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National Provider Call

Hospital Inpatient Prospective Payment System and Long-Term Acute Care Hospital Prospective Payment System Fiscal Year 2016 Final Rule

Presented by the Center for Medicare and the Center for Clinical Standards and Quality

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Agenda

- Background
- Changes to Payment Rates under IPPS
- LTCH PPS System Changes
- Medicare Disproportionate Share Hospital (DSH) Payments
- Documentation and Coding Adjustment
- Hospital Inpatient Quality Reporting (IQR)
- Electronic Health Record (EHR) Incentive (eCQM)
- Hospital Value-Based Purchasing (VBP)
- PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)

Background

- On July 31, 2015 the Centers for Medicare & Medicaid Services (CMS) issued a final rule to update FY 2016 Medicare payment policies and rates under the IPPS and LTCH PPS.
- The final rule, which will apply to approximately 3,400 acute care hospitals and approximately 430 LTCHs, will affect discharges occurring on or after October 1, 2015.
- The Administration has set measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients. The final rule includes policies that advance that vision.
- This presentation discusses the major provisions of the FY 2016 IPPS and LTCH final rules.

Changes to Payment Rates under IPPS

- The increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and demonstrate meaningful use of certified electronic health record (EHR) technology is 0.9 percent. This includes the following:
  - +2.4 percent hospital market basket update
  - -0.5 percentage points multi-factor productivity adjustment
  - -0.2 percentage points Affordable Care Act adjustment
  - -0.8 percentage points documentation and coding recoupment required by the American Taxpayer Relief Act of 2012.

Changes to Payment Rates under IPPS

- Hospitals that do not successfully participate in the Hospital IQR Program and do not submit the required quality data will be subject to a one-fourth reduction of the market basket update.
- For any hospital that is not a meaningful user of EHR, the update will be reduced by one-half of the market basket update in FY 2016.
- Other payment adjustments will include:
  - Continued -1.0 percent penalty for hospitals in the worst performing quartile under the HAC Reduction Program
  - Continued penalties for readmissions
  - Continued bonuses and penalties for HVBP

LTCH PPS System Changes

- The Pathway for SGR Reform Act of 2013 directed CMS to make significant changes to the payment system for LTCHs.
- The law directs CMS to establish two different types of LTCH PPS payment rates depending on whether the patient meets certain clinical criteria:
  - the LTCH PPS standard Federal payment rate, and
  - a new LTCH PPS site neutral payment rate generally comparable to the IPPS payment rates.
- In order for a discharge to be paid at the higher LTCH PPS standard Federal payment rate and be excluded from the site neutral payment rate the patient discharged must:
  - not have a principal diagnosis related to a psychiatric diagnosis or rehabilitation,
  - be immediately preceded by a discharge from an acute care hospital, and
  - either the acute care hospital stay must have included at least 3 days in the ICU or the discharge from the LTCH must have included ventilator services for at least 96 hours.
- The law provides a two-year transition period for those discharges paid at the site neutral payment rate. During that transition, site neutral payment rate cases are paid based on a 50/50 blend of the LTCH PPS standard Federal payment rate and the LTCH PPS site neutral payment rate.
- In the final rule, CMS is implementing these statutory requirements.

LTCH PPS System Changes

- CMS projects that LTCH PPS payments will decrease by approximately -4.6 percent, or approximately $250 million, based on the final payment rates for FY 2016.
- This estimated decrease is primarily attributable to the statutory decrease in the payment rates for site neutral payment rate cases that do not meet the clinical criteria to qualify for the standard Federal payment rate.
- Cases that do qualify for the higher standard Federal payment rate and successfully submit quality data under the LTCHQRP will see an increase in that payment rate of 1.7 percent including the following adjustments:
  - +2.4 percent market basket update
  - -0.5 percentage point multi-factor productivity adjustment
  - -0.2 percentage point Affordable Care Act adjustment

Medicare DSH Payments

- Beginning in FY 2014, the Affordable Care Act changed the Medicare DSH payment methodology.
- Hospitals now receive 25 percent of the amount they previously would have received under the statutory DSH formula.
- The remainder, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH, is aggregated nationally, adjusted for decreases in the rate of uninsured individuals and other factors, and then distributed to hospitals based on their relative share of the total amount of uncompensated care.
- In this rule, CMS is distributing an estimated $6.4 billion in uncompensated care payments in FY 2016.
- This is decrease of $1.2 billion from the estimated FY 2015 amount, primarily attributable to continued declines in the number of uninsured individuals since the passage of the Affordable Care Act.

