Potential Impact on Health Care Providers and Beneficiaries of Proposed Changes to the Inpatient Only (IPO) List

September 2017 Issue -- LTCPharmacyNews.com – Elise Smith

We are all aware of the seismic changes occurring in health care reimbursement as policy makers, beneficiary advocates, providers, durable medical equipment companies, pharmacies, physicians etc. set their sights on trying to achieve, and to convince CMS that they are achieving, the triple aim articulated and championed by Dr. Donald Berwick: improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

SNFs are involved in or impacted by wide ranging developments such as major health care payment innovations (e.g. bundling, ACOs) , focused post-acute payment reform developments addressing post-acute payments directly, and regulations and policies -- such as observations stays -- that deprive beneficiaries of covered post-acute SNF care.

However, in addition, there is CMS hospital policy, driven by advances in medical practice that if not implemented carefully could negatively affect beneficiaries and SNFs.

We discuss here a development regarding procedures that CMS has historically deemed can be performed only on an inpatient basis – the Inpatient Only (IPO) List . CMS has revisited this issue annually over the years and its latest proposals for excluding certain procedures from the inpatient only list would appear to raise serious concern for hospitals, skilled nursing facilities (SNFs), some innovative reimbursement models and beneficiaries.

The Inpatient Only Rule (IPO)

The Proposed Rule

On July 13, 2017, the Centers for Medicare & Medicaid Services (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) that includes updates to the 2018 rates and quality provisions, and proposes other policy changes. [1]

Each year, CMS uses established criteria to review the IPO list and determine whether or not any procedures should be removed from the list. For CY 2018, CMS is proposing to remove total knee arthroplasty (TKA) from the IPO list.[2]

The CY 2018 OPPS/ASC proposed rule also seeks comment regarding whether partial and total hip arthroplasty (PHA/THA) should also be removed from the IPO list for CY 2019. [3]

CMS Criteria for Removal from IPO List

In the proposed rule for CY 2018, CMS uses the existing five criteria when reviewing procedures to determine whether or not they should be removed from the IPO list and assigned to an APC group (Ambulatory Payment Classification) for payment under the OPPS (Hospital Outpatient Prospective payment System) when provided in the hospital outpatient setting. The criteria include the following and were used by CMS to propose the CY 2018 TKA exclusion and request comment on the CY 2019 proposed PHA/THA exclusion. [4]

1. Most outpatient departments are equipped to provide the services to the Medicare population;

2. The simplest procedure described by the code may be performed in most outpatient departments;

3. The procedure is related to codes that we have already removed from the IPO list;

4. A determination is made that the procedure is being performed in numerous hospitals on an outpatient basis; and

5. A determination is made that the procedure can be appropriately and safely performed in an ASC, and is on the list of approved ASC procedures or has been proposed by us for addition to the ASC list.[5]

Impact on Hospitals

Most U.S. patients who receive total hip or knee replacements, known as arthroplasties are operated on in an inpatient surgical unit, spend several days in a Part A hospital bed, then move to a skilled-nursing or rehabilitation facility or receive home healthcare.

According to senior health care analyst Harris Meyer, that is beginning to change, and tensions are rising between hospitals and orthopedic surgeons as a result.[6] Meyer comments in a June 2016 Blog that, building on advances in surgical technique, anesthesia and pain control, a small but growing number of surgeons around the country are moving more of their total joint replacement procedures out of the hospital, performing these lucrative operations in outpatient facilities.

Some are sending their patients home within a few hours, while others have their patients recover overnight in the surgery center or hospital during 23-hour stays. According to Meyer these surgeons say very few of their patients require skilled nursing, rehab or home healthcare. The Ambulatory Surgery Center Association says close to 40 centers around the country are performing outpatient joint replacements, and outpatient surgery companies such as Surgical Care Affiliates are aiming to increase them.[7]

Meyer observes that moving these procedures to outpatient settings poses a major threat to hospital finances, since total joint replacements are one of the largest and most profitable service lines at many hospitals. In 2014, more than 400,000 Medicare beneficiaries received a hip or knee replacement, costing the government more than $7 billion for the hospitalizations alone—over $50,000 per case.[8] He opined that that the financial threat will be even greater if CMS changes its rules and allows Medicare and Medicaid payment for these outpatient procedures. With the new proposed rule removing TKAs from the IPO list, that increased threat is now almost a partial reality. Meyer quotes Michael Dandorph, chief operating officer at Rush University Medical Center in Chicago the effect that up to 25% of joint replacements may be done on an outpatient basis within five years if Medicare starts paying for them.[9]

Impact on Innovation

More than one analyst writing in 2015-2016 has noted that migration of total joint replacements to outpatient settings also raised questions about the future of Medicare's mandatory bundled-payment initiative for inpatient procedures in what was to be 67 markets around the country, called the Comprehensive Care for Joint Replacement (CJR) program. However, CMS issued a proposed rule on August 17 to make participation voluntary for many of the hospitals and also proposing to cancel various payment models.[10]

While mandatory programs have thus been modified, canceled or delayed, the issue of the role of Part A bundled payment remains where the CJR program is still effective and could arise again in the future if the affected programs or anything similar is re- introduced.

