Emerging Issues in Medicare and Health Care Reform, Part 1

2016 Combined Sections Meeting

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Emerging Issues in Medicare
Part 1
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CURRENT HEALTH CARE ENVIRONMENT

2016 Health Care Trends

Technology
Value-based Payment
Population Health
Alternative Payment Models
MACRA & IMPACT
President’s FY 2017 Budget

- Series of spending and revenue changes that OMB estimates would have the net effect of reducing the federal deficit by $2.9 trillion over the next ten years
- Medicare spending would be reduced by a net $419 billion
  - Opioid abuse
  - Medicaid Expansion
  - Cancer Research
- Recommendation to remove PT for IOASE of Stark law

Technology

- Interoperability
- Data sharing/ security
- Virtual health care (telehealth)
- Patient engagement
  - Wearable devices
  - Patient reported outcomes
  - Desire for more information
Value-based Payment

HHS Transition Timelines

- Alternative Payment Models
  - 30% of payments tied to alternative payment models by 2016; 50% by the end of 2018
- Linking Payment to Outcomes
  - 85% of fee for service payments tied to outcome measures by end of 2016; 90% by end of 2018

The Health Care Transformation Task Force

- 75% of payments into value-based models by January 2020

Changing Face of Payment

- Volume of services
- No tie to outcomes

Fee for Service

- Requires data submission to avoid penalty
- No benchmarking

Pay for Reporting

- Benchmarking outcomes, quality measures
- +/- neutral/- payment adjustment

Value-based Payment
P4R Versus P4P

Pay for Reporting
- Acute care, post acute care settings
- Physician Quality Reporting System (PQRS)
- Functional Limitation Reporting (FLR)

Value-based Payment/Pay for Performance
- Innovative models (ACOs, CCJR)
- Value-based Purchasing programs (Acute care, SNF, HH)
- Merit-based Incentive Payment System (MIPS) to replace PQRS in 2017

Alternative Payment Models
- Not fee-for-service
- Accountable care organizations
- Bundling of services
- Comprehensive Care Joint Replacement Model
Population Health

**Population at Large**
- Institute of Medicine Vital Signs, Core Metrics for Health and Health Care Progress
  - Includes measures for well being, obesity, preventative services, access, patient safety, evidence-based care, care match with patient goals, etc
  

**Disease/ Condition Specific**
- Increasing use of patient registries that allow for the management of patient populations
- Bundling of services for patient populations

PAYMENT UPDATES
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- H.R. 2 signed into law April 16, 2015
- Permanent repeal of Sustainable Growth Rate (SGR)
- Annual payment updates:
  - 0.5% 2016-2019
  - 0.0% 2020-2025
  - 2026 and beyond 0.75% for eligible Alternative Payment Model (APM) participants, 0.25% for all others

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Creation of Merit-based Incentive Payment System (MIPS)
  - Current penalties under the Physician Quality Reporting System (PQRS), Electronic Health Records/ Meaningful Use (MU), and the value-based payment modifier (VBM) will end at the close of 2018.
  - MIPS begins in 2019. Bonuses are on a sliding scale penalties begin at up to 4 percent in 2019
    - Up to 5 percent in 2020;
    - Up to 7 percent in 2021; and
    - Up to 9 percent in 2022 and beyond.
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Alternative Payment Models (APM)
  - Will receive 5% bonus payments if participating in an approved APM from 2019 to 2024
  - Requires an increasing percentage of patients in APMs each year

Medicare Physician Fee Schedule Payment Update

- Conversion factor of $35.8043 (a reduction of .1 percent from 2015)
- Accounts for SGR permanent solution and statutory adjustments for misvalued codes
- Overall PT services impact is 0%
- Individual impact will depend upon the mix of services being billed
MPPR/Fee Schedule Resources

• APTA website
  – www.apta.org/medicare (Medicare fee schedule)
  – MPPR calculator
  – MPPR scenarios
  – Fee schedule calculator
  – Summary of Physician Fee Schedule Rule

Therapy Cap

• 2016 cap is $1960
• Exceptions process is extended until December 31, 2017
• Specifics for 2015 manual medical review have been released
Potentially Misvalued Codes Initiative

