Emerging Issues in Medicare and Health Care Reform, Part 2

2016 Combined Sections Meeting

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Heather Smith, PT, MPH

Session Type: Educational Sessions
Session Level: Intermediate

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is the Section on Health Policy & Administration
of the American Physical Therapy Association

www.apthap.org
Emerging Issues in Medicare
Part 2
Roshunda Drummond-Dye, JD
Heather Smith, PT, MPH
QUALITY PROGRAMS

2016 Health Care Trends

- Technology
- Alternative Payment Models
- Population Health
- MACRA & IMPACT
- Value-based Payment
### 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; value-based payment</td>
</tr>
<tr>
<td>Long Term Care Hospitals (LTCH)</td>
<td>Facility</td>
<td>LTCH-CARE, claims, NHSN</td>
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<td>Skilled Nursing Facilities (SNF)</td>
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<tr>
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<td>Facility</td>
<td>OASIS, HH CAHPS, claims, VBP</td>
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</tr>
<tr>
<td>Hospice</td>
<td>Individual or Group (TIN/NPI)</td>
<td>Hospice item set (HIS)</td>
<td>P4R Penalty -2%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Individual or Group (TIN/NPI)</td>
<td>PQRS</td>
<td>P4R Penalty -2%</td>
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<tr>
<td>Innovative Models (ACOs, BPCI, CJR)</td>
<td>Organization, Facility</td>
<td>Quality reporting requirements for each model</td>
<td>Value-based payment (ACO), P4R (BPCI), value-based payment must achieve quality threshold (CJR)</td>
</tr>
</tbody>
</table>

ACO= Accountable Care organization; BPCI= Bundled Payments for Care Improvement; CJR= Comprehensive Care for Joint Replacement
NHSN= National Healthcare Safety Network
P4R= Pay for Reporting

### Future Quality Reporting Requirements that will Impact PTs

**Major Changes to Quality Reporting Programs Under Medicare Impacting PTs**

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<td></td>
<td>Patient</td>
<td>Functional Limitation Reporting (FLR)</td>
<td>Condition of payment</td>
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Functional Data by Setting

No standardized tool | LTCH CARE | IRF-PAI | MDS | OASIS | FLR (No standardized tool)

Acute Care? Post Acute Care CARE Item Set
IMPACT Act: standardized data set and quality measures for all PAC settings (October 1, 2018, for SNF, IRF and LTCH and January 1, 2019 for HHA)

Outpatient?

Long-Term Care Hospital (LTCH)
- No. of Facilities: 430
- Average length of stay: 28 days
- No. of Beneficiaries: 13,448
- Medicare spending: $66.5 billion

Inpatient Rehabilitation Facility (IRF)
- No. of Facilities: 1,156
- Average length of stay: 13 days
- No. of Beneficiaries: 37,537
- Medicare spending: $66.7 billion

Home Health Agency (HHA)
- No. of Facilities: 12,311
- No. of Beneficiaries: 4,341,837
- Medicare spending: $18 billion

Nursing Homes
- No. of Facilities: 15,000
- Average length of stay: 39 days
- Medicare spending: $28.7 billion

32,617 Post-Acute Care (PAC) Facilities
6.8 million Medicare Beneficiaries
74 billion Medicare Spending
500 billion PAC

PAC 14.8% Growth in Medicare Spending

MLN Connects
Standardization: ‘As Is’ Transitions ‘To Be’

As Is: Multiple Incompatible Data Sources

- Nursing Homes (MDS)
- LTCH (LCDS)
- Inpatient Rehab Facilities (RF-PAs)
- Home Health Agencies (OASIS)
- Hospitals
- Physicians
- Outpatient Settings
- LTSS
- Other TBD

To Be: Aligned Assessment Data Elements

- GoAL
- Aligned Data Elements Across Providers
  - Standardized
  - Nationally Vetted

- Enable Use/re-use of Data
- Exchange Patient-Centered Health Info
- Promote High Quality Care
- Support Care Transitions
- Reduce Burden
- Expand QM Automation
- Support Survey & Certification Process
- Generate CMS Payment