Documentation and Coding Adjustment

- Section 631 of the American Taxpayer Relief Act of 2012 requires CMS to recover $11 billion by 2017 to fully recoup documentation and coding overpayments related to the transition to the MS-DRGs that began in FY 2008.
- For FY 2016, CMS is continuing the approach begun in FY 2014 by making another -0.8 percent adjustment.

Quality Reporting Programs

Removal of Measures from the Hospital IQR Program

Measure	Measure Name	Criteria
STK-01	Venous Thromboembolism (VTE) Prophylaxis	Topped Out
STK-06*	Discharged on Statin Medication	Topped Out
STK-08*	Stroke Education	Topped Out
VTE-1*	Venous Thromboembolism Prophylaxis	Topped Out
VTE-2*	Intensive Care Unit VTE Prophylaxis	Topped Out
VTE-3*	VTE Patients with Anticoagulation Overlap Therapy	Topped Out
IMM-1	Pneumococcal Immunization	Infeasibility to Implement
AMI-7a*	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	Does not result in better patient outcomes
SCIP-Inf-4	Cardiac Surgery Patients with Controlled Postoperative Blood Glucose	Leads to negative unintended consequences

* Retained as electronic Clinical Quality Measure (eCQM)

Required Chart-Abstracted Measures for FY 2018

Measure ID	Measure Name
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients
IMM-2	Influenza Immunization
SEP-1	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)
STK-04	Thrombolytic Therapy
VTE-5	Venous Thromboembolism Discharge Instructions
VTE-6	Incidence of Potentially Preventable Venous Thromboembolism
PC-01	Elective Delivery (Collected in aggregate and submitted via Web-based tool)

New Measures for FY 2018 and Subsequent Years

Short Name	Measure Name	Measure Type
Patient Safety Culture	Hospital Survey on Patient Safety Culture	Structural
AMI Excess Days	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	Claims
HF Excess Days	Excess Days in Acute care after Hospitalization for Heart Failure	Claims
THA/TKA Payment	Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty	Claims

Additional Measures for FY 2019 and Subsequent Years

Short Name	Measure Name	Measure Type
Kidney/UTI Payment	Kidney/Urinary Tract Infection Clinical Episode-Based Payment measure	Claims
Cellulitis Payment	Cellulitis Clinical Episode-Based Payment measure	Claims
GI Payment	Gastrointestinal Hemorrhage Clinical Episode-Based Payment measure	Claims

NOTE: Hospitals will be provided with confidential hospital-specific feedback reports containing performance data on these three measures during the FY 2018 payment determination prior to inclusion for public reporting.

IQR eCQM Reporting Requirements

- A hospital will be required to report a minimum of four of the 28 available electronic Clinical Quality Measures (eCQMs) for calendar year (CY) 2016 reporting.
- Hospitals are required to report for only one quarter (Q3 or Q4) of CY 2016/FY 2018 payment determination.
- The eCQM submission deadline is February 28, 2017.
- National Quality Strategy (NQS) Domain distribution will not be required.

Available eCQMs

ED-1	STK-5	AMI-8a	VTE-5	SCIP-INF-2a
ED-2	STK-6	AMI-10	VTE-6	SCIP-INF-9
ED-3*	STK-8	VTE-1	PC-01	EHDI-1a
STK-2	STK-10	VTE-2	PC-05	HTN
STK-3	AMI-2	VTE-3	CAC-3	PN-6
STK-4	AMI-7a	VTE-4	SCIP-INF-1a	

*ED-3 is an outpatient measure and not applicable for IQR.

