Proposed fy17 LTCH PPS:
New rules for Quality & Referrals

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Overview

Objectives

- Describe updates to the LTCH Quality Reporting Program
  - New measures
  - New public reporting

- Discuss full implementation of site neutral vs. LTCH criteria reimbursement

- Detail proposed changes to the “25% rule”

- Review temporary wounds reimbursement regulation

- Discuss strategies for managing public reporting and referrals rules
Current QRP & IMPACT Act Measures:

- CAUTI
- CLABSI
- New or worsened pressure ulcers
- Patients vaccinated for influenza
- Healthcare personnel vaccinated for influenza
- All-cause unplanned readmission 30-days post-discharge
- MRSA
- CDI
- Ventilator-Associated Events
- Patients experiencing 1+ falls with major injury
- Patients with functional assessment at admission and discharge, and a care plan that addresses function (QRP + IMPACT Act)
- Change in mobility for ventilator patients
Claims-Based Measures

- Medicare Spending per Beneficiary (MSPB)
- Discharge to Community
- Potentially Preventable 30-Day Post-Discharge Readmissions

All 3 proposed claims-based measures...
...were mandated by the IMPACT Act
...would effect payment for fy18 and beyond (Oct. 1, 2017)
...will be applied in other post-acute settings

Timeline:
- Confidential feedback using cy2015 and cy2016 discharges
- Public reporting will use cy2016 and cy2017 discharges — 2018 at the earliest
Medicare Spending per Beneficiary

- $67,181: mean, standardized, risk-adjusted payment in fy13 and fy14 for a post-acute care episode triggered by an admission to an LTCH
- $27,502 to $115,291: payment range from the 5th to the 95th percentile
- Reported measure will show your hospital in comparison to the national LTCH median – above, below or equal

“LTCHs involved in the provision of high quality PAC care as well as appropriate discharge planning and post-discharge care coordination would be expected to perform well on this measure since beneficiaries would likely experience fewer costly adverse events...”
Details:

- Medicare FFS patients only
- Separate measures for site neutral patients vs. LTCH criteria patients
- Episode triggered by the patient’s admission to an LTCH, with episode attributed to the admitting LTCH
- Readmissions to the same facility within 7 or fewer days do not trigger a new episode
- “Associated services” period ends 30 days after the end of the LTCH treatment period
- Excluded treatments:
  - Planned hospital admissions
  - Management of certain preexisting chronic conditions
  - Treatment of preexisting cancer
  - Organ transplants
  - Preventative screenings
Discharge to Community

- “Community” means home or self-care with or without home health services
- A successful discharge has no unplanned rehospitalizations and no death during 31 days following discharge

“Given the high costs of care in institutional settings, encouraging LTCHs to prepare patients for discharge to community, when clinically appropriate, may have cost-saving implications for the Medicare program.”
### Discharge from LTCHs to Community?

- **CMS:** 25% of cy2012 and cy2013 discharges
- **LTRAX:** 27.6% of cy2015 and 26.7% of cy2016 year-to-date
- Raw and CMI-adjusted discharge to community (without CMS measure adjustments) available in [Administrative Outcomes Reports](#)

<table>
<thead>
<tr>
<th>Discharge Destination</th>
<th>Facility</th>
<th>Weighted National</th>
<th>Unweighted National</th>
<th>Weighted Regional</th>
<th>Unweighted Regional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Discharges</td>
<td>28.23% (142)</td>
<td>25.34%</td>
<td>31.21% (41388)</td>
<td>24.98%</td>
<td>27.81% (6123)</td>
</tr>
<tr>
<td>Lower Level Of Care Discharges</td>
<td>64.61% (325)</td>
<td>66.97%</td>
<td>70.27% (93199)</td>
<td>65.38%</td>
<td>67.58% (14882)</td>
</tr>
<tr>
<td>Expired Discharges</td>
<td>17.69% (89)</td>
<td>15.52%</td>
<td>11.53% (15252)</td>
<td>17.66%</td>
<td>14.80% (3259)</td>
</tr>
<tr>
<td>Community residential setting</td>
<td>22.85% (118)</td>
<td>21.76%</td>
<td>27.60% (36607)</td>
<td>20.28%</td>
<td>22.92% (5046)</td>
</tr>
<tr>
<td>Long-term care facility (LTC)</td>
<td>6.00% (37)</td>
<td>6.55%</td>
<td>6.77% (LTC)</td>
<td>6.25%</td>
<td>6.13% (38)</td>
</tr>
<tr>
<td>Skilled nursing facility (SNF)</td>
<td>35.98% (181)</td>
<td>37.76%</td>
<td>35.23% (46726)</td>
<td>39.22%</td>
<td>38.12% (8353)</td>
</tr>
<tr>
<td>Hospital emergency</td>
<td>0%</td>
<td>1.45%</td>
<td>1.53% (2025)</td>
<td>1.60%</td>
<td>1.60% (252)</td>
</tr>
</tbody>
</table>
Details:

- Medicare FFS patients only
- Uses billing codes on LTCH claim
  - 01: home or self-care
  - 06: home w/ home health
  - 81: home w/ planned STACH readmission
  - 86: home w/ home health & planned STACH readmission
- Calculated using 2 years of data
- Risk-adjusted for age, sex, principal diagnosis, comorbidities, ventilator status, ESRD status, dialysis and other variables
Potentially Preventable 30-Day Post-Discharge Readmissions

- Few studies investigating potentially preventable 30-day readmissions following an LTCH stay
- Differs from existing QRP measure
  - QRP: All-Cause Unplanned
  - IMPACT Act: Potentially Preventable and Unplanned
- Reported measure will show your hospital in comparison to the expected rate – above, below or equal

“Hospital readmissions among the Medicare population, including beneficiaries that utilize PAC, are common, costly, and often preventable.”
Details:

- FFS patients only
- LTCH admission within 30 days of discharge from prior IPPS (including critical access or psychiatric) hospital stay
- Readmission includes readmission to an IPPS or LTCH during 30-day window that begins 2 days after LTCH discharge
- Readmitted with a diagnosis considered to be unplanned and potentially preventable
- 3 categories of potentially preventable readmissions:
  - Inadequate management of chronic conditions
  - Inadequate management of infections
  - Inadequate management of other unplanned events
- Risk-adjusted for demographics, principal diagnosis and LOS in original IPPS stay, surgeries, ventilator use, comorbidities, LOS in ICU, number of acute care hospitalizations in preceding year
- Use 2 consecutive years of data
**Assessment-Based Measure**

- Drug Regimen Review Conducted with Follow-Up for Identified Issues

**Like claims-based measures...**

...was mandated by the IMPACT Act
...will be applied in other post-acute settings

**Timeline:**

- Data collection beginning April 1, 2018, effecting fy2020 payment
- Require revision to LTCH CARE Data Set (v.4)
  - Look for other changes under IMPACT Act’s standardization mandate
Drug Regimen

Drug Regimen Review Conducted with Follow-Up for Identified Issues

- Percentage of stays in which a drug regimen review was conducted at the time of admission and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout that stay
- “Drug regimen review” means review of all medications or drugs the patient is taking to identify any potentially clinically significant medication issues

“There is universal agreement that medication reconciliation directly addresses patient safety issues that can result from medication miscommunication and unavailable or incorrect information.”
Drug Regimen

New items on the LTCH CARE Data Set:

N2001. Did a complete drug regimen review identify potential clinically significant medication issues?
- No – no issues found during review
- Yes – issues found during review
- NA – patient is not taking any medications

N2003. Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?
- No
- Yes

N2005. Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potentially significant medication issues were identified since the admission?
- No
- Yes
- NA – There were no potentially clinically significant medication issues identified since Admission, or patient is not taking any medications
Future QRP Measures

In Development:
- IMPACT Act domain: Transfer of health information and care preferences when an individual transitions

In Consideration:
- Patient’s experience of care
- Percent of patients with moderate to severe pain
- Advance care plan
- VTE prophylaxis
- Ventilator weaning (liberation) rate
- Compliance with spontaneous breathing trials (including TCT or CPAP) by day 2 of the LTCH stay
- Patients who received antipsychotic medication
Year-Round Influenza Vaccine Data Collection:

- Assessment rules not capturing flu vaccine data for all patients in the hospital during the influenza vaccination season
  - Missing patients admitted before and discharge after the season ended
  - Missing patients admitted during but discharged after the season ended
- Year-round flu vaccine data collection beginning Oct. 1 this year
- LTRAX will be updated by Oct. 1 to check for flu vaccine data on all assessments
Fall 2016:
- New or Worsened Pressure Ulcers
- CAUTI
- CLABSI
- All-Cause Unplanned Readmission 30 Days Post-Discharge

CY2017:
- MRSA
- CDI
- Influenza Vaccination for Healthcare Personnel
- Influenza Vaccination for Patients (July 1 – June 30)

Regional comparisons:
- CMS soliciting feedback re: preference for CMS or U.S. Census regions
- LTRAX uses U.S. Census regions
Correcting the Record:

- **Assessment data** must be submitted correctly or corrected within the usual deadlines for quarterly reporting (135 days after the end of the quarter).
- **Claims data** will be extracted no sooner than 90 days after the last discharge date in the applicable period for calculations.
  - Will not capture submissions, changes or corrections allowed for up to 1 year from the discharge date under billing rules.
- **Measure calculations** can be corrected during 30-day preview window for reporting.
- Reports will become available through CASPER system.
LTCH Criteria vs Site Neutral Patients

