* "near perfect" different clinical metrics that do not allow for effective integration of care delivery across settings. Components of the CARE tool developed by CMS (many of which are included in the B-CARE tool being tested in the Bundle Payment for Care Improvement - BPCI) meet this minimum requirement for developing standard quality measures across different provider settings.

Using assessment tools for quality measurement

In order to develop comparable measures across different providers, information needs to be collected in identical ways (e.g. use the same assessment tool); otherwise it is not possible to develop quality measures that can accurately compare different providers. For example, if one set of providers uses 5 questions to assess ADLs on a 5 point scale and another provider uses 4 questions to assess ADLs on a 4 point scale, it is extremely difficult if not impossible to develop one quality measure to comparably assess both sets of providers. Similarly, even if both providers used the same number of questions and same rating scale, if one provider collected the information at admission and every 4 weeks while another collected it at admission and discharge only, developing a quality measure to assess improvement over time between the two provider groups is impossible. Therefore, for those clinical conditions that we want to measure across provider settings, we support using the same assessment tools collected in the same way and at the same time intervals.

It is also important to note that an assessment tool does not equate to a quality measure. The assessment tools in use in the OASIS, MDS, and IRF-PIA as well as the CARE tool provide the data that allow us to calculate quality measures. As just mentioned, without a standard assessment tool, it is very difficult to create a quality measure. To develop a quality measure from a common assessment tool, one still needs to define which patients are included in the measure and which ones are excluded, what is the time frame the measure spans, how to risk adjust for different patient characteristics (e.g., acuity), and

how to aggregate (including how to weight) responses on an assessment scale (e.g., ADLs).

Using the CARE tool

We support replacing certain assessment items in the OASIS, MDS and IRF-PAI with standard assessment elements, which could be from the CARE tool. However, there are unique patient care issues and requirements in each setting that will warrant the need to have unique questions or different frequency of data collection for that setting. Therefore, we support adding standard assessment items and scales from the CARE tool (e.g., dementia, ADL, wound care, pressure ulcer risk, etc.) to the existing assessment tools (OASIS, MDS and IRF-PAI), as well as creating a standard minimum assessment frequency across settings to allow for accurate comparison across settings. The B-CARE tool is a shortened version of the full CARE tool that utilizes many of the commonly needed clinical assessment items and scales (e.g., dementia, ADLs, wounds, etc). Incorporating the B-CARE tool into the current comprehensive assessment tools in use (OASIS, MDS, and IRF-PAI) is an attractive option worth pilot testing should the BPCI demo show promise with the B-CARE tool. There are other clinical assessment tools available, but most are proprietary. Clinical assessment tools required for use across different provider settings need to be in the public domain.

Determining appropriate care setting

None of the current tools (OASIS, MDS, IRF-PAI) or the CARE tool was designed to determine the appropriate care setting for a patient. They can provide valuable information to help with such a determination, but the information needs to be completed prior to admission to a PAC setting (e.g., during the patient's inpatient hospital admission). Further, the determination of the appropriate setting is based not only on the patient's condition and needs but also on the capacity of the healthcare provider to meet those needs. For example, patients requiring a ventilator to breathe can receive care in a hospital ICU, LTCAH, IRF, SNF or at home. As long as the appropriate health care personnel and other supports are available, each of these settings is appropriate. However, without the appropriate personnel and other supports, each setting would be inappropriate. The determination of setting requires at least three things: (1) an accurate understanding of the patient's clinical condition, (2) measures to ensure appropriate support to meet the person's needs; and (3) similar outcome measures to ensure each setting is in fact meeting the person's needs reliably. A standard clinical assessment tool is required to achieve (1) and (3) but does not help with (2). Site neutral payments with appropriate risk-adjustment and outcome measures in place can bypass the need to develop setting specific determinations of need. AHCA supports a site neutral payment approach that relies on common clinical assessment tools collected in the hospital and across different PAC provider settings.

Value-Based Purchasing

Summary

While AHCA supports the concept of value-based purchasing (VBP), it is not possible at the present moment to declare that existing PAC systems should be transitioned to VBP. Little evidence on the impact of VBP is readily apparent from Medicare or Medicaid research. Certain steps to better understand VBP must be taken before any further movement to expand VBP models. VBP was a widely-heralded concept, and entities such as the IOM and MedPAC supported the development early on. However, evidence of the impact of such programs remains questionable.

It is imperative CMS provides Congress with an analysis of the successes and failures of VBP. Such an analysis must address issues such as incentive size, incentive structure and metric choice. For example, the existing literature suggests that simplicity is critical and thus may indicate that complex scoring algorithms frequently confuse providers and diminish effort.

Further, steps should also include completion of the evaluation of the Nursing Home VBP Demonstration. The evaluation is due in late 2013 and hopefully will constitute a solid foundation upon which to build a VBP program. The conclusions and insights reached by the evaluators should help clarify whether VBP should be applied to a single PAC setting or can be a broader program, crossing several settings. Such conclusions can help determine what payment models worked best; for example: by seeking to improve quality and efficiency by aligning the financial incentives offered to hospitals and physicians through a system of bundled payments, or alternatively, seeking to increase quality and efficiency by giving bonuses to health care providers.

As for whether the systems should rely on penalties, rewards, a combination of both or something else, AHCA believes efforts should be made to design a system that includes user rewards. The very prospect of penalties can cause a failure to positively engage providers, potentially crippling a system from the outset. Moreover, penalties can have devastating effects by depriving providers of badly needed funds to improve care delivery. CMS also should be directed to work cooperatively with stakeholders in developing any VBP systems.

Background

VBP involves linking payments to the quality and efficiency of care provided and shifting Medicare away from paying providers based solely on their volume of services. The concept encompasses a variety of models including bundling and bonus payments.

VBP received substantial recognition and support from the IOM beginning in 2001.⁹ In its report “*Crossing the Quality Chasm*,” IOM argued that payment incentives be aligned with quality improvement, allowing for providers to be given the opportunity to share in the benefits, incentives aligned with the achievement of better outcomes, and the use of good processes of care or other desired actions. The report recommended that all purchasers examine payment policies to remove barriers that impede quality and build in stronger incentives for quality enhancement, calling for government agencies such as CMS to “identify, pilot test, and evaluate various options for better aligning current payment methods with quality improvement goals.”

In 2005, the Commonwealth Fund commissioned a survey of health care opinion leaders. The leaders identified pay for performance (P4P) - the notion that the provision of better care should result in more payment - as the single most promising approach to improving the performance of the nation’s health care system.¹⁰ “The enthusiasm behind P4P was driven by a simple concept: people and institutions respond to incentives. If incentives are created that promote quality and efficiency, better care should occur.”

In its March 2004 and 2005 reports to the Congress, MedPAC discussed several important policy changes that differentiated among providers who included P4P. Taken together, these changes will improve the quality of care for beneficiaries and lay the groundwork for obtaining better value in Medicare. Over the course of these years, the Commission has recommended that Medicare create incentives to improve quality through its payment systems.

In his testimony before the Senate Finance Committee on July 27, 2005, MedPAC Executive Director Mark E. Miller testified, “This approach builds upon the experience of private purchasers in designing and running pay-for-performance programs that refocus and reward health care providers for improving the quality of care....While Medicare already has some programs in place to improve quality, these are not enough to orient the whole system towards improving quality; nor is it equitable for Medicare to pay a high quality provider the same as one that furnishes poor care.”

Mr. Miller provided a summary of MedPAC’s analysis of five settings—hospital, physician, home health, Medicare Advantage, and end-stage renal disease—where the Commission concluded P4P is ready to move forward. By 2008, MedPAC recommended that Congress establish a Medicare quality incentive payment policy for SNFs.

Little federal CMS guidance exists today regarding Medicaid VBP. Thus, states have considerable discretion in developing Medicaid payment methods. Over the years, states

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⁹ “*Crossing the Quality Chasm*,” the Institute of Medicine (IOM, 2001).

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The Commonwealth Fund Health Care Opinion Leaders Survey: Assessing Health Care Experts’ Views on Health Care Costs. New York, NY: The Commonwealth Fund; 2005.

have experimented with a variety of approaches. Typically, VBP incentive payments are amounts that are added on to a facility's base payment rate for achieving certain benchmarks. These approaches have produced highly mixed results, causing a number of them to be discontinued due to unclear outcomes or state budgetary challenges since the economic downturn.

In recent years, a number of states have developed programs that would reimburse providers for meeting certain quality benchmarks. However, in some states these programs were either never implemented, or implementation was delayed. This was due to budget problems at the state level or because VBP elements proved difficult to track. Another reason given was due to the belief by states and skilled nursing centers that the measurement elements were not meaningful relative to performance.

Tying Measurement to Incentive Payments.

Most states use a VBP approach in which points are scored for meeting certain benchmarks. Achievement of benchmarks is translated into per diem add-ons. Specifically, each NF is evaluated based on either its ranking compared to other nursing homes in the state or whether it has achieved NF-specific target levels for performance. Points across the measures are summed and translated into a per diem add-on for Medicaid resident days. Add-on calculations vary from a fixed dollar amount to a percentage of a facility's specific rate. For example, Indiana recently updated the way it pays for quality through the implementation of a VBP on July 1, 2013. Under this program, the state will pay nursing centers an add-on rate that is based on a report card score derived from survey findings (75 percent) and nursing hours per resident day /staff retention and turnover (25 percent).

Other recent efforts associated with Medicaid VBP approaches focus on embedding the incentive payment in the per diem rather than as an add-on to the per diem. For example, Ohio has increased the payment amount tied to quality measures, which impacts the potentially achievable per diem. Skilled nursing centers that fulfill at least five of 20 measures are rewarded by increasing their Medicaid per diem rate.

Research and state experience to-date raise questions about the impacts of VBP approaches.¹¹ Key challenges include:

- ***Incentive Size*** -- In classic economic models, incentives are effective if they are adequate in size to motivate behavior change and justify new investments. Additionally, understanding the size of the incentive also has implications for providers. In the VBP demo, providers do not know the incentive size until after the evaluation period. Uncertainty creates difficulty for businesses in making investment decisions. Similar concerns are raised in Medicaid efforts. However,

research has raised concerns about current VBP arrangements.¹² Specifically, experts question whether the size of the incentive payments is sufficient to stimulate change by providers. Additionally, VBP arrangements that compare NF to their peers create unattainable targets for low ranking nursing centers even if they have increased quality or achieved accepted targets of quality. Therefore, lower performing nursing centers have less of an opportunity to receive a quality incentive payment. Still other critics question whether the metrics used in VBP programs are what matters most to consumers or rather serve as cost-drivers.

- ***Incentive Structure*** -- For incentives to work, they must be structured effectively. Most VBP programs have used complex formulas in ways that seem only to increase the opacity of the payment system. For example, in one demonstration CMS started with a simple formula that awarded bonuses to the highest performers and saw modest gains in quality (compared with controls). When the program switched to a more complex formula that incorporated both improvement and achievement, the incremental gains of VBP seemed to attenuate.
- ***Metric Choice***¹³ -- Beyond issues of payment amount and scheme, VBP can only succeed in improving care if the metrics chosen for incentives represent important aspects of care. Failure to use metrics that are important to clinicians and patients makes it less likely that any VBP program will be able to engage clinicians in quality improvement or lead to results that patients value.

Furthermore, both Medicare and Medicaid managed care are rapidly replacing traditional state FFS arrangements as the dominant payment and service delivery systems. Today, approximately 30 percent of Medicare beneficiaries are enrolled in some form of Medicare Advantage plan. Recent estimates show increasing enrollment.

Until recently, NF services were not included in Medicaid managed care arrangements or only were included for what roughly equated to a PAC stay. Some examples include Minnesota and Texas. New York State's Medicaid managed long term care pilot program does not include NFs at all. However, in recent years, a handful of states have significantly expanded Medicaid managed care, including non-traditional populations (e.g., older adults and persons with disabilities) and non-traditional managed care services, specifically long term care. The states of Hawaii, New Mexico, and Tennessee include the full array of long term care in their Medicaid managed care arrangements, including long-stay NF services. Arizona has the most experience with Medicaid managed care as well as inclusion of long-stay NF services in managed long term care.

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□ Becky A. Briesacher, Ph.D., Terry S. Field, D.Sc., Joann Baril, and Jerry H. Gurwitz, M.D. Pay-for-Performance in Nursing Homes. [Health Care Finance Rev.](#) 2009 Spring;30(3):1-13.

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▫ See quality metrics section of this transmittal, page 17.

However, many states with existing programs are aggressively pursuing managed long term care expansions while other states are developing new programs. In 2011, 11 states were operating some form of Medicaid managed long term care statewide or regionally. By 2014, approximately 27 states will have some form of Medicaid managed long term care. At the same time, a number of states are pointedly exploring Medicare-Medicaid integration efforts. They are either using a capitated risk-based model under CMS' Financial Alignment Demonstration or utilizing Fully Integrated Dual Eligible Special Needs Plans, which also contract with state Medicaid agencies.

To date, the majority of VBP work has been conducted in FFS payment environments. Little work has been completed in managed care settings – MA, Medicaid-only, or in Medicare-Medicaid integration programs. Any consideration of VBP must include a better understanding of how the payment model would work in settings where providers would have contracts with multiple plans, potentially with differing VBP approaches. Such a mix of VBP perspectives would create notable challenges for providers in terms of day-to-day operations and make evaluation of such models extremely difficult for plans as well as payers.

As discussed above, the traditional FFS system is slowly being replaced by systems that pay for better outcomes and value rather than the volume of services provided. Such strategies have been underway for many years in traditional managed care. The ACA will further reform the health care delivery system through the expansion of Medicare ACOs and Medicare bundled payments. ACOs and bundled payments both seek to facilitate and encourage coordinated and integrated care and reward providers for improving quality at a lower cost. Medicare ACO initiatives seek to do this by means of organizational structure reforms, while the Medicare bundled payment initiative seeks to better coordinate and integrate care through payment reforms. The ACO model involves the measurement of savings and quality over a three-year period. The bundled payment model pertains to a bundle of services delivered within a given episode of care such as the days spent in an acute care setting plus some period of post-acute care.

The ACO Medicare Shared Savings program will allow providers who voluntarily agree to work together to coordinate care. Those who meet certain quality standards will share in any savings they achieve for the Medicare program. ACOs that elect to become accountable for losses have the opportunity to share in greater savings. In terms of measurement, ACOs will coordinate and integrate Medicare services across roughly 30 quality measures organized in four domains. These domains include patient experience, care coordination, patient safety, preventive health and services tailored to at-risk populations. Within Medicaid and the State Children's Health Insurance Program (CHIP), there is an increasing number of states moving toward accountable care. Virtually nothing is known about how VBP will impact care in Medicare ACOs and bundling, and little is known about VBP in Medicaid arrangements.

CMS Preparation for a SNF VBP Program

CMS started preparation for a SNF VBP demonstration in 2005. It contracted with Abt Associates to produce the design for the SNF VBP system. Abt delivered its final report to CMS in June 2006. The 3-year demonstration began July 1, 2009, in three states: Arizona, New York and Wisconsin.¹⁴ CMS annually assessed the performance of participants across four quality-of-care domains: (1) nurse staffing, (2) resident outcomes, (3) appropriate hospitalizations, and (4) survey deficiencies.¹⁵

The demonstration awarded financial incentives on the basis of attainment or improvement. The NHVBP Demonstration ranked SNFs relative comparatively to one another within each state. The top performers were those that ranked highest in overall care relative to other facilities. The metrics used were a combination of structure, process and outcomes; many unrelated to any savings achieved. In addition, many required a significant increase in provider costs.

