Emerging Issues in Medicare and Health Care Reform

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Session Learning Objectives

1. Discuss the potential impact of emerging policies in health care reform on delivery system reform, including opportunities to advance rehabilitation and avoid potential threats to rehabilitation.
2. Take steps in your practice to comply with existing and new regulations.
3. Identify the latest initiatives regarding implementation of an alternative payment model for physical therapy.
4. Comply with requirements for reporting quality for payment.
### Key Topic Areas

| Integrated Models of Care – redesign care | • Accountable Care Organizations  
• Medical Homes  
• Bundling |
| --- | --- |
| Expansion of Coverage | • Medicaid expansion, exchanges,  
nondiscrimination, network adequacy |
| Refining / Changing Payment Methodologies | • Cuts in payment rates, refinements to payment systems, patient assessment instruments. |
| Linking Payment to Quality | • Value based purchasing, hospital readmissions policy, electronic health records, registries, public reporting |
| Program Integrity | • Provider Enrollment  
• Funding Increases for Enforcement  
• Expansion of Auditors |

### Time of Rapid Change
**HHS Announces Transition Timelines**

**Alternative Payment Models**
- By 2016, 30% of payments to alternative payment models
- By end of 2018, 50% of payment to alternative payment models

**Linking Payment to Outcomes**
- Link 85% of fee for service payments to outcome measures by end of 2016
- 90% by end of 2018

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**Outpatient PT Payment Rates for 2015**

- Outpatient Physical therapy services are paid under the physician fee schedule
- Values are multiplied by a dollar conversion factor to determine payments. Payment is updated each year by increasing or decreasing the dollar conversion factor
- Due to flawed SGR formula, the dollar conversion factor is projected to be reduced each year significantly
## SGR Updates

### Recent Legislation: SGR

<table>
<thead>
<tr>
<th>Year</th>
<th>Legislation</th>
<th>Payment Period</th>
<th>Scheduled Payment Update</th>
<th>Legislated Payment Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>Medicare &amp; Medicaid Extenders Act</td>
<td>2011</td>
<td>-25%</td>
<td>0%</td>
</tr>
<tr>
<td>2012</td>
<td>Middle Class Tax Relief Act</td>
<td>March-Dec. 2012</td>
<td>-27.4%</td>
<td>0%</td>
</tr>
<tr>
<td>2013</td>
<td>American Taxpayer Relief Act</td>
<td>2013</td>
<td>-26.5%</td>
<td>0%</td>
</tr>
<tr>
<td>2014</td>
<td>Pathway for SGR Reform Act</td>
<td>Jan-March 2014</td>
<td>-20.1%</td>
<td>0.5%</td>
</tr>
<tr>
<td>2015</td>
<td>Protecting Access to Medicare Act</td>
<td>April 2014-March 2015</td>
<td>-24%</td>
<td>0%</td>
</tr>
</tbody>
</table>
2015 Fee Schedule

- From January –March 31, 2015 PTs will experience an aggregate 1% increase in payment.
- If Congress does not act before March 31, 2015 a 20.9% reduction in payment will occur.

MPPR/Fee Schedule Resources

- APTA website
  - [www.apta.org/medicare](http://www.apta.org/medicare) (Medicare fee schedule)
  - MPPR calculator
  - MPPR scenarios
  - Fee schedule calculator
  - Summary of Physician Fee Schedule Rule
Future Outlook: Repeal of SGR?

- Cost to Repeal SGR (permanent “doc fix”) is currently $138 billion
- Cost of Congress enacting 17 temporary “doc” fixes to the SGR since 2003 = $169.5 billion
- Full Repeal is thought to be more fiscally responsible
- But how do we pay for repeal?

SGR Repeal Bill in Congress

SGR Repeal & Medicare Provider Payment Modernization Act) (HR. 4015/S2000)
- Permanent Repeals the SGR
- 2014-2018 annual updates = 0.5%
- 2019-2023 = freezes updates (0%); providers participating in Alternative Payment Models could get a 5% bonus
- Beginning in 2024, providers participating in APMs will receive a 1% annual update and all others .5% annual updates.
SGR Repeal Bill in Congress

- New Merit-Based Incentive Payment System (MIPS)
- Blended PQRS, Meaningful Use, Value Based Modifier & New Clinical Practice Improvement Option
- Under MIPS would receive a penalty or bonus based on comparison to national mean

Therapy Cap

- Therapy Cap amount for 2015 is $1940 for physical therapy and speech therapy combined & $1940 for occupational therapy (up from $1920 in 2014).
- The therapy cap currently applies to all outpatient therapy settings.
Therapy Cap Exceptions Process:
January-March 31, 2015

Claims between $1940-3700: submit KX modifier if services are medically necessary for an exception.

Claims exceeding $3700: subject to manual medical review process.

Manual Medical Review

• Recovery Audit Contractors (RAs) responsible for reviewing the medical records and determining whether services are medically necessary.
• Temporary Pause in Manual Medical Review in effect starting February 28, 2014 due to RAC transition.
• New RAC contracts have not been awarded due to protests.
• Existing RAC contracts were extended.
RAC review process

• Existing RACs will begin limited review of facility claims (i.e. SNF, hospital, rehab agency) that exceeded $3700 between March 1 and December 31, 2014.
• Claims will be reviewed in chronological order based on month the were paid (e.g. March paid claims reviewed before April claims)
• Length of time between ADR letters will be at least 45 days.

ADR limitations for claims

<table>
<thead>
<tr>
<th>ADR Request Limitation</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First ADR:</strong> Request documentation for only one claim form March-December 31, 2014</td>
<td>28 claims March-December 31 exceeded $3700; Documentation requested for one claim</td>
</tr>
<tr>
<td><strong>Second ADR:</strong> Request up to 10% of total eligible claims</td>
<td>28 claims; Documentation requested for 3 claims.</td>
</tr>
<tr>
<td><strong>Third ADR:</strong> Request up to 25% of total remaining claims</td>
<td>24 claims remaining. Documentation requested for 6 claims.</td>
</tr>
</tbody>
</table>
**ADR limitations for claims**

<table>
<thead>
<tr>
<th>ADR Request Limitation</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fourth ADR:</strong> Request documentation for up to 50% of total remaining claims</td>
<td>18 claims remaining. Documentation requested for 9 claims</td>
</tr>
<tr>
<td><strong>Fifth ADR:</strong> Can request up to 100% of remaining eligible claims.</td>
<td>9 claims remaining; Documentation requested for all 9 claims.</td>
</tr>
</tbody>
</table>

**FUTURE OUTLOOK: THERAPY CAP**
Therapy Cap Legislation

- Medicare Access to Rehabilitation Services Act was introduced by Congressman Boustany, Congressman Becerra, Congresswoman Blackburn on February 5, 2015
- Legislation would repeal the therapy cap
- For more information on how you can help, go to http://www.apta.org/TakeAction/

Repeals the Medicare therapy cap
Retains manual medical review at $3,700 for 1 year
Transitions to a new medical review system in 2015 with a prior authorization mechanism for approval of blocks of visits
Replaces current functional limitation reporting with new therapy data collection system (around 2017)
Starting in 2015, claim form must indicate if the service is provided by a therapy assistant
Legislation: Prior Authorization

- CMS would define services subject to medical review based on factors such as:
  - Providers with unusually high billing patterns;
  - High claims denial percentages
  - Newly enrolled providers
  - Questionable billing practices
  - CMS may establish thresholds for review

CMS: Alternative Payment for Therapy

- CMS is interested in development of an alternative payment system for outpatient therapy.
- Includes discussions of episodic system, per diem systems, hybrid systems.
- DOTPA Research Triangle Institute (RTI) performed a study involving the use of the CARE–C and CARE-F assessment tools at admission and discharge.
- Study was published on website May 1, 2014
APTA Alternative Payment System

• Visit/Session Based System
• Based on clinical judgment of the therapist
• Factors include:
  – severity/complexity of the patients presentation
  – intensity of the therapist’s clinical decision making and interventions

CPT coding changes

• AMA Physical Medicine and Rehabilitation Workgroup is currently working on changes to CPT codes in 97000 series (13 specialties)
• Developing per session CPT codes to describe services. Levels based on severity of patient and intensity of service
• APTA and AOTA performed a pilot project to further investigate payment model
PQRS 2015 AND VM 2016

PQRS: 2015 payment

• If PTs did not report under PQRS in 2013, they receive 1.5% less payment for claims with dates of service from January 1-December 31, 2015, in payment in 2015.
PQRS: 2015 payment

