IRF PPS
FY 2016 Final Rule

Rochelle Archuleta & Akin Demehin
AHA Policy

August 2015

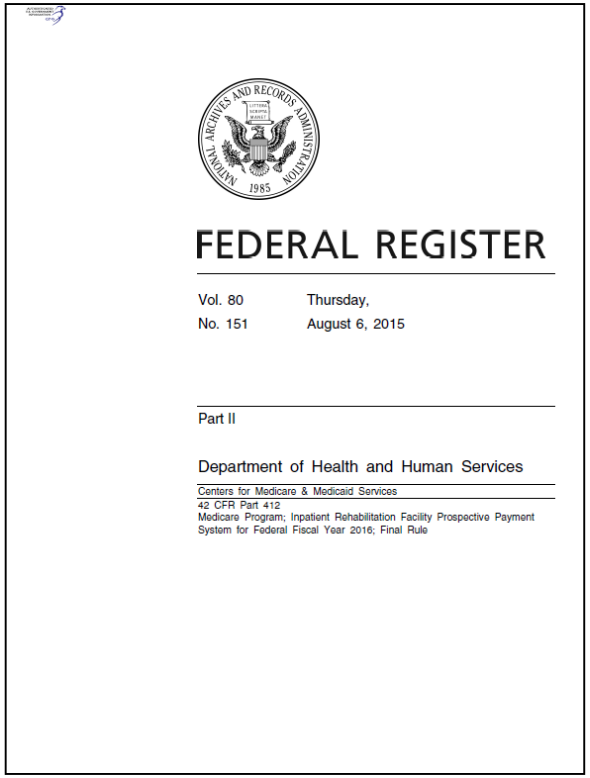
IRF PPS

Final Rule:

- ***Payment Update***
- ***Quality Reporting Program***
- ***Discussion***

American Hospital Association

IRF Payment Update



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Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 412

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016; Final Rule

American Hospital Association

Final FY 2016 Update

Payment Update

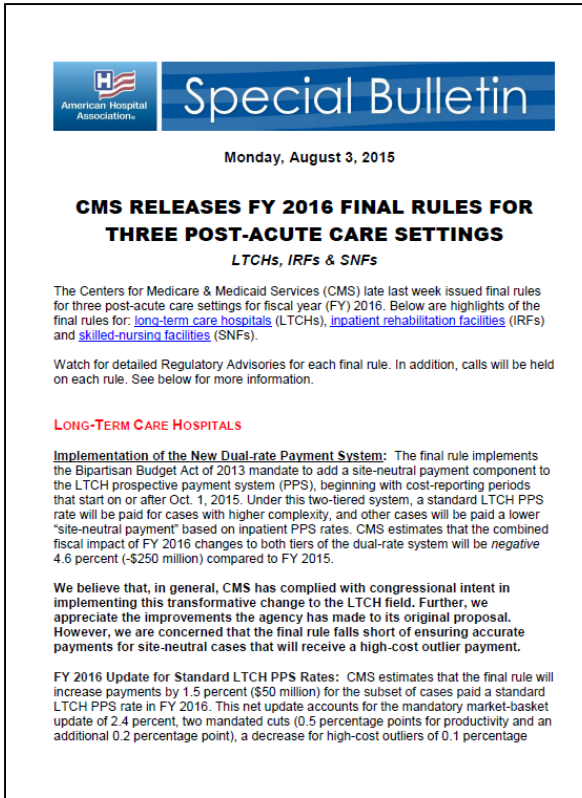
- ***New*** IRF Market basket: +2.5%
- ACA productivity cut: -0.5%
- ACA additional cut: -0.2%
- Outlier change: +0.1%
- NET UPDATE: +1.8% ($135 million)

Wage Index

- New boundaries; 105 new rural counties
- One-year transition for all IRFs: 50/50 blend
- 3-year phase-out of 14.9% rural add-on

Other Changes

- Labor related share: 71.0% (69.294 in FY 2015)
- Outlier threshold $8,658 ($8,848 in FY 2015)
- Facility adjustments: Unchanged



American Hospital Association

Special Bulletin

Monday, August 3, 2015

CMS RELEASES FY 2016 FINAL RULES FOR THREE POST-ACUTE CARE SETTINGS

LTCHs, IRFs & SNFs

The Centers for Medicare & Medicaid Services (CMS) late last week issued final rules for three post-acute care settings for fiscal year (FY) 2016. Below are highlights of the final rules for: long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs) and skilled-nursing facilities (SNFs).