The most problematic design flaw with the CMS VBP demo, however, was the funding source for the financial incentive. It was predicated on savings from reducing rehospitalizations from the split with CMS. Even if a provider significantly reduced its rehospitalization rate and/or improved on all other metrics used in the program, if there were no savings to the state from reducing rehospitalizations there was no financial incentive payment to that facility. The uncertainty of not knowing the size of the incentive relative to the cost of making changes to attain the metric targets resulted in most providers not making significant changes to their practices.

In 2010, Congress in the ACA required the HHS Secretary to implement a VBP program for Medicare payments for SNFs¹⁶. Section 3006(a)(2) of the ACA requires the Secretary

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¹⁴ The following initial number of participants (all of which are certified and licensed as SNFs and most of which are dually-certified and licensed both as SNFs under Medicare and as NFs under Medicaid): Arizona: 41; New York: 79; and Wisconsin: 62. SNFs in these three States volunteered to participate in the demonstration.

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The demonstration required participating SNFs to submit nurse staffing data that includes payroll, resident census, and agency staff data. CMS also uses data collected from MDS (for outcome measures), inpatient hospital claims (for hospitalization rates), and State health inspection surveys for scoring facilities. CMS risk-adjusted the staffing and hospitalization measures to capture quality differences as opposed to differences in patient populations or facility characteristics. This program was designed to be budget neutral. CMS derived funding for incentive payments from a State-specific “payment pool” generated by the project’s Medicare savings.

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Section 3006(a) (1) of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), enacted on March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010 (collectively known as the Affordable Care Act) requires the Secretary of Health and Human Services (“the Secretary”) to develop a plan to implement a VBP program for Medicare payments under Title XVIII of the Social Security Act (“the Act”) for SNFs.

to consider the following issues in developing a plan to implement a VBP program for SNFs:

- The ongoing development, selection, and modification process for measures (including under sections 1890 and 1890A of the Act, as added by section 3014 of the ACA to the extent feasible and practicable, of all dimensions of quality and efficiency in SNFs;
- The reporting, collection, and validation of quality data;
- The structure of VBP adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding of value-based bonus payments;
- Methods for the public disclosure of information on the performance of SNFs; and
- Any other issues determined appropriate by the Secretary.

The final year of the demonstration concluded in December 2012. The evaluation of the demonstration is scheduled for completion in the fall of 2013.

In its report to Congress, CMS indicated that it plans to use the results of the evaluation to assist it in the development of a SNF VBP program by proposing quality measures, determining the SNF VBP population, and creating an enhanced data validation process and performance incentives.^{17, 18}

CMS also indicated that it will need to consider the challenges and length of time involved with respect to developing any necessary new measures, soliciting additional multi-stakeholder input, seeking endorsement of the quality measures by the consensus group with a contract under section 1890(a) of ACA, subjecting the measures to the pre-rulemaking process under section 1890A(a), if applicable, and publishing a proposed and final rule to implement the program. If CMS decides to develop new measures, we do not expect a final rule much earlier than mid- 2016.

The Report provided to Congress by HHS presents a rich array of options for developing a SNF VBP program. However, CMS does not draw concrete conclusions from its analysis chiefly because the evaluation has not yet been completed and will not be completed until the fall of 2013. The evaluation is the absolute necessary next step. An adequate basis for going forward would at a minimum be comprised of such an evaluation, coupled with lessons learned from other VBP projects and the options provided in the HHS Report to Congress. Other VBPs should include those undertaken by several states.

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¹⁷ U.S. Department of Health and Human Services, Report to Congress: *Plan to Implement a Medicare Skilled Nursing Facility Value-Based Purchasing Program*.

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¹⁸ *Ibid.* at p. 66.

AHCA Position/Work Status

For the past eight years, AHCA has been at the forefront of efforts to develop VBP. The Association has conducted a tremendous amount of work on SNF quality measures and has been involved in and contributed to untold demonstrations on various aspects of quality measurement. During the 109th Congress, AHCA helped draft the initial legislation promoting Medicare SNF pay-for-performance concepts.¹⁹ As an adjunct to the legislative effort, AHCA propounded principles that it felt should be followed in the development of a SNF NFVBP. Since 2004, AHCA has articulated these principles in various government and policy forums, which included that:

- Appropriate and meaningful risk-adjusted and validated quality measures and standards must be developed by CMS in conjunction with the profession;
- Quality measures must be valid, reliable, and within the control of the facility;
- The measures should include:
 - Process measures (i.e., pressure ulcer prevention and/or reduction activities);
 - Structural measures (i.e., patient acuity or staffing ratio mix, implementation of new technologies);
 - Risk-adjusted outcome measures (i.e., functionality, discharge to the community); and
 - Non-clinical measures providing for a well-rounded assessment of SNF services (i.e., customer and staff satisfaction).
- Data collection process should use new technologies to minimize the provider burden and increase accuracy;
- Each measure must include criteria to determine if a SNF is large enough to yield meaningful data;
- The quality measures, data collection tools, and reporting process must be tested in each state and in representative SNFs prior to implementation;
- The application of a national NFVBP for SNFs should be phased in over a reasonable time period to allow for under-performing facilities to improve their quality before they begin being penalized;
- That initial incentives for participation should start at a low percentage and increase over time in order to deal with the impact of the phase-in to assure compliance with budget constraints; and
- SNF pay-for-performance methodology and measures should first be tested prior to full implementation; testing should be done that is representative of all types and sizes of facilities in all states.

Medicare and Medicaid budgetary pressure will continue to drive policymakers and SNF professionals to explore payment methodologies that offer the promise of greater accountability and transparency.

In addition to budget pressure, three additional factors will foster continued interest in reimbursement of quality. First, the profession and many federal and state officials increasingly recognize that regulatory and enforcement strategies are not effective in isolation as the sole mechanism for quality assurance. Second, traditional FFS Medicare and Medicaid reward volume with little regard for quality. Third, some of the payment models incentivize practices that could undermine quality efforts. While the precise form of future VBP arrangements is unclear, AHCA welcomes the opportunity to work with Congress using our VBP principle as a starting point for such a dialogue.

Reducing Hospital Readmissions

Summary

AHCA supports linking rehospitalization rates with payments for skilled nursing facilities based on setting specific measures starting in 2014. While effective transitions of care between providers are an important component of reducing rehospitalization from all settings, a majority of the reasons and efforts to prevent rehospitalizations occur within each setting. Therefore, readmission reduction programs need to be setting-specific. In addition, the incentives need to be clearly defined for each setting in order to engage providers in those respective settings. AHCA supports a two-sided incentive/penalty approach instead of a penalty-only program such as the Hospital Readmission Reduction Program (HRRP) or as included in the Administration's proposal for SNF rehospitalizations.

Rather, we strongly encourage Congress to adopt AHCA's "Guaranteed Savings Act" legislation while working to develop other hospital reduction programs. AHCA's proposal guarantees savings by setting a collective target for reducing SNF hospitalizations, which if achieved, results in no penalties. Yet, if savings are not achieved, SNF payments would be put at risk. The skilled nursing centers are divided into quintiles based on two factors: overall risk adjusted readmission rate and improvement in lowering their readmission rates. If the targeted savings are not achieved, the lowest two fifths (i.e., 40percent) of SNF providers pay a penalty to make up the difference (thus the guaranteed savings).

Background

The Landmark article in the New England Journal of Medicine by Jencks in 2009 highlighted the frequent occurrence and significant cost of rehospitalizations following discharge from acute care hospitals. According to Jencks' article, Medicare spent \$17.4 billion on rehospitalizations in 2004. This led to the development of the Hospital Readmission Reduction Program, which penalizes hospitals with higher-than-expected readmission rates for selected patient populations based on their discharge diagnosis. Initially the top three hospital discharge diagnoses (congestive heart failure (CHF), acute myocardial infarction (AMI) and pneumonia) were included. Hospitals whose readmission rate was greater than expected for their patient population could receive a penalty of up to 1 percent in the first year of the program, increasing to 2 percent in year 2 and 3 percent in year 3. According to CMS Fast Facts, CMS Medicare Part A payments to hospitals were \$128 billion in 2011 for inpatient care. On March 14, 2013, Kaiser published an article showing that hospitals in aggregate will pay a total of \$280 million in penalties this year (2013). A total of 2,213 hospitals are slated for penalty, and 276 hospitals received the maximum penalty of 1 percent.

According to Medicare and Medicaid Statistical Supplement, in 2009 CMS Medicare SNF Part A payments to SNFs were \$25.5 billion for 2.5 million SNF admissions. Using 2009 CMS Part A claims, there were 360,276 rehospitalizations among SNF Part A admissions. The average cost to Medicare for each SNF rehospitalization is estimated at \$8,418 (based on 2009 Inpatient Medpar data). Therefore, 30 day Part A SNF rehospitalizations cost Medicare \$3.03 billion.

A number of other scientific studies have examined rehospitalization rates from SNF settings. MedPAC reports the SNF rehospitalization rate occurring any time during the SNF stay (up to 100 days) is approximately 18percent for those patients with certain diagnoses. Others have shown a slightly higher SNF rehospitalization rate when all-causes are included in the rehospitalization rates. Some of these rehospitalizations are potentially preventable. The INTERACT program - a comprehensive program to reduce SNF rehospitalizations - has been shown to reduce rehospitalizations by 17percent on average.

Incentives to Reduce Rehospitalizations

For incentives to work, the amount of the incentive and penalties as well as the target levels to achieve incentives must be known at the beginning of each evaluation time period. Otherwise providers do not know what they need to achieve to receive the incentive, which prevents them from determining the potential cost-benefit of investing in changes needed to achieve the incentives. The CMS VBP demo suffered from this problem. The amount of the shared savings incentive in that demo was based on the collective amount saved by participants, which could be zero.

Thus, if a provider invested in changes and significantly reduced their rehospitalizations but collectively, little or no savings were achieved, there were no funds for shared savings. Providers therefore received no additional payment regardless of how well they did. This uncertainty resulted in few providers making the investments to implement quality improvement programs, such as INTERACT, or hiring nurse practitioners or other staff to reduce rehospitalizations.

A penalty-only program suffers the same conceptual problem. Penalty-only programs ask providers to increase their expenses, only to receive the same payment they would have received without a penalty program – offering the provider willing to invest in change no potential for additional resources to do so. Penalty-only programs need also to create changes in regulations or administrative requirements that allow providers to decrease their expenses elsewhere to cover the increased costs of implementing programs designed to reduce hospitalizations.

Rehospitalization Measurement Principles

Rehospitalization or hospitalization reduction programs in PAC settings can use the same measurement approach as used in the HRRP (observed/expected * national average), but the measures need to be risk-adjusted for each setting. The clinical characteristics associated with hospitalization from each setting will differ due to both differences in the types of patient's receiving care and differences in their level of acuity and care need. Therefore, the clinical variables used in calculating the expected rate in each setting should differ. Also, the measures need to be timely and based on information available to the PAC providers while caring for the beneficiary. Claims-based measures are neither timely nor do they provide information that PAC providers have access to while caring for individuals. AHCA supports using MDS or other electronic clinical data to measure rehospitalizations. Claims-based measures can be used retrospectively to verify measures based on MDS or other sources.

AHCA has partnered with a national provider of data analytics to the SNF sector, PointRight, to make publicly available their "OnPoint30" measure – a 30 day, all-cause risk-adjusted SNF readmission measure based on MDS 3.0 data. We currently calculate the readmission rates for all nursing homes in the country each quarter and make the

results available to our members. We are currently preparing an application for endorsement to the National Quality Forum and support CMS adopting this measure for use in any readmission reduction program as well as in public reporting.

Long-Stay Resident Hospitalization

Hospitalizations of long-stay individuals also provide the same opportunity to improve quality and reduce costs as a SNF rehospitalization reduction program. While long stay individuals are not accessing their Medicare Part A benefit, when hospitalized they do incur costs to Medicare. A CMS report by RTI has also shown that hospitalizations of dual eligible beneficiaries are principally paid for by Medicare. According to CMS report, in 2005 there were approximately 1 million persons who were dually eligible for Medicaid and Medicare as a long stay resident in a nursing center of which nearly half had a hospitalization at an average cost to Medicare of \$7,661 per hospitalization. The overall cost to Medicare is almost as costly as SNF readmissions.

Hospitalization rates for long stay residents need to be measured separately from SNF readmission rates. They should not be combined due to differences in the ration of short stay and long stay residents in skilled nursing centers which can alter a center's rate due to differences in their population rather than differences in care delivery. This difference in ratio of short stay to long stay in facilities also makes creating an incentive linked to hospitalization rates for long stay residents challenging. Thus, a Medicare program that incorporates hospitalizations for long stay residents needs to adopt a shared savings approach. Lastly, while the risk adjustment strategy can be similar for the two measures, the clinical characteristics used in the risk adjustment model will need to differ.

Rehospitalization Measures

AHCA supports the use of an all-cause readmission or hospitalization measure. We would prefer to exclude planned readmissions, but current coding and data sources make this difficult. Adding such a data element to MDS or other assessment tools regarding the reason for sending a patient back to the hospital would help alleviate this problem. Any measure that is disease or condition specific or not all-cause creates challenges to ensure accurate coding. In addition, measures which are condition specific or limited to "potentially preventable conditions" lower the potential savings, since the population being evaluated is much smaller. Experience has shown that programs such as INTERACT for SNFs have an impact on all types of hospitalizations regardless of the reason or diagnoses. Finally, trying to define which hospitalizations are preventable versus not preventable (other than planned admissions) is difficult and also discourages better integrated transitions of care. Thus, we support using all-cause readmission or hospitalization measures, similar to our OnPoint30 rehospitalization measure. Rehospitalizations should be measured during the time the beneficiary is receiving care in the PAC setting, not combined with rehospitalizations after discharge from the PAC provider. The issues related to preventing rehospitalizations during the patient's stay in the PAC setting are different from the issues following discharge to another setting. Also, an incentive to reduce rehospitalization that only applies to one provider such as a SNF but not the providers following SNF discharge (e.g., home health or physicians) will

be ineffective in promoting collaboration and better integrated care. For example, most PAC providers under the current reimbursement models - including new models such as the ACO and bundled payment demonstrations - are not in a position to bring other providers such as hospitals and physician groups together to address integrated care needs unless both groups have the same incentive and motivation to collaborate.

Ideally, there should be two rehospitalization measures: one for rehospitalizations that occur during the SNF episode and one that occurs following discharge from the SNF. Rehospitalization measures that count rehospitalizations following discharge from a PAC provider need to apply to both sets of providers to encourage integration and collaboration.

Administration's Proposal for SNF Rehospitalization Reduction Program

Details on the Obama Administration's SNF hospital readmission reduction program are limited at this point, making an analysis of the pros and cons somewhat difficult. Based on the information available, it appears that the administration's proposal tries to replicate the HRRP but differs in a couple of ways. In the HRRP, hospitals whose readmission rates are higher than expected pay a penalty regardless of their overall readmission rate or how much they have lowered their readmission rate if it remains above their expected rate. The HRRP is restricted to discharges with specific diagnoses (e.g., CHF, AMI or pneumonia) but readmissions for all causes (excluding some planned readmissions). The administration's SNF hospital reduction program differs from HRRP in three significant ways. First, the penalty is not implemented in a phased-in manner. This is in contrast to the HRRP that has a cap on penalties of 1 percent in year 1 increasing to 2 percent and 3 percent in years 2 and 3, respectively. Second, the proposal does not define the period of time to calculate readmissions as 30 days from hospital discharge as in the HRRP but leaves the time period open to the Secretary. It also includes readmissions during the SNF stay. The HRRP only measures readmission after discharge from the provider setting. Third, the penalty is based on readmissions for potentially preventable causes (e.g. CHF or Diabetes) not all causes as in HRRP.

