Post-Acute Care Primer Series

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Volume 1

Post Acute Care
Post-Acute Care (PAC) is a term describing a range of medical care services that support patients continued recuperation and improved functioning following their discharge from an acute care hospital.

This series of post-acute primers offers a general overview of the main sectors of the post-acute care continuum of healthcare in the United States, to explain the conceptual distinctions between post-acute services, and to highlight important issues currently facing providers and policymakers. This primer series includes a chapter corresponding to each PAC sector, as well as a chapter focused on related rehabilitative therapies provided in outpatient clinics.

Post-Acute care services are provided in a variety of operating environments, under a variety of names. They can be free-standing or dedicated units, separately licensed onsite with other healthcare services. Individual providers may use names or titles for their facilities to best describe their services to patients and other stakeholders.

Long-term care hospitals (LTCH) provide highly specialized care for patients who need sustained high-acuity treatment for multiple complex medical conditions such as ventilator-dependency or organ failure. LTCH services may be provided at venues titled with any of the following names: long-term acute care hospital, critical-illness hospital, transitional care hospital, specialty hospital, ventilator hospital, continuing care hospital.

Inpatient rehabilitation facilities (IRF) are hospitals that specialize in intensive rehabilitation for patients whose medical needs still require hospital-level capabilities. IRF services may be provided at venues titled with any of the following names: rehabilitation hospital, transitional care hospital, specialty hospital, ventilator hospital, continuing care hospital.

Skilled Nursing Facilities (SNF) are not hospitals. They care for residents who need intermittent on-site medical care from nurses, or therapists. Other names: nursing and rehabilitation facility, nursing home, continuing care, sub-acute care, subacute rehabilitation unit, long-term care facility.

Home Health Agencies (HHA) bring nursing, therapy and daily personal care to homebound patients. Other names: home health care, visiting nurse service.

Recognizing that PAC providers also serve patients who are not Medicare patients discharged from hospital, the Medicare definitions and dictates provide an important frame from which to describe the PAC services featured in this primer series. As America’s single largest health insurance program, Medicare’s requirements regulate the levels of service, admission criteria and payment terms for Medicare patients and influence the policies of other payers as well as the clinical resources and standards of care for all patients in PAC settings.

Under the Balanced Budget Act of 1997, Medicare introduced prospective payment systems (PPS) for 4 categories of post-acute care: long-term care hospitals, inpatient rehabilitation facilities, skilled-nursing facilities, and home health agencies. Implementation of the PAC PPS was scheduled between 1998 and 2002. These new payment schemes replaced the former cost-based reimbursement with systems compensating providers on the basis of each patient discharge (or a diem rate in the case of SNF), with adjustments for patient condition and expected resource needs. The PPS were intended facilitate directing patients to the most-appropriate care setting, and to strengthen incentives for efficiency in the provision of health care. Since the introduction of each distinctive payment system, the patient mix, reimbursement rules, and patient assessment measures and quality metrics have been periodically revised and refined. Both industry and regulators have worked towards greater understanding of the needs and opportunities attendant to the growing demand for recuperation and therapy beyond the acute hospital setting.

Post-Acute care services are provided in a variety of operating environments, under a variety of names. They can be free-standing or dedicated units, separately licensed onsite with other healthcare services. Individual providers may use names or titles for their facilities to best describe their services to patients and other stakeholders.

Therapy is a central clinical component of Post-acute care. Courtesy of Encompass Health.
As of 2013, approximately one quarter of all hospitalized patients, and forty percent of Medicare patients, were referred to some form of post-acute provider following their hospital stay. The regulatory and reimbursement changes to PAC in the recent 20 years have been focused on increasing providers' incentives to deliver and articulate efficiency and quality of care.

**Post-Acute Payment Legislation**\(^\text{4,5}\)

**PAC Reform Legislation**

- **1997**—Balanced Budget Act converted PAC reimbursement for post-acute care settings from cost-based to episode-based PPS implemented between 1998 and 2002
- **2013**—Bipartisan Budget Act introduced refined criteria for LTCH admissions and reimbursement
- **2014**—Improving Medicare Post-Acute Care Transformation (IMPACT) Act required development of consistent quality measures across all PAC settings
- **2018**—Balanced Budget Act redesigned the HH payment system

*The focus of the primer series is the post-acute services governed by Medicare prospective payment systems and the corresponding conditions of participation.*

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**COVID-19 Pandemic and Post-Acute Care**

The COVID-19 pandemic of 2020 has highlighted the distinct clinical capabilities of post-acute care settings. Many LTCHs have been an important source of surge hospital capacity to accommodate critically-ill intensive care patients, with their specialized expertise caring for complex respiratory illness and mechanically-ventilated patients. IRFs expertise in delivering intensive therapy in an acute hospital setting have also benefited patients recovering from COVID-19.

**Medicare FFS Spending on Post-Acute Care 2018**\(^\text{6}\)

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicare FFS Spending ($Billion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>58.7</td>
</tr>
<tr>
<td>2015</td>
<td>60.6</td>
</tr>
<tr>
<td>2016</td>
<td>60.0</td>
</tr>
<tr>
<td>2017</td>
<td>58.5</td>
</tr>
<tr>
<td>2018</td>
<td>58.6</td>
</tr>
</tbody>
</table>

*Source: Medpac Reports to Congress, 2016 - 2020*
### Characteristics of Post-Acute Care Settings

<table>
<thead>
<tr>
<th>Setting</th>
<th>Typical Patients</th>
<th>Physician Services</th>
<th>Nursing Services</th>
<th>Therapies (PT/OT/RT/SLP)</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LTCH</strong></td>
<td>Respiratory failure, septicemia, cardiac, kidney failure. Patients must meet one of two main admission criteria: (1) 3-days in an ICU, or (2) prolonged mechanical ventilation. LTCHs must have patients with a 25-day average length of stay (ALOS).</td>
<td>Daily physician visits. Specialist physicians on-site or on-call 24 hours a day.</td>
<td>Registered Nurses (RN) on-site 24-hours a day. High nurse to patient staffing ratio.</td>
<td>All therapies available. In-house RTs typical. LTCHs are known for weening patients off mechanical ventilation.</td>
<td>On-site pharmacy directed by licensed pharmacists. Drugs administered by licensed nurses.</td>
</tr>
<tr>
<td><strong>IRF</strong></td>
<td>Stroke, spinal cord injury, traumatic brain injury (TBI), amputation, severe orthopedic cases common. Medicare requires 60% of patients from one of 13 designated conditions.</td>
<td>Physician visits at least 3 times per week. Care overseen by specialists in rehabilitation medicine. Physicians on-site or on-call 24 hours a day.</td>
<td>RNs on-site 24 hours a day. Many nurses have special rehabilitation nursing training. Medium nurse to patient staffing ratio.</td>
<td>All therapies available. Weekly interdisciplinary clinical team meetings to review individual treatment plans. Patients must be able to tolerate 3 hours of therapy a day.</td>
<td>On-site pharmacy directed by licensed pharmacists. Drugs administered by licensed nurses.</td>
</tr>
<tr>
<td><strong>SNF</strong></td>
<td>Patients discharged from acute hospitals, LTCHs, IRFs after a minimum 3-day stay. After admission and at least every other month. SNF must have plan for physician coverage in event of emergencies.</td>
<td></td>
<td>RN coverage for 8 consecutive hours each day. Off-hour coverage can be provided by nursing licensed lower than RN. Low nurse to patient staffing ratios.</td>
<td>Therapies may be administered if ordered by physician or other authorized practitioner. Often provided via contract with independent, licensed providers.</td>
<td>On-site pharmacy not required, often provided via contract with independent providers. Drugs may be administered by unlicensed personnel if supervised by a licensed nurse.</td>
</tr>
<tr>
<td><strong>HHA</strong></td>
<td>Homebound patients from chronic debilitating illnesses. Patients are referred after discharge from acute hospitals, LTCHs, IRFs, SNFs or by a physician after an office visit. Physician visit required within 90 days prior to HHA episode or within first 30 days after start of HHA services.</td>
<td></td>
<td>RN must provide initial nursing assessment and periodic reevaluations. Routine nursing services can be provided by nursing licensed lower than RN.</td>
<td>Therapies may be administered if ordered by physician or other authorized practitioner.</td>
<td>No included pharmacy services. Nurses may help administer drugs secured independent of HHA benefit, in accordance with a physician order.</td>
</tr>
</tbody>
</table>

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1. Provided by licensed physical, occupational, or respiratory therapists or speech language pathologist.
2. High nurse-to-patient ratio is defined as 1 RN:2-4 patients (on average).
3. Medium nurse-to-patient ratio is defined as 1 RN:5-8 patients (on average).
4. Such as Licensed practical nurse or vocational nurses.
5. Low nurse-to-patient ratio is defined as 1 RN:8+ patients (on average).
6. Such as Licensed practical nurse or vocational nurses.
Future Policy Trends in Post-Acute Care

The evolution of PAC patient assessment and payment is ongoing. New patient classification systems were implemented as recently as April 2020. The growth of Medicare Advantage, Value-Based Plan Design, and Accountable Care Organizations are examples of trends that create new demands on PAC providers to partner with providers along the health care continuum and to harmonize the indicators used to measure the requirements for and value from services provided to patients. The IMPACT (Improving Medicare Post-Acute Care Transformation) Act of 2014 requires development and implementation of standardized patient assessment measures and reports across PAC settings towards a prototype and strategic roadmap for eliminating the existing compartmentalized regulatory and payment system. PAC providers, along with the American Hospital Association, have raised concerns that delays in meeting the regulatory milestones specified in the IMPACT Act and extraordinary demands, most recently the COVID-19 pandemic in 2020, threaten the efficacy of the implementation as originally envisioned. Furthermore, the extraordinary circumstances of the COVID-19 pandemic may compel regulators to revisit the original 10-year timeline laid out in the 2014 law.

