IRF Update
Policy & Federal Relations
June 2014
Call Agenda:

- Legislative Update
- FY 2015 Proposed Rules
- Delivery System Reform
Member Calls on FY 2015

Post-Acute Proposed Rules

– LTCH: Thu, June 5, 1:00ET
– IRF: Thu, June 5, 3:00ET
– SNF: Fri, June 6, 1:00 ET

• AHA Regulatory Advisories available at www.aha.org/postacute
Legislative Update
Legislative Outlook

• No grand bargains
  – No entitlement reform
  – No tax reform
  – No significant deficit reduction

• But, still have many issues on the table
  – Legislative: associated with various “cliffs” or deadlines

• New budget addiction

• Executive action
PAMA’s Post-Acute Provisions

- ICD-10-CM Delayed

- Realigns Medicare sequester at 4 percent for first 6 months of FY 2024 (Saves $4.9 billion)

- SNF Value-Based Purchasing Program (Saves $2.0 billion)

- LTCH Criteria Technical Corrections (Spends $100 million
  - Changes to the 50% Compliance Test
    - Medicare Fee-for-Service patients only
  - Moratorium Exceptions
  - Limit key site-neutral payment provision
  - Additional changes still needed…
• Framed as creating “building blocks” of post-acute care reform through collection and reporting of:
  – Standardized patient assessment data
  – Standardized quality measures

• Significantly expands data collection and reporting requirements for LTCHs, IRFs, SNFs and HHAs
  – Payment penalties for non-reporting

• Introduces post-acute care related data reporting requirements for general acute care hospitals

• Requirements phased in over time
AHA’s Take

Support the direction of the bill with cautions…

• **Remove hospital reporting requirement**

• **Ensure the feasibility of PAC patient assessment data & the suitability of PAC quality measures**

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May 12, 2014

The Honorable Ron Wyden
Chairman
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20515

The Honorable Orrin Hatch
Ranking Member
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20515

The Honorable Dave Camp
Chairman
United States House of Representatives
Committee on Ways and Means
1100 Longworth House Office Building
Washington, DC 20510

The Honorable Sander Levin
Ranking Member
United States House of Representatives
Committee on Ways and Means
1104 Longworth House Office Building
Washington, DC 20510

Dear Chairman Wyden, Ranking Member Hatch, Chairman Camp and Ranking Member Levin:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to weigh in on the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 discussion draft. Below we outline our primary concerns with and recommendations for the draft language. We look forward to seeing the next version of the language.

**COMMENTS ON PROPOSED HIPPS/CAH/CANCER HOSPITAL REQUIREMENTS**

Our members have significant concerns about the feasibility and burden of collecting the proposed patient assessment data. For example, it is likely that the data would need to be collected through a combination of both electronic health records (EHRs) and manual chart abstraction. Our members expressed little confidence that they could rely solely on an EHR to collect the data. They also expressed concerns about how the data would be used outside of post-acute payment reform efforts. For these reasons, we recommend that the reporting requirements for hospitals be removed from the legislation.
Bundled Payment Proposals

**BACPAC (HR 4673)**
- Mandatory program
- Post-acute only bundled payment
- Multiple types of conveners
- 90 day episode
- Est. savings by ensuring overall spending doesn't exceed [100 minus X]% over a 10-year period

**Comprehensive Care Payment Innovation Act (H.R. 3796)**
- Voluntary program
- Bundle across inpatient and post-acute care
- Hospital convener?
- 90 day episode
- Est. savings as an alternative pay model under SGR

Rep. Black

Rep. McKinley
Inpatient Rehabilitation Facilities
IRF PPS Proposed Rule for FY 2015

- **COMMENTS:** Due June 30
- Net update of 2.2% (+$160M)
  - +2.7% market basket
  - -0.4% productivity cut (ACA)
  - -0.2% (ACA)
- New wage index categories would take affect in FY 2016
- Freeze facility-level adjustments at FY 2014 levels
- ICD-10 delayed
- Further reduction of cases eligible for 60% Rule presumptive test
- New IRF PAI reporting requirement for group therapy
- IRF quality reporting changes
Proposed Changes To 60% Rule Presumptive Test
FY 2014 Final Rule: Reduced ICD-9-CM Codes included in Presumptive Test