• In 2015, eligible providers who bill under the physician fee schedule must report successfully under PQRS to avoid a -2.0% reduction in their 2017 fee schedule payment. PTs can report via claims or registry
  – Rehab agencies, outpatient hospitals, SNFs Part B unable to participate in PQRS; use UB-92 (UB-04) or 837I for billing to intermediary
  – No place on claim form for individual NPI

PQRS Successful Reporting

To avoid the penalty in 2017

In 2015, report at least 9 measures OR, if less than 9 measures covering apply to the eligible professional, report 1—8 measures, AND report each measure for at least 50 percent of the Medicare patients to which the measure applies
Resources on PQRS

- APTA website
  - http://www.apta.org/PQRS/
- QualityNet Help Desk
  - PQRS and eRx Incentive Program questions
    - 866-288-8912 (TTY 877-715-6222)
    - 7:00 a.m.–7:00 p.m. CST M-F or qnetsupport@sdps.org
- CMS PQRS Website

The Value-Based Modifier (VM) Program

- VM was mandated by Section 3007 of the Affordable Care Act, to begin by 2015. This program is separate from PQRS.
- Physicians are included in this program in 2015 (using CY2013 data).
- CMS is expanding the program in CY2018 (using CY 2016 data) to include:
  - Nonphysician Eligible Professionals (EPs) this includes physical therapists
Program Integrity: Strategies to Reduce Improper Payments

- Strengthen provider enrollment
- Improve prepayment reviews
- Focus postpayment reviews on vulnerable areas
- Improve oversight of contractors
- Develop a robust process to address identified vulnerabilities

Provider Enrollment

- Final rule issued December 5, 2014 (Effective 02/03/15)
- The rule allows CMS to:
  - deny enrollment of providers, suppliers, and owners that have unpaid Medicare debt
  - deny the enrollment or revoke the billing privileges of a provider or supplier if a managing employee has been convicted of certain felony offenses
  - revoke billing privileges of providers and suppliers that have a pattern or practice of billing for services that do not meet Medicare requirements
# Prepayment and Postpayment Reviews (Who Are the Auditors and What Do They Do?)

<table>
<thead>
<tr>
<th>Contractor</th>
<th>Claim Types</th>
<th>Claim Selection</th>
<th>Claim Volume</th>
<th>Purpose of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>CERT</td>
<td>All Claim Types for Medicaid</td>
<td>Random</td>
<td>Small</td>
<td>Measure improper payment rates</td>
</tr>
<tr>
<td>PERM</td>
<td>All Claim types for Medicaid</td>
<td>Random</td>
<td>Small</td>
<td>Measure improper payment rates</td>
</tr>
<tr>
<td>MAC (medical review department)</td>
<td>All claim types with Medicare fee for service</td>
<td>Targeted</td>
<td>Depends on this issue and amount of improper payments</td>
<td>Prevent improper payments; Provider Education</td>
</tr>
<tr>
<td>RA (formerly RAC)</td>
<td>All claim types with Medicare fee for service (Will begin reviewing Medicaid claims)</td>
<td>Targeted</td>
<td>Size depends of the magnitude of improper payments</td>
<td>Detect past improper payments; find program vulnerabilities</td>
</tr>
<tr>
<td>ZPIC</td>
<td>All claim types with Medicare fee for service Medi- Medi in some states</td>
<td>Targeted based on potential fraud, waste, and abuse</td>
<td>Size depends of the magnitude of potential fraud and abuse</td>
<td>Identify fraud, waste, and abuse</td>
</tr>
</tbody>
</table>
Spectrum of Program Integrity

**Program Integrity** encompasses a range of activities to target the causes of improper and fraudulent payments:

- **Mistakes**
- **Inefficiencies**
- **Bending the rules**
- **Intentional Deception**

**Examples:**
- Incorrect coding
- Inappropriate use and overutilization
- Medically unnecessary services
- Billing for services or supplies that were not provided

Recovery Audit Program Changes

<table>
<thead>
<tr>
<th>Provider Concern</th>
<th>Change to Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADR limits are not adjusted based on provider compliance</td>
<td>CMS will establish ADR limits based on provider’s compliance with Medicare rules</td>
</tr>
<tr>
<td>Providers must wait 60 days before notification of outcome of reviews</td>
<td>Recovery auditors will have 30 days to complete the reviews and notify the provider of outcome</td>
</tr>
<tr>
<td>Upon notification of appeal by provider the Recovery Auditor must stop the discussion period</td>
<td>Recovery Auditors must wait 30 days to allow for a discussion request before sending claim to MAC for adjustment. (providers do not have to decide between initiating discussion or appealing)</td>
</tr>
</tbody>
</table>
Recovery Audit Program Changes

<table>
<thead>
<tr>
<th>Provider Concern</th>
<th>Change to Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers do not receive confirmation of discussion request.</td>
<td>Recovery Auditors must confirm receipt of discussion request or other written correspondence within 3 days.</td>
</tr>
<tr>
<td>Recovery Auditors should be reported by provider of the same specialty</td>
<td>Contractor medical directors encouraged to have panel of specialists available for consultation.</td>
</tr>
<tr>
<td>Recovery Auditors are paid their contingency fee after recoupment of improper payments, even if provider appeals.</td>
<td>Recovery Auditors will not receive contingency fee until after the second level of appeal is exhausted. If claims are overturned on appeal, providers are paid interest from date of recoupment.</td>
</tr>
</tbody>
</table>

Appeals

- You have an appeal right when your carrier/intermediary/MAC determines an overpayment occurred on prepayment or post payment review.

<table>
<thead>
<tr>
<th>Appeals Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redetermination</td>
</tr>
<tr>
<td>Reconsideration</td>
</tr>
<tr>
<td>Administrative Law Judge (delays)</td>
</tr>
<tr>
<td>Medicare Appeals Council</td>
</tr>
<tr>
<td>Federal District Court</td>
</tr>
</tbody>
</table>
Backlog of Appeals

- Major backlog in appeals at the ALJ level due to increasing audits (particularly RACs)
- ALJs announced that it will take 2 years for appeals to be heard due to backlog.

Volume of Appeals Received

![Receipts by Medicare Type](image)
Solutions to Alleviate Backlog

- OMHA held provider forum on October 29th and solicited feedback on how to address the problem
- APTA submitted comments
  - Claims oversight for MMR should be suspended until correction of backlog
  - More scrutiny and streamlined process for Medicare contracted reviewers (number and scope)
  - Increased training and coordination for Medicare contractors for correct and consistent application of the law

Hospital Settlements of Appeals

- CMS announced in August that acute care hospitals and critical access hospitals may elect to resolve pending patient status appeals by receiving a partial payment equal to 68% of the net payable amount.
- Facilities that elect administrative agreement settlement option waive right to request an appeal
Medicare Advantage

Medicare Enrollment by Plan Type
(Source: MedPAC)
Impact of ACA on Medicare Advantage

• Affordable Care Act cuts may have large impacts on beneficiaries
  – 2014 payments adjusted for differences in diagnostic coding intensity between Medicare Advantage plans and traditional Medicare
• Medical Loss Ratio 85% requirement implementation in 2014
• Sequestration cuts from Budget Control Act
MA Plan Costs Are Rising

• Kaiser Family Foundation study indicates the following for 2014:
  – Higher premium payments for beneficiaries
  – No large changes in availability of plans
  – High out-of-pocket maximums for plans
    • Further cost sharing (co-payments, coinsurance) for beneficiaries

Medicare Advantage: Cost Sharing

• Unreasonably high co-payments for therapy services from many MA plans
• APTA’s advocacy efforts

• Emphasis on patient impact and access to therapy services
2015 Medicare Advantage Call Letter

- Cost Sharing Changes:
  - $40 copay limit for physical therapy services
  - Refine plan offerings so that beneficiaries can easily identify the differences between their options

- Provider Networks:
  - Notification to enrollees regarding any changes to provider networks
  - Potential future rulemaking

Provider Network Adequacy

- MA plans narrowing networks to cut costs
- Federal judge in Connecticut temporarily blocked UnitedHealthcare from dropping an estimated 2,200 physicians from its Medicare Advantage plan
  - Potential national implications
Implementation of Traditional Medicare Policies

- Multiple procedure payment reduction adopted by many MA plans since 2011 CMS implementation
- Implementation issues by Humana
  - Retroactive overpayment letters issued
  - Incorrect calculations
  - APTA advocacy efforts → Humana no longer applying policy retroactively
- Functional Limitation Reporting also being adopted by MA plans

Provider Tips for MA Issues

- Review Contracts
  - Determine risk for payment cuts (through sequestration, MPPR, etc.)
  - Seek legal counsel as needed

- Monitor MA Plan Websites
  - Many MAOs issue policy updates only via their websites
  - Notice requirements in contracts

- Encourage Patients to Get Involved
  - Emphasis on patient impact with cost sharing issue
  - Patient advocacy more meaningful
QUESTIONS

POST-ACUTE PPS UPDATE
SNF Market Basket Update

- Market basket increase: +2.4%
- Forecast error adjustment: 0.0%
- *MFP adjustment: -0.4%

Net adjusted payment update +2.0%

*Multifactor productivity adjustment

SNF Therapy Research Project

CMS contracted with Acumen, LLC to identify and evaluate potential alternatives to therapy reimbursement for SNF PPS

The report explores four alternatives:

- a patient characteristics model
- a hybrid model that blends patient characteristics and a resource-based pricing adjustment
- a fee schedule
- a competitive bidding model.

