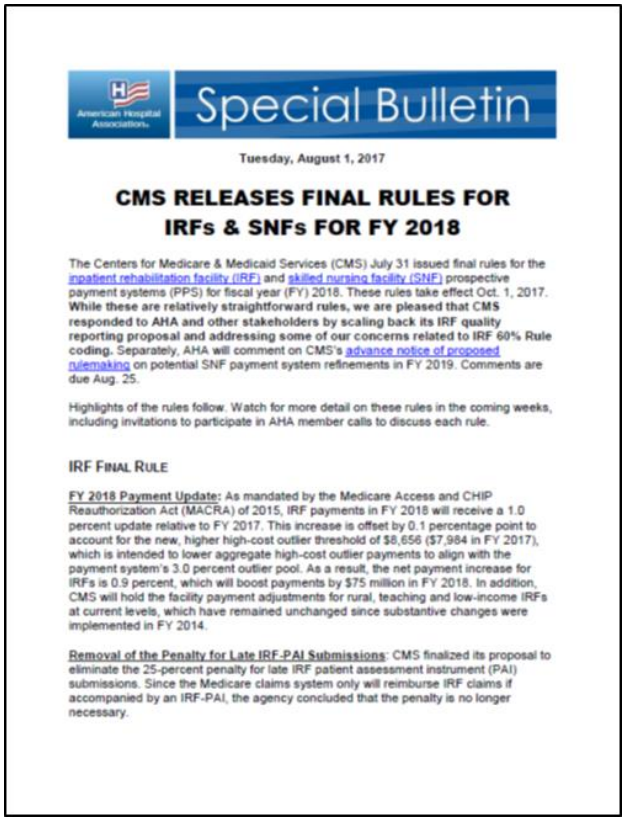
IRF PPS
FY 2018 Final Rule

Rochelle Archuleta, Nelly Leon-Chisen & Caitlin Gillooley
AHA Policy

Aug 29, 2017

Final Payment Update



American Hospital Association

Special Bulletin

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 AHA member calls to discuss each rule.

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Removal of the Penalty for Late IRF-PAI 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 will reimburse IRF claims if accompanied by an IRF-PAI, the agency concluded that the penalty is no longer necessary.

American Hospital Association

Regulatory Advisory

August 16, 2017

Inpatient Rehabilitation Facility PPS: Final Rule for FY 2018

At a Glance

The Issue:
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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 proposals 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 members-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:
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FY 2018 Final Rule: PAYMENT

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.

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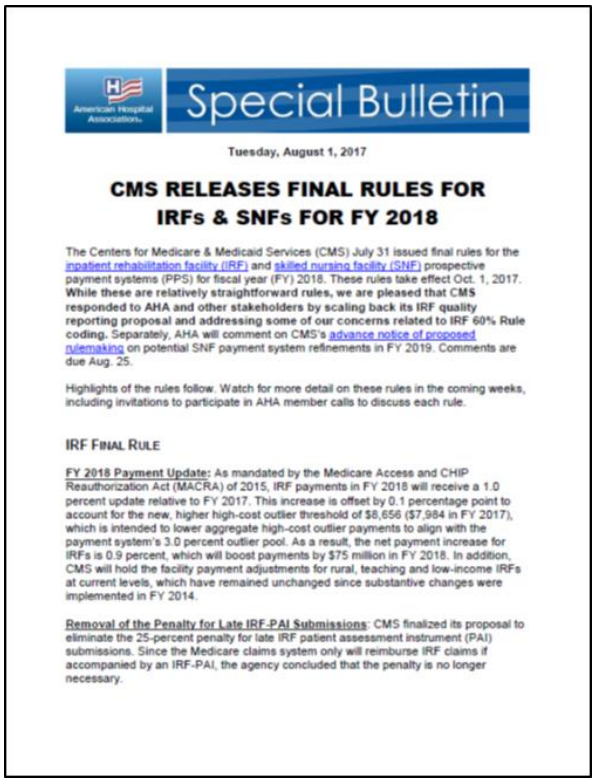
Final Coding Changes



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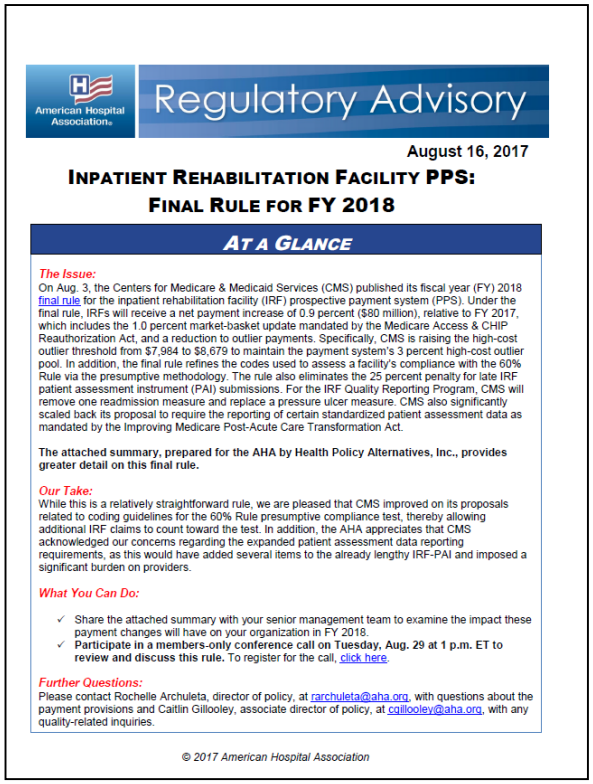

American Hospital Association Regulatory Advisory

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Presumptive Methodology Diagnosis Code List - Traumatic Brain Injury and Hip Fracture Exclusions

- 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.”