References
1. ICC Summary of information from CMS.gov/Medicare/Medicare-Fee-For-Service-Payment
2. Provider Websites, Patient-Facing Information Pages
3. American Hospital Association Post-Acute Care Fact Sheet
4. HCUP Statistical Brief #205. All-Payer View of Hospital Discharge to Post-Acute Care, 2013
6. National Health Expenditures Fact Sheet, Centers for Medicare and Medicaid Services
7. Medicare Payment Advisory Commission Reports to Congress, 2016-2020
8. ICC summary of information from CMS.gov, and provider executive interviews
9. ICC Analysis of industry newsletters and major daily newspapers, February – June 2020
11. Compiled from SEC Filings, 10-K Reports 2019 and 2018; a variety of provider websites, and industry analyst reports
12. Larson, C. (2020, February 13). Moody’s investors services releases credit opinion on Kindred healthcare LLC.

Leading PAC Companies

<table>
<thead>
<tr>
<th>Company</th>
<th>Revenue 2019</th>
<th>Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select Medical (PA)</td>
<td>$5.1B</td>
<td>49,000</td>
</tr>
<tr>
<td>Genesis Healthcare (PA)</td>
<td>$4.6B</td>
<td>55,000</td>
</tr>
<tr>
<td>Brookdale Senior Living (TN)</td>
<td>$4.1B</td>
<td>38,400</td>
</tr>
<tr>
<td>Encompass Health (AL)</td>
<td>$4.6B</td>
<td>31,570</td>
</tr>
<tr>
<td>Kindred (KY)</td>
<td>$3.2B</td>
<td>38,300</td>
</tr>
<tr>
<td>LHC Group (LA)</td>
<td>$2.1B</td>
<td>30,400</td>
</tr>
<tr>
<td>Ensign Group (CA)</td>
<td>$2.0B</td>
<td>24,500</td>
</tr>
<tr>
<td>Amedysis (LA)</td>
<td>$2.0B</td>
<td>21,000</td>
</tr>
<tr>
<td>Providence St. Josephs (WA)</td>
<td>$1.3B</td>
<td>20,000</td>
</tr>
<tr>
<td>Vibra/Ernest Health (PA)</td>
<td>$1B</td>
<td>9,000</td>
</tr>
</tbody>
</table>

PAC admissions procedures and patient mix regulations have been temporarily relaxed to allow providers the flexibility for broader use of PAC hospitals and other services. These capabilities have been vital resources during the COVID-19 public health emergency. Expanded use of telehealth and home health care enabled PAC providers to continue many services amidst stay-at-home orders and social-distancing guidelines.

The COVID-19 pandemic also exposed vulnerabilities within some sub-acute PAC facilities that were inadequately prepared or funded to marshal protective equipment, testing, and patient isolation capabilities needed to mitigate the spread of COVID-19 among residents and staff. Highly publicized outbreaks in nursing home facilities in several states drew national attention and spurred Congress to investigate the causes and necessary remedies.
Volume 2

Long Term Care Hospitals
Long-Term Care Hospitals

Long-Term Care Hospitals ("LTCH") are specialty hospitals that treat patients with medically-complex illness and needing hospital care for an extended period. Many LTCH patients are ventilator-dependent and need ongoing respiratory care. During the 2020 COVID-19 pandemic, a number of LTCHs served as venues for high-acuity hospital care.

History
The LTCH model of care originated, decades ago, in New England with long-stay tuberculosis hospitals and morphed into specialized venues for high-acuity patients, most notably those with respiratory conditions.

In the 1970s, only several dozen hospitals specialized in providing care involving long-term stays. In 1983, the new Medicare hospital payment system—the inpatient prospective payment system (IPPS)—formally recognized the role of these hospitals with the creation of the “LTCH” designation.

In 2008, there was a limited moratorium on the construction of LTCH facilities, and the number of beds stabilized. The restrictions on LTCH construction continued through September 2017.

In late 2013, Congress passed a statute establishing new LTCH patient criteria, using a patient’s stay in an ICU (and also ventilator usage) as rough proxies for distinguishing patients eligible for referral to an LTCH.

After passage of the 2013 LTCH criteria, the number of LTCHs declined by approximately 10% and Medicare LTCH spending has similarly declined.

The higher-standards in the 2013 LTCH criteria had the effect of better-defining and clearly establishing the role of LTCHs in the American healthcare continuum.

Current Role in the US Health System
Today, there are over 370 Medicare-recognized LTCHs. The majority are in urban areas and are operated by private, proprietary companies. LTCH hospitals can operate as freestanding facilities or as designated facilities co-located or leased space within the campus of a regular acute hospital.

Did You Know?
LTCH serve medically-complex patients who require extended high-acuity hospital care.

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* <1% of spending on hospital care
The hospital-within-hospital (“HIH” or “HWH”) model must comply with federal regulations regarding separate control and management of the LTCH-designated units. Approximately half of LTCHs operate under the HIH model.4

These specialty hospitals represent a small percentage of America’s overall hospital resources, but play a vital role for many of the sickest patients, and as an available resource in times when specialized surge capacity of critical care facilities are needed.

Patients Served
There are an estimated 174,000 LTCH patients annually. The average occupancy rate for LTCHs was 63%, and the average length of stay was 26.6 days in 2018. That same year, there were approximately 102,000 Medicare fee-for-service patient stays with spending at $4.2 billion. Traditional Medicare patients represent approximately two-thirds of LTCH discharges.5

Physicians and hospital case managers identify patients in an intensive care unit (ICU) or patients who have been on ventilators for possible referral to an LTCH for extended hospital stays. Patients are transferred directly from ICU to LTCH, bypassing an intervening stay in a regular med/surg bed. LTCH patients have a variety of clinical needs—they may require care for complex wounds, suffer from paralysis, organ failure or sepsis, or they may require ventilators for ongoing respiratory support. A majority of patients referred to LTCH have complex respiratory conditions.

Primary LTCH Diagnoses
Percent of Medicare discharges, 20186

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory infection</td>
<td>1.9%</td>
</tr>
<tr>
<td>Pulmonary edema</td>
<td>22.6%</td>
</tr>
<tr>
<td>Ventilator support</td>
<td>96+ hours</td>
</tr>
<tr>
<td>Septicemia w/o ventilator</td>
<td>5.7%</td>
</tr>
<tr>
<td>Renal failure</td>
<td>2%</td>
</tr>
<tr>
<td>Tracheostomy w/ ventilator</td>
<td>2.2%</td>
</tr>
<tr>
<td>Other respiratory</td>
<td>2.8%</td>
</tr>
<tr>
<td>Ventilator support &lt; 96 hours</td>
<td>3.8%</td>
</tr>
<tr>
<td>Other Conditions</td>
<td>35.4%</td>
</tr>
</tbody>
</table>

Medicare Requirements
By far the most influential payor is the United States government through the Medicare program. While private insurers maintain different policies regarding their members’ utilization of LTCH, many emulate Medicare coverage and payment policies.

To be recognized by Medicare as a LTCH, a hospital must meet several core requirements, including:
- Must be licensed as a hospital by its state of residence
- Admitted patients must require ongoing medical oversight, for example due to other comorbidities
- Maintenance of facility-level minimums, such as:
  - An Average Length of Stay (“ALOS”) of at least 25 days; and
  - Attainment of at least 50-percent of cases reimbursed at the highest (non-site-neutral level)
- Must periodically measure and report data on their patients progress across a range of functional goals (“patient assessment data”)

Medicare Reimbursement
LTCH services are covered under Part A of the Medicare program. Like other hospital services covered under Part A, benefits are subject to an annual deductible, per day cost-sharing requirements for extended stays, and annual benefit limits. In 2020, the Part A deductible is $1,408, the per day coinsurance amount for days 61-90 is $352, and the daily coinsurance for lifetime reserve days in excess of the 90th day is $704. Medicare beneficiaries are entitled to a total of 60 lifetime reserve days.

Medicare reimburses LTCHs using a unique prospective payment system (“LTCH-PPS”). Each hospital is paid a fixed amount for each admission, similar to Medicare inpatient PPS for general acute care hospitals.