Interoperability

Data Follows the Person

- Long Term and Post Acute Care (LTPAC): SNF/NF, IRF, HHA, LTCH
- Acute Care/Critical Access Hospitals (CAH)
- Other Providers (e.g., pharmacies, dentists...)
- Primary Care Provider (PCP)
- Family Member/Caregiver
- Emergency Medical Services (EMS)
- Long Term Services and Support (LTSS)
- Home and Community Care Based Services (HCBS)
- Assisted Living Facilities (ALF)
### PAC Settings: IMPACT Timeline

<table>
<thead>
<tr>
<th>Quality Domains</th>
<th>HHA</th>
<th>SNF</th>
<th>IRF</th>
<th>LTCH</th>
</tr>
</thead>
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<tr>
<td>Functional Status</td>
<td>1/1/2019</td>
<td>Finalized 10/1/2016: Percent of Patients or Residents with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)*</td>
<td>Finalized 10/1/2016: - Change in self-care score (NQF #2633)* - Discharge self-care score (NQF #2635)* - Change in mobility score (NQF #2634)* - Discharge mobility score (NQF #2636)*</td>
<td></td>
</tr>
<tr>
<td>Skin Integrity</td>
<td>Proposed 1/1/2016 (HHA), Finalized 10/1/2016 (SNF, IRF, LTCH): Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)</td>
<td></td>
<td></td>
<td></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>Finalized 10/1/2016: Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) (NQF #0674)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Preference</td>
<td>1/1/2019</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
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</tr>
</tbody>
</table>

* Based on CARE item set

### New Resource Use Measures

<table>
<thead>
<tr>
<th>Measure</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>
# IMPACT Measures: Focus on Function

**Functional Status**

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<td><em>Change in mobility score (NQF #2634)</em></td>
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* Based on CARE item set

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### Percent of Patients or Residents with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)

#### Self-care Items
- Eating
- Oral hygiene
- Toileting hygiene

#### Mobility Items
- Sit to lying
- Lying to sitting on side of bed
- Sit to stand
- Chair/bed-to-chair transfer
- Toilet transfer
- For patients walking:
  - Walk 50 feet with two turns
  - Walk 150 feet
- For patients who use a wheelchair:
  - Wheel 50 feet with two turns
  - Wheel 150 feet
IRF Measures: Change in self-care score (NQF #2633), and Discharge self-care score (NQF #2635)

Self-care Items

- Eating
- Oral hygiene
- Toileting hygiene
- Shower/ bathe self
- Upper body dressing
- Lower body dressing
- Putting on/ taking off footwear

IRF Measures: Change in mobility score (NQF #2634) and Discharge mobility score (NQF #2636)

Mobility Items

- Rolling left and right
- Sit to lying
- Lying to sitting on side of bed
- Sit to stand
- Chair/bed-to-chair transfer
- Toilet transfer
- Car transfer
- Wheel 150 feet

For patients walking:
- Walk 10 feet
- Walk 50 feet with two turns
- Walk 150 feet
- Walking 10 feet on uneven surfaces
- 1 step (curb)
- 4 steps
- 12 steps
- Picking up object
CARE Item Rating Scale

1. **Dependent**—Helper does ALL of the effort. Patient/resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient/resident to complete the activity.

2. **Substantial/maximal assistance**—Helper does MORE THAN HALF the effort of the activity. Helper lifts, holds or supports patient’s/resident’s trunk or limbs and provides more than half the effort.

3. **Partial/moderate assistance**—Helper does LESS THAN HALF the effort of the activity. Helper lifts, holds, or supports patient’s/resident’s trunk or limbs, but provides less than half the effort.

4. **Supervision or touching assistance**—Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient/resident completes activity. Assistance may be provided throughout the activity or intermittently.

5. **Setup or clean-up assistance**—Helper SETS UP or CLEANS UP; patient/resident completes activity. Helper assists only prior to or following the activity.

