IRF PPS
FY 2017 Proposed Rule

Rochelle Archuleta & Akin Demehin
AHA Policy

May 2016

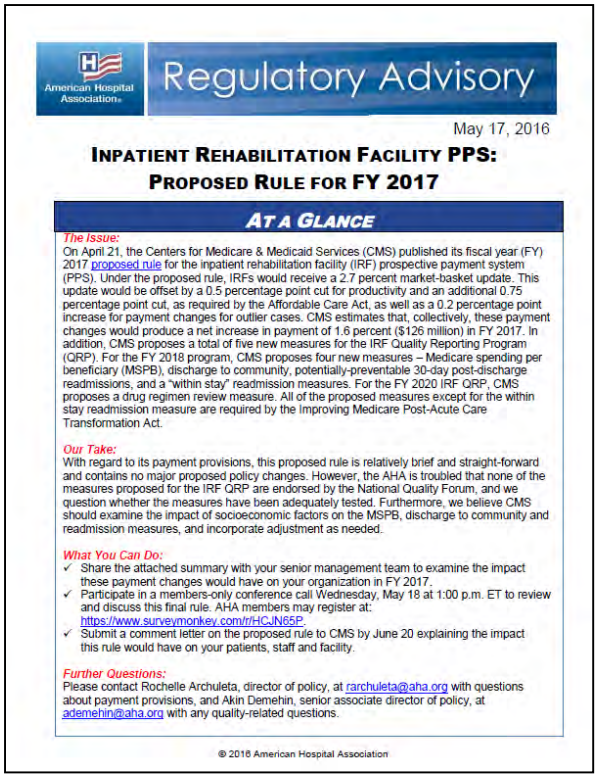
IRF PPS

Proposed Rule:

- Payment Update
- Quality Reporting Program
- Discussion

American Hospital Association

IRF Payment Update



American Hospital Association

Regulatory Advisory

May 17, 2016

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, IRFs would receive a 2.7 percent market-basket update. This update would be offset by a 0.5 percentage point cut for productivity and an additional 0.75 percentage point cut, as required by the Affordable Care Act, as well as a 0.2 percentage point increase for payment changes for outlier cases. CMS estimates that, collectively, these payment changes would produce a net increase in payment of 1.6 percent ($126 million) in FY 2017. In addition, CMS proposes a total of five new measures for the IRF Quality Reporting Program (QRP). For the FY 2018 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 measures. For the FY 2020 IRF QRP, CMS proposes a drug regimen review measure. All of the proposed measures except for the within stay readmission measure are required by the Improving Medicare Post-Acute Care Transformation Act.

Our Take:

With regard to its payment provisions, this proposed rule is relatively brief and straight-forward and contains no major proposed policy changes. However, the AHA is troubled that none of the measures proposed for the IRF QRP 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 adjustment 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 18 at 1:00 p.m. ET to review and discuss this final rule. AHA members may register at: https://www.surveymonkey.com/r/HCJN65P.
- ✓ 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 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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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

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Reduction of Unspecified Codes from Presumptive Test

- **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?
    - For example,
      - IGC 02.22 Traumatic brain injury, closed injury
      - IGC 02.21 Traumatic brain injury, open injury

American Hospital Association

IRF
Quality Reporting Program

Regulatory Advisory

May 17, 2016

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- ✓ 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.

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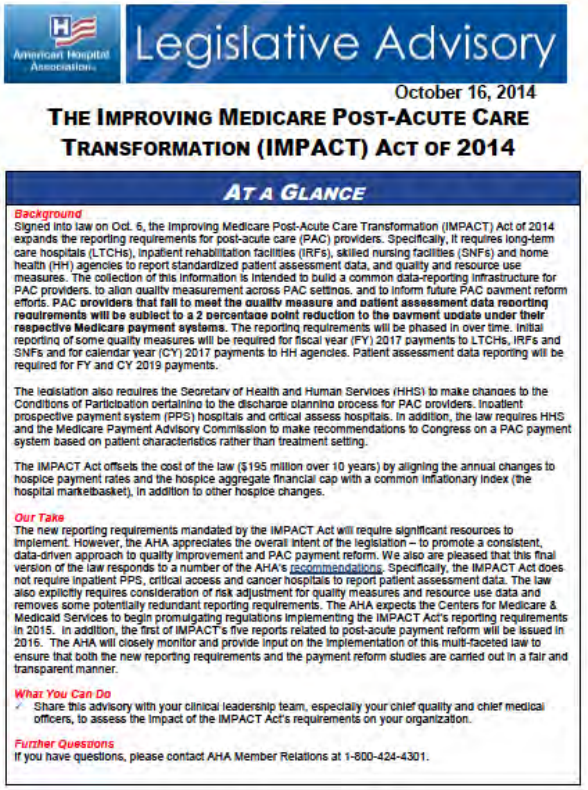
Post-Acute Reporting Changes: IMPACT Act