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
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<tbody>
<tr>
<td>97032</td>
<td>Electrical stimulation</td>
</tr>
<tr>
<td>97035</td>
<td>Ultrasound therapy</td>
</tr>
<tr>
<td>97110</td>
<td>Therapeutic exercises</td>
</tr>
<tr>
<td>97112</td>
<td>Neuromuscular reeducation</td>
</tr>
<tr>
<td>97113</td>
<td>Aquatic therapy/exercises</td>
</tr>
<tr>
<td>97116</td>
<td>Gait training therapy</td>
</tr>
<tr>
<td>97140</td>
<td>Manual therapy/regions</td>
</tr>
<tr>
<td>97530</td>
<td>Therapeutic activities</td>
</tr>
<tr>
<td>97535</td>
<td>Self-care management training</td>
</tr>
<tr>
<td>60283</td>
<td>Electric stimulation other than wound</td>
</tr>
</tbody>
</table>

New Payment System for PT Services

- APTA has been actively pursuing a new payment system since 2010
- CSM session dedicated to payment reform: A New Payment System for Therapy Services and Beyond, Saturday 11am-1pm, Hilton, Pacific Ballroom B
- Detailed information can be found on the APTA website: [http://www.apta.org/PTCPS/](http://www.apta.org/PTCPS/)
Overview of Evaluation Coding Structure

• 3 levels of complexity
  – Low complexity
  – Moderate complexity
  – High complexity

• The level of the PT evaluation dependent on clinical decision making and the nature of the condition (severity).

CPT Code Revisions
PT Re-evaluation

• Single level
• Re-valuation of established Plan of Care
• Examination including review of history, use of standardized tests and measures and revised POC based on standardized patient assessment instruments and/or measurable assessment of functional outcome
ICD-10 Transition

• October 1, 2015
• Please let us know about any ICD-10 issues
• Palmetto LCD revised 02/04/2016 – added 7th character to numerous ICD-10 codes found in the S00-T88 family of codes

ICD-10 First Listed Condition

• The guidelines state "...when a definitive diagnosis has been established for that encounter, the established diagnosis should be coded. In this case, those signs or symptoms that are integral to the established diagnosis should not be coded. Any conditions, including signs and symptoms, that are not routinely associated with the definitive diagnosis should be assigned as additional codes." You should use your clinical judgment to determine if a sign and symptom integral to the diagnosis.
  – In addition, the guidelines state “Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider.”
ICD-10 Resources

APTA’s Website
- FAQ
- Common Codes
- Case Studies
- Discussion Forum on HUB
- Online Complaint Form
- CMS Guidance

SNF Payment Update
- 2016 Market Basket 1.2 percent (reduced by multi-factor productivity and error forecast adjustment)
- All noncritical access hospital swing beds are subject to SNF PPS rates and wage index
SNF Staff Data Collection
• Requires facilities electronically submit staffing data by July 1, 2016
• Required Information:
  – resident case-mix and census data,
  – employee turnover and tenure
  – hours of care provided by certified employees, per resident, per day

Standalone IRF Market Basket
• Replaces the previously adopted rehabilitation, psychiatric, and long-term care (RPL) market basket
• Market basket increase of 1.7% in 2016
• Reflects a new IRF-specific market basket update of 2.4 (reduced for statutory adjustments)
• Overall update of 1.8% from payments in 2015
HH: Affordable Care Act Rebasing Adjustments (2014-17)

- **Fixed dollar reduction per year to 60 day episode**: $80.95
- **Annual fixed dollar increase to per visit rates**: Skilled Nursing +$3.96, Home health aide +$1.79, PT +$4.32, SLP +$4.70, OT +$4.35, and Medical social services +$6.34
- **Annual decrease to NRS conversion**: 2.82%

Home Health Additional Payments Adjustments

- **Nominal Case Mix Growth**: 3.41% (2016-17)
- **Market Basket Update**: 2.3%
**Post-Acute Care Reform Plan**

**Federal Measures (Legislative and Regulatory)**

- Passage of IMPACT legislation

**POST-ACUTE CARE REFORM**

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<tr>
<td>Demonstration under Section 5008 of the Deficit Reduction Act (creation of the CARE tool)</td>
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<td>President’s Budget FY 2007 – 2015 (site neutral payment, bundled care models and readmissions penalizations)</td>
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<td>Prospective Payment System rulemaking (rebasing, value-based purchasing, quality reporting, alternative payment studies and payment cuts)</td>
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<td>Patient Protection Affordable Care Act of 2010 (innovative models, productivity adjustments and pay-for performance measures)</td>
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<tr>
<td>Improving Medicare Post-Acute Care Reform Act of 2014 (cross-cutting quality measures, standardized assessment and uniform PAC PPS)</td>
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IMPACT Act