Watch for detailed Regulatory Advisories for each final rule. In addition, calls will be held on each rule. See below for more information.

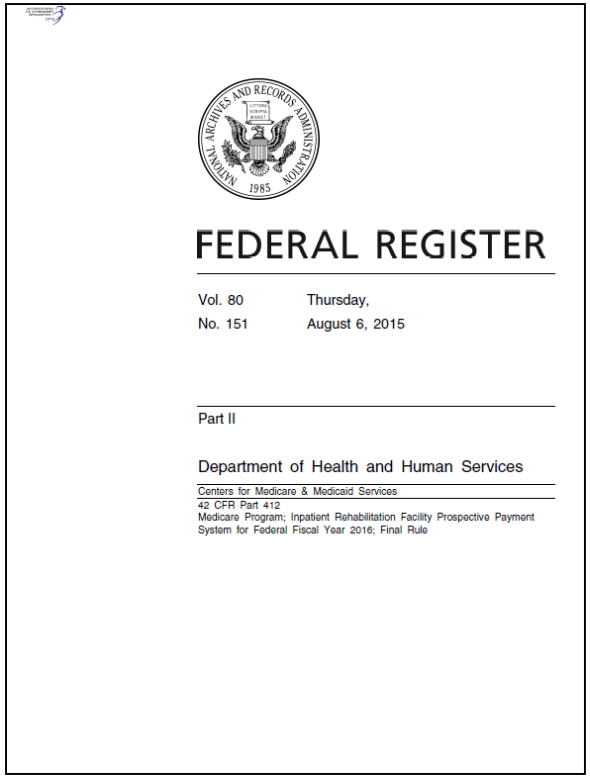
LONG-TERM CARE HOSPITALS

Implementation of the New Dual-rate Payment System: The final rule implements the Bipartisan Budget Act of 2013 mandate to add a site-neutral payment component to the LTCH prospective payment system (PPS), beginning with cost-reporting periods that start on or after Oct. 1, 2015. Under this two-tiered system, a standard LTCH PPS rate will be paid for cases with higher complexity, and other cases will be paid a lower "site-neutral payment" based on inpatient PPS rates. CMS estimates that the combined fiscal impact of FY 2016 changes to both tiers of the dual-rate system will be *negative* 4.6 percent (-$250 million) compared to FY 2015.

We believe that, in general, CMS has complied with congressional intent in implementing this transformative change to the LTCH field. Further, we appreciate the improvements the agency has made to its original proposal. However, we are concerned that the final rule falls short of ensuring accurate payments for site-neutral cases that will receive a high-cost outlier payment.

FY 2016 Update for Standard LTCH PPS Rates: CMS estimates that the final rule will increase payments by 1.5 percent ($50 million) for the subset of cases paid a standard LTCH PPS rate in FY 2016. This net update accounts for the mandatory market-basket update of 2.4 percent, two mandated cuts (0.5 percentage points for productivity and an additional 0.2 percentage point), a decrease for high-cost outliers of 0.1 percentage