Consideration of eCQMs for Removal in CY 2017/FY 2019

VTE-3	AMI-2a	SCIP-INF-1a
VTE-4	AMI-7a	SCIP-INF-2
VTE-5	AMI-10	SCIP-INF-9
VTE-6	CAC-3	
PN-6	HTN	

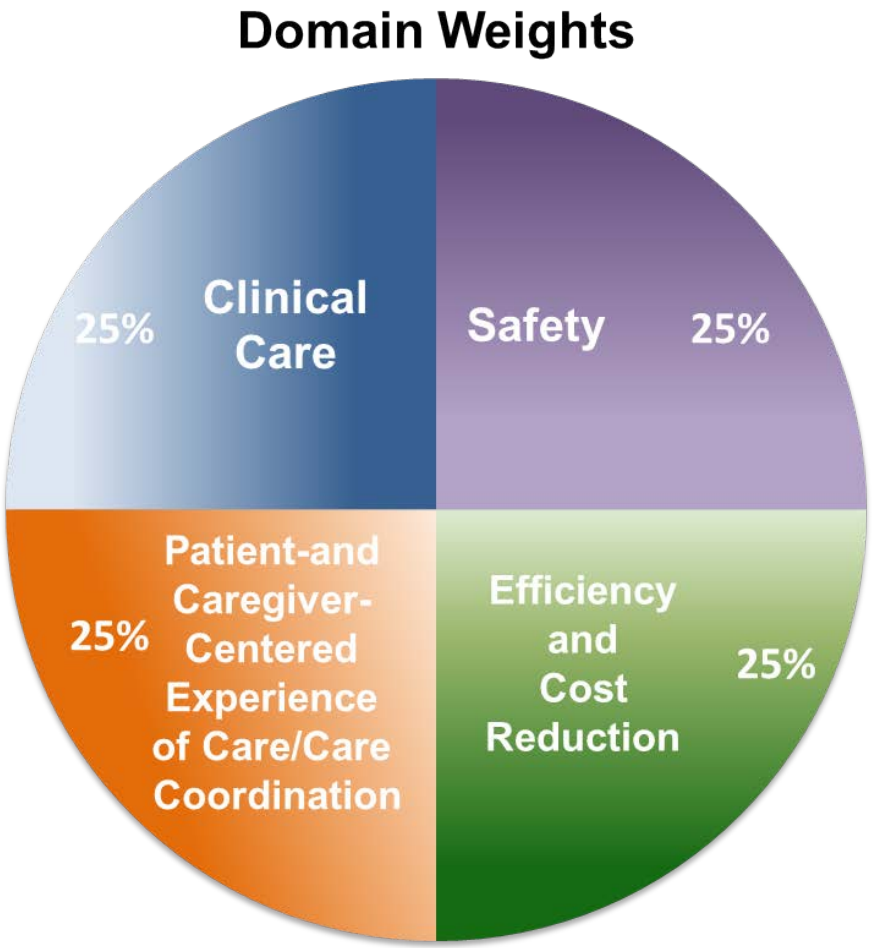
Public Reporting of eCQMs

- For CY 2016/FY 2018 reporting, any data submitted as an eCQM **will not be posted** on the *Hospital Compare* website.
- Public Reporting of eCQM data will be addressed in the CY 2017/FY 2019 rule following the conclusion and assessment of the validation pilot.

Future Considerations for Electronically Specified Measures

- The Centers for Medicare & Medicaid Services (CMS) are considering:
  - Use of core clinical data elements derived from Electronic Health Records (EHRs) for use in future quality measures
  - Collection of additional administrative linkage variables to link a patient's episode-of-care from EHR data with administrative claim data
  - Use of content exchange standards
- Rationale:
  - In response to feedback
  - Supports the CMS goal of moving toward the use of EHRs for electronic quality measure reporting

FY 2018 Hospital VBP Program Domains



Patient- and Caregiver-Centered Experience of Care/Care Coordination (PCCEC/CC)

HCAHPS Survey

Clinical Care

MORT-30-AMI
MORT-30-HF
MORT-30-PN

Safety

Central Line-Associated Bloodstream Infections (CLABSI)
Catheter-Associated Urinary Tract Infections (CAUTI)
Surgical Site Infections (SSI) (Colon & Abdominal Hysterectomy)
Methicillin-resistant *Staphylococcus aureus* (*MRSA*) Infections
C. difficile Infections (CDI)
AHRQ PSI-90
PC-01

Efficiency and Cost Reduction

MSPB-1

FY 2018 Hospital VBP Program Measure Changes

New Measure	Removed Measures	Moved Measure
CTM-3: Three-Item Care Transition Measure (NQF #0228) in PCCECC/CC Domain.	**AMI-7a:** Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	**PC-01:** Elective Delivery Prior to 39 Completed Weeks Gestation (Clinical Care/Process Domain to Safety Domain)
	IMM-2: Influenza Immunization	
Removed Domain		
Clinical Care – Process Subdomain		

Removal of Metrics from the PCHQR Program Effective Quarter (Q) 4 2015 Discharges