Regardless of the differences, we support the principles in our proposal instead of the administration's proposal for the following five reasons: First, the administration's proposal is a penalty-only program. Even providers with very low readmission rates who see small increases in those rates due to statistical variations may pay a penalty despite still maintaining lower than average rates. Also, even if all skilled nursing centers collectively improve, facilities will still pay a penalty.

Second, the administration's proposal does not specify an all- cause readmission measure, nor does it specify excluding planned readmissions.

Third, only hospital discharges coded as those in the HRRP (CHF, heart attack, and pneumonia) are to be measured not all discharges to SNF. This will make the measure population small rendering many providers ineligible due to small sample size. It also does not make clinical sense given the literature on efforts to reduce readmissions from the SNF setting.

Fourth, the penalty will be complicated and confusing. The penalty is based on the ratio of the cost of "excess readmissions" (i.e., Medicare payments to hospitals for readmissions) from the SNF. This measure requires claims from both the hospital and SNF, which means that the lag time in calculating it will be significant. We agree that among facilities who must pay a penalty, those with higher rates of readmissions should

pay a larger penalty than those with lower rates of readmissions. Yet this approach needs to be adjusted for the volume/cost of readmissions. A low volume center should not necessarily pay the same absolute penalty as a large volume center. The method outlined in the administration's proposal can be unfair because the ratio proposed by the president can be affected by just one or two very high cost patients with certain conditions with costs that are outside the control of skilled nursing center (such as HIV, transplant, cancer, etc). This will have the effect of creating an access problem for patients that are likely to have high cost readmissions. A ratio based on actual-to-expected readmission rates does not create the same type of incentive to avoid high cost patients with specific needs.

Fifth, the administration's proposal does not specify that rehospitalization rates need to be risk-adjusted. We do support the administration's proposal to make SNF rehospitalization rates available to the public on Nursing Home Compare, but only if the measure is adequately risk-adjusted. While we disagree with a penalty-only approach, we do agree with the administration's proposal to cap the penalty at no greater than 3 percent.

Bundled Payments

Summary

Bundling payment across services linked by some sort of episode of care based on clinical needs of individual patients is increasingly being used to create incentives for efficient management of the cost of care and is increasingly viewed as the solution to volume driven fee-for-service (FFS) reimbursement. Bundling payment has been tested within the inpatient prospective payment system (PPS), in outpatient payments that increasingly bundle services delivered on the same day, in the new ESRD PPS that incorporates historically separately paid drug and laboratory services and in developing new combined codes in the physician fee schedule. Introducing bundling to post-acute care (PAC) involves the new challenge of bundling across different types of providers and introduces new incentives to coordinate care to improve quality and lower cost. To date, existing Medicare fee-for-service payment systems do not pay for or reward investments in coordination of care across different providers except in select demonstration projects. Many existing policies and data structures currently serve as barriers to such coordination. Payment reform proposals from numerous policy organizations have proposed some sort of PAC bundling, including MedPAC, and the President included it as a legislative proposal in his budget for FY 2014. To develop and test PAC bundling models, The Affordable Care Act (ACA) included a provision that CMS implement a national bundled payment pilot, from which came the Bundled Payments for Care Improvement (BPCI) initiative out of CMS' Office of Innovation (CMMI).

The challenges facing effective PAC bundling are significant, and include the need for new policy, better data infrastructure, innovative risk adjustment, and a range of technical issues. AHCA believes that CMS will need time to work more closely with PAC providers, as it has begun to do within the framework of BPCI. However, the rush to launch BPCI has limited dialogue and input on many critical issues. While PAC bundling may represent an advance in quality and efficiency in the future, inadequate policy and technical features of the program could yield inadvertent undesirable outcomes. AHCA cannot support a specific bundled payment policy at this time.

Background

Different PAC bundled payment proposals within the Medicare program are under public consideration, while less public research and development of alternatives are also in process. In our response we discuss three of the highest-profile bundled payment proposals to date: The President's Budget, MedPAC, and CMMI's BPCI demonstration, and then discuss our own research in this area. The designs for all proposals surface complex issues and challenges, that if not adequately addressed, have the potential to adversely affect access to care and provider viability.

The President's Budget

The President's budget included a proposal to bundle payments for post-acute care, but the details were limited. The language included stated:

Implement Bundled Payment for Post-Acute Care (PAC) Providers:

Beginning in 2018, this proposal would implement bundled payment for post-

acute care providers, including long term care hospitals (LTCHs), IRFs, SNFs, and home health providers. Payments would be bundled for at least half of the total payments for post-acute care providers. Rates based on patient characteristics and other factors will be set to produce a permanent and total cumulative adjustment of -2.85percent by 2020. Beneficiary coinsurance would equal levels under current law. [\$8.2 billion in savings over 10 years]²⁰

While detail is lacking, there are a few characteristics of this model that are noteworthy. First, this proposal sets a benchmark for the volume of post-acute care payments (at least 50 percent) to be grouped under a bundled payment model. Second, it proposes a phase-in beginning in 2018, which would give policymakers a four-year window in which to design the program. And finally, it sets an expectation as to cost savings to Medicare at \$8.2 billion over the ten-year budget window, representing a cumulative 2.85 percent reduction in payments to post-acute providers.

MedPAC

MedPAC has long touted bundled payments as a viable alternative to FFS. In its June 2013 Report to Congress, MedPAC included a chapter on bundled payments in post-acute care. While the chapter did not endorse or propose a specific policy, it included a robust discussion of the key factors to consider when designing a bundled payment model, from which we are able to make a number of conclusions as to their preferred approach.

First, they support a model which is inherently “virtual” to the provider, meaning that it would require no change to the way most providers currently submit claims and are paid for services. This is important because certain other proposed approaches include paying one provider a lump sum to distribute among all providers within an episode. That approach would pose numerous operational challenges. In this “virtual” model a defined episode would be given a benchmark price or budget and spending during the episode would be monitored. Under MedPAC’s approach a predetermined withhold is established for each episode. If spending exceeds the budget, CMS would keep the withhold. If spending falls below the budgeted amount, CMS would pay the withhold to providers who could then share in those savings.

Second, although the chapter is titled “Approaches to bundling payment for post-acute care,” they propose an approach which would include an initial hospital stay. By bundling acute and post-acute services together, it would require post-acute providers to collaborate with both down-stream (with providers such as home health agencies) as well as the up-stream hospital provider. MedPAC’s approach to bundling acute and post-acute services follows the trend of the majority of other proposals.

Third, MedPAC goes into some discussion about which services to include and which to exclude from the defined episodes. Of note is their decision to exclude Part B physician

services. The decision of whether or not to include physician services in a bundled payment model is a difficult one for many reasons. Including physician services would require all physicians to buy into the model. In a mandatory model this is not an issue, but in voluntary models it certainly is. Furthermore, excluding Part B physician services takes the patient's primary care physician out of the model. We believe that post-acute care direction involves the patient's primary care physician. Including primary care physician services in the post-acute bundle, would be central to ensuring the desired coordination of care that is most likely to affect provider behavior, smooth care transitions, and minimize unnecessary or duplicative services.

The Bundled Payments for Care Improvement (BPCI) Initiative

In 2012 CMS called for interested applicants to participate in a voluntary demonstration project to test bundled payments in fee-for-service Medicare. In January of this year they announced the health care organizations that have been accepted into the program. The initiative will test four broadly defined bundled payment approaches across multiple providers. Model 2 (acute + post-acute) and Model 3 (post-acute only) are applicable to PAC providers. Model 2 includes the acute care hospital stay and any post-acute care services. Model 3 includes only the PAC services. While only Model 2 includes the hospital stay as part of the bundle, both models are predicated on an anchor hospital inpatient stay. Both models also utilize a "virtual" bundle where episode target prices or budgets are predetermined, claims are paid under existing regulations, and bonuses/losses are paid based on retroactive reconciliation. This "virtual" approach, similar to that proposed by MedPAC, minimizes the burden on providers to alter current claims submission, thereby avoiding increasing provider operating costs that would otherwise be necessary to create insurance-like mechanisms to pay other providers.

After the first year of operation, CMS will evaluate the results of the CMMI CPBI initiative. The go-live phase, when providers are paid under the new model, was originally scheduled to start June 1st, 2013, but was delayed until October 1st. Because contracts between CMS and the applicant providers are still being negotiated, applicants have been given the choice to delay implementation even further to January 1st. These delays speak to how complex implementing a bundled payment model is, and it is important for policy makers and legislators to be cognizant of that complexity.

AHCA Position / Work Status

AHCA continues its commitment and investment in performing research and analysis that will allow PAC providers to get much needed insight into the potential impacts of bundled payments. We also firmly believe that a true understanding of both the costs and patterns of care of PAC providers' patient populations are necessary before knowing how to effectively implement a PAC bundled payment system. Our current phase of research will produce results this summer and fall that we look forward to sharing with interested stakeholders and policy organizations.

Although we applaud CMMI's efforts to test and evaluate different models of bundled payments, the design of the BPCI demonstration models #2 (acute + post-acute) and #3

(post-acute only) is severely flawed and will not work for the vast majority of PAC providers for the following reasons:

1. First, the demonstration's models are all hospital-centric and defined by a hospital discharge. Our research has shown that the hospital MS-DRG system does a poor job of predicting the cost of care in the post-acute setting. Furthermore, the acute elements of the hospitalization which are captured by the MS-DRG, are not the characteristics of patient condition that determine the need for post-acute care. Most patients are discharged from the hospital to the community: those requiring post-acute care in PAC settings have needs associated with complex comorbid conditions, functional status, caregiver support/or lack of support, psycho-social/cognitive conditions, and/or medically complex conditions that require continued in-patient management outside the acute care hospital.
2. Second, the current risk adjustment methods used by CMMI are entirely inadequate to account for the cost variation among patients in post-acute settings. Risk adjustment based on population-based insurance programs and inpatient care do not capture the elements of risk associated with the narrowly defined MS-DRG based bundles of PAC care and were designed for use in models based on populations, not individual patients or small groups. New approaches to risk adjustment or a transition to develop those approaches based on risk mitigation through payment adjustment and outlier payment policy for predictable factors associated with high cost care are needed. At the provider level, and particularly for smaller providers, the number of patients covered by any bundled payment is relatively small, increasing the risk of accepting patients that have predictably higher costs of care. Failure to adequately risk adjust or mitigate risk for PAC bundles will lead to decreased access to care as providers avoid accepting predictably high cost patients.
3. Third, the administrative burden associated with demonstrating PAC care must be decreased to enable more providers to participate. CMS' approach to the provision of data to individual providers to support their participation, by itself, limits the participation of many providers, whose operational data systems and IT staffs are not prepared to handle Medicare claims data without retaining expensive consultants.
4. Finally, regulatory and oversight policies and program integrity measures currently function as a barrier to promoting the kind of innovation among PAC providers necessary to succeed under this payment model.

Through our continued effort to understand the potential impacts PAC bundled payments would pose to beneficiaries and providers, AHCA has identified several key considerations for thinking about PAC bundled payment program design, and we have identified several policy elements that should be included:

1. **Participation in a bundled payment system should be voluntary until CMMI has appropriately evaluated the BPCI demonstration and alternative models.** AHCA sees little value or reason in mandating a bundled payment before it has evaluated and analyzed the results of the BPCI demonstration. Therefore we believe this approach should be strictly voluntary for providers until CMMI has completed such evaluation and analysis.

2. **A bundled payment system should utilize “virtual” bundles** where episode target prices or budgets are predetermined, target prices are risk-adjusted appropriately, claims are paid under existing regulations, and bonuses/losses are paid based on retroactive reconciliation. The vast majority of PAC providers do not have the insurance-company-like infrastructure to operate under an “actual” bundled payment system where lump sums are paid to PAC providers whereby they are then responsible to pay downstream providers.
3. **A bundled payment policy should include the option of post-acute-initiated bundles separate from bundles based on MS-DRG coding that are initiated by a hospital admission.** As explained above, MS-DRGs do a poor job of predicting the cost and needs of patient care in post-acute settings; therefore, options for episodes not defined by the MS-DRG classification system must be developed and made available to providers.
4. **CMMI should solicit and/or consider testing alternative PAC models,** particularly those proposals generated by PAC providers in future rounds of the BPCI demonstration. We hope CMMI will consider AHCA’s proposed PAC episode bundles currently under development.
5. **A bundled payment system should be implemented over time,** perhaps in phases, to allow for seamless transition for all types of providers. Because bundled payments represent a drastic shift away from the current operating environment, transition must be measured and occur over a period of years to allow providers to fully adapt to the change. Sudden, mandated shifts to bundled payments could be disastrous for providers and cause downstream effects on beneficiary access to PAC services.

Later this year AHCA will unveil the results of research to develop an alternative model for bundled payments in post-acute settings. The research will introduce several potential post-acute-initiated bundles that encompass a majority of all SNF admissions. AHCA stands ready to work collaboratively with the Committees, their staffs and other policy organizations to develop thoughtful solutions that the provider community is able to implement.

Conclusion:

While AHCA recognizes that the goal of bundled payments is to reduce costs while maintaining quality, we do not believe enough evidence exists to support that as fact. Therefore, CMS must be given appropriate time to evaluate the results of its bundled payment demonstration before policy makers consider a national, mandatory bundled payment system. In an effort to help move the process along, we provide this framework of policy options to help inform policy makers’ discussions around the development of a PAC bundled payment model. Additionally, we welcome the opportunity to present our research findings to the Committees and their staffs on an alternative approach to PAC bundled payments for consideration.

Site Neutral Payments

Summary

The American Health Care Association (AHCA) supports post-acute site neutral payment reform. In an effort to improve quality of care and generate cost-saving concepts, AHCA developed a patient-focused payment model that would reduce spending on post-acute care (PAC) while facilitating movement toward a more rational system for PAC payment and delivery. This model focuses on the needs of the patients rather than the setting of care.

Currently, the Medicare system creates “silos” of care by paying each type of post-acute care provider according to different methodologies. Patients with similar clinical profiles may be treated in different settings at different costs to Medicare. The AHCA Site Neutral proposal is a person-centered approach that reimburses PAC providers based on the patient’s condition and severity of illness.

We are fully aligned with the site neutral principles that have been espoused by CMS, MedPAC, Simpson-Bowles and the President. Our plan supports true equality of payments for appropriate conditions with no differentiation.

Under AHCA’s solution, patients will be grouped by clinical condition and severity of illness using a single assessment tool, and the payment for patients within each group will be the same regardless of where the patient is being treated. The payment rates for each category would cover the expected costs of providing the appropriate type, duration and mix of services. A single Medicare payment would be made to each PAC provider to cover the services provided to the patient. Below we provide further detail of our plan.

Background

Currently, the Medicare system reimburses each type of post-acute care provider according to different payment methodologies. Existing payment policies focus on phases of a patient’s illness defined by a specific service site, rather than on the characteristics or care needs of the Medicare beneficiary. As a result, patients with similar clinical profiles may be treated in different settings at different costs to Medicare. This payment system fails to encourage collaboration and coordination across multiple sites of care and provides few incentives that reward efficient care delivery. Such misalignment has been understood and acknowledged for some time.

In May of 2005, the CMS Administrator formed the Policy Council to serve as a vehicle for the Agency’s senior leadership to develop strategic policy directions and initiatives to improve our nation’s health care system. One of the Council’s first priorities was to develop a plan for PAC reform. The Council developed a set of post-acute care reform

principles based upon a vision for post-acute care to guide current and future reform activities.