IRF
Quality Reporting Program



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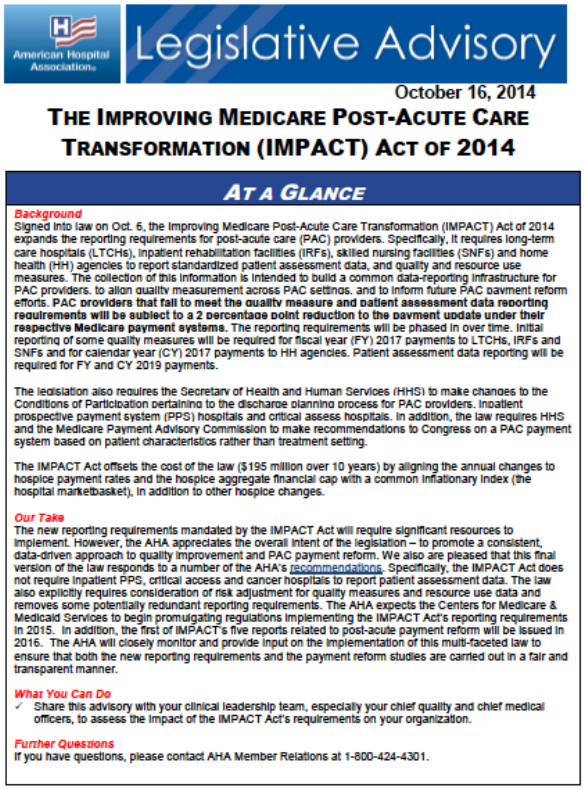
Post-Acute Reporting Changes: IMPACT Act

- **Signed into law Oct. 6, 2014**
- **Framed as creating "building blocks" of post-acute care reform through collection and reporting of "standardized and interoperable":**
  - Patient assessment data
  - Quality measures
- **Expands data collection and reporting requirements for LTCHs, IRFs, SNFs and HHAs**
  - Payment penalties for non-reporting
- **Significant regulatory activity in 2015**



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Legislative Advisory

October 16, 2014

THE IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION (IMPACT) ACT OF 2014

AT A GLANCE

Background

Signed into law on Oct. 6, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 expands the reporting requirements for post-acute care (PAC) providers. Specifically, it requires long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs) and home health (HH) agencies to report standardized patient assessment data, and quality and resource use measures. The collection of this information is intended to build a common data-reporting infrastructure for PAC providers, to allow quality measurement across PAC settings, and to inform future PAC payment reform efforts. **PAC providers that fail to meet the quality measure and patient assessment data reporting requirements will be subject to a 2 percentage point reduction to the payment update under their respective Medicare payment systems.** The reporting requirements will be phased in over time. Initial reporting of some quality measures will be required for fiscal year (FY) 2017 payments to LTCHs, IRFs and SNFs and for calendar year (CY) 2017 payments to HH agencies. Patient assessment data reporting will be required for FY and CY 2019 payments.

The legislation also requires the Secretary of Health and Human Services (HHS) to make changes to the Conditions of Participation pertaining to the discharge planning process for PAC providers, inpatient prospective payment system (PPS) hospitals and critical assess hospitals. In addition, the law requires HHS and the Medicare Payment Advisory Commission to make recommendations to Congress on a PAC payment system based on patient characteristics rather than treatment setting.

The IMPACT Act offsets the cost of the law ($195 million over 10 years) by aligning the annual changes to hospice payment rates and the hospice aggregate financial cap with a common inflationary index (the hospital marketbasket), in addition to other hospice changes.

Our Take

The new reporting requirements mandated by the IMPACT Act will require significant resources to implement. However, the AHA appreciates the overall intent of the legislation -- to promote a consistent, data-driven approach to quality improvement and PAC payment reform. We also are pleased that this final version of the law responds to a number of the AHA's recommendations. Specifically, the IMPACT Act does not require inpatient PPS, critical access and cancer hospitals to report patient assessment data. The law also explicitly requires consideration of risk adjustment for quality measures and resource use data and removes some potentially redundant reporting requirements. The AHA expects the Centers for Medicare & Medicaid Services to begin promulgating regulations implementing the IMPACT Act's reporting requirements in 2015. In addition, the first of IMPACT's five reports related to post-acute payment reform will be issued in 2016. The AHA will closely monitor and provide input on the implementation of this multi-faceted law to ensure that both the new reporting requirements and the payment reform studies are carried out in a fair and transparent manner.

What You Can Do

✓ Share this advisory with your clinical leadership team, especially your chief quality and chief medical officers, to assess the impact of the IMPACT Act's requirements on your organization.

Further Questions

If you have questions, please contact AHA Member Relations at 1-800-424-4301.