- Q1 2015 Discharges
  - Data submission required with submission period of July 1–August 15, 2015
- Q2 and Q3 2015 Discharges
  - Data submission required with submission period of July 1–August 15, 2016
- Starting with Q4 2015 Discharges
  - No further data submission

NQF #	Specific Metrics Removed
0218	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hours Prior to Surgery to 24 Hours After Surgery
0453	Urinary Catheter Removed on Post-Operative Day One (POD1) or POD2 with Day of Surgery Being Day 0
0527	Prophylactic Antibiotic Received within One Hour Prior to Surgical Incision
0528	Prophylactic Antibiotic Selection for Surgical Patients
0529	Prophylactic Antibiotic Discontinued within 24 Hours After Surgery End Time
0284	Surgery Patients in Beta-Blocker therapy Prior to Admission who Receive a Beta-Blocker During the Perioperative Period

Finalized New Measures for the PCHQR Program

For the FY 2018 payment determination and subsequent years, CMS finalized the addition of three new National Health Safety Network (NHSN) Healthcare-Associated Infection (HAI) quality measures:

1. **NQF #1717:** Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure
2. **NQF #1716:** Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure
3. **NQF #0431:** Influenza Vaccination Coverage Among Healthcare Personnel Measure (HCP)

Public Reporting Requirements for the PCHQR Program

Summary of Previously Adopted and Newly Finalized Public Display Requirements		
Measures	**NQF #**	**Public Reporting**
• Adjuvant Chemotherapy is Considered or Administered Within 4 Months (120 days) of Diagnosis to Patients Under the Age of 80 with AJCC III (lymph node positive) Colon Cancer	0233	2014 and subsequent years
• Combination Chemotherapy is Considered or Administered Within 4 Months (120 days) of Diagnosis for Women Under 70 with AJCC T1c, or Stage II or III Hormone Receptor Negative Breast Cancer	0559	
• Adjuvant Hormonal Therapy	0220	2015 and subsequent years
• Oncology: Radiation Dose Limits to Normal Tissues•	0382	2016 and subsequent years
• Oncology: Plan of Care for Pain	0383	
• Oncology: Pain Intensity Quantified	0384	
• Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Patients	0390	
• Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Patients	0389	
• HCAHPS	0166	
• CDC NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139	2017 and subsequent years
• CDC NHSN Catheter-Associated Urinary Tract Infections (CAUTI) Outcome Measure	0138	

Pneumonia Readmission Measure Cohort Expansion

- Begins with the FY 2017 program
- Finalized a modified version of the expanded cohort from what was proposed
- Adds additional pneumonia patients to the measure cohort:
  - [*Current*] Patients with a principle discharge diagnosis of pneumonia
  - [*New*] Patients with a principle discharge diagnosis of aspiration pneumonia
  - [*New*] Patients with a principle discharge diagnosis of sepsis, with a secondary diagnosis of pneumonia present on admission
- [*Not finalized*] Patients with respiratory failure or coded as having severe sepsis or septic shock
- Developed in response to changing trends in hospital coding practices for pneumonia and to address potential bias related to variations in coding practices
- Provides a more complete picture of a hospital's performance on readmissions with respect to its pneumonia patients and allows for better comparison of performance across hospitals

Extraordinary Circumstance Exception Policy

- Beginning October 1, 2015, this policy allows a hospital that has experienced an extraordinary circumstance (*e.g.*, hurricane or flood) to request a waiver of certain periods of data from inclusion in the calculation of its excess readmission ratio for a given fiscal year due to the extraordinary circumstance
- An extraordinary circumstance might affect a hospital's ability to accurately or timely submit all of its claims data
- An extraordinary circumstance exception request form will soon become available on the *QualityNet* website (similar to the request form used in the Hospital IQR and VBP programs)

Implementation of the HAC Reduction Program for FY 2017

- Applicable Time Period for the FY 2017 HAC Reduction Program
  - Domain 1 measure (AHRQ PSI-90 Composite measure), CMS will use the 24-month period from July 1, 2013 through June 30, 2015.
  - The CDC NHSN measures, (CLABSI, CAUTI, Colon and Abdominal Hysterectomy SSI, MRSA Bacteremia, and CDI), CMS will use data from CYs 2014 and 2015.
- Narrative Rule Used in Calculation of the Domain 2 Score
  - Current narrative rules for Domain 2 assign a score for each Domain 2 measure and the measure scores are averaged to provide a Domain 2 Score
  - The new rule will treat each Domain 2 measure independently when determining if a score of 10 (maximal score) should be assigned to the measure for nonsubmission of data without a waiver (if applicable).
    - For example, if a hospital does not submit data for the Colon and Abdominal Hysterectomy SSI measure and does not have a valid waiver for nonreporting, the measure would receive a score of 10.