National LTCH Hospital Systems
- Kindred Healthcare
- Select Medical
- Vibra Healthcare / Ernest Health

Utah Valley Specialty Hospital, Provo, UT. Courtesy of Ernest Health.
In the LTCH-PPS, reimbursement is based on one of a 761 Medicare Severity Long-Term Care Diagnosis Related Groups Case Mix Groups (“MS-LTC-DRG”) that are defined by the Centers for Medicare and Medicaid Services (“CMS”). The relative value or weight of each MS-LTC-DRG is based upon a variety of factors, including the patient’s primary and secondary diagnoses.7

LTCH Criteria
In 2013, Congress passed a law which dramatically reshaped the nation’s LTCH sector. The 2013 admissions criteria for hospitals to qualify as an LTCH was considerably more strict than the previous regulatory regime.

At the heart of this criteria is a new requirement that many patients must first have a three-day ICU stay in an acute hospital before they are transferred into an LTCH. The three-day ICU stay requirement has become an important fact of life for LTCHs and serves as a necessary, if also somewhat arbitrary, proxy to measure patient acuity and to justify possible admission into a LTCH hospital.

Some Well-Known Independent LTCHs
- Barlow Respiratory Hospital (CA)
- Continuing Care Hospital (KY)
- Hospital for Special Care (CT)
- RML Specialty Hospitals (IL)
- Sparrow Specialty Hospital (MI)
- Texas NeuroRehab Center (TX)
- Warm Springs Specialty Hospitals (GA)

Some LTCH patients are exempted from the three-day stay ICU requirement. Many ventilator patients are automatically deemed appropriate for LTCH care. Providing respiratory care to ventilator-dependent patients is a core part of a LTCH’s clinical mission.

As a result of the 2013 criteria law, LTCHs are essentially paid under two separate systems—one system for the higher-acuity criteria-compliant patients and another system (“Site-Neutral”) for the lower-acuity non-compliant patients.

In a big change, the 2013 LTCH criteria provided that LTCH patients treated for psychiatric or rehabilitation conditions would be paid under the site-neutral system. The American Hospital Association has estimated that 40% of LTCH patients are covered under the “site-neutral” system.9

Impact of the 2013 LTCH Criteria
Many LTCHs closed. But, for those LTCHs who were able to meet the higher standards, the LTCH criteria had the effect of better-defining and clearly establishing the role of LTCHs in the American healthcare continuum.

Recent News
- During the COVID-19 National Emergency CMS waived the regulatory requirements that LTCHs need to maintain a 25-day average length of stay.
- As part of the CARES Act, Congress temporarily waived the 2013 site-neutral payment rate to encourage some LTCHs to admit more patients from general hospitals - emptying their wards to prepare for a wave of COVID patients.
- In several hot-spot regions with high concentrations of COVID-19 patients, some LTCH facilities have been converted to COVID-19-only facilities on a temporary basis.

Future of LTCHs
The COVID-19 pandemic illustrates the essential need for LTCHs in our health care system. As long as there is a need for comprehensive respiratory care there will be a need for LTCHs. Nonetheless, there are several ongoing trends and policy discussions that could impact how LTCHs operate in the future.

The IMPACT Act of 2014 requires CMS to study and report back to Congress on the potential unification of the LTCH-PPS with other post-acute payment systems, like those for home health and skilled nursing facilities. This is expected sometime in 2023.10

Number of LTCHs
Number of Beds

Source: KNG Health Consulting analysis of Provider Service File

Number of LTCHs
Decreased by 8.3%

Number of Beds
Decreased by 13.8%

380 390 400 410 420 430 440
2012 2013 2014 2015 2016 2017
25,000 26,000 27,000 28,000 29,000

Some Well-Known Independent LTCHs
- Barlow Respiratory Hospital (CA)
- Continuing Care Hospital (KY)
- Hospital for Special Care (CT)
- RML Specialty Hospitals (IL)
- Sparrow Specialty Hospital (MI)
- Texas NeuroRehab Center (TX)
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- In several hot-spot regions with high concentrations of COVID-19 patients, some LTCH facilities have been converted to COVID-19-only facilities on a temporary basis.
As policy makers have debated the future of the IMPACT Act they have noted that LTCHs provide a type of critical care that makes them look more like an outlier in the PAC continuum. Some experts have gone as far to as say that LTCHs are the exact type of care that should be “carved-out” of any comprehensive payment reform.

Similarly, as enrollment in Medicare managed care continues to grow (through the Medicare Advantage (“MA”) program), MA plan administrators are likely to have an increasingly impactful role in setting policies that impact access to LTCHs.

In any event, LTCHs will continue to provide an important role in the continuum of care – specialized expertise to care for a small number of critically-ill patients, with particular attention to complex respiratory care needs.

References

4. ICC interviews with LTCH executives.
6. Ibid
7. 84 FR 42430
10. History of Medicare’s Long-Term Care Hospital Payment System. Georgetown University. Professor Lisa M. Grabert.
Volume 3

Rehabilitation Hospitals
Rehabilitation hospitals—or “Inpatient Rehabilitation Facilities” (IRFs) in Medicare parlance—are an important part of the continuum of care in the United States. They specialize in providing comprehensive, individualized rehabilitation services to patients who are recovering from serious injuries or illnesses, such as stroke or traumatic brain injury.

History
The concept of a dedicated rehabilitation hospital has its roots in 20th century American history. One of the very first, dedicated rehabilitation hospitals was operated by the Georgia Warm Springs Foundation—a non-profit organization founded by Franklin Delano Roosevelt in 1927. In addition to being Warm Springs’ benefactor, FDR was a patient there for nearly two decades—returning annually to benefit from its hot spring fed pools. Paralyzed by polio in 1921, FDR found Warm Springs’ waters to be therapeutic and helpful in restoring some strength and range of motion in his legs.

In the post-war period rehabilitation hospitals found a new role—helping GI’s regain function after suffering debilitating combat wounds. The Department of Defense and Veterans Administration helped lead the way—developing multiple programs and facilities dedicated exclusively to helping combat veterans recover function and reintegrate into civil life. Two of the most important contributors to these efforts were Dr. Howard Rusk, an Army physician who set up many of the Army and US Army Air Corps early convalescent training programs for injured veterans, and Dr. Simon Baruch, a physician and advisor to Presidents Wilson and Roosevelt who advocated for funding and the early development of the field of physical medicine.

Two of the more prominent rehabilitation hospitals in the post-war period were the Kessler Institute for Rehabilitation in West Orange, NJ and the Rehabilitation Institute of Chicago (now the Shirley Ryan AbilityLab). Each helped advance the field of customized prosthetics and pioneered the practice of individualized, multi-disciplinary therapy plans—all with the goal of helping restore function and independence to patients—many who had suffered amputations, paralysis or other traumatic injuries during the war.

Current Role in the US Health System
Today there are over 1,100 Medicare-recognized rehabilitation hospitals across the country. Average occupancy was 66%. Total spending on care provided by rehabilitation hospitals was estimated to be approximately $14 billion in 2018. While significant, these costs were a small fraction (less than 1.5%) of the $1.19 trillion of total hospital spending that year. While rehabilitation hospitals treat patients of all ages, aged and disabled persons eligible for Medicare account for the majority of cases—an estimated 59% of all discharges in 2018.

Typically, rehabilitation hospitals help patients recover function after a serious acute care episode. Many rehabilitation hospital patients are transferred directly from a general acute care hospital after being stabilized following a significant injury, stroke or other neurological event, or after a major surgery—such as a hip fracture.

Did You Know?
Rehabilitation Hospitals specialize in comprehensive, individualized rehabilitation

<table>
<thead>
<tr>
<th>Number of Facilities</th>
<th>Estimated Revenue</th>
<th>Average Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,170</td>
<td>$14B</td>
<td>66%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Patients (Estimated Discharges)</th>
<th>Average Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>691,000</td>
<td>12.7 Days</td>
</tr>
</tbody>
</table>

Source: ICC Analysis of a variety of sources
While at the rehabilitation hospital, a patient’s care is overseen by a physician specializing in rehabilitation medicine, and they receive intensive therapy from physical and occupational therapists, psychologists, social workers, speech-language pathologists and others – in accordance with a jointly-developed care plan.

**Medicare Coverage Requirements**

While access to rehabilitation hospitals varies somewhat across the country, and private insurers maintain different policies impacting patient access, by far the most influential payor is the United States government through the Medicare program. Many private insurers emulate Medicare coverage and payment policies.

