FY2018 Proposed Rule: Payment and Quality Reporting

Mary Dalrymple
Managing Director, LTRAX
Objectives

- Describe effects of reimbursement updates
- Look at new short stay payment system
- Touch on miscellaneous regulatory changes
- Identify new measures for LTCH Quality Reporting Program
- Review updates to public reporting schedule
- Describe data collection stemming from the IMPACT Act
- Preview areas under consideration for future quality reporting
- Review updates to HCAHPS survey (acute care) for LTRAX patient satisfaction users (*not* LTCH patient experience)
FY2018 Proposed LTCH PPS

- Net 3.75% decrease in Medicare reimbursements to LTCHs

LTCH Criteria Patients

- 58% of cases (fy16)
- Net 0.4% increase in Medicare reimbursement
- Significant increase in high-cost outlier threshold
  - From $21,943 (fy17) to $30,081 (fy18)

Site Neutral Patients

- 42% of cases (fy16)
- First year of full implementation with fy18 cost reporting period
- Net 22% decrease in Medicare reimbursement
Site Neutral Patients

- 50/50 blended payment ends in fy18
  - currently paid 50% IPPS rate + 50% LTCH PPS rate
- Ends when your hospital begins its fy18 cost reporting period
- Fully implemented, site neutral rate is the lower of...
  - Inpatient PPS comparable per diem with outliers, or
  - 100% estimated cost

LTCH Criteria Patients

- Admitted directly from subsection (d) hospital
  - AND
- 3 or more days in ICU or CCU before admission, or
- >96 hours invasive mechanical ventilation in LTCH
  - AND
- Not assigned to a psych or rehab DRG upon discharge
**New Payment for Short Stays**

- LTCH criteria patients only
- No change in definition
  - LOS \( \leq \frac{5}{6} \) geometric mean LOS for the patient’s DRG
- New payment
  - Remove payment cliff when the patient reaches \( \frac{5}{6} \) LOS
  - Graduated per diem payment
  - Blend of the IPPS per diem and 120% LTCH per diem
  - Shorter stays paid more like an IPPS patient; longer stays paid more closely to LTCH PPS rates
- Bottom Line
  - Without cliff, Medicare expects more “long” short stays offset by fewer full reimbursements
  - Net increase in payments of $102 million
  - SSO payment will be trimmed slightly to recoup the $102 million
Moratorium on 25% Rule Extended

- Moratorium on enforcement extended through Sept. 30, 2018
- Threshold requires that certain LTCHs get no more than 25% of their patients from a single acute care hospital
- Extended legislatively (21st Century Cures Act)
- CMS took cue from lawmakers and extended the moratorium even further
- Study the effect of the site neutral payment system on admission patterns without the effect of 25% rule behavior
Legislative Extension and Modification

- Prior temporary carve outs for certain hospitals and certain wound patients, very narrowly drawn
- Extended & modified in the 21st Century Cures Act
  - Removed rural requirement
  - Retained grandfathered hospital-within-hospital requirement
  - ICD-10 identifying stage 3, stage 4, unstageable, non-healing surgical wound or fistula
    - No longer includes an infected wound, osteomyelitis, or wound with morbid obesity
  - Case must be assigned to DRG 539 (osteomyelitis w/MCC), 540 (osteomyelitis w/CC), 602 (cellulitis w/MCC), 603 (cellulitis w/CC)
Hospital-within-Hospital

**HwH Regulations**

- No change to existing definitions
- Apply the current “separateness and control” regulations only when the LTCH HwH is co-locating with an acute care hospital (IPPS)
- Separateness and control regulations require the HwH LTCH to prove it is a separate entity from the acute care hospital where it’s located, with its own governing body and staff, hospital functions, source of patient admissions, etc.
- Medicare believes inappropriate patient shifting moderated by other regulatory requirements imposed in non-acute settings
Implementing Other Regulatory Changes

- Allow existing LTCHs and satellites to increase bed count if meeting qualifying criteria, retroactive to April 1, 2014
- Change to ALOS calculation for LTCHs established after Dec. 26, 2013
- Extend exemption from site neutral payment for two LTCHs that primarily treat catastrophic spinal or brain injuries and have significant out-of-state admissions
Current Measures

- New or Worsened Pressure Ulcers
- Assessed & Appropriately Given Influenza Vaccine
- Falls with Major Injury
- Functional Assessment & Care Plan
- Cross-Setting Functional Assessment & Care Plan
- Change in Mobility for Ventilator Patients
- Drug Regimen Review with Follow-Up
- CAUTI
- CLABSI
- MRSA
- CDI
- Healthcare Personnel Influenza Vaccination
- VAE
- All-Cause 30-Day Readmissions
- MSPB
- Discharge to Community
- Potentially Preventable 30-Day Readmissions
**Proposed Changes**

- New or Worsened Pressure Ulcers
- All-Cause Unplanned 30-Day Readmissions
- Changes in Skin Integrity: Pressure Ulcer/Injury
- Compliance with Spontaneous Breathing Trial by Day 2 of LTCH Stay
- Ventilator Liberation Rate

**Timeline**

- Data collection beginning April 1, 2018
- New LTCH CARE Data Set (v. 4)
- Effect fy20 reimbursement
Pressure Ulcer Measure

- Percent of patient stays with reports of stage 2-4 pressure ulcers, or unstageable pressure ulcers, that were not present or were at a lesser stage on admission
- Change in vocabulary to add “injury”
- Addition of new or worsened unstageable pressure ulcers
- Change in calculation methodology
  - Instead of using M0800 counts of new or worsened, the measure would compare discharge counts to admission counts
  - “Reduce potential for underestimating the frequency of pressure ulcers”
  - Has the potential to count any ulcer that changed stage, whether or not it is new or worsened
Spontaneous Breathing Trial Measure

