IRF PPS
FY 2017 Proposed Rule
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AHA Policy

May 2016
IRF PPS

Proposed Rule:
• Payment Update
• Quality Reporting Program
• Discussion
IRF Payment Update

INPATIENT REHABILITATION FACILITY PPS: PROPOSED RULE FOR FY 2017

AT A GLANCE

The issue:
On April 21, the Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2017 proposed rule for the inpatient rehabilitation facility (IRF) prospective payment system (PPS). Under the proposed rule, IRF would receive a 2.7 percent market-basket update. This update would be offset by a 5.5 percentage-point cut for productivity and an additional 0.75 percentage point cut, as required by the Affordable Care Act, as well as a 0.7 percentage point increase for payment changes for outlier cases. CMS estimated that, collectively, these payment changes would produce a net increase in payment of 1.9 percent ($125 million) in FY 2017. In addition, CMS proposes a total of five new measures for the IRF Quality Reporting Program (QRP). For the FY 2016 program, CMS proposes four new measures – Medicare spending per beneficiary (MSPB), discharge to community, potentially preventable 30-day post-discharge readmissions, and a “within stay” readmission measure. For the FY 2020 QRP, CMS proposes a drug regimen review measure. All of the proposed measures except for the within stay readmission measure are included in the Improving Medicare Post-Acute Care Transformation Act.

Our take:
With regard to its payment provisions, this proposed rule is relatively brief and straightforward and contains no major proposed policy changes. However, the ACE is concerned that none of the measures proposed for the IRF QPP are endorsed by the National Quality Forum, and we question whether the measures have been adequately tested. Furthermore, we believe CMS should examine the impact of socioeconomic factors on the MSPB, discharge to community, and readmission measures, and incorporate adjustments as needed.

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 in FY 2017.
• Participate in a members-only conference call Wednesday, May 10 at 10 a.m. ET to review and discuss the final rule. Ask members may register at https://www.ahe.org/c-INSPIRE.
• Submit a comment letter on the proposed rule to CMS by June 20 explaining the impact this rule would have on your patients, staff, and facility.

Further questions:
Please contact Rochelle Alvisilla, director of policy, at ralvisilla@ahe.org with questions about payment provisions, and Alvin Demeheer, senior associate director of policy, at ademeheer@ahe.org with any quality-related questions.
Proposed FY 2017 Update

**Proposed Update**
- IRF Market basket: +2.7%
- ACA productivity cut: -0.5%
- ACA additional cut: -0.75%
- Outlier change: +0.2%
- **PROPOSED NET UPDATE:** +1.6% ($126 million)
- **PROPOSED STANDARD RATE:** $15,674 ($15,478 in FY 2016)

**Proposed Wage Index**
- For IRFs that lost rural designation in FY 2016:
  - FY 2017: 2nd year of 3-year phase-out of 14.9% rural add-on
  - FY 2017: 1/3 of rural add-on
  - FY 2018: no rural add-on

**Other Proposed Payment Changes**
- Labor related share: 71.0% (same as FY 2015)
- Outlier threshold $8,301 ($8,658 in FY 2015)
- Facility adjustments: Frozen at FY 2014 levels
• FY 2014 final rule finalized policy to remove “unspecified” ICD-9-CM codes from 60% Rule presumptive test, beginning Oct. 1, 2014.
  – With ICD-10 implementation October 1, 2015, is this still a concern?
    o For example,
      • IGC 02.22 Traumatic brain injury, closed injury
      • IGC 02.21 Traumatic brain injury, open injury
IRF

Quality Reporting Program
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 continues in 2016
Measures must address following topics:

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

Finalized in FY 2016 IRF PPS Final Rule

Proposed in FY 2017 IRF PPS Proposed Rule

Detailed proposed measure specifications on CMS [website](http://example.com).

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Proposed FY 2018 IRF QRP Measures: Medicare Spending per Beneficiary

- Assesses risk adjusted, standardized Medicare part A and B payments during a defined episode of care
  - Ratio of observed to expected

- Episode “trigger”
  - Patient is admitted to an IRF

- One episode, two timeframes:
  - Treatment Period
    - Begins at trigger, ends on day of IRF discharge
    - Includes part A and B services “directly or reasonably managed” by IRF
  - Associated Services Period
    - Begins at trigger, ends 30 days after the end of treatment period
MSPB-IRF Measure Construction

Adapted from Acumen, Measure Specifications: Medicare Spending per Beneficiary – Post Acute Resource Use Measures. April 2016.
MSPB-IRF Measure – Other details