To be recognized by Medicare as a rehabilitation hospital—or an inpatient rehabilitation facility (“IRF”) in Medicare terminology—a hospital must meet several core requirements, including:

- Must be licensed as a hospital by its state of residence
- Admitted patients must require ongoing medical oversight, for example due to other comorbidities
- At least sixty percent of the hospitals' admitted patients must be from one of thirteen designated condition groups (e.g., stroke, spinal cord injury, amputation) (“60-percent rule”)
- Must provide comprehensive, multi-disciplinary therapy overseen by a rehabilitation physician
- Patients must generally undergo 3 hours of therapy a day, for 5 out of every 7 days (“3-hour rule”), or 15 hours of therapy a week.
- Must periodically measure and report data on their patients progress across a range of functional goals (“patient assessment data”)

**Medicare Reimbursement**

Rehabilitation hospital services are covered under Part A of the Medicare program. Like other hospital services covered under Part A, benefits are subject to an annual deductible, per day cost-sharing requirements for extended stays, and annual benefit limits. In 2020, the Part A deductible is $1,408, the per day coinsurance amount for days 61-90 is $352, and the daily coinsurance for lifetime reserve days in excess of the 90th day is $704. Medicare beneficiaries are entitled to a total of 60 lifetime reserve days.

Medicare reimburses rehabilitation hospitals using a unique prospective payment system (“IRF-PPS”). Each hospital is paid a fixed amount for each admission, similar to the Medicare inpatient PPS for general acute care hospitals.

**Primary Rehab Hospital Diagnoses**

Percent of Medicare discharges, 2018

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>20.0%</td>
</tr>
<tr>
<td>Other neurological</td>
<td>14.7%</td>
</tr>
<tr>
<td>Debility</td>
<td>11.6%</td>
</tr>
<tr>
<td>Brain injury</td>
<td>10.8%</td>
</tr>
<tr>
<td>Fracture of lower extremity</td>
<td>10.3%</td>
</tr>
<tr>
<td>Other orthopedic</td>
<td>7.9%</td>
</tr>
<tr>
<td>Spinal cord injury</td>
<td>4.9%</td>
</tr>
<tr>
<td>Cardiac conditions</td>
<td>5.9%</td>
</tr>
<tr>
<td>Stroke</td>
<td>4.9%</td>
</tr>
<tr>
<td>Major joint replacement</td>
<td>4.1%</td>
</tr>
<tr>
<td>Other</td>
<td>9.7%</td>
</tr>
<tr>
<td>All other</td>
<td></td>
</tr>
</tbody>
</table>

**National Rehabilitation Hospital Systems (# freestanding IRF)**

- Encompass Health (136)
- Select Medical (29)
- Kindred Healthcare (22)
- Vibra Healthcare/Ernest Health (29)

**Some Well-Known Rehabilitation Hospitals**

- Shirley Ryan Ability Lab (IL)
- Kessler Institute for Rehabilitation (NJ)
- Spaulding Rehabilitation Hospital*(MA)
- TIRR Memorial Hermann( TX)
- University of Washington Medical Center(WA)
- Mayo Clinic (MN)
- Rusk Rehabilitation Hospital (NY)
- Craig Hospital*(CO)
- Shepherd Center* (GA)
- Moss Rehabilitation Research Institute (PA)

* Medicare certified as Long Term Care Hospitals.

Source: US News Ranking, ICC Analysis
In 2017, the IRF base payment rate was $15,708. The average length of stay was 12.7 days, and the average payment, after all the case-specific adjustments, was $19,481.9 In 2020, the IRF base payment rate is now $16,489.10 CMS estimates that over 411,000 patients will be treated by IRFs this year – with total expenditures projected to be in excess of $8.0 billion.11

In the IRF-PPS, reimbursement is based on one of a hundred Case Mix Groups (“CMGs”) that are defined by the Centers for Medicare and Medicaid Services (“CMS”). The relative value or weight of each CMG is based upon a variety of factors, including the patient’s primary diagnosis, their score on functional and cognitive assessments, and their age. In addition, each CMG allows for four varying weights, based on the patient’s number of comorbidities.

Each year, in a rule providing updates for the IRF-PPS, CMS stipulates a base payment rate for the typical IRF admission. To calculate a payment for a specific case, an IRF takes the base payment rate as the starting point. A majority portion of this base rate is then adjusted based on the IRF’s geographic location (to account for varying labor costs), then multiplied by the CMG weight applicable to a particular patient. Additional adjustments may be made if the IRF is located in a rural area, has a high percentage of low-income patients (“LIP adjustment”), or hosts medical training programs. Finally, special policies reduce payments if patients are unexpectedly discharged within 3 days, and additional payments are provided in rare cases where a patient’s length of stay far exceeds that which is expected for their CMG (“high-cost outlier policy”).

Each year in its IRF-PPS rule, CMS updates its IRF-related policy requirements, provides updates to the base payment rate using an update factor dictated by Congress, and makes adjustments to the CMG relative weights and geographic wage-indices used in calculating payments.12

Future of Rehabilitation Hospitals
As long as strokes, car accidents, hip replacements and amputations persist in America, the need for rehabilitation hospitals will as well. Nonetheless, there are several ongoing trends and policy discussions that could impact how rehabilitation hospitals operate in the future.

The IMPACT Act of 2014 requires CMS to study and report back to Congress on the potential unification of the IRF-PPS with other post-acute payment systems, like those for home health and skilled nursing facilities. This is expected sometime in 2023. Similarly, several CMS demonstration projects and private insurer initiatives have encouraged the bundling of hospital services and post-acute care services into new payment models – often with providers bearing financial risk.

For example, Medicare is encouraging more cost sensitivity and risk sharing by providers through its promotion of Accountable Care Organizations (“ACOs”), new Advanced Payment Models for Medicare Part B providers, and targeted initiatives such as the Comprehensive Care for Joint Replacement demonstration.
which focuses on reducing the cost of episodes of care related to joint replacement surgeries.

Similarly, as enrollment in Medicare managed care continues to grow (through the Medicare Advantage (“MA”) program), MA plan administrators are likely to have an increasingly impactful role in setting policies that impact access to, and the role of IRFs.

Lastly, it is important to note that the Covid-19 pandemic has had significant impacts on the entire health system. As IRFs have worked to help short-term hospitals manage patient volumes during the crisis, and CMS has granted waivers to the sector, a greater number of patients outside the 13 designated conditions have been referred to IRFs in some markets rather than other post-acute care settings. It will be interesting to see if any of these treatment trends persist in the coming years.

In any event, rehabilitation hospitals will continue to be important in the continuum of care – providing specialized and intensive therapy services to patients when they are most in need.

References

2 Photo of FDR, Warm Springs, GA; Kenneth Rogers/The Atlanta Journal-Constitution via AP, accessed at http://apimages@ap.org
4 Report to Congress: Medicare Payment Policy, MedPAC, March 2020
8 See 42 C.F.R. §412.600-634; 42 C.F.R. Part 482.
Volume 4
Skilled Nursing Facilities
Skilled Nursing Facilities provide nursing, therapy, and activities of daily living for residents who cannot safely be cared for in their home, but do not need the level of care that a hospital provides. Skilled nursing care and nursing home care are two distinct services, generally provided under a common roof.

History
In England, almshouses were used for decades to provide welfare, housing and care to the marginalized people of society. These almshouses provided shelter and food to the elderly, orphans and those with mental illness. English settlers imported the practice of almshouses upon their arrival to America during the seventeenth century, with an increase in development during the eighteenth century. Recognizing the difference in care needs of the elderly population, charitable organizations established the first nursing homes. The Home for Aged Women was founded in 1849 as one of the first American nursing homes.

Other early nursing homes developed in tandem with church welfare efforts, with several religious organizations working to improve the lives of elderly almshouse residents. Though almshouses persisted into the early twentieth century, nursing homes became more pervasive in America as a result of legislation passed in 1935—which established social security payments for the elderly. The drafters of the Social Security Act intended to reduce reliance on almshouses and therefore prohibited the payment of social security funds to residents of public institutions. This stimulated growth of proprietary nursing homes. 1,2,3,4,5,6

What is the difference between a Skilled Nursing Facility and a Nursing Facility?

**Skilled Nursing Facility (SNF):**
- Facility meets Federal Medicare certification criteria and State Nursing Facility criteria
- Patient’s doctor has prescribed short-term daily skilled nursing care and/or therapy following a hospital stay

**Nursing Facility (NF):**
- Provides long-term care, such as activities of daily living and limited nursing and/or therapy services, without requiring a preceding hospitalization
- Nursing homes are licensed at the state-level, and their long-term or custodial care services (NF) are not covered by Medicare.

Source: ONS.gov/ICC Analysis

Note: This primer focuses on the services skilled nursing facilities provide as covered by Medicare.

Did You Know?
Skilled Nursing Facilities serve residents who need daily nursing, therapy services, at a lower acuity.

- **15,000** Number of Facilities
- **$28.5B** Total Spending (Medicare FFS beneficiaries)
- **84%** Average Occupancy (SNF beds)
- **1.5M** Residents Annually (Medicare FFS beneficiaries)
- **25 Days** Average Length of Stay

Source: ICC Analysis of 2018 data from a variety of sources
For qualified stays, Medicare pays 100% of the first 20 days, after which residents are responsible for 20-percent of the daily cost of their care. For Medicare beneficiaries who are also eligible for Medicaid (known as dual eligible), the patient’s co-payment may be subsidized. Typically, Medicaid is the primary payer for the majority of residents in a SNF/NF care facility. Details of Medicaid’s payment terms vary by state and are beyond the scope of this primer.