Implementation of the HAC Reduction Program for FY 2017 (cont.)

- Domain 1 and Domain 2 Weights for the FY 2017 HAC Reduction Program
  - Domain 1 will be reduced to 15 percent and Domain 2 will be increased to 85 percent of the Total HAC Score.
    - The decrease of Domain 1 occurred for two reasons.
      - First, with the implementation of the CDC MRSA Bacteremia and CDI measures in the FY 2017 program, the weighting of both domains is being adjusted to reflect the addition of the fifth and sixth measures in Domain 2.
      - Second, CMS considered the MedPAC and other stakeholders recommendations to increase the Domain 2 weighting because the CDC NHSN chart-abstracted measures in Domain 2 are more reliable and actionable than claims-based measures.

HAC Reduction Program Updates

- Measure Refinements for the FY 2018 HAC Reduction Program
  - Inclusion of Select Ward (Non-Intensive Care Unit (ICU)) Locations in Certain CDC NHSN Measures Beginning in the FY 2018 Program Year
    - CMS will include data from pediatric and adult medical ward, surgical ward, and medical/surgical ward locations in addition to data from adult and pediatric ICU locations for the CDC NHSN CLABSI and CAUTI measures beginning with the FY 2018 HAC Reduction Program.

- Update to CDC NHSN Measures Standard Population Data
  - For each NHSN measure, The CDC calculates the Standard Infection Rate (SIR), which compares a hospital's observed number of HAIs to the number of infections predicted for the hospital, adjusting for several risk factor.
  - As part of routine measure maintenance, The CDC will be updating the standard population data to ensure the NHSN measures' number of predicted infections reflects the current state of HAIs in the United States
  - The new standard population data will affect the HAC Reduction Program beginning in FY 2018 when the applicable period for the CDC NHSN measures included in the program will include CY 2015 and CY 2016 data.

LTCH Quality Reporting Program Overview – 1

CMS has adopted 13 quality measures for the LTCH QRP:

- Three quality measures for data collection and reporting for FY 2014 and FY 2015 payment update determination
- Two additional measures for FY 2016 payment update determination
- Three additional measures for FY 2017 payment update determination
- Five additional measures for FY 2018 payment update determination

LTCH Quality Reporting Program Overview – 2

Quality Measure	Data Collection Start Date	Data Collection Method	Payment Year Update Determination
Percent of Patients or Residents with Pressure Ulcers That Are New or Worsened (NQF #0678)	October 1, 2012	LTCH CARE Data Set*	FY 2014 and subsequent
NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)	October 1, 2012	CDC NHSN**	
NHSN Central Line-associated Blood Stream Infection (CLABSI) Outcome Measure (NQF #0139)	October 1, 2012	CDC NHSN	

* LTCH CARE Data Set: Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set
** Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN): http://www.cdc.gov/nhsn
***Highlighted measures were finalized in the FY 2016 IPPS/LTCH PPS Final Rule

LTCH Quality Reporting Program Overview – 3

Quality Measure (NQF #)	Data Collection Start Date	Data Collection Method	Payment Year Update Determination
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)	October 1, 2014	LTCH CARE Data Set	FY 2016, FY 2018 and subsequent
Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431)	October 1, 2014	CDC NHSN	FY 2016 and subsequent
All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (NQF #2512)	N/A**	N/A**	For Future Public Reporting

**This is a Medicare Fee-For-Service claims-based measure; hence, no LTCH QRP specific data submission is required by LTCHs.

*Highlighted measures were finalized in the FY 2016 IPPS/LTCH PPS Final Rule

LTCH Quality Reporting Program Overview – 4

Quality Measure	Data Collection Start Date	Data Collection Method	Payment Year Update Determination
NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)	January 1, 2015	CDC NHSN	FY 2017 and subsequent
NHSN Facility-Wide Inpatient Hospital-Onset Clostridium Difficile Infection (CDI) Outcome Measure (NQF #1717)	January 1, 2015	CDC NHSN	
NHSN Ventilator-Associated Event (VAE) Outcome Measure	January 1, 2016	CDC NHSN	FY 2018 and subsequent

LTCH Quality Reporting Program Overview – 5

Quality Measure	Data Collection Start Date	Data Collection Method	Payment Year Update Determination
Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)	April 1, 2016	LTCH CARE Data Set	FY 2018 and subsequent
Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632)	April 1, 2016	LTCH CARE Data Set	
Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)	April 1, 2016	LTCH CARE Data Set	
Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)	April 1, 2016	LTCH CARE Data Set	

*Highlighted measures were finalized in the FY 2016 IPPS/LTCH PPS Final Rule

LTCH CARE Data Set

The LTCH CARE Data Set must be completed for all patients admitted and discharged from an LTCH.