As a first step in addressing the current problems in the post-acute care system, the PAC Workgroup developed a set of principles for reform which were approved by the Policy Council. These principles are summarized below:

- Increasing consumer choice and control of PAC services by Medicare beneficiaries, their family members and caregivers.
- Providing high-quality PAC services in the most appropriate setting based upon patient needs. This requires getting patients into the right PAC setting at the right time, as well as measuring patients' progress and the quality of care provided in PAC settings.
- Developing effective measures (including process measures) in order to drive the PAC system toward the delivery of high-quality care in the most effective manner and, thus, improve payment efficiency.
- Providing a seamless continuum of care for beneficiaries through improved coordination of acute care, post-acute care and long-term care services, including better management of transitions between care settings.

The central concept of CMS' vision for post-acute care was that the system will become patient-centered; that is, the system will be organized around the individual's needs, rather than around the settings where care is delivered. AHCA was and remains completely in accord with these principles.

In addition, the Deficit Reduction Act (DRA) of 2005 mandated a demonstration that supported post-acute care payment reform. Implementation of the DRA demonstration thus became a key element of the CMS' strategy for PAC reform. Under this provision, the Secretary was to establish a demonstration program for diagnoses or diagnostic conditions specified by the Secretary by January 1, 2008, that would:

- Use a comprehensive assessment at hospital discharge to help determine appropriate PAC placement based upon patient care needs and patient clinical characteristics;
- Gather data on the fixed and variable costs for each individual and on care outcomes in various PAC settings; and
- Use a standardized assessment instrument to measure functional status and other factors during treatment and at discharge across PAC settings.

The demonstration was mandated for a three-year period. In January of 2012, CMS provided a Report to Congress on the Post-Acute Care Payment Reform Demonstration (PAC-PRD).

The net result of this undertaking was the development of a common assessment tool and significant movement toward the ability to compare patients across settings. The demonstration collected comparable nursing and therapy resource use and developed a

patient assessment instrument to be used across PAC settings. The evaluation found a common set of patient characteristics that explained much of the variation in nursing and therapy costs across settings and indicated that a common case-mix measure could be developed across the institutional settings (SNF, IRF and LTCH), with more analysis required to integrate HHAs into a common system.

Some differences among settings were found, but the report concluded that comparable, risk-adjusted outcomes measures are possible across PAC settings with a common assessment tool (i.e., the CARE Tool). AHCA was and is very supportive of this common assessment instrument. AHCA provider members have, for example, incorporated it into submissions for the CMMI bundling models and have espoused its use in many critical forums.

In addition to CMS, the Medicare Payment Advisory Commission (MedPAC) has considered several proposals to expand site-neutral payments. Its proposals ranged over a wide array of provider types. For example, one proposal would expand the site-neutral policy to 66 additional ambulatory payment classifications. Another more targeted proposal would equalize payment between physician offices and hospital outpatient departments for three high-volume cardiac imaging APCs.

MedPAC established criteria for selecting potential services related to the mix of sites used, patient severity, similarity of service definitions and frequency of an associated emergency department visit (which raises the service costs). This year the Commission began an examination of how Medicare could equalize payments for similar patients treated in long term care hospitals (LTCHs) and acute care hospitals. And, in his remarks to Congress in 2013, the MedPAC executive director indicated that equal payments for similar PAC services would build on the Commission's work examining Medicare's payments for select ambulatory services.

The Commission has recommended and discussed many changes to PAC that would increase the value of Medicare's purchases and improve the coordination of care beneficiaries receive. These include site-neutral payments that would create more equity across providers in different sectors. MedPAC believes that such a change could be implemented in the near term and would serve as building blocks for broader payment reforms such as bundled payments and ACOs.

MedPAC stresses that without uniform information about the patients discharged from the hospital and treated in different PAC settings, it is difficult to make appropriate placement decisions and to compare the costs and outcomes across settings. CMS completed a mandated demonstration of a common assessment tool in 2011 and concluded that the tool it developed could serve as a single tool for all settings. MedPAC calls on CMS to outline its plans for how to adopt the CARE tool, or a subset of its elements, across PAC settings and in hospitals.

Again, AHCA is very enthusiastic and supportive of the CARE tool and look forward to working with MedPAC and CMS in the development of a site neutral payment system.

Simpson-Bowles and The President's Budget FY 2014

In the April 2013 Moment of Truth Project report, “A Bipartisan Path Forward to Securing America’s Future,” the Co-Chairs, Erskine Bowles and Senator Alan Simpson, proffered a plan to put America’s fiscal house in order. As part of the plan, they proposed reforming post-acute care payments and included in that proposal equalizing payments between rehabilitation services provided in different settings.

In the condensed budget of the U.S. Government,²¹ the Administration expresses support for policies that will encourage efficient utilization of services and improve the quality of care. The Budget’s proposals include adjusting payment updates for certain post-acute care providers and equalizing payments for certain conditions commonly treated in Inpatient Rehabilitation Facilities (IRFs) and Skilled Nursing Facilities (SNFs), which will save about \$81 billion over 10 years. The Budget encourages appropriate use of inpatient rehabilitation hospitals and adjusts SNF payments to reduce unnecessary hospital readmissions, saving almost \$5 billion over 10 years.

In the “President’s Plan For Economic Growth And Deficit Reduction, Legislative Language and Analysis,”²² the Budget proposes to restructure payments for post-acute care. The legislative language adjusts Medicare payments for three conditions involving hip and knee replacements and hip fracture as well as other conditions selected by the Secretary at her discretion. The named conditions are:

- Unilateral knee replacement;
- Unilateral hip replacement; and,
- Unilateral hip fracture.

The Budget document indicates that these conditions are commonly treated at both IRFs and SNFs, but Medicare pays significantly more when treated in IRFs.

This section would reduce differences in payment for treatment of the specified conditions to limit inappropriate financial incentives and encourage the provision of care in the most clinically appropriate setting for the beneficiary. The Budget document clearly articulates that IRFs provide intensive inpatient rehabilitation care that may not be needed for patients with certain conditions and whose care needs could reasonably be expected to be met in a SNF. AHCA agrees with these observations and insights and believes that that they call for a system that truly equalizes payments between SNFs and IRFs for an appropriate set of conditions.

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Budget of the U.S. Government, Fiscal Year 2014

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²² *President’s Plan For Economic Growth And Deficit Reduction, Legislative Language And Analysis*²²

AHCA Position/Work Status

In an effort to improve quality of care and generate cost-saving concepts, the AHCA has developed a patient-focused payment model that would reduce spending on post-acute care while facilitating movement toward a more rational system for PAC payment and delivery. This model focuses on the needs of the patients, rather than the setting of care and has the potential to reduce federal spending approximately \$15-20 billion over the 10-year budget window.

Under AHCA's solution, patients will be grouped by clinical condition and severity of illness using a single assessment tool and the payment for patients within each group will be the same regardless of where the patient is being treated. The payment rates for each category would cover the expected costs of providing the appropriate type, duration and mix of services. A single Medicare payment would be made to each PAC provider to cover the services provided to the patient.

The patient assessment tool would also be used at points within the patient's episode of care, specifically at transitions and care hand-offs, to enable better care coordination and high-quality care delivery throughout the care continuum. This tool will allow CMS to monitor the quality of care provided and collect patient information in a standardized form. Providers can then share that information with each other and enable better care coordination and increase care efficiencies.

AHCA's proposal suggests that, at a minimum, this new model would cover the services currently covered under Medicare Part A and paid for at long term care hospitals, skilled nursing facilities, home health care services and inpatient rehabilitation facilities. A more nuanced approach could achieve savings in the post-acute care sector.

AHCA's proposal focuses on patients, empowering them and their physicians with the ability to determine the best post-acute care plan and placement. Meanwhile, this model encourages better care coordination and a more efficient post-acute care system, resulting in benefits to the patient with higher quality of care and to the American taxpayer with billions in savings to Medicare. At a time when Congress is looking for ways to make Medicare more cost effective, AHCA has produced a solution that achieves this goal while still ensuring our nation's seniors have access to the post-acute care they need.

BRIEF

Other Questions Raised by Alternatives to Fee-For-Service Payments

As policy makers consider a shift away from fee-for-service (FFS) payments, whether toward value-based purchasing or bundled payment models, AHCA has outlined several general recommendations for policy makers and legislators to consider in their policy reform discussions.

Background

As we explained in the Executive Summary, post-acute providers' resources are more constrained than other provider segments, and therefore they have less flexibility to invest meaningfully in innovative payment and delivery models. Any systemic change that would impact the financial health of post-acute providers only results in a reduction of investment spending or an avoidance of participation altogether. AHCA believes that without meaningful involvement from the post-acute care provider industry, many existing payment and delivery models being tested today are threatened with failure. This fact is illustrated by several realities:

- First, interest and involvement in the Bundled Payments for Care Improvement (BPCI) initiative was limited to the largest and most heavily resourced post-acute care providers. The preparation for the application alone, with the level of data analysis and planning alone required, made it nearly impossible for smaller or independently owned providers to become involved;
- Second, post-acute provider participation in other voluntary delivery innovation models, such as the Medicare Shared Savings Program (MSSP) is severely limited, due in large part to exclusion of the discussion of post-acute care in existing regulation; and
- Finally, the success of certain demonstrations, such as the nursing home value-based purchasing demonstration, may be compromised due to the exclusion of the sector in the model design and planning processes.

We have outlined the following recommendations that we believe will help secure buy-in from post-acute care providers and help to ensure the success of movement toward future non-FFS payment and care delivery models.

Recommendation 1: Include a Meaningful Transition Period in Any New Reform Model

Complex changes to the way health care is delivered and paid for require significant adjustment at the provider level, and not all of the challenges and issues associated with such complex changes are realized until the model has been implemented. In order to

minimize the burden on providers, a transition period must be built into any proposed payment or delivery reform model.

There are different ways to design an appropriate transition. One way is to keep a model voluntary to providers, like in the BPCI and MSSP models. This allows interested providers to “test the waters” before widespread implementation. These early adopters work to identify unknown issues that policymakers can then address to ensure successful wider implementation.

Another way is to adopt a phase-in approach for any new delivery or payment reform model. Current value-based purchasing programs in hospitals are being phased in, at first requiring only reporting of metrics and then later linking payment of performance on those metrics. A phase-in of any new reform model would minimize the level of change required at the provider level, thereby avoiding huge disruptions to operations.

Recommendation 2: Relax the Current Regulatory and Program Integrity Environment

In the bundled payment section of this paper we discuss the importance of easing certain existing regulatory policies. Doing so would allow providers to collaborate in ways unavailable to them under existing regulation and would make reform models more attractive. For example, AHCA recommends that CMS waive the three-day stay requirement for Medicare coverage of the SNF benefit in any new payment model in which SNFs are expected to participate. This would allow SNFs the opportunity to collaborate with groups of providers and experiment with new care management techniques. The reform models discussed in this paper require unprecedented levels of collaboration between different types of providers, and easing this restriction and others like it would allow them to work together in ways unavailable to providers now.

Additionally, program integrity measures, such as anti-kickback and antitrust regulations, must be evaluated differently under new payment models. Many of these reforms require higher degrees of care management functions, and providers are limited in what they can accomplish by working together because of fear negative repercussions. The MSSP program, for example, requires different providers to partner in new ways to manage the care of their patients, and many of their activities could be viewed negatively from an antitrust perspective under current regulation. However, without this level of collaboration the model would fail. Therefore, in order to ensure success and keep the models attractive to providers, waivers to these and other program integrity measures must be granted generously to providers who choose to participate.

Recommendation 3: Promote Provider Engagement in the Design and Planning of Any New Reform Model

AHCA maintains that provider involvement from the beginning of the design of any new reforms is necessary if the model is to succeed. Most payment and delivery reform models being tested today center around acute care providers and physicians. As these models expand to include post-acute providers, many issues and challenges unique to our sector are being identified. To minimize this, post-acute care providers must be involved in the design process.

Beneficiary Protections

In this section, AHCA outlines three policies that succeed in driving down overall health care costs without passing those cost savings down to consumers in any negative way. These policies align around changes to the current cost-sharing structures within Medicare, reimbursement policies for bad debt and payments for therapy services.

1. AHCA supports policy options for **coinsurance** that call for a single annual deductible that would apply to the combined Parts A and B Medicare benefits, a uniform percentage coinsurance policy that would apply to all Parts A and B services, and “stop loss” limits that would cap the total amount of cost sharing to which a beneficiary would be subject in each benefit year.
2. AHCA cautions against further reductions to Medicare **bad debt** reimbursement. As we will outline in this document, such reductions are poor policy options because: (1) the use of post-acute services is increasing with the aging population; (2) the options for providers to look to states for bad debt reimbursement are dwindling; and (3) beneficiaries do not have as easy access to third-party insurance alternatives as in days past.
3. AHCA maintains that beneficiary access to needed **therapy services** must not be limited by arbitrary caps in reimbursement. AHCA supports the continuation of the therapy cap exceptions process as part of any payment reform policy, and we oppose any policy that further restricts access to therapy.
4. AHCA seeks to protect beneficiary access to necessary skilled nursing services by proposing legislation which would count the number of days a patient is under **observation status** toward the mandated three-day inpatient stay requirement to qualify for a Medicare-covered SNF stay.

Coinsurance

Summary

In the last couple of years, policymakers have shown considerable interest toward comprehensive policies that would replace the existing structure of Medicare A and B cost sharing with a more uniform benefit structure. These policy options typically call for a single annual deductible that would apply to the combined A and B benefit, a uniform percentage coinsurance policy that would apply to all A and B services, and a “stop loss” limit that would cap the total amount of cost sharing to which a beneficiary would be subject in each benefit year.

As discussed below, AHCA supports this approach. We believe that such a comprehensive approach in general, with equitable and fair parameters, would and should provide beneficiaries with:

- Desperately needed clarity as to their actual benefits;
- The best possible sense of potential personal health care costs;
- Peace of mind that comes with knowing that catastrophic out-of-pocket costs would be minimized;
- True freedom of choice – the choice of appropriate provider type based on need;
- Improved access to care.

We think that such reforms should take place as soon as possible under the existing Medicare post-acute payment systems. The current situation of an assortment of coinsurance rates, co-payments, deductibles, etc. is confusing and unhelpful to beneficiaries, inhibits good care choices and discriminates against those beneficiaries with the greatest need for medical interventions. A combined Part A and B comprehensive co-insurance program is needed and would form a strong and logical cost-sharing basis for other payment reform policy options such as bundling, episodic and site neutral payment systems.

Background

There is no question that slowing the growth of health care spending is critical to improving the fiscal health of the country. Rising costs and suboptimal clinical quality have spawned efforts to redesign health care benefit packages. According to health care experts, momentum has gathered behind two trends. The first, represented by disease management initiatives and pay-for-performance programs, focuses on the quality of care and uses tools to manage patient health. The second trend, represented by increased patient cost sharing and consumer-driven health plans, focuses on the cost of care and uses financial incentives to alter patient and provider behavior.²³

These two trends create a conflict for the patient in that disease management programs—designed to improve patient self-management—aim to enhance compliance with specific clinical interventions, while rising copayments create financial barriers that discourage the use of these recommended services. Thus, the challenge for purchasers is to devise benefit packages that incorporate a range of features that complement each other in the effective and efficient delivery of care while explicitly avoiding the unwanted negative clinical effects associated with increased cost sharing.

Three aspects of the Medicare program reflect these competing aims and have the most direct and immediate effect on its beneficiaries. The first is the amount patients must pay out of pocket at the time services are used—i.e., their copayment responsibilities (coinsurance and deductibles). The second is the nature of those covered services—i.e., what Medicare will and will not help to pay for. The third is the overall complexity of the

program, which determines how easy or difficult it is for elderly people to use the Medicare program. Improvements can and should be made in all these areas.