### Current Role in the US Health System

Only one third of nursing facilities are operated by large companies. Forty percent are single location operations. The majority are privately-held, proprietary facilities. Occupancy rates vary widely by facility and by state. Medicaid reimbursement levels and certificate of need laws and state facility requirements are some of the factors influencing the availability of nursing home beds in a particular area.

### Skilled Nursing Facilities

As of 2018, there are over 15,000 Medicare-recognized skilled nursing facilities across the country. That year, approximately 1.5 million FFS Medicare beneficiaries were treated by these facilities and Medicare spent over $28.5 billion on related care. In 2018, the average SNF reimbursement per stay was $18,247 and the average length of stay was 25 days.

Typically, skilled nursing facilities help residents recover from medically complex conditions, such as septicemia and pneumonia. Nearly all SNF residents are transferred directly from a general acute care hospital because the Medicare program only covers skilled nursing facility services after a minimum 3-day stay in a general acute hospital, LTCH or IRF. While at a skilled nursing facility, a patient’s care is overseen by a physician (periodic visits), and they receive skilled nursing care and/or therapy from physical, occupational, and speech language therapists. By contrast, NF residents may be admitted from hospital or directly from home, and are generally covered under Medicaid or as self-pay residents.

Over 90% of skilled nursing facilities are dually certified to provide SNF care under Medicare, Part A, as well as NF care, largely funded by Medicaid. An individual patient can be receiving services under a SNF or a NF, all under the same physical location. The reasons for these transitions across benefit vary, but often relate to exhaustion of the allowed Medicare benefit.
Facility-based nursing homes
In addition to free-standing SNFs and NFs, a nursing home can be part of another facility. This structure is typically referred to as distinct part unit (“DPU”).14 A DPU serves as a portion of a larger institution to provide SNF or NF services. The most common form of nursing home DPU is a hospital-based SNF. Nearly 4-percent of all certified SNFs are hospital-based.15 CMS requires that the beds within a hospital-based SNF be completely separate from the hospital.

Medicare Requirements
To be recognized by Medicare as a skilled nursing facility (“SNF”) — a SNF must meet several core requirements, including:
- Must be licensed as a skilled nursing facility by its state of residence
- Must need skilled services such as skilled nursing and/or skilled rehabilitation sources that a physician has determined are medically necessary
- Admitted residents must require ongoing medical oversight, for example due to chronic conditions
- Residents must have had a prior 3-day stay in a general acute hospital, or be transferred from a long-term care hospital (LTCH) or inpatient rehab facility (IRF) (“3-day stay rule”)

Key Medicare Policy Changes
- **1997**—Congress requires development of SNF PPS; facilities previously paid on a modified cost-basis
- **2002**— Full implementation of PPS
- **2014**—Passage of IMPACT Act seeks to align all post-acute care patient assessment efforts and establishes a SNF quality reporting program
- **2014**—Congress mandates a new SNF Value-Based Purchasing (VBP) program
- **2018**—SNF VBP begins
- **2019**—CMS implements the Patient Driven Payment Model for case-mix adjustments
- Must periodically measure and report data on their Medicare residents progress across a range of functional goals (“patient assessment data”)
- Must meet minimum staffing requirement of 8 registered nurse (“RN”) hours per day (significantly less that the 24 RN hours required of hospitals). At facilities with average daily occupancy is 60 or fewer residents, the RN requirement can be met by the RN Director serving as a charge nurse.

One of the main differences between SNFs and hospitals are the requirements around nursing services. For example, registered nurses are required to provide at least 8-hours of nursing care, seven days per week.16 However, hospitals (including rehab and long-term care hospitals) must provide 24-hours of nursing care, seven days per week.17 Another difference is the additional flexibility afforded to SNFs allowing the director of nursing to serve as the charge nurse—which would result in providing even less than 8 hours of nursing care per day.18

Medicare Reimbursement
Payment for care in SNF depends on which level of service each patient is admitted for. Medicare FFS pays skilled nursing facilities using a unique prospective payment system (“SNF-PPS”). Each facility is paid a fixed amount for each day (“per diem”) of care provided.

In the SNF-PPS, the per diem rates are defined by the Centers for Medicare and Medicaid Services (“CMS”). Five per diem rates are adjusted by weights or relative values based upon a variety of factors, including the patient’s primary diagnosis, their score on functional and cognitive assessments, and their age.

These five per diem rates are: nursing, physical therapy, occupational therapy, speech-language pathology services, and non-therapy ancillary services (such as intravenous chemotherapy drugs). A sixth per diem is also used, but it is

Recent News
- During the Covid-19 National Emergency CMS waived several regulatory requirements for SNFs, including the 3-day stay rule.
- In several hot-spot regions with high concentrations of Covid-19 patients, some facilities have been converted to Covid-19-only facilities on a temporary basis.
not adjusted for patient characteristics—only accounting for room and board. All six per diem rates are further delineated by urban or rural adjustments to account for the facilities physical location of the SNF.

Each year, in a rule providing updates for the SNF-PPS, CMS stipulates a base per diem rate for a typical day. To calculate a payment for a specific case, a SNF takes the base payment rate as the starting point. A majority portion of this base rate is then adjusted based on the SNF’s geographic location (to account for varying labor costs), then multiplied by the per diem weight applicable to a particular.

Each year in its SNF-PPS rule, CMS updates SNF-related policy requirements, provides updates to the base per diem rates using an update factor dictated by Congress, and makes adjustments to the relative weights and geographic wage-indices used in calculating payments.

Medicare beneficiaries have no cost-sharing obligations for the first 20 days of a skilled nursing stay; beginning on day 21 beneficiaries are required to cover a 20-percent of the daily rate, consistent with other Medicare Part A benefits, up to the coverage limit of 100 days.

Medicare Advantage (MA) plans also negotiate per diem rates for SNF care. In 2019, FFS payments were about 20% higher than MA rates.19 The importance of MA plans is expected to continue to grow as MA plans represent an ever-increasing share of Medicare enrollment.

**SNF Value-Based Purchasing**

In 2014, Congress mandated the public reporting of an all-cause, all-condition readmission measure for SNFs.20 Congress also required the readmission measure to be used in a Value-Based Purchasing (“VBP”) program that put 2-percent of a SNF’s annual Medicare reimbursement at risk based on an individual SNF’s performance on the readmission measure—compared to a national benchmark.21 The program began in 2018. In 2020, 77-percent of SNFs are being penalized (reduced payment) in the VBP program.22

**Medicare Patient Driven Payment Model (“PDPM”)**

On October 1, 2019, CMS began using a new case-mix or risk-adjustment model for SNF reimbursement. PDPM focuses on classifying residents into payment groups based on data-driven patient characteristics, such as clinical condition and functional score. Prior to implementation of PDPM, much of SNF reimbursement relied on the number and intensity of therapy services provided.

**Future of Skilled Nursing Facilities**

As illustrated above, the SNFs have endured a significant amount of change. Though not the focus of this primer, NFs have also likely endured a similar level of change. But, the greatest era of change for the full nursing home sector is still likely to come. The COVID-19 pandemic has thrust these providers into the spotlight. A great deal of national attention has been directed toward the industry. As policy makers focus on a retrospective review of the pandemic, it is likely the oddities around what certifies a facility as a SNF or NF will undergo intense scrutiny. The Department of Health and Human Services has launched a new Coronavirus Commission for Safety and Quality in Nursing Homes.17 This (“task force”) will likely focus on these nuanced but important distinctions.

Nonetheless, there are several ongoing trends and policy discussions that could impact how skilled nursing facilities operate in the future. The IMPACT Act of 2014 requires CMS to study and report back to Congress on the potential unification of the SNF-PPS with other post-acute payment systems, like those for home health and rehab hospitals. This is expected sometime in 2023.

Meanwhile, skilled nursing facilities continue to provide an important role in the continuum of care—providing nursing, therapy, and room and board to patients after they leave hospital, but are not yet able to return home. ●

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**Key Regulatory Leaders**

- **Seema Verma**, Administrator, Centers for Medicare and Medicaid Services
- **Demetrious Kouzoukas**, CMS Principal Deputy Administrator and Director, Center for Medicare
- **Hiliary Loeffer**, Acting Director, Chronic Care Policy Group
- **Todd Smith**, SNF Division Director
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4. Rogers, Henry B. Address Delivered at the Opening of the New Home for Aged Indigent Females, Revere Street, Boston, Thursday, June 25, 1863. Boston: John Wilson & Son, 1863
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16. 42 CFR 483.35(b)
17. 42 CFR 482.23
18. 42 CFR 483.35(b)(3)
20. PL 113-93
Introduction
Home health agencies provide medically necessary skilled nursing and therapy services to patients who do not need full-time care in an institutional setting, but who would be unable to leave home for outpatient services without great difficulty.

Home Health Agencies offer a safe, convenient and potentially cost-effective mode of care within the continuum of healthcare in the United States.

