American Hospital Association®

Regulatory Advisory

August 24, 2015

Inpatient Rehabilitation Facility PPS: Final Rule for FY 2016

At a Glance

The Issue:

On August 6, the Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2016 final rule for the inpatient rehabilitation facility (IRF) prospective payment system (PPS). Under the final rule, IRFs will receive a 2.4 percent market-basket update. This update will be offset by a 0.5 percentage point cut for productivity and an additional 0.2 percentage point cut, as required by the Affordable Care Act, as well as a 0.1 percentage point increase for payment changes for outlier cases. CMS estimates that, collectively, these payment changes will produce a net increase in payment of 1.8 percent ($135 million) in FY 2016. Additionally, this rule will implement a new, IRF-specific market basket and updated wage index boundaries. To address the IRF Quality Reporting Program (QRP) changes mandated in the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, CMS re-adopts one pressure ulcer measure and finalizes six new measures assessing functional status and falls with injury. The reporting of these measures will be tied to FY 2018 payment. CMS also will begin publicly reporting certain IRF QRP data no later than the fall of 2016. Finally, CMS will suspend temporarily the IRF QRP's data validation process.

Our Take:

We are pleased that CMS has finalized a positive net update for IRFs and improved its methodology for the new, IRF-specific market basket. However, the AHA is deeply disappointed by CMS's decision to finalize functional status measures that are duplicative of data IRFs already collect, and may create confusion and unnecessary provider burden. We will urge the agency to delay implementation of the new measures and find a less burdensome approach to fulfill IMPACT Act requirements.

What You Can Do:

- ✓ Share the attached summary with your senior management team to examine the impact these payment changes would have on your organization for FY 2016.
- ✓ Participate in a members-only conference call Tuesday, August 25 at 2:00 p.m. ET to review and discuss this final rule. AHA members may register at: https://www.surveymonkey.com/s/82515.

Further Questions:

Please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org with questions about payment provisions, and Akin Demehin, senior associate director of policy, at ademehin@aha.org with any quality-related questions.

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INPATIENT REHABILITATION FACILITY PPS: FINAL RULE FOR FY 2016

BACKGROUND

On August 6, the Centers for Medicare & Medicaid Services (CMS) released its fiscal year (FY) 2016 final rule for the inpatient rehabilitation facility (IRF) prospective payment system (PPS). In the rule, CMS finalizes a net update of 1.8 percent, a $135 million increase in payment. As detailed below, this net increase takes into account a market-basket update, reductions mandated by the Affordable Care Act *(*ACA) and a payment increase for high-cost outliers. The rule also finalized substantial changes to the IRF Quality Reporting Program (QRP).

FY 2016 PAYMENT UPDATE

Market-basket Update

For FY 2016 and future years, CMS will calculate annual updates to the IRF PPS standard rate using an IRF-specific market basket. As a result, the rehabilitation, psychiatric and long-term care (RPL) market basket will no longer be used. Unlike the RPL version, which only uses data from freestanding providers, the new market basket is based on data from both freestanding and hospital-based IRFs. Table 6 in the regulation compares the relative weights of the cost categories for the prior RPL market basket (based on 2008 cost data) and the new IRF-specific market basket (based on 2012 cost data). For FY 2016, CMS estimates that the final market basket will yield a 2.4 percent update, while the RPL market basket would have yielded a 2.0 percent update.

The final rule offsets the 2.4 percent market-basket update with a 0.5 percentage point cut for productivity and an additional 0.2 percentage point cut, as required by the ACA. For IRFs that complete CMS's quality reporting requirements, the IRF standard payment for FY 2016 is $15,478, an increase from the FY 2015 rate of $15,198.

Case-mix Group Relative Weights

In the IRF PPS, each case is assigned to a case-mix group (CMG) based on the primary diagnosis and clinical severity of the patient. Each CMG is assigned a relative

weight based on estimated resource use and has four tiers that reflect the number of comorbidities that are estimated to affect resource use in a significant way. For FY 2016, CMS updates the CMG relative weights in a budget-neutral manner using FY 2014 claims and FY 2013 cost report data. Table 1 in the rule lists the FY 2016 relative weights and average lengths of stays for each CMG and its comorbidity tiers.

Labor-related Share

The labor-related share is the national average proportion of total costs that are related to, influenced by or vary with the local labor market, such as wages, salaries and benefits. The final labor-related share for FY 2016 is 71.0 percent – a slight increase from the FY 2015 labor-related share of 69.294 percent.