- Excluded from MSPB-IRF calculation
  - Planned hospital admissions within episode
  - Certain services outside SNF control
    - Management of some preexisting chronic conditions (e.g., dialysis)
    - Treatment for preexisting cancers, organ transplants, preventive screenings

- Measure is standardized and risk adjusted
  - Standardization removes geographic variation like wage index and other add-on payments
  - Risk adjusted for clinical factors contributing to spending
  - **NOT** adjusted for socioeconomic factors
Proposed FY 2018 IRF QRP Measures: Discharge to Community

- Measure assesses “successful discharge to the community” in the 31 days after discharge from IRF care

- “Successful” in this context means risk standardized rate of Medicare FFS patients discharged to community who
  - Are NOT readmitted to acute hospital or LTCH; and
  - Remain alive during time period

- “Community” defined as
  - Home/self-care (with or without home health services)
  - Uses patient discharge status codes 01, 06, 81 and 86 on the FFS claim
Discharge to Community: 
Other measure details

• Key Exclusions
  – Discharges to inpatient psych
  – Discharges to hospice
  – Planned discharges to acute or LTCH setting
  – Part A benefits exhausted
  – Swing bed stays in CAHs

• Risk adjusted for clinical factors contributing to likelihood of readmission or death, but **not adjusted for socioeconomic factors**
Proposed FY 2018 IRF QRP Measures: Potentially Preventable Readmissions

- Assesses risk-adjusted rate of unplanned, potentially preventable hospital readmissions in the 30 days post-IRF discharge

- IRF discharge must have occurred within 30 days of a prior proximal hospital stay

- Measure is risk adjusted for clinical factors contributing to likelihood of readmission, but not for socioeconomic factors
Proposed FY 2018 IRF QRP Measures: Potentially Preventable Readmissions

What is “Potentially Preventable”?

CMS uses ICD-9 codes (and preliminary list of ICD-10 codes) codes to define three broad categories of potentially preventable readmissions

<table>
<thead>
<tr>
<th>PPR Category</th>
<th>Conditions</th>
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<tbody>
<tr>
<td>Inadequate management of chronic conditions</td>
<td>• Adult asthma</td>
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<tr>
<td></td>
<td>• Chronic obstructive pulmonary disease (COPD)</td>
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<td></td>
<td>• Congestive heart failure (CHF)</td>
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<td></td>
<td>• Diabetes short-term complications</td>
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<td></td>
<td>• Hypertension / hypotension</td>
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<tr>
<td>Inadequate management of infection</td>
<td>• Influenza</td>
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<td></td>
<td>• Urinary tract infection / kidney infection</td>
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<td></td>
<td>• <em>C. Difficile</em> infection</td>
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<td></td>
<td>• Sepsis</td>
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<td></td>
<td>• Skin and subcutaneous tissue infections</td>
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<tr>
<td>Inadequate management of other unplanned events</td>
<td>• Dehydration / electrolyte imbalance</td>
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<tr>
<td></td>
<td>• Aspiration pneumonitis ; food/vomitus</td>
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<td></td>
<td>• Acute renal failure</td>
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<td>• Arrhythmia</td>
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<td>• Intestinal impaction</td>
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<td>• Pressure Ulcers</td>
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Proposed FY 2018 IRF QRP Measures: Within-Stay PPR Measure

- While NOT required by the IMPACT Act, CMS proposes to adopt a within-IRF stay potentially preventable readmission measure.

- Similar measure construction to post-IRF discharge PPR measure, except that:
  - Within-stay PPR measure has slightly different exclusions.
  - Within-stay PPR includes one additional PPR category – Inadequate prevention of injury.
    - Head injury
    - Upper/lower extremity fractures

Overlap of readmission measures helpful or confusing?
Proposed FY 2020 IRF QRP Measure: Drug Regimen Review

• Measures the percentage of IRF discharges for which the following three things are true:
  – Drug regimen review was conducted at the time of admission;
  – *For issues identified at admission*, IRF contacted a physician (or physician-designee) by midnight of the next calendar day and completed prescribed/recommended actions in response to the identified issues
  – *For other issues identified during IRF stay*, the facility contacted a physician (or physician-designee) and completed prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified

*Definition of “clinically significant”?*
Proposed FY 2020 IRF QRP Measure: Drug Regimen Review

- Measure will be reported by IRFs filling out the relevant items on the IRF-PAI

- To meet FY 2020 requirements, IRFs would be expected to report one quarter of data, and submit the information quarterly thereafter

<table>
<thead>
<tr>
<th>FY 2020 Reporting Period</th>
<th>Data Submission Deadline</th>
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<tr>
<td>Oct. 1 – Dec. 31, 2018</td>
<td>May 15, 2019</td>
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Questions & Discussion