Recommended and selected alternatives: patient characteristics and hybrid model concepts as basis for development of a final model.

Model development will take place in four stages:

- developing an analysis plan
- conducting empirical analyses
- soliciting and incorporating feedback from a technical expert panel
- summarize findings
Revisions to COT OMRA

Permitted when:

- Previously qualified for RUG-IV therapy group on prior assessment during Part A stay
- No discontinuation of therapy between Day 1 of 7-day COT observation period that classified patient in non-therapy RUG and ARD date of COT OMRA that reclassified patient in a therapy RUG

Still prohibits use of the COT OMRA for initial classification of patients into a therapy RUG


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SNF Therapy Utilization Trends

- Therapy billed in the highest therapy RUG (RU)

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>% billed</td>
<td>44.8</td>
<td>48.6</td>
<td>50+</td>
</tr>
</tbody>
</table>

- Amount of therapy on MDS was just enough to surpass applicable therapy RUG level (especially in two highest RUG levels)
IRF Market Basket Update

- Market basket increase  +2.7%
- MFP adjustment -0.4%
- Legislative adjustment -0.2%
- Outlier threshold update  +0.1

Net adjusted payment amount  +2.2%

Collection & Reporting Therapy Amount

Stated purpose: To determine what Medicare is paying for and is it appropriate

Addition of new therapy information section to IRF PAI

Record amount and mode (concurrent, co-treatment, group or individual)

For each discipline (PT, OT and SLP)
### Definitions of Modes of Therapy

**Must be collected first two weeks of IRF stay beginning on or after October 1, 2015**

**Concurrent Therapy**
- One PT/PTA with 2 patients
- Performing different activities

**Co-treatment**
- More than one therapist from different disciplines (PT/PTA, OT/COTA, or SLP) to one patient at a time

**Group Therapy**
- One PT/PTA to 2-6 patients at one time
- Performing same activities

**Individual Therapy**
- One PT/PTA to one patient at a time

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### Changes to Presumptive Compliance List

**Effective October 1, 2015 and will be transitioned in with ICD-10 implementation**

One way to evaluate compliance with 60% rule

Deletes 10 amputation status and prosthetic fitting and adjustment codes

Justification: these codes alone do not show that patient needs IRF treatment
Changes to Presumptive Compliance Methodology

Removal of impairment group codes

- IGC 0005.1 – Unilateral Upper Limb Above the Elbow
- IGC 0005.2 – Unilateral Upper Limb Below the Elbow
- IGC 0006.1 – Rheumatoid Arthritis
- IGC 0006.9 – Other Arthritis

Revision to IRF-PAI for Arthritis Conditions

Addition of data item for arthritis condition

Yes or no check to indicate whether treatment and severity requirements have been met

For patients that meet severity and prior treatment requirements to be counted toward 60% rule on the presumptive compliance list
Revisions to IRF Quality Reporting Program

Add two new outcomes measures regarding Staphylococcus aureus and Clostridium difficile for FY 2017 payment adjustments for non-compliance (NQF # 1716, 1717)

Revisions to reconsideration and appeals process

• Reconsiderations only after noncompliance
• 30 days to submit request
• Must submit all supporting documentation
• May withdraw or file new requests w/in 30 days

Home Health Market Basket Update

• Reductions in payment of $60 million or 0.3 percent
• Includes 2.1 percent payment update and second year of home health rebasing
• National 60-day per episode payment rate is $2961.38

(May be reduced by 2 additional percentages for failure to comply with HH QRP)
Changes to Therapy
Reassessment Timeframes

• Current policy: 13th and 19th therapy visits for each therapy discipline and/or every 30 calendar days.
• New policy: reassessment be conducted at least once every 30 calendar days (PT, OT and SLP).
• Therapist must perform the necessary treatment during the visit and assess the patient, measure progress and document objectives and goals.
• All other requirements remain unchanged (e.g. documenting objective measurement and done by qualified therapist).

Documentation for Face to Face Requirement

• Final policy:
  – Eliminate narrative requirement, evaluation must be completed by physician or NPP with documented date of encounter.
  – For eligibility for HH start of care, CMS will review medical record from certifying or PAC physician.
  – Physician claims for certification or recertification of eligibility will not be covered if HHA claim itself is denied for lack of sufficient documentation.
Home Health Quality Reporting

• Submission OASIS data to capture “Quality Assessments Only”

$$QAO = \frac{\# \text{ of Quality Assessments}}{\# \text{ of Quality Assessments} + \# \text{ of NonQuality Assessments}} \times 100$$

• Will transition in with 70% in 2015 and 90% by 2017

MEDICARE POST-ACUTE CARE REFORM
Basis of Current Payment Systems

Volume of services

Patient Condition and Complexity

RUGs
CMGs
HHRGs
DRGs

Payment

APTA Recommendations

Single therapy component payment methodology

Uniform set of quality measures

Standardized PAC assessment tool
How do we ultimately get to one broad system?

- Interim steps need to be recommended
  - A core data set of reportable quality measures/items reportable through OASIS, MDS, IRF PAI and LTCH B-CARE tool
  - Elimination of onerous regulations (HH Functional Reassessment, SNF OMRAs, IRF coverage criteria – “60 % rule”)
  - Incorporation of ICF language in clinical guidelines and coverage policies
  - Phased-in implementation of payment methodology
  - Analysis and data collection (possible demos and/or pilots)

MedPAC Recommendations (2013-14)

- Freeze payments for Medicare PPS LTCH and HH payments for 2015.
- Create a readmissions reduction policy that would apply a penalty to HH payments for HH readmissions to hospitals that exceed a risk-adjusted target
- Create a common post-acute assessment instrument for HH, skilled nursing facilities, IRFs and LTCHs in 2016
- Extended through 2015 its prior recommendation to freeze payments for SNFs and rebase the SNF PPS
PASSAGE OF IMPACT LEGISLATION

Timeline of Major Deliverables in the IMPACT Act of 2014

- 2014-2016: Use of Quality Data to Inform Discharge Planning
- 2017: Standardized Assessment Data Required For PAC Providers Begins
- 2018: CMS & MedPAC Reports on PAC Prospective Payment
- 2019: Standardized Quality and Resource Use Measure Reporting for PAC Providers Begins
- 2020-2021: Study on Hospital Assessment Data
- 2022: Study on Hospital Assessment Data
IMPACT Stages of Implementation

Data collection, reporting and analysis

Congressional Reports

Feedback reports

Public Reporting

Data Collection, Reporting and Analysis

- PAC providers (HH, IRF, SNF and LTCH) must collect and report standardized and interoperable patient assessment data, quality and resource use measures
- Separate but uniform assessment instruments that can be compared across settings
Reporting Patient Assessment Data

• PAC providers must report:
  – Functional status
  – Cognitive function and mental status
  – Special services, treatments and interventions required
  – Medical conditions
  – Impairments
  ➢ Claims data will be matched to assessment data for assessing prior service and current service use
  ➢ Information cannot be used for payment eligibility at a specific PAC setting

Penalizations for Failure to Report

PAC providers who fail to report quality and resource use measures subject to a two percentage point reduction under respective market basket
Congressional Reporting

First MedPAC report on alternative payment models for PACs by June 30, 2016

HHS report with recommendations on technical prototype of PAC PPS (after two years of data collection on quality measures)

Second MedPAC report on prototype based on HHS report by June 30th following HHS report

Study on impact of SES factors (two years after enactment)

Changes to Hospice Survey and Medical Review

- More frequent surveys (every 36 months from April 2015 to September 2025)
- Trigger of medical review for certain treatment cases (large percentage of cases with stays over 180 days)
- Payment cap aligned to common inflationary index
The Obama administration wants even larger portions of payments to be tied to quality- or value-based payment models.

