PALTC Sees Flurry of Legislative and Regulatory Action, but Questions Remain
Joanne Kaldy

Congress has been quite busy,” said Alex Bardakh, MPP, director of public policy and advocacy for AMDA — The Society for Post-Acute and Long-Term Care (PALTC) Medicine, at the start of the annual conference program on “Top Policy Issues in 2019.” And clearly when Congress is busy, so is the Society.

In addition to a successful Hill Day last year where members and staff met with congressional leaders to discuss issues such as expanding reimbursement for telehealth efforts and ways to improve the provisions included in the proposed Reducing Unnecessary Senior Hospitalization (RUSH) Act of 2018 (H.R. 6502), the Society continues to make inroads with Congress and work with the Centers for Medicare & Medicaid Services (CMS) on an array of issues. This session at the conference prepared the participants for the changes, updates, revisions, and developments they can expect in 2019 on issues ranging from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the Merit-Based Incentive Payment System (MIPS) to the Patient Driven Payment Model (PDPM) and the opioid crisis.

With the Democrats taking control of the House of Representatives after the 2018 elections, there are lots of changes in Washington, DC, and much talk — if little action — on issues relating to PALTC such as prescription drug prices, Medicare expansion, and changes in the observation stay rules. “There’s been a lot more talk about nursing home quality,” said Mr. Bardakh, who had recently attended a hearing about abuse and neglect. “There was a good dialogue on the issue, and there was a discussion of the physician’s role.”

Mr. Bardakh talked about the CMS “Patients Over Paperwork” campaign, which is designed to reduce the burden of regulations. Through this initiative, CMS established an internal process to evaluate and streamline regulations with the goal of reducing unnecessary burdens on practitioners. He also talked about new rules released in February by CMS and the National Coordinator for Health Information Technology mandating that by 2020 all health care organizations working with Medicare and Medicaid must share health information and claims data electronically via an application programming interface.

Mr. Bardakh also referred to the CMS “My Healthy Data” initiative, which CMS hopes will put control of health data into patients’ hands. He was most struck, however, by CMS Administrator Seema Verma’s acknowledgment that post-acute care is a setting where there is a dearth of and need for interoperability. Mr. Bardakh indicated that while these initiatives have some promise, it’s too early to tell what impact they will have on physicians and other practitioners.

Double-sided risk accountable care organizations (ACOs) are growing, Mr. Bardakh noted, so practitioners need to be prepared to take on more risk. To do this confidently, practitioners need to be able to collect, analyze, and interpret data and determine where they most accurately predict outcomes.

Overall, Mr. Bardakh said, in 2019, practitioners will find that:

- MIPS lives — the program is here to stay. The majority of practitioners are participating in it, and the Society will continue to work with them to navigate the challenges.
- Practitioners must “meaningfully” participate in MIPS to avoid penalties.
- CMS has published a “specialty set” of quality measures that are reportable in the skilled nursing facility. These are available on the CMS website (https://qpp.cms.gov/).
- The Society is actively working with CMS on its proposal to allow PALTC-based practitioners to take the facility-based score that is currently available in the hospital setting. During the annual conference, the Society held a number of sessions as part of its Practice Management track that focused on many of these issues. If you were not able to attend or would like to review those sessions, conference recordings are available at https://paltc.digitellinc.com/amda/store/9.

Evaluation and Management of Coding Changes

CMS has proposed a major reworking of the Evaluation and Managing (E&M) coding, and Karl Steinberg, MD, CMD, HMDC, offered some of the key highlights relevant to this audience. He observed that the 2018 Physician Fee

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Schedule final rule included significant changes to the office-based E&M coding documentation and billing requirements and delayed the majority of the initial proposals until 2021. CMS also finalized several proposals on documenting History of Present Illness.

It is important to note that to date these proposals only impact the office-based setting, but this may set a precedent for how the rest of E&M coding will be handled. Dr. Steinberg noted, including in nursing homes. The Society is very involved in this work and continues to be engaged with the American Medical Association CPT/RUC Workgroup, which is developing alternative proposals.

Opioids and Antipsychotics

The opioid crisis presents a serious issue for practitioners. As Dr. Steinberg said, “It’s so hard to get these drugs now for some of our patients, and they may not be getting what they need. Perhaps historically they’ve been overutilized, but we shouldn’t punish patients for whom opioids work and are necessary.”

Earlier this year, CMS announced new strategies to further help Medicare Part D sponsors prevent and combat opioid overuse, including additional safety alerts at the time of dispensing as a proactive step to engage both patients and prescribers about overdose risk and prevention. CMS’s strategy includes new policies about improved safety edits when opioid prescriptions are dispensed at the pharmacy, and drug management programs for patients found to be at-risk for misuse or abuse of opioids. CMS stresses that these policies are not “one size fits all.” For instance, residents of long-term care facilities, patients in hospice or end-of-life care, and patients being treated for active cancer-related pain are exempt.

