Nursing Facility Policy – Overview of Key Issues in 2017 and 2018
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Skilled Nursing Facilities (SNFs) have become adept at improving quality based on their commitment to excellence and their understanding of the legal and regulatory requirements governing SNF operations under state and federal law.

That is no longer enough to assure success in the new healthcare environment. Increasingly, SNFs need to understand the needs of their partners; hospitals and health systems that discharge patients into the post-acute care universe for whom the SNFs compete.

This is tough. It doesn't mean that SNFs are on a path to extinction but it does mean that dedication to the elderly and high quality care must be uppermost in their strategic thinking or indeed SNFs are individually doomed. According to Bill Kauffman, senior principal at the National Investment Center for Seniors Housing & Care (NIC), "At the end of the day, skilled nursing facilities are going to have to play a role by proving that they… are able to provide quality care, achieve good patient outcomes and avoid rehospitalization…Skilled nursing facilities are going to have to have data, to prove that they can…provide value to the health care system. [1]

As trusted partners of SNFs and Nursing Facilities (NFs), LTC pharmacies will need to step up and provide critical support as these facilities:

- Continue to meet regulatory requirements
- Prepare for substantive changes to these requirements (e.g., final changes to LTC Requirements in CMS rulemaking)
- Adjust to new payment models, such as CMS' proposed RCS-1 and MedPAC's unified PAC model, ACOs and bundling, to name a few.
- Try to think ahead to the next 5-10 years.

An impressive challenge, and we don't have the luxury of tackling one issue at a time, it all happens simultaneously. The following is a list of some of those challenges in 2017 and some of what we would expect in 2018. While not exhaustive, the list covers issues to which we have drawn your attention over the past year and would appear to have the highest impact on the industry.

CMS SNF Payment Reform

CMS proposed revision of SNF case-mix methodology in an issuance on April 27, 2017, entitled Advance Notice of Proposed Rulemaking (ANPRM). It proposed RCS-1 to replace the RUG IV payment classification system. CMS did not propose the case-mix refinements for

implementation in the FY 2018 proposed rule. Rather it intends to implement the RCS-I classification model in the FY 2019 SNF PPS proposed rule. CMS believes that RCS-1 will improve the SNF PPS by basing payments predominantly on clinical characteristics rather than service provision, thereby enhancing payment accuracy and strengthening incentives for appropriate care. SNF providers have told LTC Pharmacy News that the modifications to the SNF PPS system constitute a complex change to the current system and that at this time the industry does not have enough information to determine its impact on individual facilities and the system as a whole. SNF providers also indicated that certain SNF factors and requirements that Acumen, CMS' contractor, had not considered.

SNFs are nervous about CMS' position that budget neutrality is not mandatory, thus leaving the door open for implementation with "savings" to the program. Savings, in this case, meaning reductions in payments to nursing facilities. For further details see LTCPharmacyNews.com, April 22, 1017. We await the FY 2019 proposed rule. If this change proceeds, and there is no indication that it won't, SNFs will have a very demanding time of complying and adjusting.

MedPAC Post-Acute Payment Reform

On January 11/12, 2018, MedPAC met its primary legislative mandate to assess the payment adequacy and update payments for a broad array of provider categories post-acute care providers, including SNFs, etc. The assessment activity took place over 2017 and was finalized on January 11/12, 2018. The findings and recommendations will be published in MedPAC's March 2018 Report to Congress.

In addition, at the January 11/12 meeting, MedPAC staff also made its final formal presentation and recommendation regarding the development of a unified post-acute care payment model mandated by Congress. [2] Rather than continuing to pay separate rates depending on where the service took place, the new plan would pay a fixed rate, independent of where the service was provided.