Area Wage Index

For FY 2016, CMS will apply new labor market boundaries, a change already finalized for general acute-care hospitals and certain other providers in FY 2015. These new boundaries are based on new core-based statistical area definitions, which were updated by the Office of Management and Budget (OMB) using 2010 Census population data. CMS will implement a budget-neutral, one-year transition for all IRFs; during this transition, the agency will apply a blended wage index equal to 50 percent of an IRF's FY 2016 wage index under the new wage index boundaries and 50 percent of its FY 2016 wage index under the prior wage index boundaries. CMS's goal is to mitigate short-term instability and negative payment impacts caused by the new OMB delineations.

For any IRFs that lose their rural designation under this policy, a budget-neutral, three-year phase out will apply to the 14.9 percent payment add-on that applies to rural IRFs. Table 13 in the rule lists the 105 counties that will transition from rural to urban. Under this provision, affected IRFs will receive two-thirds of the rural adjustment in FY 2016, and one-third in FY 2017. No rural adjustment will be applied to these IRFs in FY 2018 and thereafter.

The final FY 2016 wage index values for urban and rural IRFs are found on the CMS website. (Scroll to the bottom of the page to download the files.)

Adjustment for High-cost Outliers

CMS allocates 3 percent of total IRF payments for high-cost outlier payments. CMS estimates that 2.9 percent of this pool will be paid in FY 2015 and, therefore, will slightly decrease the FY 2015 high-cost outlier threshold of $8,848 to $8,658 in FY 2016.

Facility-level Payment Adjustments

As in the FY 2015 final rule, CMS freezes IRF facility-level payment adjustments at FY 2014 levels in response to the agency's ongoing concerns about the reliability and

accuracy of the payment add-ons for rural, low-income percentage (LIP) and teaching IRFs. The FY 2016 adjustments remain:

- Rural adjustment: 14.9 percent;
- LIP adjustment factor: 0.3177; and
- Teaching adjustment factor: 1.0163.

Consistent with prior practice, CMS will apply a budget-neutrality adjustment for each of these facility adjustments, which is applied after the budget-neutrality adjustments for the area wage index and the CMG relative weights.

IRF QUALITY REPORTING PROGRAM

Since FY 2014, failure to meet IRF QRP data submission requirements and deadlines subjects IRFs to a 2.0 percentage point reduction to their annual market-basket update. For the FY 2018 IRF QRP, CMS finalizes seven measures – one of which was previously adopted for the IRF QRP – to satisfy the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. The IMPACT Act is intended to foster greater alignment of measures across CMS's post-acute care quality reporting programs, including the IRF QRP, by requiring the use of certain measures that are "standardized and interoperable" across post-acute care programs. A detailed summary of the IMPACT Act's requirements can be found in the AHA's Oct. 16, 2014 *Legislative Advisory*. CMS also re-adopts its previously finalized all-cause readmission measure so it reflects the version of the measure recently endorsed by the National Quality Forum (NQF). Table 1 below summarizes the finalized measures for the IRF QRP.

Table 1: Finalized IRF QRP Measures, FY 2014 – FY 2018

Measure	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Catheter-associated urinary tract infection (CAUTI)	X	X	X	X	X
Percent of residents / patients with pressure ulcers that are new or worsened (short-stay)	X	X	X	X	X[F]
Influenza vaccination coverage among health care personnel			X	X	X
Percent of patients who were assessed and appropriately given the seasonal influenza vaccine				X	X
Unplanned all-cause, all condition hospital readmissions within 30 days of discharge from IRFs				X	X[F]
Methicillin-resistant staphylococcus aureus (MRSA) bacteremia				X	X
Clostridium difficile (C Difficile) infection				X	X

Measure	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Application of percent of residents experiencing one or more falls with major injury					X
Percent of patients with an admission and discharge functional assessment and a care plan that addresses function					X
IRF Functional Outcome Measure: Change in self-care score for medical rehabilitation patients					X
IRF Functional Outcome Measure: Change in mobility score for medical rehabilitation patients					X
IRF Functional Outcome Measure: Discharge self-care score for medical rehabilitation patients					X
IRF Functional Outcome Measure: Discharge mobility score for medical rehabilitation patients					X

X = Finalized
X^F= Finalized in previous rules, updated version finalized in FY 2016 IRF PPS Final Rule

FY 2018 Measurement Proposals

Timing of IMPACT Act Implementation. The IMPACT Act states that penalties for non-compliance with the new IRF QRP measure requirements under the act will begin on Oct. 1, 2016 (i.e., FY 2017). However, CMS will use an implementation timeframe whereby IMPACT Act reporting requirements will be tied to payment in the fiscal year that begins two years after they are adopted in rulemaking. **As a result, the IRF QRP measures CMS adopts in this rule to fulfill IMPACT Act requirements will not affect IRF payment until FY 2018.**

The agency suggests such a timeframe "reflects operational and other practical constraints, including the time needed to specify and adopt valid and reliable measures, collect the data, and determine whether an IRF has complied with our quality reporting requirements." CMS also states the timeframe is consistent with the approach it has used to date for the IRF QRP and other quality reporting programs.