Version #	Effective Start Date	Items to Collect Data for Quality Measures
Version 1.01	October 1, 2012	Pressure Ulcer
Version 2.01	July 1, 2014	Pressure Ulcer and Patient Influenza Vaccination Status
Version 3.00*	April 1, 2016	Pressure Ulcer, Patient Influenza Vaccination Status, and Falls with Major Injury

* LTCH CARE Data Set Version 3.00 is available for download on the following CMS LTCH QRP Web page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information.html.

CDC NHSN

- CDC's NHSN is the data submission mechanism for the CAUTI, CLABSI, MRSA, CDI, and Influenza Vaccination Coverage Among Healthcare Personnel quality measures.
- As of January 1, 2016, CDC's NHSN will also be the data submission mechanism for the Ventilator Associated Event (VAE) Outcome Measure.
- For further information on data collection and submission for these measures, please visit www.cdc.gov/nhsn/.

Data Submission Deadlines for Payment Update Determination

- LTCHs must submit quality data for each quarter by the quarterly data submission deadline*.
- Data submitted after the quarterly data submission deadline will not be accepted for LTCH QRP compliance determination.
- Missing one or more of these deadlines may lead to a finding of non-compliance.

*For Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431), the expansion of the quarterly submission deadline is not applicable. The data submission deadline will remain May 15 of each year for quality data related to this measure.

Newly Adopted Data Submission Deadlines for the LTCH QRP

- Beginning with Quarter 4 (October 1–December 31, 2015), the data submission deadlines for quality measures, except Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431), have been expanded to give facilities additional time to submit, review, and correct data.
- These deadlines apply to the payment determinations for FY 2017, FY 2018, and subsequent years.
- LTCHs will have four and a half months (approximately 135 days) after the end of each quarter to submit required quality data.
- Current submission deadlines allow LTCHs to submit data within one and one half months (approximately 45 days) after the end of each quarter.

Newly Adopted Public Reporting Policy for the LTCH QRP

- Public reporting of LTCH QRP quality data:
  - Scheduled to begin in Fall 2016
  - Includes a period for review and correction of quality data prior to the public display of LTCH performance data
- Initial data will include:
  - **NQF #0678** Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay)
  - **NQF #0138** NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure
  - **NQF #0139** NHSN Central-Line Associated Bloodstream Infections (CLABSI) Outcome Measure
  - **NQF #2512** All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from Long-Term Care Hospitals

Newly Adopted Public Reporting Policy for the LTCH QRP (Cont.)

- A list of LTCHs that successfully meet the reporting requirements for the applicable payment determination will be published on the LTCH QRP Web site.
  - The list will be updated after reconsideration requests are processed on an annual basis.

Quality Measures Previously Adopted for IRF QRP

For the FY 2018 payment determination and subsequent years, we adopted two quality measures to reflect NQF endorsement or to meet the requirements of the IMPACT Act:

1. **NQF #2502** All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs
2. **NQF #0678** An application of Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened

Newly finalized Quality Measures for the FY 2018 Payment Determination and Subsequent Years: IMPACT Act

- **Domain 1** Skin integrity and changes in skin integrity
  - **Quality Measure:** "Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened" (Short-Stay) (NQF #0678)
- **Domain 2** Functional status, cognitive function, and changes in function and cognitive function
  - **Quality Measure:** Application of the "Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function" (NQF #2631; under review)
- **Domain 3** Incidence of major falls
  - **Quality Measure:** Application of the "Percent of Residents Experiencing One or More Falls with Major Injury" (Long-Stay) (NQF #0674)

Newly Finalized Quality Measures for the FY 2018 Payment Determination and Subsequent Years: Function

The four adopted functional outcome measures are:

1. Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633; under review)
2. Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634; under review)
3. Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635; endorsed)
4. Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636; endorsed)