- 30% of payments for traditional Medicare benefits to be tied to alternative payment models such as accountable care organizations by the end of 2016
- 50% by the end of 2018.
- 85% of Medicare's hospital payments made through programs such as the Hospital Value-Based Purchasing Program or the Hospital Readmissions Reduction Program by the end of 2016.
- Up to 90% by 2018.

http://www.apta.org/PTinMotion/News/2015/1/27/HHSTimelinesAnnounced/
That the physical therapy profession uses standardized collection, analysis, and dissemination of intervention and outcomes data as a regular part of practice at all levels to determine what interventions best improve the health of individual and society and to identify and emulate the positive deviants within our clinical communities.

- Alan Jette; Face into the Storm

Health Care Paradigm Shift

Pre-Reform

Post-Reform

The Healthcare Value Equation

\[
\text{Value} = \frac{\text{Quality}}{\text{Cost}}
\]
<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-9 Code Description</th>
<th>Mean Episode Days</th>
<th>SD Episode Days</th>
<th>Percent of Episodes*</th>
<th>Mean Episode Paid</th>
<th>SD Episode Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>V57.1</td>
<td>Nonspecific, other physical therapy</td>
<td>9.70</td>
<td>9.10</td>
<td>11.83%</td>
<td>$547</td>
<td>$602</td>
</tr>
<tr>
<td>724.2</td>
<td>Lumbago, low back pain</td>
<td>9.60</td>
<td>9.10</td>
<td>7.74%</td>
<td>$658</td>
<td>$953</td>
</tr>
<tr>
<td>781.2</td>
<td>Abnormality of gait</td>
<td>12.90</td>
<td>13.00</td>
<td>4.79%</td>
<td>$952</td>
<td>$1,105</td>
</tr>
<tr>
<td>719.41</td>
<td>Pain in joint, shoulder region</td>
<td>10.90</td>
<td>9.80</td>
<td>3.60%</td>
<td>$707</td>
<td>$750</td>
</tr>
<tr>
<td>719.46</td>
<td>Pain in joint, lower leg</td>
<td>10.70</td>
<td>9.50</td>
<td>3.40%</td>
<td>$729</td>
<td>$762</td>
</tr>
<tr>
<td>719.7</td>
<td>Difficulty in walking</td>
<td>14.30</td>
<td>13.70</td>
<td>3.23%</td>
<td>$999</td>
<td>$1,059</td>
</tr>
<tr>
<td>723.1</td>
<td>Cervicalgia (pain in neck)</td>
<td>9.50</td>
<td>8.70</td>
<td>3.14%</td>
<td>$617</td>
<td>$742</td>
</tr>
<tr>
<td>728.87</td>
<td>Muscle weakness (generalized)</td>
<td>14.20</td>
<td>14.60</td>
<td>2.20%</td>
<td>$937</td>
<td>$1,056</td>
</tr>
<tr>
<td>715.16</td>
<td>Primary osteoarthritis lower leg</td>
<td>13.00</td>
<td>11.90</td>
<td>1.86%</td>
<td>$990</td>
<td>$1,052</td>
</tr>
<tr>
<td>719.45</td>
<td>Pain in joint, pelvic region and thigh</td>
<td>9.80</td>
<td>8.90</td>
<td>1.68%</td>
<td>$642</td>
<td>$690</td>
</tr>
</tbody>
</table>

* Represents 43.45% of total episodes

---

The Present and Future of High Quality Patient Care
# Current Quality Reporting Programs Under Medicare Impacting PTs

<table>
<thead>
<tr>
<th>Health Care Setting</th>
<th>Reporting Level</th>
<th>Program Details/Data</th>
<th>Payment Incentive/ Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient (Acute Care Hospitals)</td>
<td>Facility</td>
<td>IQR, Readmissions &amp; VBP</td>
<td>P4R Penalty -2% &amp; P4P</td>
</tr>
<tr>
<td>Long Term Care Hospitals (LTCH)</td>
<td></td>
<td>LTCH-CARE, claims, NHSN</td>
<td>P4R Penalty -2%</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facilities (IRF)</td>
<td></td>
<td>IRF-PAI, claims, NHSN</td>
<td>P4R Penalty -2%</td>
</tr>
<tr>
<td>Skilled Nursing Facilities (SNF)</td>
<td></td>
<td>MDS 3.0</td>
<td>Not tied to payment</td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
<td>Hospice item set (HIS)</td>
<td>P4R Penalty -2%</td>
</tr>
<tr>
<td>Home Health</td>
<td></td>
<td>OASIS, HH CAHPS, claims</td>
<td>P4R Penalty -2%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Group (TIN)</td>
<td><strong>Value-based Modifier (VM)</strong></td>
<td><strong>P4P +4.0x to -4.0%</strong></td>
</tr>
<tr>
<td>Individual or Group (TIN/NPI)</td>
<td>PQRS</td>
<td></td>
<td>P4R Penalty -2.0%</td>
</tr>
<tr>
<td>Patient</td>
<td></td>
<td>Functional Limitation Reporting (FLR)</td>
<td>Condition of payment</td>
</tr>
</tbody>
</table>

NHSN= National Healthcare Safety Network
P4R= Pay for Reporting
P4P= Pay for Performance

---

## CMS Vision for Quality Measurement

- Align measures with the National Quality Strategy (NQS) and measure domains
- Identify and fill critical gaps within the six domains (patient and family engagement, patient safety, care coordination, population/public health, efficient use of healthcare resources, clinical process/effectiveness)
- Develop parsimonious (core) sets of measures
- Remove measures that are no longer appropriate
- Continuously improve quality measurement over time
- Align measures across CMS programs (and external stakeholders) whenever and wherever possible
## Current Data Collection Tools by Setting

<table>
<thead>
<tr>
<th>Setting</th>
<th>No tool</th>
<th>LTCH CARE</th>
<th>IRF-PAI</th>
<th>MDS</th>
<th>OASIS</th>
<th>FLR: No tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post Acute Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ACUTE AND POST ACUTE CARE**
Medicare Quality Measures: Acute and Post-Acute Care

<table>
<thead>
<tr>
<th>Measure</th>
<th>ACUTE</th>
<th>LTCH</th>
<th>IRF</th>
<th>SNF (A)</th>
<th>HH</th>
<th>Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary Catheter-Associated Urinary Tract Infections</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Line Catheter-Associated Bloodstream Infection</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure Ulcers measures</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>30-day Comprehensive All-Cause Risk-Standardized Readmission Measure</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Department Use without Hospitalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>CAHPS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Pain management measures</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls rate/ risk</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADL information</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient Function: Post-Acute Care Data Collection

- Post-Acute care data collection is not harmonized across settings

<table>
<thead>
<tr>
<th>Setting</th>
<th>Tool</th>
<th># of Functional Items</th>
<th>Rating Scale Levels</th>
<th>Assessment Periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTCH</td>
<td>LTCH-CARE</td>
<td>3</td>
<td>6</td>
<td>3 day period</td>
</tr>
<tr>
<td>IRF</td>
<td>IRF-PAI</td>
<td>17</td>
<td>7</td>
<td>Past 3 days</td>
</tr>
<tr>
<td>SNF (A)</td>
<td>MDS</td>
<td>12</td>
<td>8</td>
<td>Past 5 days</td>
</tr>
<tr>
<td>Home Health</td>
<td>OASIS</td>
<td>8</td>
<td>variable</td>
<td>Assessment day</td>
</tr>
<tr>
<td>Hospice</td>
<td>TBD</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pilot: LTCH, IRF, SNF (A), HH</td>
<td>CARE F</td>
<td>11 core items 25 supplemental</td>
<td>6</td>
<td>2 day period</td>
</tr>
</tbody>
</table>
## PAC Tool Scoring

