IRF PPS
FY 2018 Final Rule

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AHA Policy

Aug 29, 2017
Final Payment Update

Special Bulletin
Tuesday, August 1, 2017

CMS RELEASES FINAL RULES FOR IRFs & SNFs FOR FY 2018

The Centers for Medicare & Medicaid Services (CMS) July 31 issued final rules for the inpatient rehabilitation facility (IRF) and skilled nursing facility (SNF) prospective payment systems (PPS) for fiscal year (FY) 2018. These rules take effect Oct. 1, 2017. While these are relatively straightforward rules, we are pleased that CMS responded to AHA and other stakeholders by scaling back its IRF quality reporting proposal and addressing some of our concerns related to IRF 48% Rule coding. Separately, AHA will comment on CMS’s advance notice of proposed rulemaking on potential SNF payment system refinements in FY 2019. Comments are due Aug. 25.

Regulatory Advisory
August 16, 2017

INPATIENT REHABILITATION FACILITY PPS:
FINAL RULE FOR FY 2018

At a Glance

The Issue:
On Aug. 3, the Centers for Medicare & Medicaid Services (CMS) published its fiscal year (FY) 2018 Final Rule for the inpatient rehabilitation facility (IRF) prospective payment system (PPS). Under the final rule, IRFs will receive a net payment increase of 0.9 percent ($90 million), relative to FY 2017, which includes the 0.5 percent Inpatient Hospital Acute Care PPS update mandated by the Medicare Access & CHIP Reauthorization Act, and a reduction in outlier payments. Specifically, CMS is raising the high-cost outlier threshold from $7,964 to $8,079 to maintain the payment system’s 3 percent high-cost outlier pool. In addition, the final rule renews the index used to assess a facility’s compliance with the 60% Rule via the presumptive methodology. The rule also eliminates the 25 percent penalty for the inpatient assessment instrument (PAI) submitted for the IRF Quality Reporting Program. CMS will remove one readmission measure and replace a pressure ulcer measure. CMS also significantly scaled back its proposal to require the reporting of certain standardized patient assessment data as mandated by the Improving Medicare Post-Acute Care Transformation Act.

The attached summary, prepared for the AHA by Health Policy Alternatives, Inc., provides greater detail on this final rule.

Our Take:
While this is a relatively straightforward rule, we are pleased that CMS improved on its proposal related to coding guidelines for the 60% Rule presumptive compliance test, thereby allowing additional IRF claims to count toward the test. In addition, the AHA appreciates that CMS acknowledged our concerns regarding the expanded patient assessment data reporting requirements, as this would have added several items to the already lengthy IRF-PAI and imposed a significant burden on providers.

What You Can Do:
✓ Share the attached summary with your senior management team to examine the impact these payment changes will have on your organization in FY 2018.
✓ Participate in a member-only conference call on Tuesday, Aug. 29 at 1 p.m. ET to review and discuss this rule. To register for the call, click here.

Further Questions:
Please contact Richelle Archuleta, director of policy, at rarchuleta@aha.org, with questions about the payment provisions and Caitlin Gilrony, associate director of policy, at cgilrony@aha.org, with any quality-related inquiries.
Payment Update

- **Final UPDATE**: +0.9% (+$80 million)
  - +1.0% as mandated by MACRA
  - Offset by 2 budget neutrality adjustments for wage index and revisions to the weights.

- **Final STANDARD RATE**: $15,838 ($15,708 in FY 2017)

Other Changes

- Outlier threshold: $8,679 ($7,984 in FY 2017)
  - Set to maintain the 3% outlier pool
- Labor related share: 70.7% (70.9 in FY 2017); as proposed.
- Facility adjustments: Remain frozen at FY 2014 levels
  - LIP, rural, teaching

Elimination of Penalty for Late IRF-PAIs

- Eliminate the 25-percent penalty for late submissions.
- CMS: Penalty no longer necessary since the Medicare claims system will only reimburse IRF claims if accompanied by an IRF-PAI.
Final Coding Changes
• CMS finalized proposed revisions to remove some of the traumatic brain injury codes listed as exclusions
  – Removed codes for traumatic brain injuries, regardless of whether there is loss of consciousness (LOC) and whether the LOC is specified or not
  – Removal of four codes for fracture of base of skull
  – Retained exclusion of code S06.9X9A, Unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter
• Hip Fracture(s)
  – Removed exclusions under IGC 0008.11 and IGC 0008.12 diagnosis codes for fracture of “unspecified part of neck of femur.”
  – Retained exclusion for code “fracture of unspecified part of neck of femur of unspecified femur.”
Presumptive Methodology: Major Multiple Trauma Codes