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IMPACT Act – Patient Assessment Data Domains

To be addressed in future rulemaking

- Functional status (e.g., mobility, self care)
- Cognitive function and mental status (e.g., depression, ability to understand)
- Special services, treatments, and interventions (e.g., ventilator use, dialysis, chemotherapy, central line placement, TPN)
- Medical condition (e.g., diabetes, CHF, comorbidities such as severe pressure ulcers)
- Impairments (e.g., incontinence, impaired and an impaired ability to hear, see, or swallow.
- Other categories deemed necessary and appropriate by the Secretary of HHS

IMPACT Act: Quality Measures

Measures must address following topics:

- **Functional Status**
- **Skin integrity**
- **Major falls**

Addressed in FY 2016 IRF PPS Final Rule

- Medication reconciliation
- Patients preferences
- Resource use, including at a minimum:
  - Medicare spending per beneficiary
  - Discharges to community
  - Potentially preventable admissions and readmissions

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FY 2018 IRF QRP New Measures: Falls and Pressure Ulcers

- **Pressure Ulcers: Assesses percentage of patients with one or more pressure ulcers new or worsened**
  - Already in IRF QRP
  - Collected using IRF-PAI (with minor modifications to items to align wording with other post-acute settings)

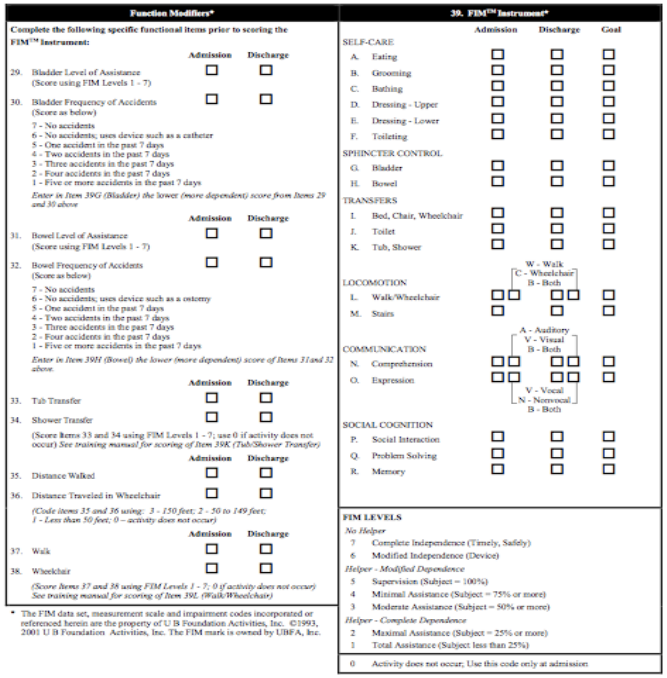
- **Falls: Assesses percentage of patients experiencing one or more falls with major injury during IRF stay**
  - Items added to IRF-PAI
  - **Not NQF-endorsed for IRF setting**

FY 2018 IRF QRP New Measures: Functional Status

- **5 functional status measures finalized**
  - One assessing whether functional status assessment completed at admission and discharge
    - At least one item must include a numerical goal score
  - Two assessing change in self-care and mobility functional status between admission and discharge
  - Two assessing whether self-care and mobility scores at discharge meet or exceed “expected” level

- **Collected using the IRF-PAI**
  - Adds significant number of items

FY 2018 IRF QRP New Measures: Functional Status



Function Modifiers*

Complete the following specific functional items prior to scoring the FIM℠ Instrument:

		Admission	Discharge
29.	Bladder Level of Assistance (Score using FIM Levels 1 - 7)	☐	☐
30.	Bladder Frequency of Accidents (Score as below)	☐	☐

7 - No accidents
6 - No accidents; uses device such as a catheter
5 - One accident in the past 7 days
4 - Two accidents in the past 7 days
3 - Three accidents in the past 7 days
2 - Four accidents in the past 7 days
1 - Five or more accidents in the past 7 days

Enter in Item 39G (Bladder) the lower (more dependent) score from Items 29 and 30 above

		Admission	Discharge
31.	Bowel Level of Assistance (Score using FIM Levels 1 - 7)	☐	☐
32.	Bowel Frequency of Accidents (Score as below)	☐	☐

7 - No accidents
6 - No accidents; uses device such as a ostomy
5 - One accident in the past 7 days
4 - Two accidents in the past 7 days
3 - Three accidents in the past 7 days
2 - Four accidents in the past 7 days
1 - Five or more accidents in the past 7 days

Enter in Item 39H (Bowel) the lower (more dependent) score of Items 31 and 32 above.