The model had been presented and discussed at prior MedPAC meetings and was finalized for the January 11/12 meeting with one important change that surfaced in November 2017. In the November, MedPAC meeting, the staff presented a variation on the unified system that prior to implementing the PAC PPS would use a blend of the setting- specific and unified PAC PPS relative rates to establish payment. Within **each setting** payments would be distributed across conditions. The blending would take place in **2019 and 2020** and transition to unified PAC PPS would begin in 2021. The draft recommendation MedPAC considered during their December meeting was the same as November and made it into the final January 11/12 set of recommendations. **The critical factor is that now 2019 is the target year implementation with blending of site specific rates and unified PAC PPS relative rates instead of the prior target of 2021.**

The question arises: how does the proposal of CMS (RCS-1) and the MedPAC PPS PAC model relate to each other? How will CMS implement its own RCS-1 for FY 2019 while trying to prepare for the PPS PAC model slated to start in blended form in FY 2019? More than likely, it will not have to this soon. Implementation of the MedPAC PPS PAC will necessitate legislation first since the IMPACT Act did not mandate implementation of a unified PPS PAC, followed by issuance of a proposed rule that has to affect all the post-acute providers (LTCHs, SNFs, IRFs and HH), followed by issuance of a final rule. As one of the MedPAC Commissioners commented, it usually takes about a year to get a new regulation through the whole process. However, somewhere down the line a unified post-acute PPS seems inevitable.

The Impact on SNFs of Enhanced Hospital Discharge Planning

In its September meeting, MedPAC took up the issue of hospital discharge planning in a session entitled Encouraging *Medicare Beneficiaries to Use Higher-Quality Post-acute Care Providers*. [3] While the topic appears to be primarily a hospital concern, it is equally important to SNFs.

MedPAC research had shown that beneficiaries were by-and-large not using higher-quality-post-acute care providers. The MedPAC staff thesis was that steps should be taken to improve beneficiary choice. MedPAC Commissioners agreed. However, the discussion reflected the myriad problems in attempting to rectify the situation given the fact that defining quality itself is far from clear and cogent. However, if CMS and Congress (where applicable) were to adopt the MedPAC recommendations, it would put new pressure on SNFs to meet more stringent hospital scrutiny of SNF quality.

Discharge planning is a hospital responsibility required by the BBA. The BBA requires hospitals to provide beneficiaries with a list of nearby SNFs and home health agencies, but the list is not required to have quality information. **Medicare statute provides that hospitals may not recommend providers.**

The IMPACT Act created new requirements that hospitals use quality data during the discharge planning process and provide it to beneficiaries, but this new requirement has not been implemented as yet. Medicare does not require the use of quality measures in discharge planning, and, confirmed by MedPAC, the efforts required by the IMPACT Act appear to have no certain implementation date. Even most of Medicare's delivery system reform programs such as the BCPI hospital bundling program leave the existing discharge planning rules in place.

In addition, MedPAC studies have examined whether current SNF quality data such as Nursing Home Compare and similar home health data have shifted beneficiaries to higher-quality providers and generally concluded that they had little effect on referral patterns.

The staff had several recommendations for CMS and Congress. They included:

- Allowing hospitals to recommend PAC providers;
- Strengthening existing requirements by recommending the following IMPACT ACT requirements
    - That hospitals use quality measures as a factor in discharge planning and
    - That hospitals be required to provide this quality data to beneficiaries;
- Creating financial incentives for hospitals and PAC providers such as expanding the Hospital Readmissions Reduction Program to apply to more conditions; and Implementing PAC value-based purchasing (VBP) programs for HHAs, IRFs and LTCHs.

Again, the implication for SNFs is increased competition for the patients of hospitals with strong effective discharge planning, and increased pressure for further delineation of SNF "quality." MedPAC staff will continue their work on discharge planning.

The 3-day Hospital Stay for SNF Coverage

Will it never go away?! If there was ever a clinical dinosaur – this is it. This is the requirement that, to be eligible for Medicare covered post-acute care in a SNF, a beneficiary must have spent at least 3 prior days in a hospital; that is to say, under CMS regulation, a patient must be categorized as an inpatient at an acute-care hospital for at least a span of three midnights to qualify for Medicare Part A coverage of SNF stays. Patients categorized as under observation at a hospital are considered outpatients by CMS, and days under observation do not count toward the 3-day stay requirement.