- Facility compliance with spontaneous breathing trial (SBT) including tracheostomy collar trial (TCT) or continuous positive airway pressure (CPAP) breathing trial by day 2 of the LTCH stay for patients on invasive mechanical ventilation support upon admission and for whom at admission weaning attempts were expected or anticipated

- 2 components
  - Percentage of Patients Assessed for Readiness for SBT by Day 2 (including TCT or CPAP breathing trial)
  - Percentage of Patients Ready for SBT who Received SBT by Day 2 (including TCT or CPAP breathing trial)
    - Uses subset of patients identified in first component

- Day 1 is admission, Day 2 is the next calendar day
- Determination of patient as non-weaning must be based on documentation found in the patient’s medical record at admission


**Spontaneous Breathing Trial Measure**

- The less invasive mechanical ventilation, the better.
- Majority of mechanically ventilated patients in the LTCH have been ventilated for at least 21 days (prolonged mechanical ventilation)
- “...unnecessarily prolonged mechanical ventilation can be an indicator of poor quality care.”
- Pushing hospitals to adopt faster, more consistent weaning protocols
  - Hospital approaches to initiating weaning vary widely
- Higher percentage is better
**Ventilator Liberation Rate**

- Liberated patient does not require any invasive mechanical ventilation support for at least 2 consecutive calendar days immediately prior to the date of discharge
- Discharged alive
- Liberation measured only for patients admitted on invasive ventilation for whom at admission weaning is expected or anticipated
- Like SBT, determination of patient as non-weaning must be based on documentation found in the patient’s medical record at admission
**Ventilator Liberation Rate**

- Risk adjusted
  - Age
  - Prior functioning: Everyday activities
  - Metastatic cancer
  - Severe cancer
  - Left ventricular assistive device with known ejection fraction \( \leq 30\% \)
  - Progressive neuromuscular disease
  - Severe neurological injury, disease, or dysfunction
  - Post-transplant (lung, heart, kidney, and bone marrow)
  - Vasoactive medication
  - Dialysis
Public Reporting Timeline

- Calendar 2018
  - Admission and Discharge Functional Assessment & Care Plan
  - Cross-Setting Application of Functional Assessment & Care Plan
  - Falls with Major Injury
- October 2018
  - Medicare Spending per Beneficiary
  - Discharge to Community
  - Potentially Preventable 30-Day Readmissions
  - All-Cause Unplanned 30-Day Readmissions
- Calendar 2020
  - Change in Mobility Among Vent Patients
- October 2020
  - Changes in Skin Integrity: Pressure Ulcer/Injury
  - New or Worsened Pressure Ulcers
**Transfer of Information**
- Mandatory under IMPACT Act
- Undergoing development and pilot testing
- Will be added in an April 1, 2019,
- Another new LTCH CARE Data Set (v.5)

**Two Measures**
- Transfer of Information at Post-Acute Care Admission, Start or Resumption of Care from other Providers/Settings
- Transfer of Information at Post-Acute Care Discharge and End of Care to other Providers/Settings
Patient Experience of Care

- In development and pilot testing
- Domains
  - Beginning stay
  - Interactions with staff
  - Experience during stay
  - Preparing to leave
  - Overall Rating
- CMS wants feedback
  - Implementation and logistics
  - Survey-based measures
  - General feedback
Future Measures

- Application of percent of residents who self-report moderate to severe pain (NQF #0676)
- Advance care plan
- Patients who received antipsychotic medication
- Modification of discharge to community
  - Exclude nursing facility residents from calculation because they did not live in the community prior to LTCH stay
**Data Standardization**

- Mandated under IMPACT Act
- Requires that the same question be asked in multiple post-acute settings in the same way & available responses identical in all settings
- Precursor to unified post-acute payment system
- Includes some items already collected

**Categories**

- Functional status
- Cognitive function
- Special services, treatments and interventions
- Medical conditions and comorbidities
“We intend to use these data for a number of purposes, including facilitating their exchange and longitudinal use among health care providers to enable high quality care and outcomes through care coordination, as well as for quality measure calculation and identifying comorbidities that might increase the medical complexity of a particular admission.”

**Broadening the use and universe of data collection**

- LTCH QRP – help patients, prevent harm
- Cross-setting – compare outcomes settings
- Standardized – policy, research and future use
Criteria for Evaluating Standardized Data

- Supported by current science
- Reliable and valid
- If shared among post-acute settings, improve care coordination and outcomes
- Inform development of future measures and payment methodologies
- Can be used by practitioners in clinical decisions and care planning
Standardized Data New to LTCH CARE Data Set

- Brief Interview for Mental Status (BIMS)
- Confusion Assessment Method (CAM)
- Behavioral signs and symptoms
- Patient Health Questionnaire-2 (PHQ-2)
- New special services, treatments & interventions
Replace Pain Management Questions

- New focus on communication about pain
- In response to concerns that pain management questions pressured hospitals to prescribe more opioids to achieve higher scores in the Pain Management measure
- Effective Jan. 1, 2018

New Questions

Q: During this hospital stay, did you have any pain?
Q: During this hospital stay, how often did hospital staff talk with you about how much pain you had?
Q: During this hospital stay, how often did hospital staff talk with you about how to treat your pain?

New Measure: Communication about Pain
Questions?
assistance@ltrax.com

Part 2: New LTCH CARE Data Set, effective April 1, 2018
May 11 at 2pm EDT