- 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 continues in 2016



American Hospital Association 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 (IPPS) 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: Quality Measures

Measures must address following topics:

- Functional Status
- Skin integrity
- Major falls

Finalized in FY 2016 IRF PPS Final Rule

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

Proposed in FY 2017 IRF PPS Proposed Rule

Detailed proposed measure specifications on CMS website.

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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

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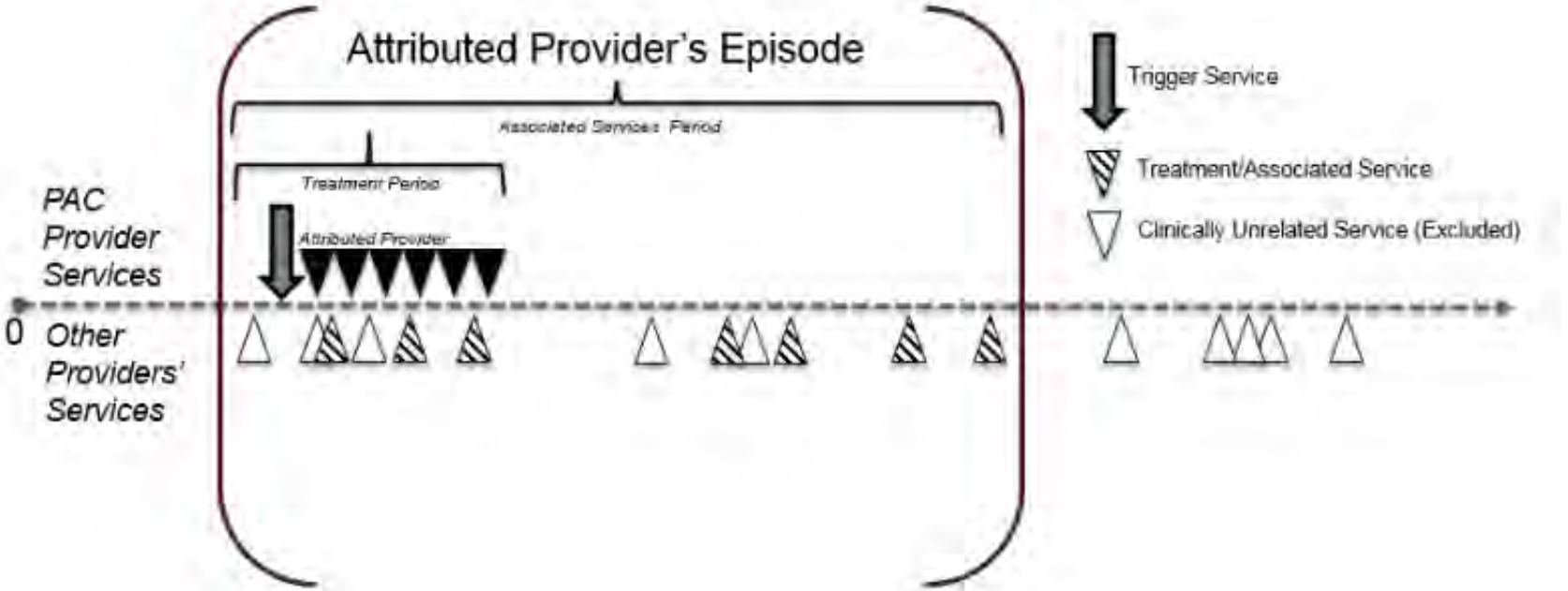
MSPB-IRF Measure Construction



Source: Acumen, *Measure Specifications: Medicare Spending per Beneficiary – Post Acute Resource Use Measures.* April 2016.

