Housekeeping

- You will not hear any audio until the webinar begins.
- To join the audio, select “call me” and enter your phone number or select “I will call in”.
- If you select “I will call in, follow the prompts and be sure to enter the access code and “Attendee ID”.
- Submit typed questions through the Q&A panel. Send to All Panelists.
- If you experience technical issues, Type a message in the Chat panel to AAMC Meetings.
FY 2018 Inpatient Prospective Payment System (IPPS) Proposed Rule Teleconference

May 15, 2017

AAMC Staff:
Ayeisha Cox, aycox@aamc.org
Scott Wetzel, swetzel@aamc.org
Susan Xu, sxu@aamc.org
Important Information on Proposed Rule

• The FY 2018 IPPS Proposed Rule was published in the Federal Register on April 28

• Comments are due June 13, 2017

• CMS expects the final rule to be issued on or about August 1
AAMC Resources

Individual Institution Reports
• AAMC Hospital Medicare Inpatient Impact Report (mbaker@aamc.org)
• AAMC Hospital Compare Benchmark Report (swetzel@aamc.org)
• FY 2016 AAMC Report on Medicare Inpatient Quality Programs

General Resources
• AAMC IPPS & OPPS Regulatory Page - Contains previous IPPS webinars and comment letters (www.AAMC.org/hospitalpaymentandquality)
• AAMC Quality Spreadsheet (https://www.aamc.org/download/412838/data/aamcqualitymeasuresspreadsheet.xlsx)

Listservs
• Quality updates (email Scott Wetzel at swetzel@aamc.org)
• Reimbursement (email Ayeisha Cox at aycox@aamc.org)
# Today’s Agenda

## Payment Provisions

<table>
<thead>
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<th>Payment Provisions</th>
<th>Federal Register Page #(#(s))</th>
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<tbody>
<tr>
<td>Documentation &amp; Coding</td>
<td>p. 19815-19816</td>
</tr>
<tr>
<td>Disproportionate Share Hospital (DSH) Payments</td>
<td>p. 19940-19955</td>
</tr>
<tr>
<td>EHR Incentive Program</td>
<td>p. 20135-20139</td>
</tr>
</tbody>
</table>

## Quality Provisions

<table>
<thead>
<tr>
<th>Quality Provisions</th>
<th>Federal Register Page #(#(s))</th>
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<tbody>
<tr>
<td>Hospital Readmissions Reduction Program</td>
<td>p. 19956 - 19967</td>
</tr>
<tr>
<td>Hospital Value Based Purchasing Program</td>
<td>p. 19968 - 19986</td>
</tr>
<tr>
<td>Hospital Acquired Conditions Program</td>
<td>p. 19986 - 19990</td>
</tr>
<tr>
<td>Inpatient Quality Reporting Program</td>
<td>p. 20031 - 20075</td>
</tr>
</tbody>
</table>
Payment: Key Takeaways

Documentation & Coding
- +0.4588 adjustment

Medicare DSH UCP Payment
- UCP pool increases by $1 Billion from FY17
- Phase in of Worksheet S-10 data

EHR Reporting
- Continuous 90-day reporting period in 2018
- 21st Century Cures Act Exceptions
Payment Updates
FY2018 Market Basket Update

Market Basket Projected Increase: 2.9%

Multifactor Productivity Adjustment: -0.4%

ACA Adjustment: -0.75%

Documentation & Coding: +0.4588%

Two-Midnight Rule: -0.6%

FY2018 Payment Update: 1.6088%

Overall Impact:
- All Hospitals: 1.7%
- Major Teaching Hospitals: 1.6%
Outlier Payments
FY18 Outlier Fixed Loss Cost Threshold

- The proposed prospective payment rate for the MS-DRG
  + any IME
  + empirically justified DSH payments
  + estimated uncompensated care payment
  + any new technology add-on payments
  + $26,713
Documentation & Coding
The American Taxpayer Relief Act of 2012 (ATRA) required $11B recoupment adjustment by FY2017 for documentation and coding.