6. **Independent**—Patient/resident completes the activity by himself/herself with no assistance from a helper.

7. **Patient/resident refused**

8. **N/A**

9. **Not attempted due to medical condition or safety concerns**

What will the new tools look like?
Where Can I Find the Updated Tools?

<table>
<thead>
<tr>
<th>Setting</th>
<th>Location on Medicare Website</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Located at bottom of the page in the downloads section</td>
</tr>
<tr>
<td></td>
<td>• LTCH CARE data set V3.0</td>
</tr>
<tr>
<td>IRF</td>
<td><a href="https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html">https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html</a></td>
</tr>
<tr>
<td></td>
<td>• Located middle of the page</td>
</tr>
<tr>
<td></td>
<td>• Proposed Draft IRF_PAI version 1.4 (corrected)</td>
</tr>
<tr>
<td></td>
<td>• MDS version 3.0 v1.13 does not include CARE items</td>
</tr>
<tr>
<td></td>
<td>• OASIS- C1/ ICD10 does not include CARE items</td>
</tr>
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</table>

SNF VBP

- Value-based incentive payments must be applied to services provided on or after October 1, 2018 (FY2019)
- CMS will include the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) (NQF #2510) in the program
- CMS will outline further details on the program including in future rule making including:
  - Performance standards,
  - Baseline and performance periods,
  - Performance scoring methodology,
  - Public reporting of performance information, and
  - Feedback reports
HH VBP

Who
• CMS proposes to geographically group the 5 states into 9 groups with one state randomly selected from each group to participate. The states selected are: Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee.

How
• Participating HHAs would receive a total performance score (using the higher of an HHA’s achievement or improvement score for each measure) which would determine their payment adjustment in a given year.
• The first payment adjustment would begin January 1, 2018 applied to that calendar year based on 2016 performance data
  – 5% (up/downward) in 2018 & 2019
  – 6% in 2020
  – 8% in 2021 & 2022

MACRA and the Future of PQRS

MIPS (2017)

PQRS Physician Quality Reporting System
MU Meaningful Use
VM Value-based Modifier
MIPS Merit-based Incentive Payment System
Functional Limitation Reporting

• No changes to FLR
• All ongoing cases that cross the calendar year will continue reporting as scheduled
  – Cases do not need to restart reporting as of January 1, 2016

• Early research indicates a lack of sensitivity to change
  – Change more likely with scores at the higher end of the range within a severity modifier level than with scores in the lower end of the range.

Physician Quality Reporting System (PQRS)

• PQRS is a quality reporting program that encourages individual eligible professionals (EPs) – including PTs - to report information on the quality of care to Medicare.
• In 2016, EPs- including PTs in private practice- who bill under the physician fee schedule must report successfully under PQRS to avoid a -2.0% reduction in their 2018 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
Physician Fee Schedule:
PQRS Changes in 2016

<table>
<thead>
<tr>
<th>Program Detail</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful reporting requirements</td>
<td>• Same as 2015: 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>Available measures</td>
<td>• No new measures/ no measures removed</td>
</tr>
</tbody>
</table>
| Specific measure changes        | • No coding changes to report  
• Additional clarifying details added to some measures  
• Please review all measures that you are reporting                                                                        |
| Reporting Mechanisms            | • No changes                                                                                                                                                                           |

PQRS Participation 2016

Should I participate in PQRS in 2016?