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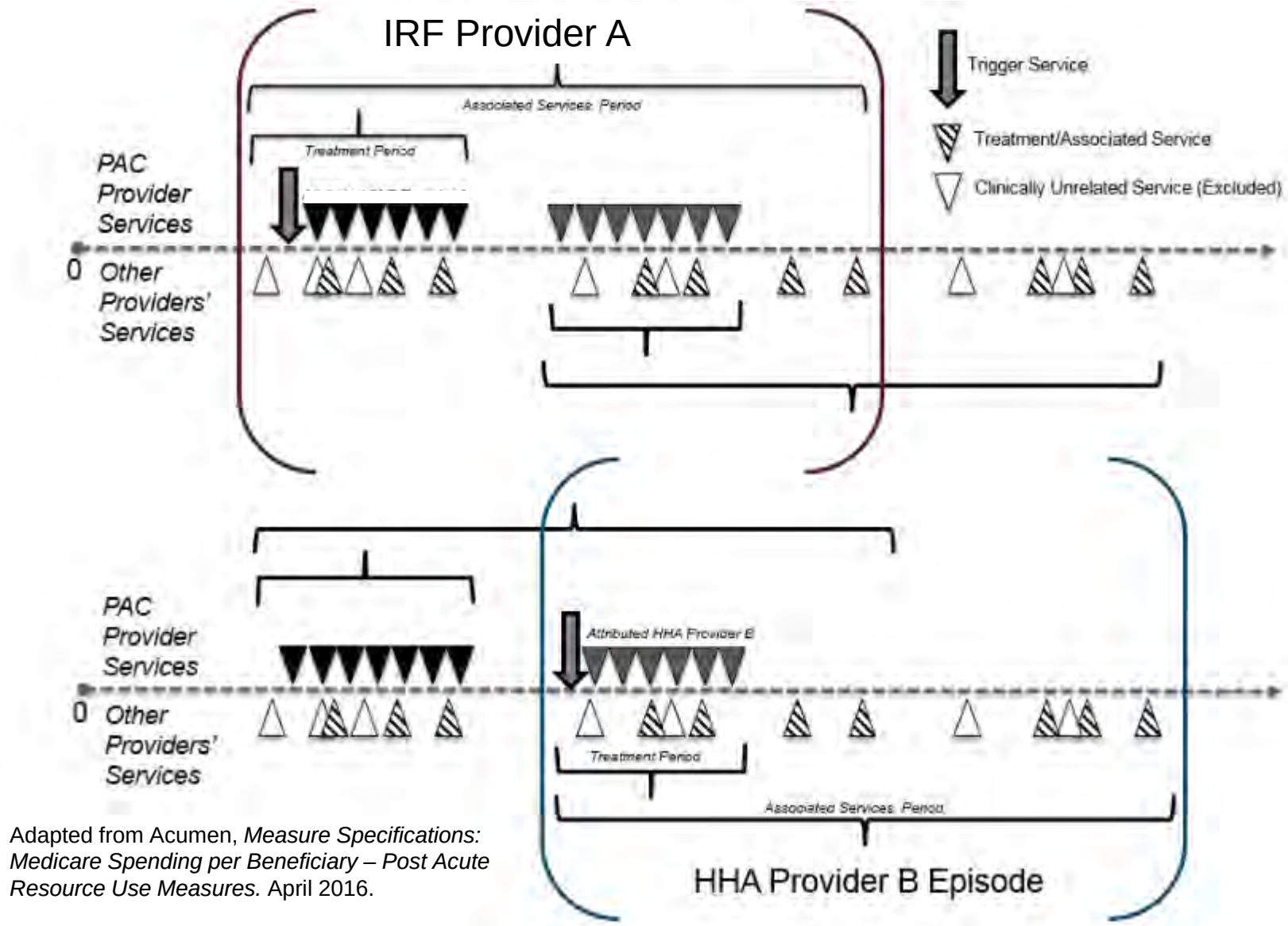
MSPB-IRF Measure – Intentional Overlap with other providers



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**

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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

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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**

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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**

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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

PPR Category	Conditions
Inadequate management of chronic conditions	• Adult asthma • Chronic obstructive pulmonary disease (COPD) • Congestive heart failure (CHF) • Diabetes short-term complications • Hypertension / hypotension
Inadequate management of infection	• Influenza • Urinary tract infection / kidney infection • *C. Difficile* infection • Sepsis • Skin and subcutaneous tissue infections
Inadequate management of other unplanned events	• Dehydration / electrolyte imbalance • Aspiration pneumonitis ; food/vomitus • Acute renal failure • Arrhythmia • Intestinal impaction • Pressure Ulcers

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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 difference 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?

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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"?

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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

FY 2020 Reporting Period	Data Submission Deadline
Oct. 1 – Dec. 31, 2018	May 15, 2019

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Questions
&
Discussion

American Hospital Association