History
The concept of home health care has its origins in the early 19th century in the United States. Hospitals were considered extreme and mostly served patients without families or caregivers. Wealthy families hired doctors, nurses and midwives to provide care in their homes. Volunteer “visiting nurse” groups formed across the country to provide home care to those families who were unable to hire their own medical care.

In 1909, the Metropolitan Life Insurance Company included home nursing care in their insurance packages for policyholders. In the 1930s and 40s hospitals began to reach capacity and home care was viewed as a solution to reduce hospital census.

With the establishment of Medicare and Medicaid in 1965, home care was included as a covered benefit primarily to offer an alternative to hospital care.

The term “home health” is often used to represent a broad array of nursing or caregiving services provided in a patient’s residence. This primer pertains to medically-necessary skilled care provided at home, and eligible for coverage under public or private health insurance.

Current Role in the US Health System
Home health agencies help patients recover from a wide variety of needs. Home health care can be prescribed as follow-up care after a hospitalization or as care unassociated with a hospital stay.

Visiting Nurse Society of Philadelphia—1909

While in the home, patients will primarily receive care because they are in need of skilled nursing services and therapy. In addition, some patients will receive visits from an aide to support activities of daily living and for certain social services. Today there are over 11,500 Medicare-recognized home health agencies across the country.

Did You Know?
Home health agencies bring medically necessary services to patients at home.

<table>
<thead>
<tr>
<th>Number of Agencies</th>
<th>Total Spending</th>
<th>Proportion of Patients referred post-hospital stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>11,500</td>
<td>$102B</td>
<td>34%</td>
</tr>
</tbody>
</table>

Average Number of visits per patient: 34
Medicare Beneficiaries: 5.13M

Source: Cms.gov; Medpac 2020 report to Congress; ICC Analysis
**Medicare Coverage Requirements**
To be recognized as a home health agency (“HHA”) for reimbursement purposes, the provider must meet several requirements:
- The provider must be licensed as a home health agency in the state where they provide services.
- The provider must periodically measure and report data on their patients progress across a range of functional goals (“patient assessment data”).

**Homebound Requirement**
For some patients in need of intermittent skilled nursing or therapy, a doctor may determine that it is safer, more convenient, and potentially less expensive to receive services at home, rather than in a care facility. Eligible home health services are provided to Medicare FFS enrollees with no-cost-sharing obligation. However, the Medicare program limits its coverage of home health services to beneficiaries who are unable to leave home for medical services. Referred to as the “homebound” requirement, a home health provider must be able to prove that leaving the home is to “taxing” on a beneficiary. The Social Security Act defines home confinement as either: 1) illness or injury requiring the aid of supportive devices such as crutches, canes, wheelchairs and walkers, the use of special transportation, or the assistance of another person in order to leave a place of his/her residence; or 2) a condition such that leaving the home is medically contraindicated. If this requirement is unable to be met and services are still delivered, the home health provider may face a payment denial. Until March 2020, only a physician could certify that a beneficiary was homebound. This requirement was being permanently rescinded as part of the emergency waivers in response to the COVID-19 pandemic emergency. From March 2020, other professionals such as nurse practitioners and physician assistants can certify the need for home health services.

In 2018, $102 billion was spent on Home Health in the U.S. Medicare was the single largest payer, at $40 billion in services to 5.13 million beneficiaries, including 3.4 million Medicare FFS beneficiaries. Medicaid and CHIP paid $37 billion, private third party payers $16 billion, and out-of-pocket payments $10 billion.

**Top Home Health Providers**
- Kindred at Home (AL)
- Amedisys (LA)
- LHC Group (LA)
- Encompass Health (AL)
- AccentCare (TX)
- Brookdale Senior Living Solutions (TN)
- Bayada Home Health Care (NJ)

**Top Primary Diagnoses of Home Health Patients Referred from Hospital**
- Diabetes 7.14%
- Orthopedic aftercare 6.17%
- Other chronic obstructive pulmonary disease 4.89%
- Encounter for other postprocedural aftercare 4.42%
- Essential (primary) hypertension 3.61%
- Hypertensive heart disease 3.53%
- Pressure ulcer 3.51%
- Other disorders of muscle 3.21%
- Sequelae of cerebrovascular disease 3.21%
- Hypertensive heart and chronic kidney disease 2.30%
- Abnormalities of gait and mobility 2.25%
- Heart failure 1.90%
- Fracture of femur 1.76%
- Atrial fibrillation and flutter 1.75%
- Other disorders of urinary system 1.45%
- Dorsalgia 1.43%
- Parkinson’s disease 1.42%
- Other disorders of veins 1.38%
- Osteoarthritis of knee 1.19%
- Encounter for fitting and adjustment of other devices 1.15%

**Total for Top 20 Primary ICD-10 Diagnoses** 57.67%

**Home Health Payers (2018)**
- Medicare 39% | $40B
- Medicaid 35% | $37B
- Out-of-Pocket 10% | $10B
- Private Insurance/Other 15% | $16B
- Third Party Payers 15% | $16B

Source: Home Health News
Source: MedPAC Report to Congress, March 2020
insurance and other third party payers paid for almost $16B, and patients spent just over $10 billion out-of-pocket.\textsuperscript{10}

**Medicare Reimbursement**

Medicare pays home health agencies using a unique prospective payment system ("HHA-PPS"). Each agency is paid a fixed amount for a 30-day period ("episode") of care provided.

In the HHA-PPS, the episode rates are defined by the Centers for Medicare and Medicaid Services ("CMS"). There are 432 different types of episodes which are adjusted by weights or relative values based upon a variety of factors, including the patient's primary diagnosis, their score on functional or cognitive assessments, and their age. The episodes are assigned by a hierarchy of four different criteria: 1) timing and referral source; 2) clinical category; 3) functional and cognitive level; and 4) presence of co-morbidities.\textsuperscript{12}

The timing and referral criteria further delineate into early/late and institutional/community categories, as noted in the figure above. The clinical category breaks down into 12 subcategories: musculoskeletal rehab, neurological/stroke rehab, wound care, behavioral health care, complex care, medication management, teaching and assessment for surgical aftercare, cardiac and circulatory conditions, endocrine conditions, infectious diseases, respiratory conditions, gastrointestinal conditions, genitourinary conditions and other conditions.

**Initial criteria for home health episode assignment**

The functional and cognitive criteria are derived from patient assessment data and fall into three categories of low, medium and high. Finally, the comorbidity adjustment is determined from secondary diagnosis codes and is further classified into none, low and high.

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**Key Medicare Policy Changes**

- **1997**—Congress requires development of HHA PPS; facilities previously paid on a modified cost-basis
- **2000**—Full implementation of PPS
- **2007**—Establishment of the HHA Quality Reporting Program
- **2014**—Passage of IMPACT Act seeks to align all post-acute care patient assessment efforts and establishes a HHA quality reporting program
- **2016**—CMS initiates the Home Health Value-Based Purchasing Model
- **2020**—CMS implements the Patient Driven Groupings Model for case-mix adjustments
In 2018, the average HHA reimbursement per stay was $3,089. The average length of stay was 1.9 episodes, with about 17 visits per 30-day episode.15

**Patient Driven Groupings Model (“PDGM”)**

On January 1, 2020, CMS began using a new case-mix or risk-adjustment model for HHA reimbursement. PDGM focuses on classifying patients into payment groups based on data-driven patient characteristics, such as clinical condition and functional score. Prior to implementation of PDGM, much of HHA reimbursement relied on the number and intensity of therapy services provided.16

**Future of Home Health Agencies**

The demand for Home Healthcare is expected to continue to increase due to demographic trends and as payers face increased pressure to carefully manage cost growth in healthcare. Optimizing the use of home health may help reduce costs on both pre-acute and post-acute institutional care settings.17

There are several ongoing trends and policy discussions that could impact how HHAs operate in the future.

The IMPACT Act of 2014 requires CMS to study and report back to Congress on the potential unification of the HHA-PPS with other post-acute payment systems, like those for nursing homes and rehab hospitals. This is expected sometime in 2023. Similarly, several CMS demonstration projects and private insurer initiatives have encouraged the bundling of hospital services and post-acute care services into new payment models – often with providers bearing financial risk.

Meanwhile, HHAs continue to provide an important role in the continuum of care—a trend which is expected for years to come. Another trend to watch in the future will be the difference in the scope of services beneficiaries have access to between the tradition FFS and MA benefits. MA has greater ability to provide benefits, such as personal care services. As the MA advantage program continues to grow, policy makers will need to consider the divergence in benefits for home health between FFS and MA.

**Key Regulatory Leaders**

- **Seema Verma**, Administrator, Centers for Medicare and Medicaid Services
- **Demetrious Kouzoukas**, CMS Principal Deputy Administrator and Director, Center for Medicare
- **Hiliary Loeffler**, Acting Director, Chronic Care Policy Group
- **Brian Slater**, Director, Division of Home Health and Hospice
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18. Photo courtesy of Encompass Health
Volume 6

Outpatient Rehabilitation Therapy
Outpatient Rehabilitation Therapy includes a variety of clinical services to help patients to improve function and movement, to improve their ability to perform daily tasks, to improve communication or to ease pain.