- I want to avoid the -2.0% penalty in 2018
  - Report via claims
  - Report via registry

- Report all available individual measures (128, 130, 131, 154, 155, 182)
- Select 9 individual measures (or if less available 1-8)
PQRS: Errors to Avoid

Failing to include PQRS data on an original claim
• Make sure PQRS codes are included on all eligible initial claims
• Claims cannot resubmitted for the sole purpose of adding a PQRS code

Placing invalid modifiers on the PQRS codes including GP or KX
• Placing unnecessary modifiers (GP or KX) may cause the PQRS codes to reject form the system
• You cannot resubmit the claim to correct PQRS code errors

Failing to meet 50% reporting rate for all selected measures
• Consistently report PQRS measures on all eligible patients throughout the year
• Do not select different measures for each patient; report selected measures on all patients
• Report on all eligible visits including 97002 and 97532

Access your feedback reports throughout the year at Quality Net:
https://www.qualitynet.org/portal/server.pt/community/pqri_home/212

PQRS versus MIPS

PQRS
• Report on a specific number of quality measures for 50% or more of all eligible Medicare patients
• Pay for reporting; if you meet reporting requirements no penalty
• Current measures are not always meaningful to practice
• 2015: report on 6 measures for 50% or more for all visits in which a 97001/ 97002 is billed

MIPS
• 4 performance categories:
  – Quality measures (PQRS) 45%
  – Resource use 15%
  – Clinical improvement activities 15%
  – Meaningful use 25%
• Providers will earn a performance score (0-100) and will be incentivized/ penalized based on performance
• Opportunity to develop measures meaningful to practice
• CMS will be outlining further details of MIPS over the 2015-2016 years
MIPS in Detail

**Quality Measures**
- 45%
- PQRS measures (indications that some will move to MIPS)
- Process and outcome measures (move toward outcome)
- All new measures must be published in peer reviewed journal or developed by QDCR

**Resource Use**
- 15%
- Currently, PTs do not have any measures in this category

**Clinical Activities**
- 15%
- Not yet outlined
- Categories include: expanded practice access, population management, care coordination, beneficiary engagement (Secretary required to specify activities)

**Meaningful Use**
- 25%
- PTs would have the weight from this category redistributed to other categories

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### MIPS Data Reporting Timeline

- **2016**: Report PQRS data. Subject to 2.0% penalty if you failed to report PQRS data successfully in 2015.
- **2017**: No reporting. Subject to 2.0% penalty if you failed to report PQRS data successfully in 2016.
- **2018**: No reporting. Subject to 2.0% penalty if you failed to report PQRS data successfully in 2017.
- **2019**: Report MIPS data?? (Secretary has ability to add PTs to program in 2017). No payment adjustment.
- **2020**: Report MIPS data. No payment adjustment.
- **2021**: Report MIPS data. Subject to potential incentive or penalty based on reporting in MIPS program in 2019 (3.0% to -7.0%).

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[APTA Logo]
Preparing PTs for the Future

Provider Education
- Written resources
- Podcasts and webinars
- Lectures
- Hub

Physical Therapy Outcomes Registry
- Standardized data collection
- Usable data for clinical quality improvement/practice management

Quality Measurement
- Criteria/recommendations for functional tools in practice
- Development of quality measures for the profession

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.
Moving Towards the Future

**Quality Today**
- Separate and distinct reporting programs
- Varied methods of data reporting
- Disconnected feedback process
- High percentage of process measures
- Identification of measure gaps by government/national measurement groups
- Multiple measures of patient function

**Quality Tomorrow**
- Harmonize measures under Medicare quality programs
- Electronic reporting
- Continuous feedback
- Focus on outcome measures and patient/family centered measures
- Increasing role of associations in the creation of meaningful quality measures for professionals
- Single unified functional metric that crosses the continuum of care?

Post-Acute Care Measure Details

- Additional details available:
  [http://www.apta.org/Payment/Medicare/PayforPerformance/](http://www.apta.org/Payment/Medicare/PayforPerformance/)
  [http://www.apta.org/Payment/Medicare/PACReform/](http://www.apta.org/Payment/Medicare/PACReform/)

- Publically reported Medicare data:
  - Nursing home compare
  - Home health compare
INNOVATIVE AND ALTERNATIVE PAYMENT MODELS

Shifting from Volume to Value

- HHS measurable goals and timeline
- Tying payment to alternative payment models and pay for performance
- 30 percent by the end of 2016 to APM
- 50 percent by the end of 2018 to APM
- 85 percent to quality by end of 2016 and 90 percent by 2018