IMPACT Act Measures. The IMPACT Act mandates that CMS adopt measures addressing several measure "domains" for all of its post-acute care quality reporting programs. To address the domains of skin integrity, major falls and functional status, CMS finalizes seven measures – one previously adopted measure, and six new measures. These measures will be collected using the CMS-mandated IRF Patient Assessment Instrument (IRF-PAI) and submitted using CMS's Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. CMS will adopt significant modifications to the quality indicators section of the IRF-PAI to capture new measure data and to promote greater standardization of collected data elements across post-acute care providers.

The AHA believes these measures will entail significant resources to collect and report. We encourage IRFs to review the detailed measure specifications and

planned modifications to the IRF-PAI on CMS's IRF QRP website to assess the potential operational impact to their organizations.

Pressure Ulcers. To address the IMPACT Act's "skin integrity" measure domain, CMS adopts a modified version of the IRF QRP's existing pressure ulcer measure. The measure assesses the percentage of patients with stage 2 to 4 pressure ulcers that are new or worsened since admission to the IRF. This measure is NQF-endorsed, supported for use in the IRF QRP by the Measure Applications Partnership (MAP) and has been collected in the IRF QRP since the program's inception. However, the agency will modify the wording and formatting of the pressure ulcer-specific questions in the IRF-PAI to align with the version of the measure that CMS recently proposed for the long-term care hospital (LTCH) and skilled nursing facility (SNF) quality reporting programs.

Major Falls. To address the IMPACT Act domain of "major falls," CMS finalizes a measure assessing the percentage of patients that experience one or more falls with major injury during their IRF stay. The measure is used in the LTCH QRP, and was recently proposed for the SNF QRP. While the measure is NQF-endorsed and supported for use in the IRF QRP by the MAP, the measure specifications and testing data used to obtain NQF endorsement are specific to nursing homes. As a result, it is not specifically endorsed for use in IRFs. Nevertheless, CMS adopts the measure and suggests it is needed to meet the IMPACT Act's requirement that measures be "standardized and interoperable" across care settings.

The AHA will continue to urge that the measure receive NQF endorsement for use in IRFs before it is adopted for the IRF QRP. We also will continue to urge CMS to adopt a risk-adjustment approach for this measure, since a patient's propensity for falls is determined not only by the quality of care, but also by underlying clinical risk factors. While we agree with the measurement of falls with injury, risk adjustment would enhance the fairness of performance comparisons across facilities.

Functional Status. The IMPACT Act requires post-acute care providers to collect measures on "functional status, cognitive function and changes in function and cognitive function." In general, functional status measures assess the extent to which patients regain the ability to perform activities (or "functions") essential to daily living. For the FY 2018 IRF QRP, the agency adopts five functional status measures:

- One measure assessing the percentage of IRF patients who have functional status assessments completed at both admission and discharge and who have a care plan that addresses function;

- Two risk-adjusted "functional outcome" measures assessing the extent to which the self-care (e.g., personal hygiene, eating) and mobility (e.g., ability to walk a certain distance with or without assistance) functions of an IRF's patient population changes between admission and discharge; and

- Two risk-adjusted "functional outcome" measures determining the percentage of IRF patients whose self-care and mobility functional status at the time of discharge meet or exceed "expected" levels.

To calculate these measures, CMS will add 92 new items to the quality indicators section of the IRF-PAI; IRFs will complete these items for each patient at admission and discharge. Twenty-eight of these new items ask IRFs to provide a numerical score (using a six-level scale) of the level of independence patients demonstrate on self-care and mobility functional assessment items. The remaining 64 items ask about issues such as mobility prior to IRF admission, cognition and bladder continence. CMS will use this information as part of the risk adjustment approach for the functional outcome measures. The items and rating scale are derived from the Continuity Assessment Record and Evaluation (CARE) tool that was piloted as part of the Post-Acute Care Payment Reform Demonstration (PAC-PRD) project.

These new functional status measure data will be collected *in addition to* the 28 Functional Independence Measure (FIM) items IRFs are required to report on the IRF-PAI for payment purposes. In contrast to the six-level rating scale used to report the finalized functional status measures, the FIM uses a seven-level rating scale. In fact, the FIM items address most of the same topics as the finalized functional status measures. Nevertheless, CMS states the "function items…do not duplicate existing items" on the IRF-PAI, and reiterates its belief that the measures are needed to create standardized functional status measures whose results "can be understood across clinical disciplines and practice settings."