The key question is whether the various approaches to patient cost sharing, such as copayments, deductibles and higher rates of coinsurance, can be an effective means of lowering health care costs and discouraging overutilization without causing adverse health outcomes.

In spite of the interest in cost sharing's effects on health outcomes among vulnerable populations, the Robert Wood Johnson Foundation's report on cost sharing concluded that few studies conducted over the past two decades have had good control groups and collected data on good measures of adverse health events or outcomes.²⁴ Nevertheless, the report discusses what the author feels is strong evidence that low-income populations are disproportionately affected by increased cost sharing, which can have adverse financial and health effects for this group.

The report concludes that there are still many questions unanswered on the effects of patient cost sharing. In particular, there are gaps in knowledge around the long term effects of cost sharing on health, the specific types of services that are reduced when patients face greater cost sharing, and the types of interactions that occur between cost sharing and different types of health insurance. In short, much is still unknown on how best to structure cost sharing without creating unintended adverse cost and health consequences.

A second major issue for the elderly is the complex web of Medicare deductibles and copayments in existence today. As we have discussed in our section on site neutral, the payment for a specific post-acute service should be the same regardless of the site of service. The increasingly inexplicable array of program payments and beneficiary out-of-pocket costs contributes to the silo effect of health care and distorts the appropriate provision of care.

In the last couple of years, policymakers have shown considerable interest toward more comprehensive policies that would replace the existing structure of Medicare A and B cost sharing with a more uniform and equitable benefit structure. These policy options typically call for a single annual deductible that would apply to the combined A and B benefit, a uniform percentage coinsurance policy that would apply to all A and B services, and a "stop loss" limit that would cap the total amount of cost sharing to which a beneficiary would be subject in each benefit year.

Current Law

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²⁴ Katherine Swartz, Ph.D, *Cost-Sharing: Effects on Spending and Outcomes* The Synthesis Project, New Insights from Research Results , Research Synthesis Report No 20, Robert Wood Johnson Foundation, December 2010, page 12; Companion Brief available at www.policysynthesis.org.

Under current law, Medicare beneficiaries receiving services covered under Parts A and B face cost-sharing obligations that vary materially, depending on the title under which services are covered and the type of provider from whom the services are received. Currently, with respect to Part A, there is no deductible for long-term care hospital (“LTCH”) stay beneficiaries and no copayments if the patient comes from an acute care stay. The same applies for beneficiaries who receive post-acute services at an Inpatient Rehab Facility (“IRF”). In addition, there is neither a deductible nor a copayment for home health.

For SNF beneficiaries, the situation is very different. The current coinsurance policy creates serious financial ramifications for the most seriously ill who need longer periods of recuperation in a SNF. For example, a beneficiary who experiences the current average length of stay of around 30 days experiences a coinsurance bill of \$1,480.²⁵ If a beneficiary needs 100 days of care (the so-called benefit period), he or she will experience a co-pay of \$11,840.

Further complicating the beneficiary’s understanding of his or her out-of-pocket costs is the fact that the coinsurance varies as a percent of SNF Part A payments. A beneficiary may be paying a co-pay of anywhere between 20 and 80 percent of his or her care, depending on the copayment group to which a common clinical assessment form assigns him or her.

For example, the rate for a non-rehabilitation group with an acuity level of approximately 1.00 is \$261.77. After day 20, a patient in that payment group would incur a co-pay equal to 57percent of the payment. There are 19 different payment groups in which beneficiaries in those categories will pay more than half the daily payment out of their own pocket for days 21 through 100 of a SNF stay.

Major Proposals

The following table presents the major proposals that appear to offer the most potential for beneficiary equity.

Proposed by	Annual	Uniform	Annual	Comments	Reported
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²⁵ This constitutes 10 days of Medicare SNF post-acute care at \$148.00 per day, the co-payment for FY 2013.

	Deductible	Coinsurance Rate	Catastrophic Limit		Savings
Congressional Budget Office	\$525	20%	\$5,250	Presented in 2011 dollars. Growth would be tied to growth in Medicare's per capita cost	\$26 billion over the 2010-2019 period if implemented 01/01/11
Simpson-Bowles Commission	\$550	20% Reduced to 5% after \$5,500	\$7,500		\$110 billion over the period ended in 2020
Bi-partisan Policy Center Debt Reduction Task Force (Dominici-Rivlin)	\$560	20%	\$5,250	Indexed to increases in Medicare spending per beneficiary	\$14 billion from 2012-2018

AHCA Position/Work Status

AHCA supports the approach taken in the policies presented in the above table. They all offer the concepts of common deductible, a uniform co-insurance rate and a catastrophic limit – the bedrocks of coinsurance reform. We believe that the approach in general, with equitable and fair parameters, would and should provide beneficiaries with:

- Desperately needed clarity as to their actual benefits;
- The best possible sense of potential personal health care costs;
- Peace of mind that comes with knowing that catastrophic out of pocket costs would be minimized;
- True freedom of choice – the choice of appropriate provider type based on need;
- Improved access to care.

Bad Debt

Summary

AHCA opposes any further reductions in bad debt. Several factors will make continued access to Medicare bad debt important for beneficiaries and the providers delivering care:

1. ***Use of post-acute care will increase in the coming years.*** First, in the near future, access to high quality post-acute care will become increasingly important. Demographics trends indicate rising numbers of persons over age 65 with multiple chronic conditions. Second, modern clinical practice is to discharge people from hospitals as quickly as possible. Insurers and health plans view step-down care as a savings strategy, and quality models have shown shorter hospitalizations as a best practice. Therefore, people are being discharged from hospitals and into post-acute care settings in larger numbers than in the past and often with more intense care needs.
2. ***For people who are Medicare and Medicaid eligible, states are covering less of Medicare coinsurance.*** In recent years, states have reduced the amount they cover in Medicaid payment of Medicare coinsurance. In 2003, more than 21 states severely limited Medicaid payments for Medicare Part A copayments, and four paid nothing at all.²⁶ Based on a comparison of the 2008 payment system surveys to those updated in 2013, an additional five states have reduced their Part A cost sharing and five states have reduced their Part B cost sharing. Thus, the 26 states that pay any amount in Medicaid coinsurance pay well below levels that cover total costs. Of the remaining states, 24 (plus the District of Columbia) cover no Medicare coinsurance with Medicaid.²⁷ In turn, SNF providers have become increasingly reliant upon Medicare bad debt reimbursement to address unrecoverable costs for people who are both Medicare and Medicaid eligible (duals).
3. ***The capacity of Medicare beneficiaries to pay cost sharing is dwindling.*** Since the economic downturn, retiree income has decreased notably, resulting in a decline in retiree capacity to pay out of pocket for health care expenses, either purchasing private coverage or directly paying providers. Second, since the economic downturn, retiree income has decreased notably resulting in limited capacity to pay for health care expenses, including private insurance coverage or out-of-pocket payments to providers.

The confluence of increasing demand for high quality post-acute care services and declining resources to cover the full costs of such services will be an important factor impacting access.

Background

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²⁶ AHCA Survey: *Medicaid Payment Rules for Medicare Part A Coinsurance: by State, March 31, 2003*

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²⁷ AHCA Surveys: *Medicaid NF Payment Systems Updates 2008 and 2013.*

In 1966, the Health Insurance Benefits Advisory Committee (HIBAC) (authorized by section 1867 of the Social Security Act, repealed in 1984) recommended that Medicare cover the unpaid deductible and coinsurance amounts that arose in connection with the provision of covered services to beneficiaries. Medicare coverage of such unpaid amounts to Medicare providers is referred to as “bad debt.” This recommendation was meant to avoid cross-subsidization that might occur if health care providers, such as SNFs or hospitals, attempted to fill the fiscal hole left by bad debt from other payers.

The reasoning behind the HIBAC recommendation is based on Section 1861(v)(1)(A)(i) of the Act, which states that the costs for individuals covered by the Medicare program must not be borne by individuals not covered by the program, and the costs for individuals not covered by the program must not be borne by Medicare. In the Medicare fee-for-service prospective payment system, Medicare bad debt reimbursement is available under U.S. Department of Health and Human Services regulations in scenarios where Medicare beneficiaries or Medicaid are unable or do not make Medicare cost sharing payments. That is, the prospective rates used to reimburse providers for services furnished to Medicare patients have basis in cost of services and are calculated using cost data reported by the providers on a base year cost report.

CMS provides criteria that must be met by providers in order to receive bad debt reimbursement from Medicare:

- The debt must be related to covered services and derived from deductible and coinsurance amounts.
- The provider must be able to establish that reasonable collection efforts were made.
- The debt was actually uncollectible when claimed as worthless.
- Sound business judgment established that there was no likelihood of recovery at any time in the future.

Once these criteria are met, bad debt may be included in a facility’s Medicare cost report.

Current Bad Debt Environment

Medicare currently reimburses SNFs for Part A bad debt incurred by Medicare-eligible patients. As noted above, such bad debt is reported on Medicare cost reports. Regarding Medicare-eligible patients, the federal government requires that beneficiaries who receive care in a SNF pay their Medicare co-pay beginning on the 21st day of a Medicare qualified stay. Beneficiaries responsible for such co-payments are either Medicare eligible only or are Medicare-Medicaid eligible (e.g., duals).

Regarding the latter group of people, Medicare-Medicaid eligibles are by definition low income and often have difficulty paying their co-pays. Medicare-Medicaid eligibles account for more than 90 percent of the bad debt incurred by SNFs. Such bad debt represents a fiscal hole from which SNFs must attempt to recover. Thus, if a state does not pay Medicare coinsurance or does not cover the full amount, it is impossible for SNFs to collect any remaining balance. In fact, providers are prohibited from collecting any remaining balance (e.g., balance billing) from specific types of dual eligibles.

Last year, reimbursement of allowable Medicare bad debt was further tightened. On February 22, 2012, President Obama signed the *Middle Class Tax Relief and Job Creation Act of 2012*, which delayed the implementation of the Medicare sustainable growth rate (SGR) for physician payments and included significant implications for Medicare bad debt reimbursement for hospitals, critical access hospitals and skilled nursing facilities. Federal payments to hospitals, skilled nursing facilities and other providers that are reimbursed for Medicare bad debts are estimated to shrink by \$6.8 billion from 2012-2022.

In order to pay for the SGR extension, the bill reduces Medicare bad debt reimbursement for non-critical access hospitals from the current 70 percent to 65 percent beginning in FY 2013. Critical access hospitals will see Medicare bad debt payments reduced from the current level of 100 percent reimbursement to 65 percent reimbursement. This will occur in phases over the next three years, starting for cost reporting periods beginning in FY 2013. Critical access hospital Medicare bad debt reimbursement will decrease to 88 percent in FY 2013, 76 percent in FY 2014 and 65 percent in 2015.

Prior to the enactment of the legislation, skilled nursing facilities were reimbursed 100 percent of bad debts for dual-eligible beneficiaries and 70 percent of bad debts for all other Medicare beneficiaries. The new legislation reduces Medicare reimbursement to 65 percent for non-dual-eligible skilled nursing facility Medicare bad debts beginning for cost report periods in FY 2013. Medicare bad debt payment reductions to skilled nursing facilities for dual eligibles will be implemented in phases from 100 percent reimbursement to 65 percent reimbursement over three years in the same manner as the payment reductions for critical access hospitals.

In addition, the new legislation repealed the “Bad Debt Moratorium,” effective for cost-reporting periods beginning on or after October 1, 2012. In the late 1980s, Congress enacted a series of statutory provisions to protect Medicare providers from Medicare bad debt policy changes by the Centers for Medicare and Medicaid Services (CMS). These provisions became known as the Bad Debt Moratorium. The moratorium prohibited CMS from requiring a provider to change its policies on the allowance of Medicare bad debts from what had been accepted prior to August 1, 1987.

CMS regulations state a provider may claim reimbursement for Medicare bad debts deemed “uncollectible” only after “reasonable collection efforts” have been made.

Subsequent to the moratorium, CMS has taken the position that Medicare bad debts are not deemed “uncollectible” until the bad debt is returned from an outside collection agency. The moratorium prevented CMS from revising what constitutes a “reasonable collection effort.” With the repeal of the Bad Debt Moratorium, CMS may amend its definition. In addition, CMS may impose additional requirements on hospitals and skilled nursing facilities before claiming bad debt reimbursement. For example, CMS may extend the current 120-day requirement before a provider can claim a debt as uncollectible to a longer time period or require additional documentation of a provider’s recovery efforts. However, any efforts by CMS to revise its bad debt reimbursement policies would only be effective for cost report periods beginning on or after October 1, 2012.

The effect of these legislative changes is that Congress has reduced the amount of Medicare reimbursement related to Medicare bad debts for hospitals, critical access hospitals and skilled nursing facilities and also may increase the requirements to claim Medicare bad debts for reimbursement. For an overview of state-by-state impacts of the 2012 law, see the table below.

Proposed Further Reductions in Bad Debt

As noted above, states make decisions about Medicaid payment of Medicare coinsurance for full Medicare-Medicaid eligible and for partial Medicare-Medicaid eligible beneficiaries within federal criteria. These payment arrangements often are confusing and difficult to interpret. Since the economic downturn, a number of states have reduced the amount Medicaid will pay towards Medicaid coinsurance, thus increasing financial pressures on providers.

Additionally, Medicare Advantage (MA) plan enrollment is projected to grow significantly. Currently, approximately 30 percent of all Medicare beneficiaries are enrolled in some form of MA plan (e.g., HMO, PPO, etc.). Bad debt is not available to providers for MA plan enrollees. The expectation is that providers will negotiate rates with plans sufficient to cover costs for services as well as any bad debt. The reality is that such negotiations are rarely successful for SNFs.

Finally, the Affordable Care Act Financial Alignment Demonstration does not provide for the inclusion of Medicaid payment of Medicare coinsurance. Therefore, the Medicaid portion of the blended capitation will not include Medicaid payments amounts for Medicare coinsurance. Because of this, plans will be forced to turn to other avenues, such as provider rates, to fill this financial gap.

Finally, under current law, for most hospitals and SNFs, Medicare currently pays 65 percent of bad debts resulting from beneficiaries' non-payment of deductibles and coinsurance after providers have made reasonable efforts to collect the unpaid amounts. In the President's 2014 budget proposal, starting in 2014, the White House would further reduce bad debt payments to 25 percent over three years for all providers who receive bad debt payments. This proposal is intended to more closely align Medicare policy with private payers, who do not typically reimburse for bad debt. Estimated savings over ten years are \$25.5 billion.

The culminating impact of reductions to Medicaid payment of Medicare coinsurance, expansion of MA plan enrollment, proliferation of duals demonstrations and demographic trends creates a significantly challenging operating environment for SNFs. This combination of factors could negatively impact access to care at a time when our delivery system changes and demographics likely will drive up demand for high quality post-acute care services.

AHCA Position/Work Status

AHCA urges Congress to engage the industry in any discussion about further reductions in bad debt. We are currently exploring options related to Medicare bad debts and would welcome the opportunity to work with Congress on payment alternatives, particularly for the collections process of bad debt for persons who are Medicare-Medicaid eligible.

Part B Therapy

Summary

Part B rehabilitation therapy is a skilled professional service that often plays a critical role as an extension of the post-acute care continuum in either, restoring function lost during a recent illness or injury, or preventing avoidable health issues or functional loss associated with age-related conditions. This is particularly true in today's health reform environment where innovative models are being sought to maintain or improve the quality and outcomes of health care services while reducing the cost of these services. As such, Part B therapy policy should also be considered within the context of beneficiary protections and issues being discussed within PAC reform. This will help assure that changes in post-acute and/or outpatient therapy policy are not counterproductive in ensuring that beneficiaries receive care in the appropriate setting, have their preferences accommodated, and do not face unwarranted restrictions in care or access to care.