- **FY2014-FY2016**
  - CMS collected $6 billion
  - -0.8 percent reduction each year

- **FY2017**
  - CMS collected remaining $5 billion with a -1.5% recoupment adjustment
  - The cumulative total is -3.9 percent

Offsets -0.8 percent x 3 years = -2.4 percent

FY2017 reduction = -1.5 percent

Total Reduction = -3.9 percent
FY2018 begins six-year process to restore payment adjustments from the $11 billion recoupment.

For FY2018, CMS proposes an increase of 0.4588%, as required by the 21st Century Cures Act, to partially restore cuts made as a result of the documentation and coding changes from FYs 2010-2012.
Medicare DSH
Medicare DSH Payments: Background

Section 3133 of the ACA modified the methodology for computing the Medicare DSH payment adjustment

Empirically Justified DSH Payment

The amount that will continue to be paid under the statutory formula for Medicare DSH payments

25%

Uncompensated Care Payment (UCP)

What otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under age 65 who are uninsured

75%
DSH Uncompensated Care Payment (UCP)

Factor 1: $12.002 billion
- Equals 75 percent of the aggregate DSH payments that would have been made under the old statutory formula

Factor 2: 58.01%
- Reduces the amount of Factor 1 by insured pre-ACA to uninsured post-ACA
  - FY2018 Proposed UCP Amount: $6.9 billion*

Factor 3
- Amount to be distributed among all hospitals that receive Medicare DSH payments in FY2018

*CMS uses Office of the Actuary (OACT)'s National Health Expenditure Accounts (NHEA) January 2017 Medicare DSH estimates
CMS Proposed to Start the Transition to Worksheet S-10 for Factor 3 in FY2018

- **FY2014 - FY2016**
  - Used data from one cost reporting period
  - Medicaid days + SSI days

- **FY2017**
  - Used average from three cost reporting periods
  - Medicaid days + SSI Days

- **FY2018**
  - Proposed to use average from three cost reporting periods
  - Blend (Medicaid days + SSI days) and S-10 data
Proposed 3-year Transition into S-10

FY2018
- 2012 MCD Days + 2014 SSI Days
- 2013 MCD Days + 2015 SSI Days
- 2014 S-10 Data

FY2019
- 2013 MCD Days + 2015 SSI Days
- 2014 S-10 Data
- 2015 S-10 Data

FY2020
- Complete Transition to S-10
- 2014 S-10 Data
- 2015 S-10 Data
- 2016 S-10 Data
Definition of Uncompensated Care Costs From Worksheet S-10

- Uncompensated Care Costs (Line 30) = Charity Care Costs (Line 23) + Bad Debt Costs (Line 29)

- CMS proposes methodological refinements:
  - Annualize uncompensated care costs if a hospital’s cost report doesn’t equal to 12 months
  - Use urban/rural statewide average CCRs for hospitals with extremely high CCR

- Revisions to S-10 instructions released in November 2016 and S-10 review instructions for MACs under development
Request for Examples of S-10 Issues

• Please send:

• Examples of unclear or inconsistent S-10 instructions and recommendations for how to improve

• Examples of erroneous S-10 data, an explanation as to why the data are erroneous, and recommendations to ensure collection of accurate data

• Recommendations of methodologies that will help mitigate financial harm to hospitals
EHR Incentive Programs
CMS proposes to modify the EHR reporting periods for 2018 for all participants (new and returning) attesting to CMS or to a state Medicaid agency to a minimum of any continuous 90-day period within CY 2018

• Attestation deadlines remain the same
• Applicable incentive payment year and payment adjustment years remain the same
21st Century Cures Act Exception

Medicare Payment Adjustment for Decertified EHR Technology

• To qualify:
  • CERHT must be decertified under ONC Health IT Certification Program during 12 month period preceding the applicable EHR reporting period for the payment adjustment year or during the applicable EHR reporting period
  • EP, eligible hospital, or CAH must apply for the exception and must demonstrate:
    • intention to attest for a certain EHR reporting period and
    • good faith effort to adopt and implement another CEHRT in advance of that EHR reporting period

*or later date if CMS specifies otherwise
### Medicare Payment Adjustment for Decertified EHR Technology (cont.)