<table>
<thead>
<tr>
<th>IRF-PAI</th>
<th>MDS</th>
<th>OASIS</th>
<th>CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>7= Complete independence</td>
<td>0= Independent</td>
<td>0= Bathe independent tub/shower</td>
<td>6= Independent</td>
</tr>
<tr>
<td>6= Modified (device)</td>
<td>1= Supervision</td>
<td>1= With devices, independent</td>
<td>5= Set up or clean up assistance</td>
</tr>
<tr>
<td>5= Supervision</td>
<td>2= Limited Asst. (guided maneuvering)</td>
<td>2= With person (reminders, access, reach difficult areas)</td>
<td>4= Supervision or touching assistance</td>
</tr>
<tr>
<td>4= Minimal Assistance 25%</td>
<td>3= Extensive Asst. (3+ times/week)</td>
<td>3= Participates but req. other person</td>
<td>3= Partial/ moderate assistance</td>
</tr>
<tr>
<td>3= Moderate Assistance 50%</td>
<td>4= Total Dependence</td>
<td>4= Unable, bathes in bed/chair</td>
<td>2= Substantial/ maximal assistance</td>
</tr>
<tr>
<td>2= Maximal Asst. 25%</td>
<td>5= Activity NA</td>
<td>5= Totally bathed by other</td>
<td>1= Dependent</td>
</tr>
<tr>
<td>1= Total Asst.</td>
<td>0= Activity NA</td>
<td>Unknown</td>
<td>Task not attempted</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Task attempted/ not completed</td>
</tr>
</tbody>
</table>

### 6 Self-Care Items

<table>
<thead>
<tr>
<th>CORE PAC CARE TOOL ITEMS</th>
<th>LTCH</th>
<th>IRF</th>
<th>SNF-A</th>
<th>HH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Tube feeding</td>
<td>Included in &quot;Eating&quot;</td>
<td>Included in &quot;Eating&quot;</td>
<td>Included in &quot;Eating&quot;</td>
<td></td>
</tr>
<tr>
<td>Oral hygiene</td>
<td>Included in &quot;Grooming&quot;</td>
<td>Included in &quot;Grooming&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toileting hygiene</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Upper body dressing</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lower body dressing</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
### 5 Mobility Items

<table>
<thead>
<tr>
<th>CORE PAC CARE TOOL ITEMS</th>
<th>LTCH</th>
<th>IRF</th>
<th>SNF-A</th>
<th>HH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.</td>
<td>X</td>
<td></td>
<td></td>
<td>Included in &quot;Bed Mobility&quot;</td>
</tr>
<tr>
<td>Chair/bed-to-chair transfer: The ability to safely transfer to and from a chair (or wheelchair). The chairs are placed at right angles to each other.</td>
<td>X</td>
<td></td>
<td></td>
<td>Included in &quot;Transfer&quot;</td>
</tr>
<tr>
<td>Longest distance patient can walk: Once standing, can walk at least 150ft, walk at least 100ft, or walk at least 10 feet (3 meters) in corridor or similar space.</td>
<td></td>
<td></td>
<td></td>
<td>X X X X</td>
</tr>
<tr>
<td>Longest distance patient can wheel: Once seated, can wheel at least 150ft, wheel at least 100ft, wheel at least 50ft, or wheel at least 10 feet (3 meters) in corridor or similar space.</td>
<td></td>
<td></td>
<td></td>
<td>X X X X</td>
</tr>
</tbody>
</table>

### Changes Outlined by IMPACT

- **LTCH CARE**
- **IRF-PAI**
- **MDS**
- **OASIS**

**Post Acute Care**

**IMPACT**

**Standardized Patient Assessment Data**

(October 1, 2018, for SNF, IRF and LTCH and January 1, 2019 for HHA)
Additional Quality Measures in IMPACT

Table 1: Timeline for New Quality Domains

<table>
<thead>
<tr>
<th>Quality Domains</th>
<th>HHAs</th>
<th>SNFs</th>
<th>IRFs</th>
<th>LTCHs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Status</td>
<td>1/1/2019</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Skin Integrity</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>1/1/2017</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
</tr>
<tr>
<td>Major Falls</td>
<td>1/1/2019</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Patient Preference</td>
<td>1/1/2019</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
</tr>
</tbody>
</table>

*Displayed dates are deadlines for measure specification and data collection. Confidential feedback reporting and public reporting is required one and two years, respectively, after the dates displayed above.

Timeline for New Resource Use Measures

<table>
<thead>
<tr>
<th>Measures</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare spending per beneficiary</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Discharge to community</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Hospitalization rates of potentially preventable readmissions</td>
<td>10/1/2016</td>
</tr>
</tbody>
</table>

Acute and Post-Acute Care Measure Details

- Additional details available:  http://www.apta.org/Payment/Medicare/PayforPerformance/
- Publically reported Medicare data: http://www.medicare.gov/quality-care-finder/
  - Nursing home compare
  - Home health compare
OUTPATIENT- MEDICARE
PART B

Quality Reporting and PTs in 2014
SGR Reform and Quality Reporting

**PQRS**
- Quality reporting under Medicare Part B under several different programs including PQRS.
- Variable penalties tied to each program (2.0% +)

**POST SGR (proposed)**
- Current programs replaced by Merit-Based Incentive Payment System (MIPS) in 2018
- Performance based on: quality, resource use, meaningful use and clinical practice improvement activities

**FLR**
- FLR participation is required by all providers billing therapy services under Medicare part B
- Claims based data submission
- Condition of payment

**PRE SGR**
- FLR will be expanded to include additional variable as identified by the Secretary and stakeholders in 2017 (demographic info, diagnosis, severity, expanded ICF, etc)
- Data to be submitted via web-portal or other mechanism
- Data utilized to support new payment system (case mix adjustments, episodic payment)

Future of Medicare Part B Quality Reporting

- Future reporting systems
- Private Payers
- PQRS
- SGR
- PAC
- FLR

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FLR Claims Processing Issues 2014

- Claims splitting (1500)
- Delayed/ out of sequence processing
- Incorrect visit counts
- Required reporting at 10th/20th/etc despite early reporting
- Issues with 3Gcode submission with an active POC
- Problems with 60 day discharge

- Edits in CWF on May 6 fixed many of the issues
- Edits in CWF on September 15 fixed 60 day D/C issues
- No changes to FLR in 2015
Examples of FLR Errors

Simple or clerical errors

• Use of $0.00 instead of $0.01
• Leaving off the GP or severity modifiers
• Submitting the wrong Gcodes (discharge vs current)

Misunderstanding of FLR guidance

• Reporting a single FLR code instead of two codes
• Changing categories mid episode without ending reporting on original limitation
• Issues with tracking (beneficiary/ facility/ therapy service)

PQRS Eligible Providers

• In 2015, eligible providers who bill under the physician fee schedule must report successfully under PQRS to avoid a -2.0% reduction in their 2017 fee schedule.
  – Rehab agencies, outpatient hospitals, SNFs Part B unable to participate in PQRS; use UB-92 (UB-04) or 837I for billing to intermediary
  – No place on claim form for individual NPI
Medicare Quality Reporting and Payment

<table>
<thead>
<tr>
<th>Calendar/Current Year (Data Year)</th>
<th>Year Penalty/Payment Applied</th>
<th>PQRS Penalty* (calculated by NPI/TIN)</th>
<th>VM Incentive/Penalty** (calculated by TIN)</th>
<th>Cumulative PQRS &amp; VM Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 2015</td>
<td>-1.5%</td>
<td>N/A</td>
<td>-1.5%</td>
<td></td>
</tr>
<tr>
<td>2014 2016</td>
<td>-2.0%</td>
<td>N/A</td>
<td>-2.0%</td>
<td></td>
</tr>
<tr>
<td>2015 2017</td>
<td>-2.0%</td>
<td>N/A</td>
<td>-2.0%</td>
<td></td>
</tr>
<tr>
<td>2016 2018</td>
<td>-2.0%</td>
<td>Up to -4.0%</td>
<td>Up to -6.0%</td>
<td></td>
</tr>
</tbody>
</table>

*The PQRS penalty applies to eligible PTs who don’t participate in or who fail to successfully report for PQRS in the data year.

**The VM penalty will apply to PTs who don’t participate in or who fail to successfully report for PQRS in the data year.