- Signed into law October 6, 2014
- The Act requires the submission of standardized assessment data by:
  - Long-Term Care Hospitals (LTCHs): LCDS
  - Skilled Nursing Facilities (SNFs): MDS
  - Home Health Agencies (HHAs): OASIS
  - Inpatient Rehabilitation Facilities (IRFs): IRF-PAI
- The Act requires that CMS make interoperable standardized patient assessment and quality measures data, and data on resource use and other measures to allow for the exchange of data among PAC and other providers to facilitate coordinated care and improved outcomes
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

SNF Part A providers who fail to report quality and resource use measures subject to a two percentage point reduction under respective market basket
MedPAC Work on Unified Payment System

- Must evaluate and recommend design of one PAC-PPS based on patient characteristics
- Address considerations of replacement of existing PAC payment systems
- Current plan is to build a bigger beta test off of PAC demo that included the CARE tool
- Report due to Congress by June 30, 2016

Past MedPAC Recommendations

- Use of a common patient assessment instruments for HH, IRF, SNF and LTCH (1999 and 2014)
- Development of a unified PAC classification system (2001)
- Site-neutral payments for IRFs and SNFs for selected conditions (2015)
Jimmo Update (Skilled Maintenance)

- Center for Medicare Advocacy’s Jimmo Council
- Lawsuit to direct CMS to expand education campaign
- Declarations of support
- Conduit to report unfair denials

PROGRAM INTEGRITY
Targeted Manual Medical Review

• MACRA replaced the manual medical review process for Medicare Part B therapy services that exceed a $3,700 threshold with new medical review process that became effective in July 2015
• CMS will determine which therapy services to review by considering:
  – aberrant billing practices
  – high claims-denial percentages or issues with compliance
  – newly enrolled providers
  – Treatment of specific medical conditions that warrant increased scrutiny
  – groups that includes another therapy provider identified for medical review.

Targeted MMR Implementation

• Strategic Health Solutions (Supplemental Medical Review Contractor) will perform targeted MMR on a post-payment basis.
• Claims for review based on:
  – Providers with high percentage of patients receiving therapy beyond $3700 as compared to peers during the first year of MACRA.
  – Therapy provided in SNFs, private practice, and outpatient physical therapy (OPTs) or other rehabilitation providers
• Emphasis on evaluation of the number of units/hours of therapy provided in a day.
  • APTA is working with CMS to find out more information
Provider Enrollment

- Revalidation every 5 years (resubmission, recertification and reverification of enrollment)
- Off-cycle revalidations (triggered as a result of random checks, information indicating local health care fraud problems, national initiatives, complaints, or other reasons that cause to question the compliance)
- Site visits and enrollment of new PTs in an existing practice

How to Return Overpayments

Identification
- 60-day return period
- Burden on provider “reasonable diligence”

Look-Back Period
- 6-years
- From date received

Guidance
- Self-reported refund
- Self-referral Disclosure Protocol
Returning Overpayments

- An overpayment must be reported and returned by 60 days after the date on which the overpayment was identified or the date any corresponding cost report is due.
- An overpayment is identified when the person exercises reasonable diligence and determines an overpayment and quantifies the amount.
- Overpayments must be reported and returned only if a person identifies the overpayment within six years of the date the overpayment was received.
- Must use an applicable claims adjustment, credit balance, self reported refund, or another appropriate process to satisfy the obligation to report and return overpayments.
- In compliance if reported through either the CMS Self-Referral Disclosure Protocol or OIG the Self-Disclosure Protocol.

OIG 2016 Work Plan

- Focus on outpatient physical therapy services provided by independent therapists who have a high utilization rate.
- Determination of compliance with Medicare.
- States that prior findings are that claims were not reasonable or were not properly documented or that the therapy services were not medically for outpatient physical therapy services.
Comparative Billing Reports

- CMS Educational tools and not punitive carried out by eGlobal Tech
- Comparison to peers across the country
- Information is shared with MACs
- CBR201511: analysis for PT included the CPT codes 97001, 97035, 97110, 97112, 97140, 97530, G0283
- CBR201602: Electrodiagnostic Testing (EDX) CPT codes 95905, 95907 - 95913, 95860, 95861, 95863 - 95870, 95885 - 95887

Resources

- Fee Schedule:
  http://www.apta.org/Payment/Medicare/CodingBilling/FeeSchedule/
  http://www.apta.org/Payment/Medicare/2015/Changes/
- CJR:
  http://www.apta.org/BundledModels/CCJR/
- PQRS:
  http://www.apta.org/PQRS
  https://www.cms.gov/PQRS/
  https://www.qualitynet.org/
- Comparative Billing Reports
  http://www.cbrinfo.net/index.html