<table>
<thead>
<tr>
<th>When entity qualifies for exception</th>
<th>Application Due</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EP</strong> CY 2018 payment adjustment year</td>
<td>October 1, 2017*</td>
</tr>
<tr>
<td><strong>Eligible hospital</strong> Beginning with the FY 2019 payment adjustment year</td>
<td>July 1, 2018*</td>
</tr>
<tr>
<td><strong>CAH</strong> Beginning with the FY 2018 payment adjustment year</td>
<td>November 30, 2018*</td>
</tr>
</tbody>
</table>
21st Century Cures Act Exception

Ambulatory Surgical Center (ASC)-based EPs

- For 2017 and 2018, EP who furnishes **substantially all** covered professional services in an ASC is excluded from payment adjustment for the meaningful use requirement
- Definition of “**substantially all**”?  
  - CMS asking for comments on two proposals:
    - Level applied to hospital-based MIPS eligible clinicians
      - 75 percent of professional services in sites of service identified as an ASC setting in the CY that is 2 years before the payment adjustment year; OR
    - Level applied to hospital-based EPs for EHR Incentive Programs
      - 90 percent of professional services in sites of services identified as an ASC setting in the CY that is 2 years before the payment adjustment year
- Comments requested on use of POS 24, or other ways to identify ASC services
Hospital-within-Hospital Proposal

- CMS proposal: separateness and control requirements would only apply with the IPPS-excluded hospital is co-located with an IPPS hospital
- Comments requested on whether the separateness an control requirements are still necessary
Questions?

Click the “Raise Hand” icon to ask a question. Your name will be called and your phone line will be unmuted.

Click the hand again to put your hand down.

Submit typed questions through the Q&A panel.

Send to All Panelists.
Quality Programs in IPPS
AAMC Quality Resources

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Listserves

- Quality updates (email Scott Wetzel at swetzel@aamc.org)
- Reimbursement (email Ayeisha Cox at aycox@aamc.org)
FY 2018 Quality Summary

6.0% at risk in FY 2018 for performance

Hospital Compare

IQR
25% reduction of market basket update for not reporting

EHR Incentive Program
2.175% reduction for not-reporting

E-meaures

VBP
2.0% of base DRG

• Rewards for good performance/penalties for poor performance
• Credit for improvement
• Readmission measures cannot be in VBP; HAC measures eligible for VBP

Readmissions
3.0% of base DRG

• Penalties for excess readmissions
• No credit for improvement
• Up to 3% of base DRG at risk
• Payment penalties adjusted for SDS starting FY 2019

HAC
1.0% of total payment

• Automatic penalty for one quarter of hospitals deemed as having “worst” performance.
• No credit for improvement
• HAC measures are in VBP too
FY 2018 IPPS Proposed Rule Key Takeaways

Readmissions Reduction Program
- Proposed methodology (21st Century Cures) to adjust penalties beginning FY 2019 by dual-eligible peer groups
- No new measures proposed
- Request for feedback: accounting for social risk factors

Value Based Purchasing Program
- Measure Changes:
  o Removal of PSI-90 (current version) starting FY 2019
  o Addition of PN episode-of-care payment measure Starting FY 2022
    o Addition of modified PSI-90 (version 6.0) starting FY 2023
- Scoring changes for efficiency domain starting FY 2021
- Request for feedback: accounting for social risk factors
FY 2018 IPPS Proposed Rule Key Takeaways, Cont.