• FY 2014 final rule finalized policy to remove 259 ICD-9-CM codes from 60% Rule presumptive test, beginning Oct. 1, 2014.
  – Intended to account for changes and variation over time in hospital coding, clinical practice, condition frequencies and 60% Rule enforcement by CMS contractors.
  – May still be counted based on medical record audit

- Rule would remove additional 10 codes for amputation cases from the codes that qualify under the presumptive test beginning Oct. 1, 2014.
  - CMS’s rationale: diagnosis codes cannot, on their own, indicate whether a patient with an amputation status or with prosthetic fitting and adjustment needs has a condition for which IRF treatment is medically necessary.
- Discussion of impact
# Proposed Removal of Amputation ICD-9-CM Codes from Presumptive Test

**EXCERPT FROM PROPOSED RULE:**

**TABLE 7—ICD–9–CM CODES PROPOSED TO BE REMOVED FROM “ICD–9–CM CODES THAT MEET PRESUMPTIVE COMPLIANCE CRITERIA”**

<table>
<thead>
<tr>
<th>ICD–9–CM code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>V49.65</td>
<td>Below elbow amputation status.</td>
</tr>
<tr>
<td>V49.66</td>
<td>Above elbow amputation status.</td>
</tr>
<tr>
<td>V49.67</td>
<td>Shoulder amputation status.</td>
</tr>
<tr>
<td>V49.73</td>
<td>Foot amputation status.</td>
</tr>
<tr>
<td>V49.74</td>
<td>Ankle amputation status.</td>
</tr>
<tr>
<td>V49.75</td>
<td>Below knee amputation status.</td>
</tr>
<tr>
<td>V49.76</td>
<td>Above knee amputation status.</td>
</tr>
<tr>
<td>V49.77</td>
<td>Hip amputation status.</td>
</tr>
<tr>
<td>V52.0</td>
<td>Fitting and adjustment of artificial arm (complete) (partial).</td>
</tr>
<tr>
<td>V52.1</td>
<td>Fitting and adjustment of artificial leg (complete) (partial).</td>
</tr>
</tbody>
</table>
FY 2015 Prop. Rule: Removal of IGCs from Presumptive Test

- CMS proposed to remove IGCs beginning Oct. 1, 2014
  - IGC 0005.1 – Unilateral upper limb above the elbow
  - IGC 0005.2 – Unilateral upper Limb below the elbow
  - IGC 0006.1 – Rheumatoid arthritis
  - IGC 0006.9 – Other arthritis.

- Rationale: Additional information is necessary to determine to count toward the 60% Rule.

- Discussion of impact
FY 2015 Prop. Rule: Exclusion of Etiologic Diagnosis IGCs

• CMS would prohibit any IGC from qualifying under the presumptive test if the patient’s etiologic diagnosis (the primary reason that led to the condition for which the patient is receiving rehabilitation) is excluded for that IGC.
  
  – Provided in 2015 Data Files [http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html](http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html).

• Discussion of impact
IRF
Quality Reporting Program
Submit quality measures for FY 2014 payment determination and beyond

Compliance is tied to 2 percent of the annual update

<table>
<thead>
<tr>
<th>Measure</th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>FY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catheter-Associated Urinary Tract Infection (CAUTI)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Percent of nursing home residents with pressure ulcers that are new or worsened (short-stay)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Influenza vaccination coverage among healthcare personnel</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Percent of patients who were assessed and appropriately given the seasonal influenza vaccine</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Unplanned all-cause, all condition readmissions within 30 days of discharge from IRFs to acute care hospitals and IRFs</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia</td>
<td></td>
<td></td>
<td></td>
<td>P</td>
</tr>
<tr>
<td>Clostridium difficile (C Difficile) infection</td>
<td></td>
<td></td>
<td></td>
<td>P</td>
</tr>
</tbody>
</table>

X = Previously Finalized
P = Proposed
FY 2017 IRF QRP Measure Proposals – Healthcare Associated Infections (HAIs)

- CMS proposes that IRFs report the same *C Difficile* and MRSA measures part of other quality reporting programs.

- Data would be submitted via CDC’s National Health Safety Network (NHSN).