Introduction
Outpatient rehabilitation therapy providers are a large, growing and critical component of the United States health system. Outpatient therapy is the natural continuum of care for many patients – particularly those recovering from serious debilitating injuries or illnesses, major orthopedic surgeries and a variety of other neurological and musculoskeletal disorders. Each year in the United States, outpatient therapy professionals — including licensed physical therapists, occupational therapists and speech-language pathologists — help millions of patients as they strive to regain function and independence and adjust to life after a serious health incident.

History
The origins of outpatient therapy – and today’s various therapy professions – are found in the mid to late 19th century in Europe, as physicians and patients alike began to grapple with the new challenges associated with the industrialized world, improving medical treatments, and higher recovery rates. By the early twentieth century, with the advent of the worldwide poliomyelitis pandemic, and two world wars featuring weapons from an industrialized age, the need for therapy for patients became acute. Many of the pioneers of today’s therapy professions began by treating children afflicted with polio, or helping combat wounded soldiers regain strength and function, or to adapt to living with the debilitating results of war – such as amputations, burns or partial loss of limb.

Current Role in the US Health System
According to the market research firm Marketdata, there were over 38,000 rehabilitation therapy clinics in the United States in 2018, and over $34 billion was spent on related services with a predicted growth rate over 6% the next 5 years.1

Today, most outpatient rehabilitation therapy services are provided or supervised by one of the following three therapy disciplines.

Physical Therapy: Physical therapists (“PTs”) help patients regain strength, mobility and gross motor skills after a serious injury. For example, they often help stroke patients regain balance and ambulation, or help those who have undergone joint replacement surgery or other orthopedic procedures rebuild strength and range of motion in the affected limbs and muscles. PTs are trained to help patients using manual therapy techniques and therapeutic movements. PTs develop personalized therapy plans for their patients, instruct them on how to properly do rehabilitative exercises and educate them on how to maintain their progress independently. There are approximately 209,000 licensed physical therapists in the United States.2

Occupational Therapy: The focus of occupational therapy (“OT”) is helping patients regain the ability to perform routine activities of daily living (“ADLs”), such as dressing, bathing

Did You Know?
Outpatient therapy is a large and growing component of the US health care continuum.

<table>
<thead>
<tr>
<th>Number of Clinics</th>
<th>Annual Spending</th>
<th>PT/OT/Speech Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>38,000+</td>
<td>$34B</td>
<td>500,000</td>
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Source: ICC Analysis of Industry and Government Reports
Therapy professionals work in a variety of outpatient settings. These include hospital outpatient departments, multidisciplinary medical practices and stand-alone therapy clinics. In addition, therapy professionals often provide services to homebound patients and residents of nursing homes, in addition to inpatients at general and specialty hospitals (such as inpatient rehabilitation facilities). The majority of therapists in the outpatient setting work in clinics with fewer than 10 practitioners. Therapists may work for themselves in private practice, be employed by a physician’s office or hospital, by a school district or by a specialty therapy clinic.

Medicare Coverage Requirements

Approximately 34% of the patients in physical therapy clinics are aged 65 and over, and receive therapy coverage through Medicare. As the largest insurance program in the US, the Medicare program’s coverage requirements for outpatient therapy are the most influential. Private insurers often emulate many of these standards. Generally, for outpatient therapy services to be covered under Medicare the following requirements must be met:

- The patient must be under the care of a physician or Medicare-recognized non-physician practitioner (“NPP”), who attests to the medical necessity of, and refers the patient for therapy;
- Therapy services must be provided by a qualified practitioner, defined as a licensed PT, OT or SLP, or a licensed OT assistant or PT assistant who is acting within their scope of practice;
- Services must be furnished on an outpatient basis in one of Medicare’s recognized settings, such as a private therapy clinic, comprehensive outpatient rehabilitation facility (“CORF”), outpatient rehabilitation facility (“ORF”) or hospital outpatient department, or in coordination with other Medicare-covered skilled nursing facility (“SNF”) or home health agency (“HHA”) services;
- Services must be provided in accordance with an individualized plan of care (“PoC”), developed by a qualified therapist, physician or NPP;
- The PoC must be certified by the patient’s physician or NPP, under whom the patient remains in their care, and recertified in the event of any changes to the PoC;
- In the event of extended episode of care, a patient’s PoC must be recertified by their physician or NPP at least every 90 days.

Leading Outpatient Therapy Providers

- Athletico Physical Therapy (AL)
- ATI Physical Therapy (IL)
- CORA Health Services (OH)
- PT Solutions (GA)
- Pivot Physical Therapy (MD)
- Select Medical/Physiotherapy Associates (PA)
- Upstream Rehabilitation / Drayer Physical Therapy (AL)
- U.S. Physical Therapy (TX)
Medicare Reimbursement Overview

Cost-Sharing. Outpatient therapy services are covered under Part B of the Medicare program. As such, patients are generally required to pay cost-sharing equal to 20% of allowable charges for the services they receive — after meeting their annual Part B deductible. Medicare pays the provider of services the remaining 80% through its established payment systems and processes.

Medicare Physician Fee Schedule. Almost all reimbursement for outpatient therapy services are provided for through the Medicare Physician Fee Schedule (“PFS”). Reimbursement may be provided directly to an enrolled therapy professional, under arrangements with a Medicare-recognized therapy provider, such as a rehabilitation agency, or as a service incident to a physician visit.

Payments for outpatient therapy services utilize a range of billable codes specified in Level II of the Healthcare Common Procedure Coding System (“HCPCS”), also known as Current Procedural Terminology (“CPT”) codes. The CPT coding system was created in the 1960s and is the intellectual property of, and is maintained by, the American Medical Association (“AMA”). CPT codes are used by Medicare with the permission of the AMA.

Each HCPCs Level II code (including those commonly used by therapists) is assigned a relative value through the AMA’s RVS Update Committee (“RUC”). The RUC was established to consider and set relative values for physician provided and ordered procedures prior to Medicare’s transition from charge-based billing to a Resource-based Relative Value Unit Scale (“RBRVS”) payment system in the early 1990s.

In assigning relative weights to procedural codes, the RUC considers and assigns values to three separate components for each code:

- a work component that considers the time and professional expertise required to perform the service (“Work RVU”);
- a practice expense component, that considers the indirect costs required to provide the services, such as supplies, rented space and supporting staff (“PE RVU”); and;
- a practice expense liability component that takes into account the relative risk of the procedure and its impact on applicable professional liability premium costs (“PLI RVU”).

The RUC revisits the relative weights assigned to each of the over ten thousand CPT codes at least once every five years. From the launch the RBRVS physician fee schedule policy until today, the Centers for Medicare and Medicaid Services (“CMS”), the agency that administers Medicare, has elected to use the CPT coding system to manage its payments.

Once a year CMS issues a rule to make modifications to its Part B physician payment rates and policies — including those governing outpatient therapy services. CMS typically defers to the AMA’s designation of CPT codes and the RUC’s assigned relative weights but reserves the right to make changes.

Payment amounts for outpatient therapy services — like physician services — are based on two primary factors. The relative value of the code that is billed is multiplied by a standard conversion factor (“CF”). This enables the relative value of each procedure to be translated into a dollar amount. For CY2020, the CF is $36.0896.7

Recent News

- During the Covid-19 national health emergency, CMS has used its waiver authority to authorize the use of telehealth to deliver some therapy services
- Due to budget neutrality requirements now in law, and significant increases in the relative valuation of physician evaluation and management codes by the RUC, CMS has indicated that therapists and over 20 other specialties could see significant cuts to CY2021 Medicare payments — as much as 8% for PTs, OTs and SLPS

Overall, CMS estimates that total Medicare covered outpatient therapy charges will exceed $4.2 billion in 2020.8 This amounts to approximately 4.5% of the dollars paid through the Medicare PFS, and less than .005% of total projected Medicare spending, which is projected to exceed $885 billion this year.9

CMS makes revisions to the conversion factor annually based on requirements in law. There are two principal steps to this process.

Budget Neutrality. First, CMS is required to make adjustments to make projected spending under the new fee schedule the same as the prior year. This is referred to as the "budget

Outpatient Rehabilitation Therapy
neutrality” requirement. In implementing this provision, CMS takes into account the revised weights for each HCPCS code and any projected changes in volume of services by code for the upcoming year. If some codes are expected to have a significantly higher value or weight, or the volume of some codes is expected to rise, CMS must make offsetting adjustments to the conversion factor so that total projected spending remains the same.