Hospital Acquired Condition Reduction Program
- No new measures proposed
- Request for feedback:
  - Accounting for social risk factors
  - Domain 1: Additional measures for future adoption
  - Domain 2: Accounting for disability and medical complexity in the CDC NHSN measures

Inpatient Quality Reporting Program
- Measure Changes:
  - Refined: HCAHPS pain management questions
  - Refined: Stroke mortality
  - Voluntary: Hospital wide readmissions supplemented with EHR data
- Change in requirements for eCQMs
- Request for feedback: accounting for social risk factors
Request for Feedback on Social Risk Factors

CMS has requested feedback on incorporating social risk factors into the reporting and performance programs. Examples include:

• Confidential reporting of stratified measure rates to providers
• Public reporting of stratified measure rates
• Risk adjustment of a particular measure as appropriate based on data and evidence
• Adjustment of the payment methodology
• Adjustment of provider performance scores
• Providing financial incentives for achievement of low readmission rates for beneficiaries with social risk factors

What are your recommendations?
Readmissions Reduction Program (HRRP)
Hospital Readmissions Reduction Program Updates

FY 2018 Updates

• No new measures added to HRRP in this rule
• CMS HRRP Hospital Specific Reports for FY 2018 expected to be available in late Summer 2017
• Proposal of SDS provisions mandated by 21st Century Cures legislation
• Most recent performance period includes use of ICD-9-CM, ICD-10-CM, and ICD-10-PCS codes
  • Code sets for each condition are available on qualitynet
HRRP Measure Timeline

- **FY 2013** (July 1, 2008 – June 30, 2011)
  - AMI
  - PN
  - HF

- **FY 2014** (July 1, 2009 – June 30, 2012)
  - COPD
  - THA/TKA
  - AMI
  - PN
  - HF

- **FY 2015** (July 1, 2010 – June 30, 2013)
  - COPD
  - PN (expanded population)
  - THA/TKA
  - AMI
  - HF

- **FY 2016** (July 1, 2011 – June 30, 2014)
  - COPD
  - PN (expanded population)
  - THA/TKA
  - AMI
  - HF

- **FY 2017** (July 1, 2012 – June 30, 2015)
  - COPD
  - PN (expanded population)
  - THA/TKA
  - AMI
  - HF

- **FY 2018** (July 1, 2013 – June 30, 2016)
# SDS Adjustment in the HRRP

<table>
<thead>
<tr>
<th>Topics for Comment</th>
<th>CMS Recommendation</th>
<th>CMS Alternative Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of Duals</td>
<td>Data from state Medicare Modernization Act (MMA) file of dual eligibility</td>
<td>No alternatives provided</td>
</tr>
<tr>
<td>Proportion of Duals Inpatient Stays</td>
<td>Total # of dual eligible hospital stays / total # of FFS and MA enrollees</td>
<td>Only including FFS enrollees in the denominator</td>
</tr>
<tr>
<td>Data Files to Identify Inpatient Stays</td>
<td>Medicare Provider and Analysis Review (MedPAR) files</td>
<td>Other data sources, such as integrated data repository (IDR) files</td>
</tr>
<tr>
<td>Data Period</td>
<td>Three year measure performance period</td>
<td>Most recent one year period</td>
</tr>
<tr>
<td>Assigning Hospitals to Peer Groups</td>
<td>Hospitals grouped into quintiles</td>
<td>Hospitals placed into groups of two or ten</td>
</tr>
</tbody>
</table>
SDS Adjustment in the HRRP: Payment Adjustment Formula

Current payment adjustment:

$$1 - \min\{0.03, \sum_{dx} \frac{\text{Payment}(dx) \cdot \max((\text{ERR}(dx) - 1.000), 0))}{\text{All payments}}\}$$

CMS Recommendation

Replace 1.000 with the median excess readmission ratio (ERR) for the hospital’s peer group

CMS Alternatives

1) Use **mean** ERR instead of median ERR

2) Use the percentile (e.g., 52nd) for each peer group that is budget neutralizing instead of 1.000

3) Use a **standardized** ERR within each peer group
Impact of CMS’s Proposed Payment Adjustment Formula

- AAMC estimates that COTH hospitals will see savings of approximately $5 million ($22,000 per hospital)
- Savings or loss varies by current dual eligible quintile
- More details will be provided this week in the hospital-specific AAMC Impact Report