- ICD-10-CM does not provide diagnosis codes for combinations of multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum.
- Coding Guidelines require that codes for specific bones fractured be reported.
- CMS finalized proposal to identify major multiple trauma using IRF-PAIs that contain 2 or more of the ICD-10-CM codes from three major multiple trauma lists in specific combinations so that at least one lower extremity fracture code is combined with an upper extremity fracture and/or a rib/sternum fracture or fractures are present in both lower extremities.
Presumptive Methodology: Unspecified Arthritis Codes and Myopathies

- CMS did NOT finalize proposal to remove unspecified diagnosis codes and arthritis codes
- CMS did NOT finalize the proposed removal of code G72.89, Other specified myopathies.
  - CMS will deal with inappropriate utilization through focused medical reviews of claims, provider education and ongoing monitoring of usage.
IRF Quality Reporting Program

Tuesday, August 1, 2017

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Highlights of the rules follow. Watch for more detail on these rules in the coming weeks, including invitations to participate in AHCA member calls to discuss each rule.

IRF FINAL RULE
FY 2018 Payment Update: As mandated by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, IRF payments in FY 2018 will receive a 1.0 percent update relative to FY 2017. This increase is offset by a 0.1 percentage point to account for new, higher high-cost outlier thresholds of $5,020 ($3,964 in FY 2017), which is intended to lower high-cost outlier payments to align with the payment system’s 3.0 percent outlier pool. As a result, the net payment increase for IRFs is 0.9 percent, which will boost payments by $15 million in FY 2018. In addition, CMS will hold the facility payment adjustments for rural, teaching and low-income IRFs at current levels, which have remained unchanged since substantive changes were implemented in FY 2014.

Removal of the Penalty for Late IRF PPS Submissions: CMS finalized its proposal to eliminate the 25-percent penalty for late IRF patient assessment instrument (PAI) submissions. Since the Medicare claims system only reimburses IRF claims if accompanied by an IRF-PAI, the agency concluded that the penalty is no longer necessary.

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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 2017
IMPACT Act: Quality Measures

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*

*Finalized in FY 2017 IRF PPS Final Rule*

Detailed measure specifications on CMS website.
FY 2020 IRF QRP Measures: Changes in Skin Integrity: Pressure Ulcer/Injury

- Removes current pressure ulcer measure, “Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay)”
- Replace with Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
  - Includes unstageable pressure ulcers, including deep tissue injuries (DTI)
  - Uses number of unhealed pressure ulcers at each stage after subtracting number present upon admission
- Uses NPUAP definitions of ulcers/injuries
- New data element
FY 2020 IRF QRP Measures: Items Removed

- All-Cause Unplanned Readmissions measure
  - Duplicative of other readmissions measures, including Potentially Preventable Readmissions and Within-Stay Potentially Preventable Readmissions
- IRF-PAI Voluntary item 27: Swallowing status
Standardized Patient Assessment Data

- IMPACT Act requires collection of standardized patient assessment data; failure to comply would result in payment reduction.
- Currently four different assessment instruments (LCDS, MDS, PAI, OASIS).
- Elements must satisfy five domains:
  - Functional status
  - Cognitive function
  - Special services
  - Medical conditions and comorbidities
  - Impairments
- Most elements tested in PAC-PRD
  - Most already implemented in other PAC tools.
FY2020 Standardized Patient Assessment Data Reporting Details

- IMPACT Act requires data reporting starting with FY 2019
  - Pressure Ulcer measure for Q4 of CY 2017 would satisfy FY 2019 requirements
- For FY 2020, reporting required for Medicare Part A and MA admissions and discharges that occur between October 1, 2018 and December 31, 2018
  - Subsequent years based on full calendar year of data
- CMS proposes to extend administrative requirements for QRP data to patient assessment data, including
  - Participation
  - Exception and extension
  - Reconsiderations
  - Data completion thresholds
• Comments raised substantial concerns regarding burden and feasibility of implementing new/modified data elements
• In response, CMS will only require reporting for 2/5 domains
  – Functional Status
    • Requirement met by reporting Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (existing measure)
  – Medical Conditions and Comorbidities
    • Requirement met by reporting Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (newly finalized measure)
• Assessment Measures:
  – Application of Percent of LTCH Patients With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function
  – Application of Percent of Residents Experiencing One or More Falls with Major Injury

• Claims Measures
  – Medicare Spending Per Beneficiary
  – Discharge to Community
  – Potentially Preventable 30-Day Post Discharge Readmission
  – Potentially Preventable Within-Stay Readmission

• Transition from calendar year to fiscal year: data publicly available by October 2018

• Low-volume cases
Questions & Discussion