30 percent by the end of 2016 to APM
50 percent by the end of 2018 to APM
85 percent to quality by end of 2016 and 90 percent by 2018
Health Care Payment and Learning Action Network

- Serve as a convening body to facilitate joint implementation of new models of payment and care delivery,
- Identify areas of agreement around movement toward alternative payment models and how best to report on new payment models,
- Collaborate to generate evidence, share approaches, and remove barriers,
- Develop common approaches to core issues such as beneficiary attribution, financial models, benchmarking, quality and performance measurement, risk adjustment, and other topics raised for discussion, and
- Create implementation guides for payers, purchasers, providers, and consumers.

Medicare Shared Savings Program

- New rules released last summer and this January
- Rules seek to relax rules and allow more pathways to share in greater savings and higher risks
- Waives certain regulatory requirements
- Seeks to improve data transmission and patient data to ACOs and providers
ACOs in Your State

https://www.cms.gov/Medicare/Medicare‐Fee‐for‐Service‐Payment/sharedsavingsprogram/ACOs‐in‐Your‐State.html

CMMI: Bundled Payment for Care Initiative

- **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)
Innovation 2.0 Learning Labs

• Opportunity to learn from your colleagues about how to join or develop an innovative payment/practice model
• Interactive learning experiencing from your work or home
• Registration will be limited!
• Stay tuned for more information on how to register in March

Comprehensive Care for Joint Replacement Payment Model

• CJR Model is focused on elective primary hip and knee replacement patients. It will begin on April 1, 2016 and run for 5 years
• Model includes inpatient stay and post discharge care 90 days after discharge
• Unlike other innovative models, CJR requires that all IPPS hospitals in the selected MSAs must participate
• The average Medicare payment for hip and knee procedures ranges from $16,500 to $33,000, according to the CMS
• Medicare estimates a cost savings of $153 million over the 5 years of the model
CJR: Need to Know

1. Are you in a selected metropolitan area?
2. Do you see elective primary hip and knee replacement patients in your practice?
3. What are your costs per episode for this patient population?
4. What are your outcomes for this patient population?
5. Would your practice benefit from engaging as a collaborator in this model?
Financial Arrangements: Gain Sharing

- Providers are still paid under FFS payment models as they are today (may share in savings)
- Hospitals may have certain financial relationships with collaborators (can share reconciliation payments and internal cost savings with collaborators)
- Must furnish services during episode to be collaborator
- Collaborators may include:
  - Physicians and nonphysician practitioners
  - Home Health Agencies
  - Skilled Nursing Facilities
  - Long Term Care Hospitals
  - Physician Group Practices
  - Inpatient Rehabilitation Facilities
  - Providers or suppliers of therapy services
CCJR Quality Measures

- Required:
  - Hospital-level Risk-Standardized Complication Rate following elective primary THA and/or TKA (NQF #1550), an administrative claims-based measure
  - HCAHPS Survey measure

- Optional:
  - Patient reported outcome measures
    - PROMIS Global or VR (Veterans RAND) 12 AND
    - HOOS Jr or HOOS Pain AND Function, Daily Living Subscales / KOOS Jr or Stiffness, Pain AND Function, Daily Living Subscales

Beneficiaries

- Beneficiaries may still select any provider of choice with no restrictions.
- May still receive any Medicare covered service with no restrictions.
- No copayment change
- Hospitals may offer certain items and services to beneficiaries during episode (may not be inducements)
Waivers

• Can waive the SNF 3 day rule if SNF is rated 3 stars or higher on Nursing Home Compare
• Can waive “incident to” rule for physician services to allow clinical staff of a physician to furnish home visits. (only for non HHA covered patients)
• Telehealth- waives originating site requirements so service may be originated in patient’s home

What’s Next?

• APTA is planning to update webpage with resources including:
  – Basic information on the model
  – Contracting considerations
  – Clinical practice guidelines, best practices
  – Functional tools
  http://www.apta.org/BundledModels/CCJR/