<table>
<thead>
<tr>
<th>Per Hospital</th>
<th>COTH</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current Penalties</td>
<td>Avg Penalty Change</td>
</tr>
<tr>
<td>1 - High SES</td>
<td>$292,000</td>
<td>$50,000 17%</td>
</tr>
<tr>
<td>2</td>
<td>$669,000</td>
<td>$58,000 9%</td>
</tr>
<tr>
<td>3</td>
<td>$481,000</td>
<td>$22,000 5%</td>
</tr>
<tr>
<td>4</td>
<td>$598,000</td>
<td>-$51,000 -9%</td>
</tr>
<tr>
<td>5 - Low SES</td>
<td>$427,000</td>
<td>-$84,000 -20%</td>
</tr>
<tr>
<td>Total</td>
<td>$506,000</td>
<td>-$22,000 -4%</td>
</tr>
</tbody>
</table>
Value Based Purchasing (VBP) Program
Updates to VBP Program

FY 2018 Updates

• Hospitals have up to 2% of their base DRG payments at risk to fund incentive pool

• CMS VBP Hospital Specific Reports for FY 2018 expected to be available in late Summer 2017

• Amount at risk is $1.9 billion

• CMS expects to release final FY 2018 VBP payment adjustment factors in the Fall (Table 16B)
Proposed Changes for Removal and Addition to VBP

**Removal:** PSI-90 (Version 5.0)  
FYs 2019 - 2021

**Addition:** PN Episode of Care Payments  
FY 2022  

**Addition:** Modified PSI-90 (Version 6.0)  
FY 2023  
October, 2015 – June, 2017

- **Payment Year:** FYs 2019 - 2021
- **Performance Period:** August, 2018 - June 2020

Data expected on Hospital Compare July 2017

- **Payment Year:** FY 2022
- **Baseline Period:** October, 2015 – June, 2017
- **Performance Period:** July, 2019 – June, 2021

Data expected on Hospital Compare Oct. 2017
PN Episode of Payment Measure

- Measure assesses hospital risk-standardized payment associated with a 30-day episode-of-care for pneumonia
- Proposed starting FY 2022
  - Adopted for IQR starting FY 2018
- Original measure - NQF #2579 (CMS is using an expanded cohort for this measure)
- VBP Domain: Efficiency and Cost Reduction
- MAP Recommendation: Do not support
Modified PSI-90 (Version 6.0)

- Revised PSI-90 renamed *Patient Safety and Adverse Events Composite* (NQF# 0531)
- Proposed starting FY 2023
  - Adopted for IQR starting FY 2018
  - Adopted for HACRP starting FY 2018
- VBP Domain: Safety
- MAP recommendation: Support
Proposed VBP Domain Weighting FYs 2019 - 2023

- AMI Mortality
- HF Mortality
- PN Mortality
- THA/TKA Complications
- COPD Mortality [starting FY 2021]
- CABG Mortality [starting FY 2022]

- CLABSI
- CAUTI
- CDI
- MRSA
- SSI
- Early Elective Delivery
- Modified PSI-90 [starting FY 2023]

- MSPB*
- AMI Payment [starting FY 2021]
- HF Payment [starting FY 2021]
- PN Payment [starting FY 2022]

* MSPB performance weighted at 50% of Efficiency and Cost Reduction Domain starting FY 2021

The full list of VBP measures, baseline, and performance periods can be found at www.aamc.org/hospitalpaymentandquality
Hospital Acquired Condition (HAC) Reduction Program
HAC Reduction Program Updates

FY 2018 Update

- Fourth year of the HACRP
- CMS HACRP Hospital Specific Reports for FY 2018 expected to be available in late Summer 2017
- Expected that half of major teaching hospitals will be penalized in FY 2018
- First year of modified PSI-90 Composite
- Request for Feedback: Domain 1 measures, Risk Adjusting CDC NHSN Measures and social risk factors
## HACRP Measures and Domain Weights Through FY 2018

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>FY 2017</th>
<th>FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>35%</td>
<td>25%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>• PSI 90</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x (Modified PSI-90)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 2</th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>FY 2017</th>
<th>FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>65%</td>
<td>75%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>• CLABSI</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>• CAUTI</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>• SSI – Colon Surgery and Abdominal Hysterectomy</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>• MRSA</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>• C. Diff</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>