- Both measures NQF-endorsed, but only conditionally supported by the Measure Applications Partnership (MAP).
  - Ready for IRF implementation?
  - Appropriate topics for IRF patient population?
Proposed Data Completeness Requirements (for FY 2016 payment)

- CMS proposes thresholds for data completeness under its authority to require measure submission in a ‘form, manner and time’ designated by the Secretary of HHS
  - IRFs that do not meet requirements subject to 2 percent reduction to annual payment update

- CMS would require 95 percent complete data for measures based on IRF-PAI
  - That is, 95 percent of assessments include 100 percent of required IRF-PAI quality indicator items

- CMS would require 100 percent complete data for HAI measures submitted via NHSN
  - Must complete all data fields required for measure numerator and denominator
IRF QRP Measure Validation Proposal (for FY 2016 payment determination)

• CMS will validate only the pressure ulcer measure, but indicates interest in expanding to other measures

• Process
  – CMS randomly selects sample of 260 IRFs each year
  – CMS randomly selects 5 IRF-PAI assessments from each IRF in the validation sample
  – CMS contractor sends written request to IRFs to submit patient medical record information
  – Contractor compares data elements in patient record to data submitted on the IRF-PAI assessment

• IRFs must achieve 75 percent validation score to avoid 2 percent reduction

• The reconsideration process for IRF QRP updated to provide chance for IRFs to appeal findings of non-compliance
Future Measurement Topics

• Functional status measures (under development by RTI)
  – Assess whether IRF patients show improvement in self-care and mobility function
  – Data would be collected using the CARE Tool
  – Risk-adjusted scores reported for:
    • Functional status score at discharge
    • Change in functional status score between admission and discharge
    – Would likely require significant changes to be workable for IRFs)

• Other measures (currently specified for nursing homes)
  – Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) (NQF #0674)
  – Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay) (NQF #0676)
IRF QRP Proposals: Discussion questions

• Do you support CMS’s FY 2017 measurement proposals? How could they be improved?

• Do you support the data completeness and validation proposals?
  – Are the thresholds fair?
  – Is there other information CMS should provide to educate the field on its process?

• What other measurement topics should CMS address in future years?
TOP ISSUES

• 60% Rule
• Merits of group therapy
• Quality issues
• Other?
Delivery System Reform

- MedPAC
- AHA Webinar Series
AHA Letter to MedPAC

- April 2014
- Tab 4 in your packet

Key Messages

- Must match clinically similar patients
- Prior hospital discharge diagnosis inadequate basis
- Look at readmissions for 30-days, 60-days, 90-days
- Exclude CMS-13 of 60% Rule
- Exclude stroke cases
- Equalize regulatory burden

April 1, 2014
Glenn M. Hack Barth, J.D.
64275 Hueston Road
Bend, OR 97701

Dear Mr. Hack Barth:

On behalf of the American Hospital Association’s (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 1,300 inpatient rehabilitation facilities (IRFs) and 850 hospital-based skilled nursing facilities (SNFs), I write to you to express concerns regarding the March 6 presentation on site-neutral payment for IRFs and SNFs. During the presentation, the Medicare Payment Advisory Commission (MedPAC) discussed potential “site-neutral payment” approaches to reduce IRF rates to “SNF-like” levels for patients discharged from a general acute care hospital with one of three conditions (stroke, major joint replacement, hip and femur fracture) who are clinically similar and commonly receive post-acute services in both IRFs and SNFs.

Paying for care in the IRF and SNF settings in a truly site-neutral manner is extremely complex and may be difficult to achieve. Nonetheless, the AHA supports the cautious exploration of a site-neutral payment policy that applies exclusively to patients who are clinically similar and can safely be treated in either setting. However, as outlined below, we are concerned that MedPAC has not targeted appropriate patients and urge the Commission to refine its approach. As also outlined below, it is imperative that for services subject to IRF-SNF site-neutral payments, IRFs should face a level playing field with respect to regulatory requirements; that is, for services subject to site-neutral payments, the Medicare regulations requiring IRFs to provide hospital-level care must be removed.

SITE-NEUTRAL POLICY MUST TARGET CLINICALLY SIMILAR PATIENTS

When designing an IRF-SNF site-neutral payment policy, it is critical to ensure that the policy targets clinically similar patients. As discussed by MedPAC commissioners, achieving such an apples-to-apples comparison can be difficult due to the incompatible IRF and SNF patient classification systems. However, we have several suggestions that we believe would help ensure that MedPAC’s policy targets clinically similar patients.
WEBINAR SERIES

- Provide a policy context
- Highlight innovations in the field
- Hospital perspective
- PAC perspective
- Discussion with lead innovators
- AHA members may register at:
  https://www.surveymonkey.com/s/NJQSBFS
Questions & Discussion