2015 PQRS Payment Adjustment

- What if I did not participate in PQRS in 2013 or I failed to meet the reporting requirements for PQRS in 2013
  - Successfully reports 3 measures on 50% or more of eligible Medicare patients or
  - Reported at least one measure on one patient
- Providers will receive 98.5% of Medicare Part B PFS allowed charges amount (or 1.5% less reimbursement) for all charges with dates of service from January 1 – December 31, 2015
- If feedback report indicates that you were successful in reporting, you may request an informal review process through February 28, 2015
  - [www.qualitynet.org/portal/server.pt/community/informal_review_request/](http://www.qualitynet.org/portal/server.pt/community/informal_review_request/)
The Financial Impact of PQRS for PTs

<table>
<thead>
<tr>
<th>Calendar/Current Year (Data Year)</th>
<th>Year Penalty/Payment Applied</th>
<th>PQRS Penalty (calculated by NPI/TIN)</th>
<th>Estimated Loses per Therapist*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 2015</td>
<td>-1.5%</td>
<td>$485.10</td>
<td></td>
</tr>
<tr>
<td>2014 2016</td>
<td>-2.0%</td>
<td>$646.80</td>
<td></td>
</tr>
<tr>
<td>2015 2017</td>
<td>-2.0%</td>
<td>$646.80</td>
<td></td>
</tr>
</tbody>
</table>

*Penalty dollar amounts based on the median total Medicare payment amount for physical therapists in 2012 $32,340.10

Medicare quality reporting penalty expected to strike most physicians

Medicare’s top doctor, however, disputes the study commissioned by radiologists, saying additional new reporting options mean that most doctors will avoid reduced pay in 2015.

By CHARLES FIEGL — Posted Jan. 21, 2013

Washington Physicians could lose up to a total of $1.3 billion a year from their Medicare pay by not satisfactorily reporting quality measures to the program, researchers determined in an analysis of reporting trends.

The loss would be the result of hundreds of thousands of physicians and other health professionals not participating in, or not meeting criteria for, the Medicare physician quality reporting system. Medicare payments will be cut 1.5% in 2015 — and 2% in 2016 and beyond — for every eligible physician who fails to meet PQRS requirements by sending quality data to the Centers for Medicare & Medicaid Services. The 2015 penalty will be based on 2013 reporting activity.
Increasing PT/OT Participation in PQRS

PT/OT PQRS Data Submission Mechanism
Recent PPS Survey on PQRS

• Response: 540 members
• 85.0% participating in PQRS in 2014
  – The top reason sited for non-participation: practice does not have resources to manage the PQRS reporting burden; we are willing to take the 2.0% penalty to avoid the reporting burden (8.0%)
• 83.7% report via claims
• 76.5% have never accessed a feedback report
  – Only 31.0% have received a bonus in past years

Physician Fee Schedule:
PQRS Changes in 2015

<table>
<thead>
<tr>
<th>Program Detail</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful reporting requirements</td>
<td>• Reporting of 9 measures (or 1-8 as applicable) on 50% of eligible patients will be needed to avoid the -2.0% penalty</td>
</tr>
<tr>
<td></td>
<td>• Requires reporting of 1 cross cutting measure</td>
</tr>
<tr>
<td>Available measures</td>
<td>• Elimination of 245 Chronic Wound Care measure</td>
</tr>
<tr>
<td></td>
<td>• Elimination of 148-151 Back Pain Measures Group</td>
</tr>
<tr>
<td></td>
<td>• New category of measure – cross cutting</td>
</tr>
<tr>
<td>Specific measure changes</td>
<td>• Removal of 97110 and 97140 as eligible CPT codes for reporting of measure #130 Medication documentation</td>
</tr>
<tr>
<td>Future changes</td>
<td>• Strongly encouraging providers to move away from claims-based reporting</td>
</tr>
<tr>
<td>New Programs</td>
<td>• Value-Based Modifier in CY2016 (penalty year 2018)</td>
</tr>
</tbody>
</table>
Should I participate in PQRS in 2015?

I want to avoid the -2.0% penalty in 2017

Report via claims

Report all available individual measures
(128, 130, 131, 154, 155, 182)

Report via registry

Select 9 individual measures (or if less available 1-8)

2015 Individual Measures for PTs

<table>
<thead>
<tr>
<th>#</th>
<th>Measure Description</th>
<th>Claims</th>
<th>Registry</th>
</tr>
</thead>
<tbody>
<tr>
<td>126</td>
<td>Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>127</td>
<td>Diabetic Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention Evaluation of Footwear</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>128</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>130</td>
<td>Documentation and Verification of Current Medications in the Medical Record</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>131</td>
<td>Pain Assessment Prior to Initiation of Patient Treatment</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>154</td>
<td>Falls: Risk Assessment</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>155</td>
<td>Falls: Plan of Care</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>182</td>
<td>Functional Outcome Assessment</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
### 2015 Individual Measures for PT’s

<table>
<thead>
<tr>
<th>#</th>
<th>FOTO Measure Description</th>
<th>Claims</th>
<th>Registry</th>
</tr>
</thead>
<tbody>
<tr>
<td>217</td>
<td>Change in Risk-Adjusted Functional Status for Patients with Knee Impairments</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>218</td>
<td>Change in Risk-Adjusted Functional Status for Patients with Hip Impairments</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>219</td>
<td>Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot or Ankle Impairments</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>220</td>
<td>Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>221</td>
<td>Change in Risk-Adjusted Functional Status for Patients with Shoulder Impairments</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>222</td>
<td>Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist, or Hand Impairments</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>223</td>
<td>Change in Risk-Adjusted Functional Status for Patients with a Functional Deficit of the Neck, Cranium, Mandible, Thoracic Spine, Ribs, or other General Orthopedic Impairment</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

### 2015 PQRS Measures

<table>
<thead>
<tr>
<th></th>
<th>National Quality Strategy Domains</th>
<th>Cross Cutting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Care Coordination</td>
<td>Population Health</td>
</tr>
<tr>
<td>#126-127</td>
<td>Diabetes Foot Care</td>
<td></td>
</tr>
<tr>
<td>#128</td>
<td>BMI Screening</td>
<td></td>
</tr>
<tr>
<td>#130</td>
<td>Medication Documentation</td>
<td></td>
</tr>
<tr>
<td>#131</td>
<td>Pain Assessment</td>
<td></td>
</tr>
<tr>
<td>#154</td>
<td>Falls Screening</td>
<td></td>
</tr>
<tr>
<td>#155</td>
<td>Falls Plan of Care</td>
<td></td>
</tr>
<tr>
<td>#182</td>
<td>Functional Assessment</td>
<td></td>
</tr>
<tr>
<td>#217-223</td>
<td>FOTO Measures</td>
<td></td>
</tr>
</tbody>
</table>

**Successful reporting requirements**: 9 measures in 3+ domains (if less 1-8 then 1-3 domains)*

1 required

* For an eligible professional who reports fewer than 9 measures covering 3 NQS domains via the claims-based reporting mechanism, the eligible professional will be subject to the Measure Applicability Validation (MAV) process, which would allow us to determine whether an eligible professional should have reported quality data codes for additional measures and/or covering additional NQS domains.
### How Do I Choose a Reporting Method?

<table>
<thead>
<tr>
<th>Claims</th>
<th>Registry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>Variable</td>
</tr>
<tr>
<td>QDC Selection</td>
<td>Each practitioner is responsible for entering data into the registry</td>
</tr>
<tr>
<td>Updating</td>
<td>Annual measure updates must be monitored by the facility</td>
</tr>
<tr>
<td>Reporting Requirements</td>
<td>Data must be submitted on +50% of all eligible Medicare patients</td>
</tr>
<tr>
<td>Timing of Data Submission</td>
<td>Done throughout the year; ability to retrospectively submit data</td>
</tr>
<tr>
<td>Auditing</td>
<td>Registry provides participants with feedback reports throughout the year</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Reporting Question</th>
<th>Clinical Importance</th>
<th>Information Needed form Measure Specification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who</td>
<td>“Who counts?”</td>
<td>18 years and older CPT codes: 97001, 97002, or 97532 ICD9: N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This measure is intended to determine whether or not documentation of a current medication list occurred for all patients aged 18 years and older. See Numerator for details.</td>
</tr>
<tr>
<td>When</td>
<td>“When do I report?”</td>
<td>“Each visit” where any of the CPT codes are billed (97001, 97002, 97110, 97140 OR 97532)</td>
</tr>
<tr>
<td>What</td>
<td>“What do I need to include in my documentation?”</td>
<td>G8427- complete information G8430- not documented/incomplete info G8428- not eligible</td>
</tr>
<tr>
<td>How</td>
<td>“Which code do I report?”</td>
<td>19 years and older CPT codes: 97001, 97002, or 97532 ICD9: N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This measure is intended to determine whether or not documentation of a current medication list occurred for all patients aged 18 years and older. See Numerator for details.</td>
</tr>
</tbody>
</table>

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Claims-based PQRS: Example 1500 Claim Form

Functional limitation data with therapy modifier and severity modifier (GP & CK/CI)

PQRS Quality Data Codes (QDCs)

Functional limitation G-codes are submitted with a $0.01 charge; CMS recommends that PQRS G-codes are submitted with a $0.01 charge. Both functional limitation and PQRS G-codes are submitted with “1” unit attached.