Maybe the 3-day stay requirement made sense in 1965 as a supposedly rational method of gatekeeping. But no more. According to James Michel, formerly Senior Director of Medicare Reimbursement and Policy at AHCA and now Director of Policy at Better Medicare Alliance, University of Michigan, "On average, hospital stays are much shorter than they were in the 1960s, but the three-day stay requirement still applies to all Medicare patients…As the hospital stays become shorter, the effect of the three-day rule is to block more and more Medicare beneficiaries from being able to access the skilled nursing facility benefit."[4]

As a veteran of post-acute care policy, I can attest to the fact that SNFs started questioning the continued application of such an archaic requirement many years ago - - but without success. The overriding suspicion in the provider world was that CMS feared a tremendous spike in Medicare post-acute costs if it treated observation stay patients as inpatients for the purpose of providing access to needed post-acute care.

While the utter inappropriateness of the 3-day stay requirement has contributed to the debacle surrounding observation stays, the archaic nature of the 3- day stay requirement evinces itself in other ways such as the Inpatient Only List (IPO list).

On July 13, 2017, CMS issued the Calendar Year (CY) 2018 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule (CMS-1678-P). The proposed rule included the annual review of outpatient and inpatient

appropriate services. The Inpatient Only (IPO) list was created by CMS when it was mandated to develop a hospital outpatient system and had to determine what services could be performed on an outpatient basis. The IPO list indicates procedures that CMS has historically deemed can be performed only on an inpatient basis. [5] CMS has revisited this issue annually over the years, and each year it has used established criteria to review the IPO list and determine whether any procedures should be removed from the list.

For CY 2018, CMS proposed to remove total **knee** arthroplasty (TKA) from the IPO list[6] and in the Final Rule, CMS did proceed to remove TKA, CPT code 27447. [7] CMS also addressed the removal of certain types of hip replacement from the IPO list, but did not proceed with removal for CY 2018 leaving the issue to future rulemaking. CM appears to be leaning towards removal within a year or two.

There were commenters agreeing with knee surgery removal from the IPO list and commenters who disagreed. Those not in favor of removal stated that discharging outpatient TKA patients without a 3-day stay and access to adequate rehabilitation would increase the likelihood of further medical concerns that may result in readmissions, which will result in higher expenses for the beneficiary, the Medicare program, and the hospital. Also, those not in favor of removal stated that the risk of postsurgical complications was too high for patients with the TKA procedure performed in the outpatient setting for the **Medicare population** and noted that patients appropriate for the TKA procedure performed on an outpatient basis tend to be younger, more active, have fewer complications, and have more at home support than most Medicare beneficiaries. Of critical importance to the care of Medicare beneficiaries is the concern of several commenters that regarding the ability of beneficiaries to access SNF post-acute care for a TKA procedure.

Joint surgery being offered on an inpatient or outpatient basis should not be a problem if good criteria for choice are developed and adhered to. The problem rather is that physician choice of inpatient or outpatient places a lot of pressure on physicians to make the right call for all patients but in particular for Medicare beneficiaries. *A decision to proceed with knee surgery on an outpatient basis guarantees that SNF rehab is not covered.*

Managed Care

With respect to Medicare and Medicaid, SNFs face increasing managed care on both fronts and must deal with Managed Care Organization "management." For example, MCOs by and large pay less than Medicare FFS, tightly control length of stay and in many cases send patients home without a stop at a SNF.

As for Medicaid, many states have historically handled Medicaid medical expenses on a fee for service basis. However, according to Avalere[8] and Health Market Resources,[9] the expansion of Medicaid has prompted states to use more managed care. Avalere had found that enrollment in Medicaid managed care is particularly high in states that decided to expand Medicaid. The primary reasons: because these states relied on managed care more heavily before ACA expansion and because newly eligible beneficiaries are largely enrolling in managed care plans.

Avalere estimated that more than three-quarters of Medicaid beneficiaries will be enrolled in a managed care plan as of 2016. According to Avalere, SNFs will lose out, since Medicare Advantage programs have been shown to have more use of home-based and community services if long term care is capitated.

From a state's perspective the critical factor regarding MCOs is their ability to control costs. And high on the list of costs is institutional placement in facilities such as nursing facilities. Among managed care organizations (MCOs), these costs can often be perceived to be avoidable and potentially unnecessary. This would drive the increased use of lower cost alternatives such as home based and community services in lieu of institutional placement.