Revision to the Previously Adopted Data Collection Timelines and Submission Deadlines

- Quality measures in the IRF QRP will have a data collection time frame based on the calendar year, unless there is a clinical reason for an alternative data collection time frame.
  - For example, if the data collection period is tied to the influenza vaccination season
- When additional quality measures that use IRF-Patient Assessment Instruments (PAIs) as the data collection mechanism are adopted for future use in the IRF QRP, the first data collection time frame for those newly-adopted measures will be three months (October–December) and subsequent data collection periods would follow a calendar year data collection time frame

Data Submission Mechanism: IRF-PAI Version 1.4

- Effective October1, 2016
- Includes:
  - Modified pressure ulcer items collected at admission and discharge
  - New fall items collected at discharge
  - New self care and mobility functional status items collected at admission and discharge
  - New risk factor items for the self-care and mobility measures collected at admission
- Available at http://www.cms.gov/Medicare/Quality-Initiatives-PatientAssessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-MeasuresInformation-.html

Timing for New IRFs to Begin Submitting Quality Data

To ensure that all IRFs have a minimum amount of time to prepare to submit quality data to CMS under the requirements of the IRF QRP, a new IRF is required to begin reporting quality data under the IRF QRP by no later than the first day of the calendar quarter subsequent to 30 days after the date on its CCN notification letter.

Suspension of the IRF QRP Data Validation Process for the FY 2016 Payment Determination and Subsequent Years

- Finalized decision will temporarily suspend the implementation of a process to validate the data submitted for quality purposes, finalized in the FY 2015 IRF PPS rule
- Data accuracy validation will have no bearing on the applicable FY annual increase factor reduction for FY 2016 and subsequent years unless and until we propose to either reenact this policy or propose to adopt a new validation policy through future rulemaking
- Development of a more comprehensive data validation policy that is aligned across the PAC quality reporting programs is in progress, as well as consideration of ways to reduce the labor and cost burden on IRFs

Other Policy Updates

- CMS has finalized its proposal to codify Data Submission Exception and Extension Requirements at §412.634
- CMS will continue using the IRF QRP Reconsideration and Appeals Procedures that were adopted in the FY 2015 IRF PPS Final Rule (79 FR 45919 through 45920) for the FY 2017 payment determination and subsequent years, with the addition of notifying non-compliant IRF providers using the Quality Improvement Evaluation System (QIES) in addition to USPS.

Public Display of IRF QRP Quality Measure Data

- CMS will display performance information regarding the quality measures, as applicable, required by the IRF QRP by fall 2016 on a CMS website after a 30-day preview period.
- The initial display of information will contain IRF provider performance on three quality measures:
  - Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678).
  - NHSN CAUTI Outcome Measure (NQF #0138)
  - All-Cause Unplanned Readmission Measure for 30 Days Post Discharge From IRFs (NQF #2502).

Acronyms in this Presentation

- **CAUTI** Catheter-Associated Urinary Tract Infection
- **CEHRT** Certified Electronic Health Record Technology
- **CLABSI** Central Line-Associate Bloodstream Infection
- **DSH** Disproportionate Share Hopsital
- **eCQM** electronic Clinical Quality Measure
- **CY** Calendar Year
- **ED** Emergency Department
- **EHR** Electronic Health Record
- **FY** Fiscal Year
- **GI** Gastrointestinal
- **HAI** Healthcare-Associated Infection
- **HCAHPS** Hospital Consumer Assessment of Healthcare Providers and Systems
- **HCP** Influenza Vaccination Coverage Among Healthcare Personnel Measure
- **HF** Heart Failure
- **IMM** Immunization

Acronyms in this Presentation

- **IPPS** Inpatient Prospective Payment System
- **IQR** Inpatient Quality Reporting
- **LTCH** Long-Term Acute Care Hospital
- **NHSN** National Health Safety Network
- **NQF** National Quality Forum
- **NQS** National quality Strategy
- **PCCECC** Patient- and Caregiver-Centered Experience of Care/Care Coordination
- **POD** Post-Operative Day
- **Q** Quarter
- **QRDA** Quality Reporting Data Architecture
- **SCIP** Surgical Care Improvement Project
- **SSI** Surgical Site Infection
- **STK** Stroke
- **THA** Elective Total Hip Arthroplasty
- **TKA** Total Knee Arthroplasty
- **UTI** Urinary Tract Infection
- **VTE** Venous Thromboembolism

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