Claims-based PQRS: Explanation of Benefits RARC & CARC

Remittance Advice Remark Code (RARC) for QDCs with $0.00

- The new RARC code N620 is your indication that the PQRS codes were received into the CMS National Claims History (NCH) database.
  - EPs who bill with $0.00 charge on a QDC line item will see N620 instead of N365.
  - N620 reads: This procedure code is for quality reporting/informational purposes only.
  - EPs who bill with a $0.00 charge on a QDC line item will receive an N620 code on the EOB and may or may not receive any Group Code or CARC.

Claim Adjustment Reason Code (CARC) for QDCs with $0.01

- The new CARC 246 with Group Code CO or PR and with RARC N572 indicates that this procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted.
  - In addition to N572, the remittance advice will show Claim Adjustment Reason Code (CARC) CO or PR 246 (This non-payable code is for required reporting only).
  - CARC 246 reads: This non-payable code is for required reporting only. EPs who bill with a charge of $0.01 on a QDC item will receive CO 246 N572 on the EOB.

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CMS Remarks on the Future of PQRS Claims-based Reporting

“We understand that the claims-based reporting mechanism remains the most popular reporting mechanism. However, to streamline the PQRS reporting options, as well as to encourage reporting options where eligible professionals are found to be more successful in reporting, it is our intention to eliminate the claims-based reporting mechanism in future rulemaking. During this time, we encourage eligible professionals to use alternative reporting methods to become familiar with reporting mechanisms other than the claims-based reporting mechanism.”

Annual Feedback Report Timeline for 2015 Reporting Year

- **February 28, 2015**: Close of 2014 reporting period, last day to submit claims
- **Summer 2015**: Q1 2015 interim dashboard released
- **September/October 2015**: Release of 2014 annual feedback reports and bonuses
- **Fall 2015**: Q2 2015 interim dashboard released
- **Winter 2015**: Q3 2015 interim dashboard released

---

**First Quality and Resource Use Report (QRUR) for VM Program**

**Spring/Summer 2014 data analysis of**
Quality Net Online Report Access

https://www.qualitynet.org/portal/server.pt/community/pqri_home/212

PQRS Feedback Reports

Interim Dashboard

- Raw data only
- Roll up of the facilities performance (TIN level)
- Individual reports for each eligible provider in the practice (NPI level)

Annual

- Roll up of the facilities performance (TIN level)
- Individual reports for each eligible provider in the practice (NPI level)
  - Summary of reporting by measure
  - Detailed report of measure errors
  - Reporting and performance rates
The Value-Based Modifier (VM) and PTs

- CMS has finalized the inclusion of PTs in the VM program in CY2018, however this would be based on the PTs performance in CY2016.
- The VM program has a quality tiering methodology that takes into account both quality and cost.
  - The quality portion of the methodology is based largely on PQRS performance.
  - The cost portion of the methodology would not typically apply to PTs and PTs would be given an average rating on this section based on CMS guidelines.

VM Program Expansion

<table>
<thead>
<tr>
<th>Participants</th>
<th>Data Year</th>
<th>VM Year</th>
<th>Payment Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician groups over 100 providers*</td>
<td>2013</td>
<td>2015</td>
<td>-1.0% to +2.0x</td>
</tr>
<tr>
<td>Physician groups over 10-99 providers</td>
<td>2014</td>
<td>2016</td>
<td>-2.0% to +2.0x</td>
</tr>
<tr>
<td>Physicians in groups 2-9 AND solo providers</td>
<td>2015</td>
<td>2017</td>
<td>-4.0% to +4.0x (MD groups 10+)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-2% to +2x (MD groups up to 9 and solo providers)</td>
</tr>
<tr>
<td>Non-physician Eligible Professionals (EPs) in groups 2-9 AND solo providers</td>
<td>2016</td>
<td>2018</td>
<td>TBD: up to -4.0%</td>
</tr>
</tbody>
</table>

*Group size determined by number of total eligible professionals who have reassigned payment to the practice in the calendar (reporting) year.
Estimated Impact of PQRS & VM for PTs in 2018 Based on 2016 Data

<table>
<thead>
<tr>
<th>Reporting Scenario</th>
<th>PQRS Penalty</th>
<th>VM Incentive/Penalty*</th>
<th>Total Impact in 2018*</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT practice successfully reports in PQRS</td>
<td>0%</td>
<td>0% to +2.0x to 4.0x based on group size (high quality performers may earn incentives)</td>
<td>0% to +2.0x to 4.0x based on group size</td>
</tr>
<tr>
<td>PT practice does not report successfully</td>
<td>-2%</td>
<td>Additional penalty (-2% to -4%)</td>
<td>Combined penalty up to -6%</td>
</tr>
<tr>
<td>PT practice chooses not to participate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Penalty estimates based on 2017 VM penalties. CMS will set 2018 VM penalties in the CY2016 rulemaking.

Estimated Financial Impact of PQRS & VM for PTs in 2018

<table>
<thead>
<tr>
<th>CY2016 Reporting Year Penalties</th>
<th>PQRS (2%)</th>
<th>VM (up to -4%)</th>
<th>Total (up to -6%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Losses per Therapist in CY2018*</td>
<td>$646.80</td>
<td>$1293.60</td>
<td>$1940.40</td>
</tr>
</tbody>
</table>

* Penalty dollar amounts based on the median total Medicare payment amount for physical therapists in 2012 $32,340.10.
Keys to PQRS Success and Preparing for VM Program

Access and review your feedback reports

- Review your PQRS feedback throughout the year
- Make practice changes as needed to improve your reporting performance
- Review your QRUR reports in the fall in preparation for VM program.

PQRS/ VM Resources

- APTA: PQRS page
  [http://www.apta.org/PQRS](http://www.apta.org/PQRS)
- CMS- PQRS page
  [https://www.cms.gov/PQRS/](https://www.cms.gov/PQRS/)
- Quality Net (general questions or feedback reports)
  [https://www.qualitynet.org/](https://www.qualitynet.org/)
  866 288 8912 (option #1, then #7)
- APTA: Quality Resources
- CMS- VM Program page
  [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html)
THE FUTURE OF QUALITY MEASUREMENT AND THE PHYSICAL THERAPY OUTCOMES REGISTRY

Quintiles and the American Physical Therapy Association (APTA) today announced a new strategic collaboration to develop and implement the Physical Therapy Outcomes Registry—which will be the largest and most comprehensive physical therapy electronic repository to date.

“Patient registries are an increasingly vital component of real-world, comprehensive evidence development for identifying the causes of disease and, in this case, injuries, and designing effective treatments,” said Cynthia Verst, president of Real-World & Late Phase Research at Quintiles. “Working together with APTA and leveraging our expertise in designing and implementing registries, our goal is to build a new registry that will provide clinicians and practices with benchmark data to improve healthcare delivery and achieve better patient outcomes.”

APTA selected Quintiles for this initiative based on Quintiles’ extensive experience in post-marketing research, multi-stakeholder strategy, and systems-oriented registry design and development. Recruitment of users for a pilot version of the registry will begin in the third quarter of 2016, with a full launch envisioned for early 2017.

“APTA is in a unique position to help physical therapists comply with requirements by payers, employers, certification boards, healthcare facilities, and other entities to ensure participation, accreditation, and allowance,” said APTA President Paul A. Rocker Jr., PT, DPT, MS. “We are committed to providing data to advance physical therapist practice, education, and research, and look forward to working with Quintiles in this endeavor.”
THE POWER TO CHANGE LIVES

The Physical Therapy Outcomes Registry is an organized system for collecting data to evaluate patient function and other clinically relevant measures for the population of patients receiving physical therapist services. The registry will serve to inform reimbursement, improve practice, fulfill quality reporting requirements, and promote research.

Data contributed to the registry will show how physical therapy can change lives. This knowledge will help physical therapists deliver even better care and outcomes for their patients.