Medicare Part D plans may implement a drug management program that limits access to certain controlled substances that have been determined to be “frequently abused drugs” for patients who are considered to be at-risk for prescription drug abuse. For 2019, CMS has identified opioids and benzodiazepines as frequently abused drugs. Potentially at-risk patients are identified by their opioid use involving multiple prescribers and pharmacies. The prescriber limitations require these patients to obtain their prescriptions for frequently abused drugs only from certain prescribers.

Later this year, the Society’s Board of Directors approved a policy statement on opioid use in nursing homes. It calls for providing access to opioids when indicated to relieve suffering and to improve or maintain function, and promoting opioid tapering, discontinuation, and avoidance when these goals are not achievable in order to prevent adverse events, dependence, and diversion.

Elsewhere, aggressive efforts to address antipsychotic prescribing and use have consumed a great deal of providers’ and practitioners’ time and attention in recent years, with generally positive results. Dr. Steinberg noted that the Society has heard from CMS about troubling reports of false schizophrenia diagnoses to enable the use of antipsychotics without negatively impacting Five Star ratings. At the same time, he said, “CMS elected not to include bipolar disorder as an acceptable condition for antipsychotic use, when these drugs are actually FDA-approved for this condition.” He noted that the Society has developed a workgroup to address these and other concerns.

PDPM: Big News, Big Change

“It took me 3 months to understand with this acronym meant,” joked David Nace, MD, CMD, in his presentation on the Patient Driven Payment Model. He was able to boil the model down to the basics for his audience. PDPM, he said, “recognizes that some patients are more complex” and also “represents a marked improvement over the [Resource Utilization Group] RUG IV model for several reasons.” These include:

- Improved payment accuracy and appropriateness by focusing on the patient rather than the number of therapy minutes provided.
- Significant reductions in the administrative burden on providers.
- Improved SNF payments to currently underserved beneficiaries.

“We can make a real difference here,” Dr. Nace stressed. PDPM consists of five case-mix–adjusted payment components: utilization of physical therapy, utilization of occupational therapy, utilization of speech-language pathology services, utilization of nursing and social services, and utilization of non-therapy ancillary (NTA) services. The model would maintain the existing non-case-mix components to cover utilization of SNF resources that do not vary according to resident characteristics. These involve payments for:

- Physical therapy
- Nursing
- Speech-language pathology
- NTA services
- Occupational therapy

Similar to RUG IV, the per-diem payment under PDPM will be determined by two main factors: base rates, which correspond to each component of payment, and case mix indexes (CMIs), which correspond to each payment group. Each resident will be classified into a group for each of the five case-mix–adjusted components. The base rate for each component then is multiplied by the CMI corresponding to the assigned resident group.

“Some communities will fare pretty well under PDPM, while others will see declining revenue from Medicare,” Dr. Nace said. He added, “My own data analysis shows a 10% reduction in Rehab Ultra High patients. Communities with a high distribution of RU compared to other RUG categories will most likely see a reduction in their overall revenue.” He noted that NTA payments can greatly affect a community’s reimbursement. “Payments with an NTA CMI in the top four case mix groups have a positive reimbursement disposition under PDPM, even for RU patients,” Dr. Nace said.

“This is code-driven model, so it comes down to capturing codes. Accurate coding will be extremely important,” Dr. Nace noted. “We can go to facilities and say, ‘We can help you with this.’ It presents an opportunity to finally see appropriate payments for medically complex patients.”

ABCs of SNF VBP

As health care continues its march into value-based medicine, practitioners need to understand the Skilled Nursing Facility 30-Day All-Cause Readmission Measure, which is used in the SNF Value-Based Purchasing (VBP) payment program. The SNF readmission measure estimates the risk-standardization rate of unplanned readmissions within 30 days for patients with fee-for-service Medicare who were inpatients, Prospective Payment System (PPS) critical access, or psychiatric hospitals. Dr. Nace noted, “SNFs will earn a SNF VBP performance score of 0 to 100 and ranking, which is calculated based on that SNF’s performance on the measures. The SNF VBP performance score is equal to the higher of the achievement score and improvement score.” SNFs will be awarded points for achievement based on a scale of 0 to 100 and improvement on a scale of 9 to 90, based on how their performance compares to national benchmarks and thresholds.

Expect the parade of changes to continue, Mr. Bardakh said, noting that the Society has never been more active on the Hill in Washington, DC, and continues to have regular interactions with CMS officials and other stakeholders. He urged his audience to stay informed and engaged: “The Society makes it easy for you to get involved in advocacy, even if you have limited time and experience.” For example, the organization’s Advocacy in Action page lets members send emails and comments on key issues quickly and easily. Go to https://paltc.org/advocacy to get started.

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