Bundled Payment for Care Model (BPCI) Advanced

The Request for Applications (RFA) for BPCI Advanced was released on January 9, 2018. It outlines the different elements of the Model in detail and explains how the applications will be reviewed. As described in the RFA, the Innovation Center will test an alternative voluntary payment model to incentivize financial accountability, care redesign, data analysis and feedback, provider engagement, and patient engagement using bundled payments, care redesign activities, and accountability for performance on quality measures.

In 2013, the Innovation Center began testing the Bundled Payments for Care Improvement (BPCI) initiative. The BPCI initiative was created to link payments across all healthcare providers delivering care during an episode of care. BPCI focuses on generating savings and improving quality through better care management during episodes, eliminating unnecessary care, and reducing post-discharge Emergency Department (ED) visits and readmissions. Evaluation results from the BPCI initiative are also informative as to the potential for bundled payments to reduce Medicare expenditures.

Providers by and large appreciate the fact that the model is not mandatory. However, certain other aspects may give SNFs cause for concern. Post-acute providers can only participate though financial partnerships with other providers. "This initiative effectively sunsets the SNF setting as the location for initiating an episode and taking risk as a participating provider," Anne Tumlinson, CEO of Anne Tumlinson Innovations told McKnight's. "That was the original BPCI Model 3, and a lot of providers are disappointed that they won't have the opportunity to continue in that role." [10]

The new model is more like the previous BPCI Model 2, in which hospitals or conveners took on risks and limited partnerships, referring their patients to home healthcare or shortening skilled-nursing lengths of stay. Applications must be submitted by March 12. The first cohort of participants will start participation in the Model on October 1, 2018, and the Model Period Performance will run through December 31, 2023. CMS will provide a second application opportunity in January 2020.

LTCPharmacyNews will look further into this new initiative from the perspective of SNFs and report our findings in our March Newsletter!

Arbitration

On October 4, 2016, CMS had issued its final rule providing for reform of the requirements that long-term care facilities must meet to participate in the Medicare and Medicaid programs. In the rule, CMS listed the requirements facilities needed to follow if they chose to ask residents to sign agreements for binding arbitration. Further, and very alarming to long term care facilities, the final rule prohibited pre-dispute agreements for binding arbitration. Thus, ensued a trail of actions including public comments arguing vociferously for and against the prohibition, a lawsuit asking for preliminary and permanent injunction, and CMS' rethinking of the prohibition.

CMS followed and declared that in a June 2017 proposed rule that the prohibition on **pre-dispute binding** arbitration agreements was removed. But it did not abandon all its 2016 new arbitration policies. It retained those that focused on transparency surrounding the arbitration process. The issue seems closed for now. But advocates strongly oppose mandatory arbitration and may still pursue a prohibition of pre-dispute agreements for binding arbitration. SNFs must adhere diligently to the remaining CMS arbitration policies.

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[1] *SNFs Must Find Their Place in New Payment Models to Last*, Elizabeth Jakaitis, *Skilled Nursing News,* August 14, 2017, https://skillednursingnews.com/2017/08/snfs-must-find-place-new-payment-models-last/

[2] Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

[3] http://www.medpac.gov/-public-meetings-

[4] *HealthLeaders Media* article by Christopher Cheney , Senior Finance Editor at *HealthLeadersMedia* , October 9, 2017 http://www.healthleadersmedia.com/finance/snfs-seek-relief-three-day-hospital-stay-requirement

[5]Before implementation of the Outpatient Prospective Payment System (OPPS) in August 2000, Medicare paid reasonable costs for services provided in the Hospital Outpatient Department (HOPD). Congress gave HHS broad authority to determine the services to be covered and paid for under the newly implemented OPPS.

[6]This is **knee surgery** related to the procedures described by the following codes from the IPO list for CY 2018: CPT code 27447 (Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty) and CPT code 55866 (Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed).

[7] CMS *Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs*, Final Rule for CY 2018, 82 Federal Register 52356, November 13, 2017.

[8] http://avalere.com/expertise/managed-care/insights/avalere-analysis-medicaid-managed-care-enrollment-set-to-grow-by-13.5-milli

[9] http://www.healthmr.com/snfs-lose-in-mcogame/

[10] https://www.mcknights.com/guest-columns/snfs-time-to-step-up-not-give-up/article/736961/