Part B therapy may be provided: 1) immediately following an acute care stay; 2) immediately following a post-acute care stay; or 3) without a prior inpatient or post-acute care stay. These services may be provided in an office or facility setting, as well as in the beneficiary's home.

However, there are significant differences in the clinical characteristics of patients receiving therapy services in different settings. In particular, the health and functional status of individuals residing in nursing facilities are so negatively impacted that they cannot live independently or with home support services, yet do not require intensive inpatient services. Many of these individuals have the potential to return to these more independent and lower-cost home environments if provided appropriate high quality rehabilitation services. In addition, nursing home residents that are likely to need ongoing nursing facility care may also benefit from skilled therapy services in order address age-related functional needs that lead to better overall health and a higher quality of life. Such life-saving and enhancing therapy services are an essential component of nursing facility regulatory requirements, and are a necessary complement to successful post-acute care and help prevent re-admission to acute care.

However, the current Part B therapy payment model is obsolete and requires modernization. AHCA believes that the current payment policy is not patient-centric and negatively impacts the appropriate patient access and provider payments in a disproportionate manner for patients with complex needs, particularly those receiving care in nursing facilities. Payment policy modernization must be transparent, evidence-based, data-driven, and considered and analyzed in the context of the special needs of the beneficiary and the incredible benefits and outcomes that appropriate and medically necessary therapy provides.

AHCA supports improvement of the way that Medicare pays for therapy services, in alignment with the National Quality Strategy, which transitions from the current procedure-based model, to a beneficiary-centric model that incentivizes innovations to achieve cost-effective patient outcomes. AHCA has to date actively supported research and consideration of alternatives to the current system since the initial sweeping Part B therapy changes first enacted in the Balanced Budget Act of 1997. However, since the BBA, Congress and the CMS have only demonstrated a piecemeal approach at working

towards a viable beneficiary-centric solution. In addition, the ongoing implementation of arbitrary cost control administrative policies since has instead created additional challenges for the provider community to collaboratively work towards the desired solution.

AHCA supports the adoption of a national strategy to achieve this objective that that will achieve the following goals:

- 1) Apply patient-centered principles towards the creation of a new payment model in a transparent manner,
- 2) Preserve beneficiary access to medically necessary and evidence-based therapy services,
- 3) Reduce provider and payment contractor administrative burden, and
- 4) Reduce unwarranted payment variation.

AHCA believes that, any such transformation will take time and the process must be transparent, collaborative, evidence-based, and based on a solid set of data. We support the creation of a framework that allows for a transition to an alternative payment model for Part B therapy. The model should include common-sense patient-centered modifications to the current system that align with, and are consistent with, any post-acute policy changes, and that the policy modifications are properly tested, valued, and sufficient beneficiary, provider and contractor education is provided in advance.

Background

- ***The Importance of Rehabilitation Therapy For All Part B Beneficiaries***

Rehabilitation therapy is a health care service that is fundamental to the well-being of all individuals but in particular for the elderly. We are all aware of its role in post-acute recovery following orthopedic surgery. The goals appear clear regarding the need to regain mobility and functionality after, for example, hip or knee surgery. Skilled nursing facilities are a cost-efficient and effective site of care for such rehabilitation – a fact that underlies the need for post-acute site neutral care which AHCA espouses and has addressed separately in this response letter.

What perhaps is less well understood is the role and great need for rehabilitation therapy for the elderly aside from the environment of post-acute care. There is no question that rehabilitation therapy in general plays a key role in preventing the deterioration and decline of human beings. Even a key government watch-dog for the cost of Medicare services, the Medicare Payment Advisory Commission (MedPAC), felt compelled to outline the benefits of rehabilitation therapy. In its mandated Report to Congress, *Improving Medicare's Payment System for outpatient Therapy Services*,²⁸ MedPAC stated:

- Many types of patients can benefit from outpatient therapy. For example, for people recovering from a stroke, physical therapy can facilitate the recovery of balance and strengthen a lower paretic limb (Van Peppen et al.

2004). Stretching and strengthening physical therapy exercises can improve symptoms associated with chronic lower back pain (Hayden et al. 2005).

- Further, physical therapy can reduce a beneficiary's risk of falling (Michael et al. 2010). Occupational therapy can improve a patient's ability to perform activities of daily living (Donnelly and Carswell 2002). For people with rheumatoid arthritis, for example, occupational therapy is effective in reducing pain (Steultjens et al. 2002).
 - Several studies show that patients who receive occupational therapy after a stroke have a lower risk of death, deterioration, and dependency in personal activities of daily living (Legg et al. 2007). In addition, occupational therapy interventions for community-dwelling older adults, particularly those who live alone, can improve their functional ability, social participation, and quality of life (Steultjens et al. 2004).
 - Intense speech therapy over a shorter time has been found to improve the speaking ability of patients who suffer from aphasia (difficulty speaking) following a stroke (Bhogal et al. 2003).
 - For people with Parkinson's disease, speech therapy has been shown to improve vocal intensity and to decrease complaints of weak, monotonous, and unintelligible speech (de Angelis et al. 1997). Speech– language pathology services may also help patients restore communicative, cognitive, and swallowing function after a stroke or head injury or because of declining motor control (Robbins et al. 2008).²⁹
- ***Medicare Requirements for the Provision of Rehabilitation to Facility Residents***
Medicare Part B covers therapy services in SNFs/NFs claims if:
 - A patient is a long-term resident of a care facility who has a documented need (generally referred to as a “medical necessity”) for skilled therapy services (requires the skills of a licensed therapist)
 - The patient's stay or residence in the facility is not preceded by a qualifying 3-day hospital stay, required to receive SNF Medicare Part A coverage
 - If a resident has exhausted his or her 100 days of SNF Medicare coverage

These requirements must be understood in the context of two seminal principles:

A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care..." Omnibus Budget Reconciliation Act (OBRA) of 1987³⁰; and

Coverage of therapy "...does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care." *Jimmo v. Sebelius* Settlement Agreement³¹

- ***Who Are Facility Residents and What Does Part B Therapy Accomplish for Them?***

There are significant differences in the clinical characteristics of patients receiving therapy services in different settings:

- SNF/NF residents are older (average age 82), have a higher therapy need and cost (average payment per beneficiary \$2,307), more likely to exceed therapy caps (38.4 percent of beneficiaries exceeding either cap), more likely to need and receive 2 or more disciplines of therapy (53.8 percent of therapy users) and receive more therapy visits (31.1 is the average number of visits per beneficiary).
- Part B outpatient in the community are younger (average age 73), experience a Lower therapy need and cost (average payment per beneficiary \$850), less likely to exceed therapy caps (14.7 percent of beneficiaries exceeding either cap, less likely to need and receive 2 or more disciplines of therapy (6.7 percent of therapy users), receive fewer therapy visits (11.0 is the average number of visits per beneficiary).

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³⁰ Omnibus Budget Reconciliation Act (OBRA) of 1987.

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The *Jimmo* agreement indicates that Medicare coverage is available for skilled services, including therapy, to maintain an individual's condition. Under the maintenance coverage standard articulated in the *Jimmo* Settlement, the determining issue regarding Medicare coverage is whether the skilled services of a health care professional are needed, not whether the Medicare beneficiary will "improve." *Jimmo* emphatically rejects the so-called "improvement standard" for skilled services. The Medicare beneficiaries most likely to be negatively affected by the improvement standard include individuals with chronic, long-term conditions such as Alzheimer's Disease, Multiple Sclerosis, and Parkinson's Disease.

Therapy helps long-stay residents achieve and maintain maximum functional independence

- Therapy services provided to residents with chronic conditions may focus on preventing an adverse event, such as a fall, or helping a resident re-gain function after an event, such as inability to walk due to a contracture.
- A therapist may provide a resident at risk for falls with balance training, exercises to strengthen the residents' lower extremities, and gait training to help residents learn to walk safely.
- A patient suffering from a contracture may receive therapy to help release the muscle thereby restoring functionality to the patient. This program may also include training in exercises to avoid development of new contractures.
- Longer-stay residents in nursing facilities often need more than one type of therapy and, in some cases, all three types of therapies. In a nursing home setting, 50.2 percent of the patients receiving outpatient therapy receive services from two or all three disciplines*

Intensive therapy provided to SNF patients increases the rate of return to the community:

- Therapy in skilled nursing facilities helps patients return home; and
- Published research demonstrates that patients receiving higher combined levels of rehabilitation therapy have a higher probability of returning to a community setting

Patient need for therapy differs by setting:

- SNF Residential Part B Setting: Incident occurs such as a fall, new pressure ulcer, weight loss or an injury, Nursing referral due to changing patient status, Screening completed by therapist per OBRA or state requirements, Facility required to meet needs and prevent decline, Usually multiple co-morbidities; often require complex treatment plan, interdisciplinary team management and high need for maintenance skilled care
- Outpatient Part B Setting (Community): Generally treated for an isolated diagnosis, Patient is usually mobile and transports self to the clinic, there is a lower intensity of need, and reduced caregiver assistance

Restrictions on the Provision of Part B Therapy

Concern about cost is real and important. Further, the abuse of any Medicare services is beyond unacceptable and hurts taxpayers, all Medicare beneficiaries, and recipients of all Medicare services.

However, any payment restrictions that disproportionately impact the access and provision of therapy services to facility residents must be considered and analyzed in the context of the unique characteristics and special needs of residents and the incredible benefits that appropriate and medically necessary therapy provides – better overall health and a higher quality of life.

Caps on the provision of Part B therapy have a long history. The Medicare cap on outpatient rehabilitation therapy services was originally instituted for office-based professionals, but was extended to facility-based providers (excluding hospitals) under the Balanced Budget Act of 1997 as a combined cap on speech-language pathology (SLP) and physical therapy (PT) services, as well as a separate cap on occupational therapy (OT) services to Medicare beneficiaries. The BBA \$1,500 cap on Part B Medicare therapy services was intended as a cost control mechanism. There was no clinical basis offered for the cap.

The therapy caps were implemented in 1999 and again for a short time in 2003 with devastating impact on beneficiary access. Congress placed moratoria on these caps for 2000-2002, and again from mid-2003-2005, but the caps were re-implemented on January 1, 2006.

On February 1, 2006 Congress passed the Deficit Reduction Act of 2005 (S. 1932) which provided that (only for calendar year 2006) exceptions to caps may be made when provision of additional therapy services is determined to be medically necessary. CMS applied patient-centered and data-driven methodologies and instituted both an auto-exceptions process related to certain conditions and criteria and a secondary “manual” process whereby documentation was submitted to obtain prior-approval for exceeding the cap on Part B therapy services.

Specifically, both processes had to be in place by March 13, 2006. Manual requests for exception to the caps had to be submitted to the Medicare contractors with complete documentation, including an evaluation, plan, treatment notes, progress reports, and a justification explaining why these services appropriately exceeded the caps. The process was that of pre-approval. The carrier had 10 days from receipt of the claim to decide whether to approve or disapprove it. If the decision had not been made in 10 days, the statute required that the services be approved as medically necessary.³²

However, beginning January 1, 2007, there was no longer a manual process for exceptions.³³ All services that required exceptions to caps had to be processed using the

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³² CMS Manual System, Transmittal 853, Q55 and A55. 2007. MLN matters MM4364, Effective date January 1, 2006, Implementation date-- no later than March 13, 2006.

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³³ CMS Manual System, Pub 100-04 Medicare Claims Process, Transmittal 1145, Change Request 5478, December 29, 2006.

automatic process. All requests for exception were in the form of a KX modifier added to claim lines. CMS did not indicate why it was eliminating manual review, but it was understood at the time that the fiscal intermediaries (FIs) could not cope with the burden presented by the process and that a great majority of those claims that received manual review were approved as being medically necessary. Of note is that during 2006, therapy utilization growth tapered off suggesting that the policy was effective in controlling costs while assuring appropriate access to medically necessary care.

After 2007, the therapy cap and the exceptions process were extended annually, and the utilization growth rate returned to pre-2006 trends. On January 1, 2013, Congress passed the American Taxpayer Relief Act of 2012 which extended the Medicare therapy cap exceptions process until December 31, 2013. The extension costs about \$1 billion annually.

Congress also instituted a new requirement that went into effect October 1, 2012. A manual medical review is now required when expenditures reach \$3,700 for occupational therapy and/or a \$3,700 combined threshold for physical therapy speech-language pathology services. Per Congress, this process was to be "...similar to the manual medical review process used for certain exceptions under this paragraph in 2006³⁴"

CMS sought input from interested parties on how it should implement the medical manual review requirement. AHCA submitted a letter suggesting that CMS conduct the review on a post-payment basis. In other words, our members provide the therapy and receive reimbursement before the review takes place. This is a far superior approach to either pre-approval which delays in many cases badly needed continuous therapy or pre-payment which ties up revenue flow and impedes operations.

Instead of following the legislative language to apply the new medical review process to be similar to the patient-centered and data-driven targeted approach applied in 2006, CMS instead applied burdensome and poorly defined blanket reviews, including arbitrary pre-pay reviews in specific states that are seriously jeopardize beneficiary access and provider cash-flow. CMS announced in March that beginning April 1, it would institute Recovery Audit (RA) post-payment review in 39 states. In 11 states it required RA pre-payment review. Those 11 states are:

- California
- Florida
- Illinois
- Louisiana
- Michigan
- Missouri
- New York
- North Carolina
- Ohio
- Pennsylvania
- Texas

The 11 states chosen for the pre-payment are the same states that have been part of the hospital RA demonstration project that began in September 2012. There was no published determination to the effect that the nursing facilities in these 11 states had higher utilization of therapy than in the remaining states. Thus the arbitrary nature of the choice of these 11 states adds to the provider pain and government pain of continued uneven and inefficient administration of the manual medical review process.

Part B Therapy and the National Quality Strategy

AHCA supports the three aims and related priorities of the National Strategy for Quality Improvement in Health Care (National Quality Strategy). This strategy, initiated by provisions of the Affordable Care Act establishes a framework for coordinating and focusing efforts of diverse stakeholders to improve the quality of health and healthcare for all Americans. Rehabilitation therapy professionals in nursing facilities are in a unique position to support the National Quality Strategy aims of: 1) Better care; 2) Healthy People / Healthy Communities; and 3) Affordable care, as they work as part of interdisciplinary teams and are able to address many of the physical, psycho-social, and environmental factors that contribute to restoring or maintaining an individual's highest practicable function and quality-of-life, whether it be within the nursing facility, or whether the therapist facilitates an individual's return to home.

Within the health care continuum, Part B therapy services in a nursing facility may be provided: 1) immediately following an acute care stay; 2) immediately following a post-acute stay; or 3) without a prior inpatient or post-acute stay. Often, there is no difference in the clinical presentation of nursing facility therapy patients admitted in either of these scenarios. In fact, the only difference between many nursing facility Part A and Part B therapy patients is whether they had a qualifying 3-day hospital stay (beneficiaries would be entitled to Part A post-acute SNF benefits with a qualifying hospital stay).

Traditionally, outpatient therapy payment policy has been developed and refined in isolation, without consideration of its unique cost-effective role in the health care continuum. Indeed, in addition to being a cost-effective approach to completing the post-acute functional rehabilitation process, it is also a cost-effective approach to providing services that would prevent an individual from needing high cost inpatient and post-acute care services. However, misguided efforts to control Part B therapy costs to-date that are not transparent, patient-centered, and data-driven have created barriers to achieving the aims of the National Quality Strategy, particularly to the most vulnerable populations.