25% of worst performing hospitals receive 1% reduction
Request for Feedback

HACRP Additional Proposed Changes:

• Possible Domain 1 measures:
  o Falls with injury, adverse drug events, glycemic events, and ventilator associated events

• Possible Domain 2 measure updates: Risk-adjusting for disability or medical complexity
  o CMS cited ASPE recommendations to improve clinical risk adjustment of CDC NHSN measures

• Inclusion of social risk factors
Breakdown of Hospitals Affected By HAC Reduction Program

Predicted Percent of Hospitals Penalized by Type

- Rural: 13.4%
- Urban: 27.2%
- Bed Size Under 100: 14%
- Bed size Over 500: 47.2%
- Non Teaching: 17.6%
- Large Teaching: 56.8%

Source: FY 2018 IPPS Proposed Rule Federal Register, Page 20210-20211. These estimates are repeated from FY 2017 due to an error with the AHRQ software.
Inpatient Quality Reporting (IQR) Program
IQR Program Updates and Feedback

• Measure Changes:
  • Two revised measures proposed
  • One hybrid voluntary measure proposed

• Request for feedback:
  • Future inclusion of measures
  • New eCQM measures
  • Social risk factors
  • Reporting of PN readmissions and mortality stratified by dual eligible status

• Changes to eCQM reporting Requirements (FYs 2019 and 2020)
Proposed Refinements: HCAHPS
Pain Management Question

• Pain management questions remain in IQR; removed from VBP for FY 2018

• Proposing refined questions (below) for IQR for FY 2020 (CY 2018 reporting)

• Reported on Hospital Compare in October 2019 at the earliest

• MAP recommendation: refine and resubmit
### Proposed Refinements: HCAHPS

#### Pain Management Question, Cont.

<table>
<thead>
<tr>
<th>Current “Pain Management”</th>
<th>Proposed “Communication about Pain”</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. During this hospital stay, did you need medicine for pain?</td>
<td>• HP1: “During this hospital stay, did you have any pain?”</td>
</tr>
<tr>
<td>□ Yes ☐ No ➔ If No, Go to Question 15</td>
<td>□ Yes</td>
</tr>
<tr>
<td>13. During this hospital stay, how often was your pain well controlled?</td>
<td>□ No ➔ If No, Go to Question __</td>
</tr>
<tr>
<td>□ Never ☐ Sometimes</td>
<td>• “During this hospital stay, how often did hospital staff talk with you about how much pain you had?”</td>
</tr>
<tr>
<td>3☐ Usually</td>
<td>□ Never</td>
</tr>
<tr>
<td>4☐ Always</td>
<td>□ Sometimes</td>
</tr>
<tr>
<td>14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?</td>
<td>□ Usually</td>
</tr>
<tr>
<td>□ Never ☐ Sometimes</td>
<td>□ Always</td>
</tr>
<tr>
<td>3☐ Usually</td>
<td>• “During this hospital stay, how often did hospital staff talk with you about how to treat your pain?”</td>
</tr>
<tr>
<td>4☐ Always</td>
<td>□ Never</td>
</tr>
<tr>
<td></td>
<td>□ Sometimes</td>
</tr>
<tr>
<td></td>
<td>□ Usually</td>
</tr>
<tr>
<td></td>
<td>□ Always</td>
</tr>
</tbody>
</table>
Proposed Refinements: Stroke Mortality

- 30 Day stroke mortality measure risk adjustment would incorporate NIH Stroke Scale
- The stroke scale is a 15 item neurologic exam evaluating stroke patient’s level of consciousness, language, neglect, etc.
- Revised measure would be implemented in IQR for PY 2023
- CMS would provide hospitals with confidential dry run reports on measure performance in 2021; public reporting in CY 2022
- Revised measure is not NQF endorsed
Proposed Hybrid Voluntary Measure: HWR