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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

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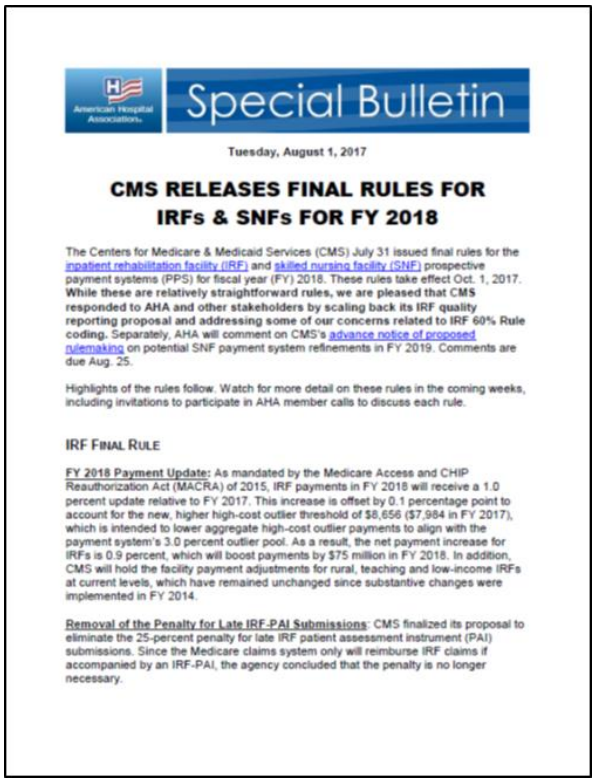
Presumptive Methodology: Unspecified Arthritis Codes and Myopathies

- 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.

American Hospital Association

IRF
Quality Reporting Program



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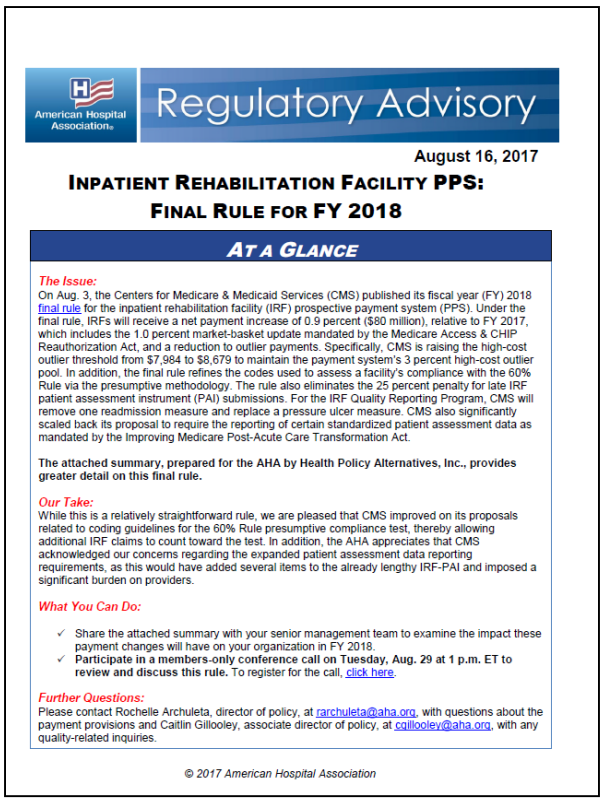

American Hospital Association

Regulatory Advisory

August 16, 2017

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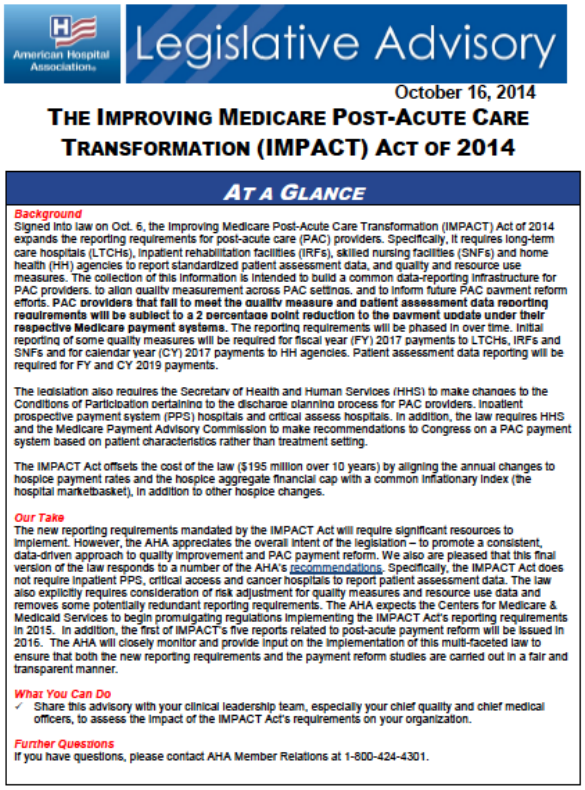
Post-Acute Reporting Changes: IMPACT Act

- 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



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 (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.

American Hospital Association

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

Finalized in FY 2017 IRF PPS Final Rule

Detailed measure specifications on CMS website.

American Hospital Association

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

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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

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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

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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

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FY2020 Standardized Patient Assessment Data Elements: Finalized Requirements

- 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)

American Hospital Association

CY 2018 QRP Public Reporting

- 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

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Questions
&
Discussion

American Hospital Association