AHCA Position/Work Status/Solutions

AHCA supports improvement of the way that Medicare pays for therapy services, in alignment with the National Quality Strategy, which transitions from the current procedure-based model, to a beneficiary-centric model that incentivizes innovations to achieve cost-effective patient outcomes. AHCA has to date actively supported research and consideration of alternatives to the current system since the initial sweeping Part B

therapy changes first enacted in the Balanced Budget Act of 1997. However, since the BBA, Congress and the CMS have only demonstrated a piecemeal approach at working towards a viable beneficiary-centric solution. In addition, the ongoing implementation of arbitrary cost control administrative policies since has instead created additional challenges for the provider community to collaboratively work towards the desired solution.

AHCA supports the adoption of a three-phase national strategy to achieve this objective that that will achieve the following goals:

- 1) Apply patient-centered principles towards the creation of a new payment model in a transparent manner,
- 2) Preserve beneficiary access to medically necessary and evidence-based services,
- 3) Reduce provider and payment contractor administrative burden, and
- 4) Reduce unwarranted payment variation.

The remaining text in this section provides additional details related to the three AHCA proposed payment policy transition phases.

Phase 1 – Immediate Actions – Regulatory Relief

AHCA proposes consideration of the following immediate regulatory relief modifications to the current system to permit therapy providers to focus on efforts to support the transition to a better overall patient-centered payment system.

- ***Improve Part B Therapy Manual Medical Review Process:***

A transparent, patient-centered, and evidence-based data-driven manual review process that targets outlier services could be an effective therapy cap cost-saving alternative strategy to discourage inappropriate utilization, and identify and prevent inappropriate payments for unnecessary services. However, as implemented, this policy requires the following refinements to assure appropriate beneficiary access to necessary services, and to reduce unnecessary administrative burdens to providers and Medicare contractors.

- ***Eliminate pre-payment review at the \$3,700 threshold in the designated 11 states:***

As discussed above, blanket pre-payment review for Part B therapy in these states would appear to have been an artifact of the ongoing RAC demonstrations and not a conscious decision based on therapy data. Pre-payment review is disruptive, wreaks havoc on cash-flow and makes it unnecessarily difficult for facilities to provide needed services. In addition it runs in the face of well-established CMS criteria for pre-payment review.³⁵

³⁵ CMS Guidance is as follows: “The MACs shall initiate a targeted provider-specific prepayment review only when there is the likelihood of sustained or high level of payment error. MACs are encouraged to initiate targeted service-specific prepayment review to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis.” See *Medicare Program Integrity Manual Chapter 3 - Verifying Potential Errors and*

Punitive pre-payment reviews on therapy providers without evidence of prior high-level payment error are unwarranted. Any pre-payment review process, if applied, must be limited in scope, targeted, transparent, and data-driven, including patient-centered risk-adjustment factors.

- ***Target post-payment review at the top 5% risk-adjusted outliers:***

Medical review is expensive for providers and Medicare contractors and, in the absence of specific evidence of payment errors, should be implemented in a random or a targeted methodology. Blanket post-pay medical review for all beneficiaries that receive \$3,700 or more of therapy services regardless of beneficiary characteristics provides a disproportionate burden on nursing facility providers who treat beneficiaries with more complex needs. We believe that a targeted methodology that is transparent and data-driven utilizing patient-centered risk-adjustment factors to identify clinical outliers would be the most effective approach at identifying inappropriate utilization. While the current \$3,700 medical review threshold was established based upon the top five percent per-beneficiary annual expenditures, we recommend that CMS utilize information gained during the current medical review effort, and other available data, to classify beneficiaries into different risk threshold groups and target the reviews to the top five percent within each group. Just as good provider behavior in providers that treat complex patients should not be disproportionately burdened with review, nor should bad provider behavior in providers who treat less complex conditions, but under the \$3,700 limit, be ignored.

- ***Modernize and standardize manual medical review forms and documentation requirements:***

Many nursing facility providers have the technical capabilities to submit claims and related documentation electronically which can facilitate the timeliness of medical review documentation submission in a manner that is less burdensome and costly than traditional methods. In addition, many nursing facility chains provide services that span multiple states and multiple Medicare payment contractors. The current lack of standardization of manual medical review forms and documentation requirements across contractors creates unnecessary burdens and increases the risk for data submission errors. Effort should be directed at ensuring that providers can submit electronic manual medical review materials, and that the forms and documentation requirements are standardized across contractors.

- ***Establish transparent minimum qualifications for reviewers:***

As previously established, the characteristics of outpatient therapy patients, and the interventions they receive may vary significantly depending on the therapy discipline and patient-centered characteristics. For example, nursing

facilities frequently treat individuals with more complex medical, functional and psycho-social issues than are typical for ambulatory outpatient settings, AHCA recommends that reviewers should have an appropriate clinical background, preferably as a therapist peer-reviewer, and have experience working in, or have demonstrated competence in reviewing claims in the setting under review.

- ***Enforce specific time frames for review processing:***

It is now clear that the manual medical review process instituted for the last three months of 2012 was an administrative nightmare for CMS, for the MACs, and for the providers. The GAO, in its report on the 2012 MMR process mandated by the Middle Class Tax Relief and Job Creation Act of 2012,³⁶ detailed the degree of the confusion, delay and disruption.³⁷ We propose, consistent with the 2006 manual review policy,³⁸ that claims not reviewed within by RACs within 10 business days should be deemed approved, and time frames should be established for timely provider notification from the responsible contractors.

- ***Reverse the Multiple Payment Reduction (MPPR):***

“MPPR” refers to a Medicare policy that applies a reduction to payments for “practice expenses” associated with therapy services provided to the same patient, on the same day in “outpatient” settings (including outpatient clinics, hospital outpatient departments, and SNFs).

The rationale for the policy is that when therapy services are provided to the same patient, on the same day, in consecutive therapy sessions or in a single session, then the expense associated with those services is less than what the expense would be if therapy services were provided in different, non-consecutive, sessions. These expenses include “set up” costs and other activities that must be done as part of therapy treatments. In 2011, CMS applied a 25% reduction to facility payments for practice expenses based on this rationale and now

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³⁶ *Medicare Outpatient Therapy: Implementation of the 2012 Manual Medical Review Process*, GAO-13-613, July 2013.

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For example: The MACs did not receive complete CMS guidance before the start of the 3-month MMR process regarding how the MACs should manage incomplete preapproval requests, how they should count the 10-day review time frame, and how they should handle preapproval requests received in the wrong phase. In addition, the MACs did not have enough time to fully automate systems for tracking and processing preapproval requests before the start of the MMR process. *Ibid*, p.14.

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³⁸ Social Security Act, Title XVIII, §1833(g)(5)(C)(i)

policymakers have changed it to 50% reduction in payments for this purpose. Our analysis of the Medicare Standard Analytic File 5% beneficiary sample projected to the 100% national estimate suggests that increasing the MPPR reduction to 50% will result in an additional 9.75% reduction in total payments to providers on top of the initial similar reduction observed when the initial 25% reduction was implemented.

The MPPR policy was originally developed for therapy delivered in “outpatient” settings on the assumption that it is common for Medicare beneficiaries to receive *consecutive* therapy sessions from multiple therapy disciplines or multiple therapy interventions in a single outpatient visit (Physical, Occupational and/or Speech Therapy).

In contrast, in the SNF setting, due to the clinical characteristics of the patients and the operational realities of delivering therapy services in SNFs, it is very uncommon for patients to receive consecutive therapy services or more than one therapy treatment in a single session. Instead, most SNF patients receive therapy services from different therapy disciplines at different times of the day because they are physically and cognitively unable to tolerate intensive therapy services delivered consecutively or in a single session. Some patients have a gap of at least 30 minutes between therapy sessions, and a great majority have a gap of 1 hour or more between sessions.

In addition, it is improper to apply the MPPR edits across the three therapy disciplines. These services represent distinct Medicare benefits and the application of the cross-discipline application of these edits created a disproportionate negative impact on nursing facilities and other providers that provide multi-disciplinary rehabilitation therapy services.

Lastly, when CMS proposed and finalized the MPPR payment reduction they did not use SNF therapy data to support the policy but instead relied on patient data from hospital and other outpatient settings. MedPAC’s recent report likewise did not include SNF data to support their MPPR policy recommendations. Although there may be minor overlap in practice expense of some time-based procedures furnished by PT or OT services furnished within a single session, the rationale for the MPPR policy is not appropriately applied when considering the unique patient-centered needs of nursing facility patients, and certainly does not justify a 50% reduction. Policymakers should study the issue further—including an analysis of data for therapy delivered in SNF settings—before making any further payment-reduction changes to the MPPR policy.

Phase 2 – Short Term Actions – Collaborative Payment Alternatives Evaluation

We propose consideration of the following short-term CMS actions be taken in collaboration with AHCA and other stakeholders to gather the necessary patient-

centered and evidence-based information necessary to identify the most effective innovative approaches to reforming therapy policy.

- ***Expedite Work on the Development of Adequate Clinical Data to Determine the Medical Necessity or the Outcomes of Care:***

Many of the data elements that have found to be useful predictors of patients' resource needs are being evaluated under CMS's Developing Outpatient Therapy Payment Alternatives (DOTPA) study. The DOTPA study evaluated two Continuity Assessment Record and Evaluation (CARE) tools for outpatient therapy. One tool, CARE-C, targets community providers such as private practice therapists, while the CARE-F tool targets measurement in facilities. CMS should expedite this study which it is hoped will validate certain items for a potential assessment tool for outpatient therapy services. In addition, CMS should consider opportunities to harmonize outpatient therapy clinical and outcomes data items with those being explored to track therapy functional progress across acute and post-acute settings (as discussed elsewhere in this document). Such harmonization will facilitate the development of patient-centered value-based bundled and Accountable Care Organization type payment models that incorporate outpatient services.

- ***Explore Opportunities to Leverage Existing Data Collection Mechanisms:***

While CMS recently implemented the claims-based functional data collection methodology for outpatient therapy services in 2013, the type, amount, and value of data that can be submitted via claims is limited, is burdensome, and may not provide the information necessary to build an episodic or value-based payment model from. For other payment and incentive systems, CMS has developed a variety of mechanisms to collect patient-centered data. These include: electronic health records; the IRF-PAI for inpatient rehabilitation; OASIS for home health; and the MDS for SNF services. Modification of these instruments to include outpatient therapy specific items could preclude the need to develop an entirely independent submission methodology. Additionally, registry submission is an option for physician quality reporting, and direct data entry or file transfer via a secure CMS portal is an option for group practice, ACO, and other quality reporting. Providers that have already invested in technology to participate in these programs may only need to have their software updated to include outpatient therapy specific items which could preclude their need to invest in an entirely independent submission technology.

With three therapy disciplines, eleven practice settings, and billing provider sizes ranging from sole independent practitioners to large multi-state provider chains in urban and rural locations, CMS should consider maximum provider data submission flexibility by leveraging the variety of existing technologies available.

- ***Evaluate the Efficacy of Standardized Claims-Based Functional Data Items:***

During 2013 CMS implemented the claims-based functional data collection process for outpatient therapy services. The process implemented by CMS was a

variation of the methodology recommended by the CMS contracted STATS project in that data related to beneficiary function, treatment goals, and progress towards those goals was reported at the onset of care and at periodic intervals. As implemented, providers have the option of reporting progress using any of a wide range of assessment tools, or their clinical judgment to describe patient function. While this process represents a step forward in collecting patient-centered functional data, the lack of standardization limits the usefulness of the data obtained to supporting medical review.

AHCA recommends that CMS explore the feasibility of developing, testing and implementing standardized claims-based functional data items for payment policy purposes, or to determine if this method is ineffective, and whether useful beneficiary-centered information needs to be submitted via an alternative methodology.

- ***Conduct a National Demonstration/Pilot of a Patient-Centered Per-Session Payment Coding System:***

The current procedure codes are based on clinician and not patient factors and there is insufficient information on the claim to explain payment variations. As a result of improper behaviors of some providers misusing the current coding system vulnerabilities, CMS has implemented several arbitrary cost-containment procedure code edits that place significant burdens on all providers, good and bad³⁹.

Previously, the CMS contracted Short Term Alternatives for Therapy Services⁴⁰ project recommended that CMS should transition to a beneficiary-centered per-session payment methodology which would reduce the per-session payment variance, would eliminate the administrative burden associated with most of procedure edits which would be rendered obsolete, and would "...lay the groundwork for the transition towards an episode-based payment model". In this project, the contractor also developed a proposed per-session coding scheme that would incorporate the complexity of the patient-centered characteristics along with the intensity of the intervention necessary for that session.

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³⁹ CMS procedure-code payment edits that impact outpatient therapy services include: Multiple Procedure Payment Reduction (MPPR); Medically Unlikely Edits (MUE); Deficit Reduction Act (DRE) edits; Correct Coding Initiative (CCI) edits; and local Medicare Administrative Contractor (MAC) medical necessity edits.

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⁴⁰ Ciolek DE, and Hwang W. Short Term Alternatives for Therapy Services (STATS) Task Order: Project Report. September 13, 2010. Contract Number: GS-23F-8029H. Task Order Number: HHSM-500-2008-00065C

Recently several trade associations have proposed to Congress that they believe that moving to a per-session methodology for each discipline is an appropriate next step to a more accurate payment system. The proposed coding models contain multiple levels to account for the severity of the condition and the intensity of the intervention, and are currently being processed through the American Medical Association's Current Procedural Technology (CPT) and Relative Value Update Committee (RUC) process to obtain formal recognition for use to describe outpatient therapy services on a per-session basis.

There is currently insufficient information regarding the impact of implementing such per-session codes for AHCA to support at this time, however, we do support the concept of a patient-centered model that could reduce many administrative code edit burdens. However, we strongly believe that prior to national implementation, such a dramatic change in coding should be tested for all three therapy disciplines, eleven practice settings, and billing provider sizes ranging from sole independent practitioners to large multi-state provider chains in urban and rural locations, and for a representative sample of the spectrum of clinical conditions, to assure appropriate code valuation.

- ***Conduct a National Demonstration/Pilot of Promising Patient-Centered Episode- and Value-Based Outpatient Therapy Payment Models for National Implementation:***

The Affordable Care provided significant funding to the CMS Innovation Center to develop and test innovative health care payment and service delivery models. Since the Balance Budget Act was enacted, numerous outpatient therapy alternative payment models have been proposed by CMS contractors and private industry, but professional therapy associations and the provider industry do not have access to timely Medicare data, nor the resources necessary to develop and conduct a scientifically valid full-scale study.

To AHCA, it is imperative that CMS initiate, and conduct transparent studies of the most promising payment models, that stakeholders are actively engaged in the process, and that adequate sample sizes are identified and tested for all three therapy disciplines, eleven practice settings, and billing provider sizes ranging from sole independent practitioners to large multi-state provider chains in urban and rural locations, and representative patient clinical cohorts, to permit adequate patient-centered risk adjustment.

Phase 3 – Long-Term Actions – Payment Alternative Selection and Implementation

Once innovative patient-centered and evidence-based payment models have been tested and validated through the Innovation Center with the support and collaboration with AHCA and other stakeholders, CMS will then have the data necessary to make an informed decision regarding how the models align with the National Quality Strategy, with other acute and post-acute payment systems, and when it is appropriate to implement a national roll-out of the model deemed most appropriate.

The implementation strategy should include consideration of, development of, and timely dissemination of sufficient educational outreach materials to beneficiaries, providers, software developers, and contractors in advance of a national rollout to ensure a seamless and successful implementation.