- Voluntary Hospital Wide Readmissions (HWR) measure would combine claims and EHR abstracted data (NQF# 2879)
- Participating hospitals would report data on discharges for first two quarters of CY 2018
- Hospitals who report data will receive confidential feedback reports
- Data not publicly reported and does not impact payment determination
- Core clinical data elements and lab results would need to be submitted
  - Vital signs: heart rate, respiratory rate, temperature, systolic blood pressure, oxygen saturation, weight
  - Linking variables: CCN, HIC Number or Medicare Beneficiary Identifier, date of birth, sex, admission date, and discharge date
- CMS considering hybrid HWR as a required measure for IQR starting FY 2023 (CY 2021 reporting period)
Reporting PN Readmissions and Mortality Measures

- CMS is seeking comment on confidential reporting/public reporting of two PN measures below, stratified by patient dual eligibility
  - Pneumonia Readmissions (NQF# 0506)
  - Pneumonia Mortality (NQF#0468)
- CMS cites goal as illuminating differences in outcomes among patients within a hospital and to allow comparisons across hospitals
### Proposed eCQM Changes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Required # of measures</td>
<td>8 out of the 15 eCQMs available</td>
<td>6 out of the 15 eCQMs available</td>
</tr>
<tr>
<td>Reporting Period</td>
<td>Full calendar year</td>
<td>Two self-selected quarters of data for CY 2017</td>
</tr>
<tr>
<td>Submission Deadline</td>
<td>February 28, 2018</td>
<td>February 28, 2018</td>
</tr>
</tbody>
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Meeting eCQM IQR program requirements satisfies eCQM EHR Incentive program requirements

CMS has also requested feedback on future measure topics:
- Quality of informed consent documents for elective hospital procedures
- End of life measures for cancer patients
- Nurse staffing measures
- Behavioral health issues
Public Posting of AO Survey Reports

- CMS is proposing to require national accrediting organizations (AOs) to publicly post all Medicare provider or supplier final accreditation survey reports and plan of correction reports.

- Under the proposal, reports must be posted on the AOs website within 90 days of the information being available. Reports must be available for the most recent 3 years.
Request for Information (RFI)
Request for Information (RFI)

CMS states it wants to “reduce burdens, improve the quality of care, and decrease costs.”

Request for ideas related to:

- Payment system redesign
- Elimination of streamlining of reporting
- Monitoring and documentation requirements
- Aligning Medicare requirements and processes with those from Medicaid and other payers
- Operational flexibility
- Feedback mechanisms and data sharing that would enhance patient care
- Support of the physician-patient relationship in care delivery

With particular interest in opioid and other substance use disorders:

- Reimbursement methodologies
- Care coordination
- Systems and services integration
- Use of paraprofessionals including community paramedics and other strategies
Request for Information (RFI)

Responses to RFI should include:

- Clear and concise proposals that include data and specific examples
- Recommendations regarding when and how CMS issues regulations and policies
- How CMS can simplify rules and policies for beneficiaries, clinicians, physicians, providers, and suppliers
- If the proposals involve novel legal questions, analysis regarding CMS’ authority

CMS will not respond to RFI comment submissions in the final rule, but rather will consider input in developing future regulatory proposals or future sub-regulatory guidance.
Questions?

Click the "Raise Hand" icon, to ask a question. Your name will be called and your phone line will be unmuted.

Click the hand again to put your hand down.

Submit typed questions through the Q&A panel.

Send to All Panelists.
AAMC Resources

Individual Institution Reports
• AAMC Hospital Medicare Inpatient Impact Report (mbaker@aamc.org)
• AAMC Hospital Compare Benchmark Report (swetzel@aamc.org)
• FY 2016 AAMC Report on Medicare Inpatient Quality Programs

General Resources
• AAMC IPPS & OPPS Regulatory Page - Contains previous IPPS webinars and comment letters (www.AAMC.org/hospitalpaymentandquality)
• AAMC Quality Spreadsheet (https://www.aamc.org/download/412838/data/aamcqualitymeasure sspreadsheet.xlsx)

Listservs
• Quality updates (email Scott Wetzel at swetzel@aamc.org)
• Reimbursement (email Ayeisha Cox at aycox@aamc.org)