Pending CY2021 Budget Neutrality Cuts. In 2021, the budget neutrality requirement is expected to force unprecedentedly large revisions to Medicare payments for many health specialties. This is due primarily to a long-awaited reassessment of the relative weights assigned to evaluation and management codes (“E&M codes”) by the RUC. These E&M codes are the majority of the codes billed by primary care clinicians when seeing patients in most routine office visits. As such, the volume of E&M codes paid for by Medicare each year is enormous – accounting for approximately 40% of all Medicare PFS allowed charges in 2020.10 In 2021 the relative weights of the E&M codes are scheduled to increase significantly. Because the budget neutrality rule requires offsetting changes, this is forecast to result in significant decreases in reimbursement amounts for therapists, surgeons and a host of other professionals who don’t typically bill a lot of E&M codes. Because of this policy, outpatient therapy providers are currently projected to receive an 8% cut in reimbursements in 2021. Other specialties expected to be adversely impacted by this development are listed in the chart below.11

Conversion Factor Updates. After the required budget neutrality adjustments are made, CMS applies a statutorily prescribed update factor. This factor represents Congress’ expected increase in total spending through the Medicare PFS. In recent years this update factor has been essentially flat, with a .5% update authorized in 2018, a .25% update paid in 2019, and a 0% update required for the years 2020-2025.12

Medicare Policies Impacting Therapy
In recent years there have been several policies implemented through the Medicare PFS rule that have impacted therapy providers.

Outpatient Therapy Caps. From the late 1970s until 2018, there was a statutory limit on the amount of outpatient therapy benefits a Medicare beneficiary could receive in a calendar year. The therapy benefit was capped at various levels between $100 and $3,700 during this period.13 While in place, therapy caps were consistently criticized as an arbitrary and dangerous policy, and an impediment to the recovery of seriously ill and injured patients. Throughout most of this period application of the caps was effectively suspended or waived due to either temporary statutory provisions, administrative delays, pending litigation, or a congressionally authorized patient-level exceptions process.

Finally, as part of the Balanced Budget Act of 2018, Congress permanently repealed the hard caps on the outpatient therapy benefit. Instead, the law institutionalized a mandatory, targeted medical review process that requires CMS contractors to examine the appropriateness of claims once a patient’s annual outpatient therapy costs exceed a statutorily defined threshold. For 2020 the review threshold is set at $2,080.14

Specialties Most Adversely Impacted by Pending E&M Code Reweighting & the Budget Neutrality Rule

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Est. Impact on CY2021 Payments</th>
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</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>-7%</td>
</tr>
<tr>
<td>Cardiac Surgery</td>
<td>-8%</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>-9%</td>
</tr>
<tr>
<td>Clinical Psychology</td>
<td>-7%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>-7%</td>
</tr>
<tr>
<td>Nurse Anesthetists</td>
<td>-9%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>-10%</td>
</tr>
<tr>
<td>Pathology</td>
<td>-8%</td>
</tr>
<tr>
<td>Physical/Occupational Therapy</td>
<td>-8%</td>
</tr>
<tr>
<td>Radiology</td>
<td>-8%</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>-7%</td>
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</tbody>
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Multiple Procedure Payment Reduction. The Affordable Care Act of 2010 required CMS to undertake a new mis-valued code review initiative. Among other things, CMS was instructed to examine the appropriateness of reimbursements for codes which...
Key Medicare Policy Changes
- 1979—Therapy caps begin with authorization of PT billing
- 1992—Enactment of RBRVS physician fee schedule
- 1996—Full implementation of physician fee schedule
- 2011—Multiple Procedure Payment Reduction initiative begins
- 2015—Passage of MACRA
- 2018—Therapy cap repeal
- 2021—Scheduled cuts in therapy reimbursements due to E&M codes revaluations
- 2022—Therapy assistants 15% reimbursement reductions to begin

are frequently billed in conjunction with each other when furnishing a single service. This led CMS to initiate its Multiple Procedure Payment Reduction (“MPPR”) policy beginning in 2011. Under the MPPR initiative, CMS has reduced payments for many therapy services including time-based therapeutic activity and other therapy-only codes. Under the MPPR policy, CMS discounts the PE RVU component of secondary codes that are billed on the same day as a primary therapy code by 50%.

Therapy Assistants Payment Policy. In conjunction with the repeal of therapy benefit caps, the Balanced Budget Act of 2018 included another provision requiring a reduction in payments for services provided in whole or in part by a physical therapy assistant (“PTA”) or an occupational therapy assistant (“OTA”). Beginning in 2022, services provided entirely by a PTA or an OTA, as well as those for which the PTA’s or OTA’s services account for 10 percent or more of the total minutes devoted to the service, will be paid at 85% of the otherwise applicable reimbursement rate.15

Medicare Physician Payment Reform
Lastly, no review of outpatient therapy reimbursement policy is complete without a discussion of the ongoing structural changes made to the Medicare physician payment system by the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”). MACRA contains the most significant changes to Medicare's payment policies for physicians (and other covered professionals like PTs, OTs and SLPs) since the creation of the RVRBS system in 1992.

The primary objective of MACRA was to replace the prior structure for updating the pool of budgeted funds available to pay claims through the Medicare PFS. That system, known as the Sustainable Growth Rate (“SGR”), had fixed total, allowable, annual Part B physician spending to a derivative of general economic growth, and was widely viewed as unsustainable in a time of significant Medicare population expansion. Without changes, the SGR system would have resulted in increasingly large cuts in physician reimbursements each year. MACRA replaced the SGR system with a more sustainable – albeit relatively flat – comprehensive budgeting trajectory for Medicare PFS services.

In conjunction with this fix, MACRA included a fundamental restructuring and consolidation of Medicare's Part B quality improvement programs. These changes are just now being fully implemented and will have a growing impact on therapy professionals in the coming years.

Quality Payment Program. MACRA included a new mandatory, quality reporting and performance-based reimbursement system that applies to every physician and other clinician that bills through the Medicare PFS. The program is referred to as the Quality Payment Program (“QPP”).

Under the QPP, clinicians who bill Part B will have an increasing percentage of their Medicare reimbursements adjusted each year based on a variety of relative performance measures. Those who perform well relative to their peers will receive bonuses. Those who perform poorly will see commensurate levels of cuts.

Under MACRA, clinicians have two options for participating in the QPP. They can either participate in the Merit-based Incentive Payment System (“MIPS”) or be enrolled in an

Key Regulatory Leaders
- Seema Verma, Administrator, Centers for Medicare and Medicaid Services
- Demetrious Kouzoukas, CMS Principal Deputy Administrator and Director, Center for Medicare
- Ing Jye Cheng, Acting Director, Hospital and Ambulatory Policy Group
- Tiffany Swygert, Director, CMS Division of Outpatient Care
- John Pilotte, Director, CMS Performance-based Payment Policy Group

Advanced Payment Model (“APM”), such as an accountable care organization. Given the slow growth of APMs, and their more comprehensive integration requirements, it is currently projected that most clinicians will participate in the MIPS program.
**Merit-based Incentive Payment System.** Under MACRA, clinicians began reporting performance data across four domains in 2017. The data collected pertains to quality, resource use (or cost), health improvement activities, and electronic data sharing (through electronic health records or “EHRs”). Based on this data Medicare payments to physicians were adjusted for the first time in 2018. Per MACRA, the lowest performing clinicians in MIPS may receive negative payment updates of -5% in 2020. This percentage is slated to grow to as much as -9% by 2022. By contrast, the best performing clinicians can theoretically obtain higher positive updates—or bonuses. However, due to a lack of differentiation in most participating clinicians’ performance scores, almost all received slightly positive updates – but none more than 1.7%.

**Advanced Payment Models.** To be eligible for the APM performance track, clinicians must participate in a qualifying APM. For an APM to qualify, it must—among other things—have at least 75% of its clinicians actively using integrated EHRs and bear more than nominal risk for the overall cost of care for the patients it serves. Participating clinicians in an APM must be eligible for performance bonuses of at least 5% over the initial five years of the program (2019-2024) and are generally expected to have a higher percentage at risk in future years. MACRA creates incentives over the long term for clinicians to join an APM. Participants in APMs are set to receive future CF updates of .75% a year beginning in 2026, while those participating in MIPS are only scheduled to receive .25% annual updates.

**Future of Outpatient Therapy Services**

As the US health system continues to evolve, and the Medicare population continues to increase as the baby boomer generation retires and ages, the need for outpatient therapy services is only expected to grow too – although change is inevitable. As Medicare and other payers seek to encourage greater data sharing and move toward greater contractual integration, it is likely that therapy providers may see both increasing demand for services and increasing demands for more advanced data reporting and accountability for outcomes. Similarly, as the focus on cost reduction increases, it is likely that therapists – like all health professionals – will face ongoing economic pressures from both Medicare and private payers or be driven to perform more of their services in lower-cost settings – such as the home.

Nevertheless, because the United States has a very large and aging population, and a growing population of both chronic disease patients and acute illness survivors, the value and importance of outpatient therapy services to the system is expected to only increase as well.

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8. 84 Fed. Reg. 63153
10. 84 Fed. Reg. 62844
11. 84 Fed. Reg. 63156-7
14. 84 Fed. Reg. 62709
15. 84 Fed. Reg. 63191
16. See Merit-Based Incentive Payment System and Alternative Payment Model final rule, 81 Fed. Reg. 77008
17. 98% of MIPS participants earned a bonus for 2020 – but don’t expect a big payout, Advisory Board Daily Briefing, Jan 7, 2020.