The AHA is very disappointed that CMS has finalized functional status measures that duplicate existing IRF reporting requirements and fail to capture important functional changes in the IRF patient population. We will urge the agency to delay implementation of the new measures and find a less burdensome approach to fulfill IMPACT Act requirements.

Readmissions Measure. CMS adopted a readmission measure for the FY 2017 IRF QRP program in the FY 2014 final rule. For FY 2018, CMS re-adopts the version of the measure endorsed by the NQF in December 2014. This measure assesses the rate of readmissions to short-stay acute care hospitals and LTCHs within 30 days of discharge from an IRF. The measure is calculated using Medicare fee-for-service (FFS) claims data, and captures returns of Medicare patients within 30 days of IRF discharge from the community or another care setting of lesser intensity (e.g., SNFs, home health) to a short-stay acute care hospital or LTCH. It excludes transfers from an IRF to either another IRF or to an acute care hospital. The measure also excludes certain procedures and diagnoses where readmissions are generally considered "planned" events (e.g., amputations, some colorectal procedures).

The AHA remains concerned that the readmission measure is not adjusted for sociodemographic factors beyond an IRF's control, such as income or dual-eligibility for Medicare and Medicaid. A substantial body of research shows these

factors greatly influence readmission rates. The AHA will continue to urge the agency to incorporate sociodemographic adjustment into all of its readmissions measures to ensure providers' performance does not suffer for factors beyond their control.

Data Submission Requirements

Data Collection Periods and Submission Timelines. CMS finalizes several revisions to the data collection and submission timeframes for the IRF QRP for FY 2018 and beyond. For all measures submitted via the IRF-PAI, IRFs must submit data for discharges occurring between Oct. 1 and Dec. 31, 2016. For FY 2019 and beyond, CMS will require a full calendar year of data. The data collection periods and submission deadlines are outlined in Table 2 below.

Table 2: Finalized Data Collection and Submission Timeframes for IRF QRP Measures Collected Using the IRF-PAI, FY 2018 and beyond

Fiscal Year	Data Collection Timeframe**	Data Submission Deadline
2018	Oct. 1, 2016 – Dec. 31, 2016	May 15, 2017
2019	Jan. 1, 2017 – Mar. 31, 2017 Apr. 1, 2017 – Jun. 30, 2017 Jul. 1, 2017 – Sep. 30, 2017 Oct. 1, 2017 – Dec. 31, 2017	Aug. 15, 2017 Nov. 15, 2017 Feb. 15, 2018 May 15, 2018
Subsequent years	Four calendar year quarters: Jan. 1 – Mar. 31 Apr. 1 – Jun. 30 Jul. 1 – Sep. 30 Oct. 1 – Dec. 31	TBD

***These data collection timeframes do not apply to the patient influenza vaccination measure, which is collected only during flu season, which runs from Oct. 1 (or whenever the vaccine becomes available) through Mar. 31.*

Measure Validation. CMS will temporarily suspend the measure validation process it finalized in the FY 2015 final rule. IRFs will not be subject to validation requirements unless and until CMS adopts a revised policy through notice-and-comment rulemaking. Measure validation processes are used in other CMS quality reporting programs, such as the hospital inpatient quality reporting (IQR) program, to ensure that measure data have been accurately collected, thereby enhancing the accuracy of measure results. In this final rule, CMS reiterates its intent to develop a more efficient, less burdensome validation process that is aligned across its post-acute quality reporting programs.

IRF QRP Public Reporting

CMS will to begin reporting each IRF's performance on certain IRF QRP measures publicly no later than the fall of 2016. CMS indicates it may use its *Hospital Compare*

website to display measure information. CMS specifically will report data on three measures:

- Catheter-associated urinary tract infection (CAUTI)
- Pressure ulcers
- Readmissions

The initial CAUTI and pressure ulcer measure data will reflect IRF performance for CY 2015. CMS will report readmission measure performance for CYs 2013 and 2014. CMS states the CAUTI and pressure ulcer data will be updated quarterly, and reported on a rolling four quarter basis. For example, the first update of the data would report performance from Apr. 1, 2015 through Mar. 31, 2016. The readmission data will be refreshed on a yearly basis using a rolling two years of data. For instance, the first refresh would report readmission performance from CYs 2014 and 2015.

Similar to other CMS quality reporting programs, the agency will give IRFs a 30-day period to preview their performance. However, this 30-day period would not provide an opportunity to submit corrections to the data. Instead, CMS states that the data submission period for IRFs is sufficiently long to give IRFs the opportunity to review and submit corrections to their data.

The agency intends to announce the preview period, as well as the specific date when it would begin to publicly display data, using its listservs, website and other communication vehicles.

FURTHER QUESTIONS

Please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org with any questions about the payment provisions, and Akin Demehin, senior associate director of policy, at ademehin@aha.org, with any quality-related questions.