- Improve patient outcomes
- Increase patient satisfaction
- Improve physical therapist decision making
- Further develop best practices
- Support quality improvement initiatives

Improve your Practice
- Benchmark performance of PTs and facilities
- Improve efficiency
- Maximize performance
- Justify services to payers
- Identify training/educational opportunities

Grow your Business
- Market your practice to payers and consumers
- Demonstrate value of your practice to stakeholders
- Differentiate your practice in the PT market
- Increase referrals
- Compare performance year-by-year

Meet Regulatory Requirements
- Fulfill PQRS requirements
- Easily access PQRS feedback reports
PTs and the Future of Quality Measurement

<table>
<thead>
<tr>
<th>Today</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Separate and distinct reporting programs</td>
<td>• One quality program under Medicare Part B</td>
</tr>
<tr>
<td>• Varied methods of data reporting</td>
<td>• One measure of global patient function that crosses the PAC setting; Entire continuum of care?</td>
</tr>
<tr>
<td>• High percentage of process measures</td>
<td>• Electronic reporting</td>
</tr>
<tr>
<td>• Multiple measures of patient function</td>
<td>• Focus on outcome measures and patient/family centered measures</td>
</tr>
<tr>
<td>• Identification of measure gaps by</td>
<td>• Increasing role of associations in the creation of meaningful quality measures for professionals</td>
</tr>
<tr>
<td>government/ national measurement groups</td>
<td></td>
</tr>
</tbody>
</table>
Three Categories of ACO Patients

Number of patients cared for by an entity participating in a government or commercial accountable care organization is now between 25 million and 31 million

- 2.4 million Medicare patients are cared for by an ACO
- 15 million non-Medicare patients are receiving care within a medical practice that is part of a Medicare ACO
- 8 million to 14 million commercially insured patients are in non-Medicare ACOs

Medicare ACO Programs

- 19 Pioneers
- MSSP includes more than 330 ACOs in 47 states, providing care to more than 4.9 million beneficiaries in Medicare fee for service.
- Recent results:
  - 58 SSP ACOs held spending below their benchmarks by a total of $705 million and earned shared savings payments of more than $315 million.
  - Another 60 ACOs had expenditures below their benchmark, but not by a sufficient amount to earn shared savings.
Next Steps for ACOs

- Proposed rule released on December 1, 2014
- Proposed changes to:
  - beneficiary assignment
  - data sharing
  - available risk models
  - eligibility requirements
  - participation agreement renewals
  - compliance and monitoring
- Changes to the quality reporting requirements were finalized in the CY2015 Fee Schedule (October 31, 2014)

Bundled Payments for Care Improvement (BPCI) Initiative

- Launched by the Innovation Center designed to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients both when they are in the hospital and after they are discharged.

Objectives:
- Support and encourage providers through three part aim (better health, better care, and lower costs through continuous improvement)
- Decrease the cost of an acute episode of care and the associated post-acute care while improving quality
- Develop and test new payment models for three-part aim outcomes for acute and post-acute medical care
- Shorten the cycle time for adoption of evidence-based care
Bundling Initiative: Four Models

- Model 1: Inpatient Stay Only (Physician services paid separately)
- Model 2: Inpatient and PAC Stay (30 or 90 days)
- Model 3: Discharge from Inpatient stay and PAC 30 days after
- Model 4: Inpatient Stay (all services including physician)

BPCI Structure

- Defined patient populations with chronic and other conditions
- Target price set for entity to meet
- If target price is met and there is savings derived from bundled payment – bonus payments will be distributed to providers
- Current payment – still under fee for service (bill directly to Medicare)
ICD-10
• Transition from ICD-9 to ICD-10 diagnosis coding on October 1, 2014
  – No earlier than October 1, 2015
  – Congress delayed implementation date with the Protecting Access to Medicare Act of 2014 (passed on March 31, 2014)
• Will be used in all settings – hospital inpatient, hospital outpatient, PTPP, etc.
• Allows for greater detail for laterality, primary encounters, external causes of injury, etc.

How Different Is It?
GEM Example of ICD-9 to ICD-10

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM/PCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses: 14,025</td>
<td>Diagnoses: 68,069</td>
</tr>
<tr>
<td>Procedures: 3,824</td>
<td>Procedures: 72,589</td>
</tr>
<tr>
<td>820.02: Fracture of midcervical section of femur, closed</td>
<td>S72031A, Displaced midcervical fracture of right femur, initial encounter for closed fracture</td>
</tr>
<tr>
<td></td>
<td>S72031G, Displaced midcervical fracture of right femur, subsequent encounter for closed fracture with delayed healing</td>
</tr>
<tr>
<td></td>
<td>S72032A, Displaced midcervical fracture of left femur, initial encounter for closed fracture</td>
</tr>
<tr>
<td></td>
<td>S72032G: Displaced midcervical fracture of left femur; subsequent encounter for closed fracture with delayed healing</td>
</tr>
</tbody>
</table>
ICD-10: Key Practice Impacts

• **Identification of where diagnosis codes are used today:** Paperwork, electronic systems, and other processes, such as submitting reimbursement claims, identifying patient eligibility, getting prior authorization from a payer, reporting quality data, and more, will need to be updated to reflect new ICD-10 diagnosis codes.

• **Documentation:** The ICD-10 code set provides greater specificity for patient diagnosis, so it will be critical to assess current documentation and how it will support coding for ICD-10.

• **Vendor Updates:** If practices are using electronic systems for billing, they will need to have their systems updated by vendors.

• **Staff Training:** All staff that work with the current ICD-9 system must be trained on the ICD-10, such as clinicians, front desk staff, and coding/billing staff.

ICD-10: Tips to Prepare

• Evaluate readiness of vendors and payers
• Develop a communication plan for providers, patients, and support staff
• Determine financial impact including cost of training, software upgrades, potential denials during transition
• Develop training plan for coding staff, clinicians
  – Identify specific documentation gaps to focus educational needs
• Test systems both internally and externally
  – CMS End-to-End testing this summer cancelled; future testing will be announced through MACs
• [http://www.apta.org/Payment/Coding/ICD10/](http://www.apta.org/Payment/Coding/ICD10/)
Medicaid Expansion: Impact on States

- States can choose to expand Medicaid to non-elderly adults up to 133% (138%) of FPL

- Specifically, the federal government will assume 100 percent of the Medicaid costs of covering newly eligible individuals for the first three years that the expansion is in effect (2014-2016).

- Federal support will then phase down slightly over the following several years, and by 2020 (and for all subsequent years), the federal government will pay 90 percent of the costs of covering these individuals.

Medicaid Expansion: Impact on States

- States decide when to expand; and may later drop the coverage without any federal penalty

- No deadline for state decision

- The EHBs must be offered to the Medicaid expansion population

- The EHBS may be offered to other Medicaid beneficiaries choosing Alternative Benefit Plans (ABPs)
Exchanges

• Provides Qualified Health Plans (QHPs) for purchase through a one-stop shop Web portal

• QHPs:
  – Cover the essential health benefits
  – Are modeled after the state’s benchmark plan
  – Are subject to federal regulations and state insurance laws

• Tax credits and subsidies facilitate coverage
  – Premium tax credits (100%-400% FPL): Help people pay the monthly cost to have a plan through the Marketplace
  – Cost sharing subsidies (Up to 250% FPL): Decrease the charges enrollees must pay when receiving health care services covered by the plan
    • Federal government pays the health insurer upfront

Exchanges: Provider Networks

• Network Adequacy Standards for Marketplace Plans: network of providers sufficient in number and type to assure that all services will be accessible without unreasonable delay
  – Narrow networks across the country
  – Concerns expressed from many provider/patient advocacy groups

• New regulations and guidance
  • Plans will have to submit list of certain providers in-network: Hospitals, Primary Care, Mental Health, and Oncology
  • Future rulemaking re: time/distance standards
### Health Care Reform in 2015: Exchanges Tips

**Grace Period**
- Verify patient insurance benefits upfront and check subsidy status
- Maintain and consistently follow facility’s indigent policy
- Be aware of state laws regarding patient abandonment and anti-kickback issues
- Ethical considerations
- Establish and adhere to written Grace Period policy
- Add clause regarding nonpayment of health insurance premium to patient financial agreement

**Networks**
- Check to see if more stringent network adequacy standards apply in the state
- If facility is seeing narrow networks, collect anecdotal evidence of patient access issues
- Use outcome data, cost data, and niche services to leverage in-network contracts

http://www.apta.org/HealthCareReform/

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**QUESTIONS**