Impact on SNFs and Beneficiaries

The most direct impact on SNFs is the effect on the number of patients coming to them for post-acute care. While this impact challenges SNF financial prospects it may also be dangerous for beneficiaries. While certain exclusions from the inpatient only rule may on paper look clincially acceptable, CMS may not have adequately considered complexities of elderly, post-acute care needs.

With respect to TKA, CMS believes that the TKA procedure is an appropriate candidate for removal from the IPO list. With respect to PHA and THA, CMS does admit that, like most surgical procedures, both PHA and THA need to be tailored to the individual patient's needs. CMS postulates that patients with a relatively low anesthesia risk and without significant comorbidities who have family members at home who can assist them may likely be good candidates for an outpatient PHA or THA procedure. These patients may be determined to also be able to tolerate outpatient rehabilitation in either an outpatient facility or at home post-surgery.[11]

On the other hand, CMS acknowledges that patients with multiple medical comorbidities, aside from their osteoarthritis, would more likely require inpatient hospitalization and possibly post -acute care in a skilled nursing facility or other facility.[12] CMS also indicates that surgeons who have discussed outpatient PHA and THA procedures in public comments in response to the CY 2017 OPPS/ASC proposed rule comment solicitation on the TKA procedure have emphasized the importance of careful patient selection and strict protocols to optimize outpatient hip replacement outcomes.

In further support of its proposed policies CMS emphasizes an important principle of the IPO list to the effect that "… just because a procedure is not on the IPO list does not mean that the procedure cannot be performed on an inpatient basis. [13]

However, there is enormous complexity in choosing between inpatient versus outpatient care – a complexity that showed itself in full force regarding the issue regarding two midnight rule regarding observation stays versus Part A stays. A hospital choosing inpatient care rather than outpatient care may indeed invite scrutiny and a tangle of hospital reimbursement issues.

Conclusion

Health care in all its aspects will continue to develop and improve and advances in medicine should and will continue. And it is the patient – including the Medicare patient -- who is the beneficiary or inadvertently the victim of the "improvement." Thus, for example, as CMS avers, careful patient selection and strict protocols is crucial to optimize both outpatient knee and hip replacement outcomes for inpatient and outpatient.

This caution is especially critical with regard to Medicare beneficiaries since hospital experience with TKA and PHA/THA provided on an outpatient basis has been limited to non-Medicare patients - - a far younger and healthier cohort than elderly Medicare beneficiaries.

In particular, pain management post-surgery in the age of anti-opioid use has been made more complex especially for an elder with multiple chronic conditions who may have been already been prescribed an average of 9-11 medications.

Further, when the hospital and physician choose outpatient versus inpatient for a particular patient, this very decision slams the door in the face of that beneficiary with respect to post-acute rehabilitation in a SNF because of the 3-day hospital stay pre-requisite for SNF post-acute care. Thus, the question may be posed as to whether CMS in proposing exclusion criteria for the inpatient only rule adequately took into account the complexities of health care for the elderly and their special post-acute needs.

The comment period ends September 11. It will be interesting to see how the major long term care associations, AHCA and Leading Age, comment.

(Endnotes)

1 CMS **Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs,** Proposed Rule for CY 2018, 82 Federal Register 33642. Comments are due no later than September 11, 2017.

2 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).

3 **Partial Hip Arthoplasty (PHA) and Total Hip Anthroplasty (THA)** involves the following codes: Partial hip arthroplasty (PHA), CPT code 27125 (Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty), and total hip arthroplasty (THA) or total hip replacement, CPT code 27130 (Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft), have traditionally been considered inpatient surgical procedures. The procedures were placed on the original IPO list in the CY 2001 OPPS final rule (65 FR 18780).

4 Note that CMS has applied a twostep approach to review of IPO procedures. In the year 2016, CMS asked for comment on removal of TKA from the IPO list. It did not propose the removal for CY 2017 but rather for CY 2018. Now in year 2017, CMS has formally proposed the removal of TKA from the IPO list. In addition, in the same Federal register issuance, CMS, using the same type of two step approach has now asked for comments on the removal from the IPO list of PHA/THA for CY 2019 but did not propose removal for FY 2018.

5 Ibid. at p. 33643.

6 See Harris Meyer, Replacing joints faster, cheaper and better? June 4, 2016 http://www.modernhealthcare.com/article/20160604/MAGAZINE/306049986

7 Ibid.

8 Ibid.

9 Ibid.

10 The August 17 proposed rule makes participation voluntary for all hospitals in approximately half of the geographic areas selected for participation in the Comprehensive Care for Joint Replacement (CJR) model (that is, in 33 of the 67 Metropolitan Statistical Areas (MSAs) selected; (see 80 FR 73299 Table 4)) and for low-volume and rural hospitals in all of the geographic areas selected for participation in the CJR model. In this proposed rule CMS is also proposing to cancel the Episode Payment Models (EPMs) and the Cardiac Rehabilitation (CR) incentive payment model. 82 Federal Register 39310, August 17, 2017, https://www.gpo.gov/fdsys/pkg/FR-2017-08-17/pdf/2017-17446.pdf

11 Ibid. at p. 33645.

12 Ibid.

13 Ibid.