Observation Stays

Summary

Medicare beneficiaries' access to SNF care is being constrained by the increased use of extended hospital stays in observation status. Days spent in observation status do not count toward the three-day hospital required for SNF post-acute coverage. The immediate result of this policy is that beneficiaries are harmed twice over: (1) they incur costs that they would not incur as inpatients such as drugs and co-payments and (2) they are deprived of SNF coverage.

AHCA has long advocated that all days spent in a hospital, regardless of "inpatient" or "observation" status, should count toward Medicare's three-day hospital stay requirement. AHCA believes that incorporating time spent under observation toward the three-day stay requirement represents an important step that will better align the nation's health care policies with our goal of achieving a more –person centered, seamless health care system.

There is bipartisan support in both the House and Senate to fix this problem.

Representatives Joseph Courtney (D-CT) and Tom Latham (R-IA) have introduced the *Improving Access to Medicare Coverage Act of 2013* (H.R.1179) to address these situations. This bipartisan bill, endorsed by AHCA would deem time an individual spends under observation status eligible to count towards satisfying the three-day stay requirement. Senator Sherrod Brown (D-OH) has introduced a companion bill, S.569, cosponsored by Senator Susan Collins (R-ME). H.R. 1179 currently has 93 cosponsors, while S. 569 has 16.

It is important to note that AHCA is part of a coalition that consists of key provider and beneficiary groups in Washington, D.C. focused on the observation stays issue. The coalition includes AHCA, American Case Management Association, American Medical Association, AMDA, Center for Medicare Advocacy, Inc., LeadingAge, National Academy of Elder Law Attorneys, Inc., National Association of Professional Geriatric Care Managers, National Association of State Long-Term Care Ombudsman Programs, The National Consumer Voice for Quality Long-Term Care, National Senior Citizens Law Center, National Committee to Preserve Society Security & Medicare, and Society of Hospital Medicine.

Background

In order to access the SNF benefit under Medicare Part A, patients currently must be admitted to a hospital for at least three days. Currently, days spent in observation status do not count toward the required three-day stay for SNF post-acute coverage. The number of observation stays and their duration are both increasing. A study found a 34% increase in the ratio of observation stays to inpatient admissions between 2007 and 2009, leading the researchers to conclude that outpatient observation status was becoming a

substitute for inpatient status. The same study also documented increases in long-stay outpatient status, including an 88% increase in observation stays exceeding 72 hours.⁴¹ A primary motivation for hospitals' increasing use of observation status has been concern about the Recovery Audit Contractor (RAC) program. If the RAC or another Medicare reviewer determines that a patient has been incorrectly classified as an inpatient, the hospital is denied reimbursement for most services provided to the patient, despite the fact that the services were medically necessary and coverable by Medicare. In addition, readmission penalties imposed against hospitals may increase the incentives for hospitals to label patients as outpatients. Patients who are called outpatients do not trigger any readmission penalty when they return to the hospital.

OIG HHS Report of July 29, 2013⁴²

On July 29, 2013, the Office of Inspector General (OIG) for the Department of Health and Human Services issued a report to Marilyn Tavenner, Administrator, CMS, describing hospitals' use of observation stays and short inpatient stays in 2012. The OIG found that Medicare beneficiaries had 1.5 million observation stays in 2012; these beneficiaries commonly spent 1 night or more in the hospital. Beneficiaries had an additional 1.4 million long outpatient stays; some of these may have been observation stays.

Beneficiaries also had 1.1 million short inpatient stays, which were often for the same reasons as observation stays. On average, short inpatient stays cost Medicare and beneficiaries more than observation stays. Some hospitals were more likely to use short inpatient stays, whereas others were more likely to use observation or long outpatient stays. Beneficiaries had over 600,000 hospital stays that lasted three nights or more but did not qualify them for SNF services.

The OIG report also found that hospitals vary in their use of observation status.

Some hospitals use observation and long outpatient stays for over 90 percent of Medicare beneficiaries' hospital stays, and others placed beneficiaries into observation status or long outpatient stays less than 30 percent of the time.

The OIG indicated that its results raise concerns about SNF services for beneficiaries in observation stays, long outpatient stays, and short inpatient stays. It recommended that CMS consider how to ensure that beneficiaries with similar post-hospital care needs have the same access to and cost-sharing for SNF services. It opined that allowing nights spent as an outpatient to count toward the three nights needed to qualify for SNF services may require additional statutory authority.

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Zhanlian Feng, Brad Wright and Vincent Mor, *Sharp Rise In Medicare Enrollees Being Held In Hospitals For Observation Raises Concerns About Causes And Consequences*, Health Affairs, 31, no.6, (2012):1251-1259, <http://content.healthaffairs.org/content/31/6/1251.full.html>.

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⁴² Memorandum Report: *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, OEI-02-12-00040, July 29, 2013.

CMS Activity

In the FY 2014 inpatient payment rule (the “Final Rule”),⁴³ released by CMS on Friday, August 2, CMS appeared to make an effort to improve upon the current “observation status” issue and beneficiaries not satisfying the three-day qualifying hospital stay requirement for Medicare coverage of SNF care.

CMS has acknowledged the negative effect extended observation stays have on Medicare beneficiaries and the “significant” financial implications faced by Medicare beneficiaries being treated as outpatients rather than being admitted as inpatients, including the inability to access their Part A post-acute SNF benefit. CMS will not make any other changes to address the effect of observation stays on Medicare coverage of SNF care. The agency believes that the policies finalized in this FY 2014 inpatient payment rule regarding Part B inpatient billing and medical review of inpatient hospital admissions appropriately address the issue of extended observation stays.

The final rule indicates that CMS is engaging in a two-pronged approach for dealing with the increasing number of Medicare beneficiaries receiving observation services for more than 48 hours. First, CMS is adopting several clarifications and changes in Medicare’s policies regarding payment of hospital inpatient services under Part B. Second, CMS will modify the definition of a hospital “inpatient,” the inpatient admission guidelines, and Medicare’s medical review criteria for inpatient stays.

- ***First Prong—Part B Inpatient Billing in Hospitals***

CMS’ final rule provides that when a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was deemed not to be reasonable and necessary, or when a hospital determines after a beneficiary is discharged that his or her inpatient admission was not reasonable and necessary, the hospital may be paid for all the Part B services that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient rather than admitted as an inpatient, if the beneficiary is enrolled in Medicare Part B. The only exception would be for services that specifically require an outpatient status. Those would not be reimbursable.

CMS is taking this step in part in an effort to ameliorate hospitals’ concerns about Medicare Part A and Part B billing policies that may be contributing to the trend towards the provision of extended observation services.

We believe that CMS’ proposal to allow additional rebilling, while perhaps quieting to some extent hospital anxiety over inpatient Recovery Audit Contractor (RAC) denials, unfortunately will not do much for beneficiaries caught up in overly long observation stays.

First of all, there is a technical problem. The final rule applies CMS’s existing timely filing rules. This provision significantly reduces the number of Part A denials eligible for Part B payment by restricting eligibility to only those claims for services provided during the **prior year**. This limitation is particularly problematic considering that RACs audit claims for services provided during the previous *three* years. The impact and utility of the Part B inpatient billing provisions in the final rule is substantially diminished by the

timeframe in which providers are allowed to resubmit Part B claims – one year after the date of service.

However, our major concern is the impact on the beneficiaries whose care is to be rebilled. **The beneficiary will be harmed by this rule.** Under the Part B inpatient billing policy proposed in this rule, if the hospital subsequently submits a timely Part B claim after the Part A claim is denied, the financial protections afforded under section 1879 of the Act to limit liability for the denied Part A claim cannot also be applied to limit liability for the covered services filed on the Part B claim.

The beneficiary (who may previously have had no out-of-pocket costs for the denied Part A claim) is responsible for applicable deductible and copayment amounts for Medicare covered services, and for the cost of items or services never covered (or always excluded from coverage) under Part B of the program. In response to CMS' request for comment on this issue, we certainly urge CMS to prevent such liability for beneficiaries.

Additional liabilities coupled with no guarantee of a lessened trend towards observation make matters even worse for beneficiaries.

Lastly, there is no certainty that the final rule will effectively diminish the trend toward more and longer observation stays. Additional Part B billing may not be able to overcome the fear of potential MS-DRG losses. Indeed, the proposed rebilling process and timelines seem extremely burdensome for the hospitals.

- ***Second Prong—Admission and Medical Review Criteria for Hospital Inpatient Services***

CMS finalizes several regulatory changes related to the two-midnight “benchmark” and the two-midnight “presumption. The two-midnight benchmark “represents guidance to admitting practitioners and reviewers to identify when an inpatient admission is generally appropriate for Medicare coverage and payment,” while the “two-midnight presumption directs medical reviewers to select claims for review under a presumption that the occurrence of two midnights after admission appropriately signifies an inpatient status for a medically necessary claim.” CMS states that inpatient hospital stays that exceed two-midnights will be presumed generally appropriate for Part A payment” and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the two midnight presumption.

While the time that an Medicare beneficiary spends as an outpatient will not be considered inpatient time, it may be considered by physicians in determining whether a patient should be admitted as an inpatient, and during the medical review process for the limited purpose of determining whether the two-midnight benchmark was met and therefore payment is generally appropriate under Part A.

CMS goes so far to state that it expect that this revision should virtually eliminate the use of extended observation.

However, the final rule does not: (1) count days spent in observation specifically toward meeting that requirement; or (2) adjust the definition of inpatient itself to include beneficiaries receiving observation services. CMS specifically states that although outpatient time may be considered in whether a beneficiary should be admitted as an inpatient and during the medical review process, it does not count as inpatient time.

Thus, if a beneficiary is kept in “observation status” for over a day, then is admitted as an inpatient, and then is discharged two days later, the beneficiary would still not receive Medicare coverage for SNF care. In addition, because medical reviewers will still review claims in which the beneficiary span of care after admission crosses two midnights “to ensure the services provided were medically necessary,” hospitals may still be concerned about medical necessity decisions, and therefore, even with the application of the two-midnight presumption, may still keep certain Medicare beneficiaries in outpatient status on an extended basis.

The OIG itself does not believe that this rule will reduce observation stays. It is the OIG’s position that the number of short inpatient stays would be reduced under the policy, but “the number of observation and long outpatient stays may not be reduced if outpatient nights are not counted towards the two-night presumption – thus, its recommendations that CMS consider how to ensure that beneficiaries with similar post-hospital care needs have the same access to and cost-sharing for SNF services.

AHCA Position

As indicated above, AHCA does not believe that the CMS policies implemented in the FY 2014 inpatient payment rule alleviates the problem of observations stays. We applaud CMS’ efforts to ameliorate the situation, but CMS itself does not believe that it has the authority to take the most direct approach and include observation days in the count toward the required three-day stay. The OIG acknowledges that allowing nights spent as an outpatient to count toward the three nights needed to qualify for SNF service may require additional statutory authority. Hence, we ask Congress to provide the required statutory authority to CMS to address this issue.

Appendix A

July 1, 2013

The Honorable Max Baucus
Chairman
Senate Finance Committee
United States Senate
Washington, D.C. 20510

The Honorable Dave Camp
Chairman
House Committee on Ways & Means
House of Representatives
Washington, D.C. 20515

The Honorable Orrin G. Hatch
Levin
Ranking Member
Senate Finance Committee
United States Senate
Washington, D.C. 20510

The Honorable Sander M.
Ranking Member
House Committee on Ways & Means
House of Representatives
Washington, D.C. 20515

Dear Members of the House Committee on Ways & Means Leadership and the Senate Finance Committee Leadership:

On behalf of our entire profession, thank you for your June 19th, 2013 letter calling for a bipartisan effort to receive input on post-acute payment reform. We applaud your initiative and look forward to responding and continuing our collaborative relationship with you and your colleagues in this important work. Congress can make changes that will improve quality and lower costs. It is refreshing that you are working together to find them. We want to be a part of that solution.

Prior to submitting our responses, I feel compelled to clarify one item in the June 19th request. In Table 1, the letter reflects the skilled nursing facility (SNF) Average Medicare Margin as 22-24 percent. While this is what MedPAC reported for 2011, this figure is such an anomaly and differs so significantly from current margins that we must comment. As we enter into a post-acute care payment reform dialogue, it is important that we have a shared and accurate understanding of SNF margins.

The 2011 MedPAC margins are inapplicable for the following reasons. First, 2011 represented an outlier year that CMS quickly corrected with a 12.6 percent cut in 2012. Second, since 2011, the skilled nursing sector has incurred two productivity adjustments, the sequester and reductions in bad debt reimbursement. The cumulative impact of these cuts has reduced the Medicare margin further, and returned it to the present range of 10 percent. Indeed MedPAC itself estimated post-2012 margins as 10-12 percent, but even that estimate was before these additional cuts. On top of this we still have seven more years of productivity adjustments that will further erode margins.

The overall margin for skilled nursing centers is calculated to be between one and three percent because Medicaid dramatically underpays providers. Medicaid pays for the reimbursement of 63 percent of all residents in nursing centers, leading to \$7 billion in

aggregated underpayments in 2012⁴⁴. MedPAC itself predicted in 2011 that overall SNF margins were only four to six percent, but that was before the above mentioned productivity adjustments, sequester, bad debt reductions and Medicaid reductions in many states. An analysis done by the Moran group found that in light of all the above, the overall operating margin for the skilled nursing sector was less than one percent⁴⁵.

It should come as no surprise that the financial markets recognize this and have responded to these declining, razor thin margins. An April 30, 2013 story⁴⁶ on the profession in the *Wall Street Journal* quoted investors saying they were “pulling back from nursing homes” as places to look for growth. “[Medicare and Medicaid] entitlement programs combined make up about 90percent of nursing home revenue. If they are diminished, some nursing homes could have difficulty paying their rent.”

To make matters worse, the implementation of the Affordable Care Act will not provide SNFs the benefits of expanded coverage to the same degree it will other types of providers. First, commercial insurance typically does not cover a skilled nursing stay at the same level as Medicare. Second, people enrolled under ACA-related coverage are unlikely to use post-acute care. As a result, the dramatic expansion of coverage through the ACA will not benefit SNF providers to the same degree as other providers such as physicians and hospitals.

The concerns noted above are not meant to imply that we do not support payment reform that will lead to improved patient quality and lower costs. Indeed, we support, or support with clarification, the topic areas outlined in the letter: 1) Site Neutral Payment; 2) IRF “75percent Rule;” 3) SNF Readmissions Policy; and 4) Bundled Payment. However, we strongly oppose any further arbitrary market basket cuts that could jeopardize our ability to maintain access to care.

As we prepare to submit our response on August 19th, we felt it was important to have a shared understanding of the status of the profession. A series of cuts over the last five years, combined with stagnant or declining Medicaid rates, have resulted in little or no margin in the skilled nursing profession.

Such combined cuts have produced a new and unprecedented reality for skilled nursing centers. The language and solutions of the past do not fit this new challenging reality.

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[Ⓜ] Eljay, LLC., *A Report on Shortfalls in Medicaid Funding for Nursing Center Care*. December 2012.

45

[Ⓜ] The Moran Company, *National Nursing Facility Margin Analysis: All Payer Revenue and Costs*. Presented to the American Health Care Association, December 2011.

46

[Ⓜ] Health-Care Owners Shun Nursing Homes. *The Wall Street Journal*. April 30, 2013.

While this should not prevent reform, it does magnify the importance of a thoughtful, non-sequester-like policy dialogue which incorporates the issues above.

Best,

A handwritten signature in black ink, appearing to read "Mark Parkinson". The signature is written in a cursive style with a large initial "M".

Mark Parkinson
President & CEO
American Health Care
Association