		Admission	Discharge
33.	Tub Transfer	☐	☐
34.	Shower Transfer	☐	☐

(Score Items 33 and 34 using FIM Levels 1 - 7; use 0 if activity does not occur) *See training manual for scoring of Item 39K (Tub/Shower Transfer)*

		Admission	Discharge
35.	Distance Walked	☐	☐
36.	Distance Traveled in Wheelchair	☐	☐

(Code items 35 and 36 using: 3 - 150 feet; 2 - 50 to 149 feet; 1 - Less than 50 feet; 0 – activity does not occur)

		Admission	Discharge
37.	Walk	☐	☐
38.	Wheelchair	☐	☐

(Score Items 37 and 38 using FIM Levels 1 - 7; 0 if activity does not occur) See training manual for scoring of Item 39L (Walk/Wheelchair)

* The FIM data set, measurement scale and impairment codes incorporated or referenced herein are the property of U B Foundation Activities, Inc. ©1993, 2001 U B Foundation Activities, Inc. The FIM mark is owned by UBFA, Inc.

39. FIM℠ Instrument*

		Admission	Discharge	Goal
SELF-CARE				
A.	Eating	☐	☐	☐
B.	Grooming	☐	☐	☐
C.	Bathing	☐	☐	☐
D.	Dressing - Upper	☐	☐	☐
E.	Dressing - Lower	☐	☐	☐
F.	Toileting	☐	☐	☐
SPHINCTER CONTROL				
G.	Bladder	☐	☐	☐
H.	Bowel	☐	☐	☐
TRANSFERS				
I.	Bed, Chair, Wheelchair	☐	☐	☐
J.	Toilet	☐	☐	☐
K.	Tub, Shower	☐	☐	☐
LOCOMOTION (W - Walk; C - Wheelchair; B - Both)				
L.	Walk/Wheelchair	☐☐	☐☐	☐
M.	Stairs	☐	☐	☐
COMMUNICATION (A - Auditory; V - Visual; B - Both) (V - Vocal; N - Nonvocal; B - Both)				
N.	Comprehension	☐☐	☐☐	☐
O.	Expression	☐☐	☐☐	☐
SOCIAL COGNITION				
P.	Social Interaction	☐	☐	☐
Q.	Problem Solving	☐	☐	☐
R.	Memory	☐	☐	☐

FIM LEVELS

No Helper
7 Complete Independence (Timely, Safely)
6 Modified Independence (Device)
Helper - Modified Dependence
5 Supervision (Subject = 100%)
4 Minimal Assistance (Subject = 75% or more)
3 Moderate Assistance (Subject = 50% or more)
Helper - Complete Dependence
2 Maximal Assistance (Subject = 25% or more)
1 Total Assistance (Subject less than 25%)

0 Activity does not occur; Use this code only at admission

&

Patient _____ Identifier _____ Date _____

Section GG **Functional Abilities and Goals**

GG0130. Self-Care (3-day assessment period)

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale.

CODING:
Safety and **Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:
07. **Patient refused**
09. **Not applicable**
88. Not attempted due to **medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
		A. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.

- Measure data collected in addition to (not in place of) FIM functional status items on the IRF-PAI
- FIM uses 7-level scale, proposed measures use 6-level scale
- Areas of concern:
  - Resource intensive and duplicative
  - Measure lacks NQF endorsement

FY 2018 IRF QRP: Other Programmatic Issues

- Updated readmission measure to reflect NQF-endorsed status
  - Still no sociodemographic adjustment
- Suspension of data validation process
- Submission timeframes for IRF-PAI Measures

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

Questions
&
Discussion

American Hospital Association