- All hospitals will have transitioned to the new, blended payment system by Oct. 1, 2016
- Blended payments will continue for a second year (according to your hospital’s cost reporting periods)
- CMS anticipates payments to decrease by 6.9% ($355 million) in fy17 (including all fy17 payment changes)
- Estimated 45% of LTCH cases will be paid as site neutral in fy17

LTRAX Resources

- Patient-level criteria analysis available on the Metrics tab of each assessment
  - See the Metrics tab HELP document for details about the LTRAX 3-part patient criteria test
- Overall hospital analysis available on the Patient Criteria Report
25% Threshold Policy (aka, 25% Rule)

- Limits the number of LTCH admissions from any single referring hospital to 25% (or your hospital’s relevant exception threshold)
- Admissions in excess reimbursed at lesser of applicable LTCH PPS or IPPS amount (but not the same IPPS equivalent used for site neutral or short stay reimbursement calculations)
- Intended to prevent “gaming” of Medicare reimbursement by shifting patients from one setting to another to trigger two hospital reimbursements
25% Rule “Simplification”

- Beginning with discharges Oct. 1, 2016, and later
- Rural LTCHs would be subject to a 50% threshold
- “MSA-dominant” LTCHs would be subject to 25-50% threshold, limited to the percentage of Medicare patients discharged from the dominant STACH
- Site neutral cases will count toward the 25% Rule calculation
- MA patients excluded
- No change to rule that high-cost outliers in the STACH do not count toward the 25% Rule calculation
- Grandfathered LTCHs statutorily exempt

25% Rule on LTRAX

- Use LTRAX Administrative Outcomes > Highest Referral Percentage to track percentage of admissions from top referring facility
- Use LTRAX referrals tracking even without pre-admission screening
“Rifle Shot”

- Provision of law crafted so narrowly that only one or a few entities benefit

This rifle shot ...

- Benefits rural, grandfathered LTCHs that were co-located with another hospital as of Sept. 30, 1995
- Allows LTCH PPS reimbursement rates for “severe wound” cases discharged before Jan. 1, 2017
  - Stage 3, stage 4, unstageable, non-healing surgical wound, infected wound, fistula, osteomyelitis or wound with morbid obesity
  - Also require complex, continuing care, including local wound care occurring multiple times a day
- Wounds will be identified by ICD-10s on the claim or a payer-specific condition code
- LTCHs will have to flag these cases for their MACs
Probably will not benefit your hospital, but...

- Provides a starting point for more discussion about reimbursement for wound patients
- Creates a definition lacking in prior discussions about who should qualify for a hypothetical wound exemption from site neutral payment rates
- Continued ambiguity around how to use ICD-10 codes to clearly identify a morbidly obese patient with a complex wound or an infected wound
Compliance with CMS QRP

- Upcoming deadline on May 15th for Q4 2015 data
- Validation
  - LTRAX QRP override reports
  - CASPER

Public Reporting

- Current performance
- Managing perceptions
  - Referral sources
  - Patient/families
- Use of data
New Measures

- MSPB, discharge to community, readmissions, medication regimen
  - Considerations
- Commentary period
  - Increased access to readmission data
- Readmission reduction program
  - Combine forces: Acute Outs and Readmissions
Changes to the 25% Rule Threshold

**Significant impact across the LTACH industry**

- Is your hospital at risk?
  - Assess admission distribution
  - Determine untapped opportunities to increase volume for other sources

- Commentary to CMS
  - Provide data of impact
  - State your position on this proposed rule
  - Provide evidence in support of your position
Wound Case Reimbursement

Considerations

- Are you one of the few included?
  - Identification of patients
  - Ensuring appropriate reimbursement for these cases

- Commentary to CMS
  - Conduct analysis on your wound population, costs and reimbursement under IPPS for these patients
  - Describe impact to date
    - Ability to provide adequate services within the expected LOS
    - Impact on outcomes
    - Access to services
  - Future considerations of wound case payments
    - How this can improve access, treatment and improved patient outcomes
Resources

IMPACT Act Downloads:

Measure Specifications: Medicare Spending per Beneficiary

Proposed Measure Specifications for Measures Proposed in the FY 2017 LTCH QRP Notice of Proposed Rulemaking
- Discharge to Community
- Potentially Preventable 30-Day Post-Discharge Readmission Measure
- Drug Regimen Review Conducted with Follow-Up for Identified Issues

Download Table of ICD-10 Codes for Wound Reimbursement (CMS-1664-IFC)
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices.html