LeadingAge Oregon

inspire. serve. advocate.

LeadingAge Federal Update
March 28, 2014

Provided by: Barbara Gay, LeadingAge Director of Governmental Affairs
(202) 508-9489/ BGay@leadingage.org

Medicare therapy caps: Bowing to reality, yesterday the House passed H.R. 4302, the Protecting Access to Medicare Act, to put another temporary patch on Medicare physician reimbursement. The bill prevents a large physician payment cut that otherwise would take effect on April 1.

The temporary fix is controversial because many members of Congress, including the new chair of the Senate Finance Committee, want to hold out longer for permanent reform of the physician payment formula. The House and Senate reached consensus on reforming physician payment, but so far have been unable to agree on how to offset the cost of reform. In theory, Congress could still legislate permanent reform that would supersede the temporary fix. But the reality is that the temporary fix removes the pressure that often is necessary to generate consensus on the Hill.

H.R. 4302 also contains a twelve-month extension of the therapy caps exceptions process. These provisions satisfy one of our primary advocacy goals for this year, which has been to ensure that therapy caps are addressed as part of physician payment legislation. As with physician payment, a permanent fix would be preferable, but with therapy caps otherwise due to take effect Tuesday, we are pleased that H.R. 4302 would continue the exceptions process.

The current plan is for the Senate to begin consideration of the House-passed bill on Monday afternoon, March 31. We are sending an alert to members who participated in Hill visits to ask them to contact their senators in support of H.R. 4302. From what we can tell at this point, the bill is likely to pass the Senate after a suitable amount of angst is expressed over the way the measure has been brought to the floor, the need for permanent reform, etc.

Other provisions: Two other provisions of H.R. 4302 are of interest. One would extend the deadline for converting to the ICD-10 coding system for medical billing. Under the bill, health care providers will now have until October 1, 2015 to have the new coding system in place.

While the extra time would be helpful, health and post-acute care providers still need to take steps necessary to convert to the new system. We've received some questions as to whether webinars and other training on ICD-10 should be cancelled or postponed. CMS has been telling health care providers

for years that they need to get ready for ICD-10, so it would seem like a good idea to go on with any planned training to make sure the members are ready for the new system.

The physician payment bill also calls for value-based purchasing for skilled nursing facilities to take effect October 1, 2019. The bill sets 2015 and 2016 deadlines for CMS to develop measures to implement this system.

Cheryl Phillips' take on these provisions:

This bill calls for a SNF readmission measure, no later than Oct 1, 2015 – which will be all cause, all condition and will have adjustments for low-volume readmissions from a given nursing home. The following year, this measure will be refined to be an all-condition, *risk-adjusted*, measure of *potentially preventable hospital readmissions*. Both the risk-adjustment method and the definition of potentially preventable are yet to be publically shared.

These readmission measures are to be publically reported and posted on the Nursing Home Compare website. We have been supportive of public reporting and are hopeful that the Secretary of Health and Human Services will incorporate input from consumers and stakeholders to ensure that such measures reported are not only valid, but are interpretable and usable by consumers.

The bill also links the risk-adjusted readmission measure to a value –based purchasing strategy that will include incentive payments for high performers and penalties for low performers. Our focus is to ensure that risk adjustment is both at the nursing home level (eg: those homes serving lower socio-economic populations), and that there is adjustment at the beneficiary level (eg: a patient with a hip fracture and multiple other chronic complex care needs would have a higher expected rate of return to the hospital than a patient with a hip fracture who is otherwise relatively healthy).

We have been preparing LeadingAge members for readmissions for the past year. Not only must providers be tracking their own rates, but they need to have QI systems in place to identify opportunities to reduce avoidable hospital admissions. We recognize that Advancing Excellence, specifically the goal that addresses hospital admissions, is an excellent resource and available to all.

We will update you next week as to how the Senate vote goes.

Nursing home regulatory update: In addition to all the excitement on Capitol Hill, Evvie Munley developed this snapshot of where regulatory activity stands:

From the current survey and cert perspective - some items/actions coming down the road/anticipated from CMS:

- Transition to QIS surveys [Quality Indicator Surveys vs. the traditional survey process] are still on hold, i.e., not bringing any new states on board for the time being and no target date for resuming, etc. – CMS is currently working on adapting the QIS pathways [part of the QIS survey protocol/decision-making process] to incorporate into the traditional survey process.

- The sprinkler extension proposed rule is still being held in OMB, with no target date for publication.

- There will be formal guidance issued regarding the agreements between nursing homes and hospice [for nursing home residents electing the hospice benefit]; while the final rule came out awhile go, CMS advised they are not always seeing agreements or agreements may not be in compliance with the requirements as contained in the final rule. The guidance is anticipated within the next couple of months.

- CMS is also looking at reducing the use of personal alarms and will be revising the guidance in this area. This will take awhile, i.e., they are exploring alternatives now, but no revised guidance in the immediate or near future. [This is part of an overall 'sound-level' concern / issue, e.g., also looking at 'announcement' and call-systems, etc.]

- On the enforcement side, CMS is 'still' looking at how to assess the efficacy of the array of remedies available, e.g., directed plans of compliance, temporary managers, etc. – This is something we've long supported because it's too easy for fines/civil money penalties to become the sanction of choice as a knee-jerk reaction to noncompliance. The law states and was intended for enforcement actions to be those that '…are most likely to achieve sustained compliance…'

- QAPI is the big one coming down the pike. No target date for the proposed rule (last I heard from CMS was that they were hopeful it would be in 2014), but the CMS website is populated and being currently updated with tools/guidance/resources for facilities to get started –
    - The Affordable Care Act requires the Centers for Medicare & Medicaid Services (CMS) to develop new regulations for Quality Assessment and Performance Improvement, (QAPI) to complement the current Quality Assessment and Assurance regulations that have been in place since 1990.
    - The ACA also requires CMS to provide technical assistance to nursing homes on best practices to meet these requirements/standards.
    - QAPI requirements will be in addition to the current Quality Assessment and Assurance requirements (483.75(o)) that requires homes to maintain a QAA committee that meets at least quarterly to address quality-related concerns and deficiencies.
    - QAPI requirements will include a mandate that all facilities submit a plan for meeting the QAPI standards and implementing best practices, including coordination of a QAPI plan with existing QAA activities.