FY 2019 Inpatient Prospective Payment System (IPPS) Proposed Rule Webinar

AAMC Presenters:
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AAMC Contacts

Hospital Payment Policy

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Hospital Quality and Meaningful Use Programs

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Important Information on Proposed Rule


Comments are due June 25, 2018.

AAMC IPPS Resources:

Proposals would take effect October 1, 2018 unless otherwise noted.
Webinar Agenda

- Payment Update
- Outlier Payments
- Disproportionate Share Hospital (DSH) Payments
- Direct Graduate Medical Education (DGME) Affiliation Agreements and Open Slots
- Urban to Rural Reclassification
- Inpatient Admission Requirements
- Physician Certification of Claims
- Post-Acute Care Transfer Policy
- Cost Report Submission Requirements
- CAR-T Therapy
- Public Reporting of Hospital Standard Charges
- Hospital Quality Provisions
Payment Updates
Proposed FY2019 Market Basket Update

Market Basket Projected Increase: +2.8%

Multifactor Productivity Adjustment: -0.8%

ACA Adjustment: -0.75%

MACRA Documentation & Coding: +0.5%

FY2019 Payment Update: 1.75%

Overall Impact: All Hospitals: 2.1%
Major Teaching Hospitals: 2.6%
Outlier Payments
Proposed FY19 Outlier Fixed Loss Cost Threshold

- Proposed Prospective Payment Rate for MS-DRG
- IME Payments
- Empirically Justified DSH Payments
- Estimated Uncompensated Care Payments
- New Technology Add-On Payments
- FY 2019 Fixed Loss Amount ($27,545)

Proposed Outlier Fixed Loss Cost Threshold
Medicare DSH Payments
Medicare DSH Payments: Background

• Section 3133 of the ACA modified the methodology for computing the Medicare DSH payment adjustment
  • Qualifying hospitals receive two separately calculated payments, shown below:

  • Empirically Justified DSH Payment
    • The amount that will continue to be paid under the statutory formula for Medicare DSH payments.

  • Uncompensated Care Payment (UCP)
    • What otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of all individuals who are uninsured.

25%  75%
Proposed DSH Uncompensated Care Payment (UCP)

**Factor 1: $12.221 billion**
- Equals 75 percent of the aggregate DSH payments that would have been made under the old statutory formula (without application of the ACA)

**Factor 2: 67.51%**
- Reduces the amount of Factor 1 by insured pre-ACA to uninsured post-ACA
- FY2019 Proposed UCP Amount: $8.25 billion*

**Factor 3**
- A hospital’s UCP amount over set time period compared to UCP for all qualifying hospitals over the same time period.
- Proposal to advance S-10 data time period will increase.

*CMS uses Office of the Actuary (OACT)’s National Health Expenditure Accounts (NHEA) December 2017 Medicare DSH estimates*
Proposed Changes to Factor 3 Methodology

**Transmittal 11**
- Applies to cost reporting periods beginning on or after Oct. 1, 2013.
- Clarified definitions.
- Discounts to uninsured included on Line 20, Column 1 of S-10.

**Time Period and Data Source**
- Proposes to advance time period of data used in calculation of Factor 3.
- Moving from FY12-14, to FY13-15.

**Uncompensated Care Definition**
- Same as last year.
- Line 30 of S-10, which is cost of charity care (Line 23) combined with non-Medicare and non-reimbursable Medicare bad debt (Line 29).

**Aberrant Data**
- CMS proposes alternate methodology for hospitals where ratio of UCP to total operating costs is unusually high.
- CMS will send back and allow for corrections.
- AAMC commented last year.
Direct Graduate Medical Education (DGME)
Proposal for GME Affiliated Groups for New Urban Teaching Hospitals

Background

- Restrictions on new urban teaching hospitals participating in affiliated groups – could only get increase in cap, not decrease.
- Concern that existing residency programs would circumvent FTE caps.

Proposed Changes

- CMS proposes to allow “new urban teaching hospitals” to form affiliated groups.
- Beginning with affiliation agreements entered into July 1, 2019 to June 30, 2020 residency training year.
- Applies to GME affiliation agreements and emergency affiliation agreements.
Available Resident Slots

Notice of Closure of Two Teaching Hospitals

Round 11: Affinity Medical Center – Massillon, OH

<table>
<thead>
<tr>
<th>CCN</th>
<th>Provider name</th>
<th>City and state</th>
<th>CBSA code</th>
<th>Terminating date</th>
<th>IME FTE resident cap (including +/- MMA Sec. 422(^1) and ACA Sec. 5503(^2) adjustments)</th>
<th>Direct GME FTE resident cap (including +/- MMA Sec. 422(^1) and ACA Sec. 5503(^2) adjustments)</th>
</tr>
</thead>
<tbody>
<tr>
<td>#151</td>
<td>Affinity Medical Center.</td>
<td>Massillon, OH</td>
<td>15940</td>
<td>February 11, 2018.</td>
<td>28.63 - 4.27 sec. 422 reduction - 2.00 sec. 5503 reduction = 22.36 (^a)</td>
<td>29.49 - 4.79 sec. 422 reduction - 2.22 sec. 5503 reduction = 22.49 (^a)</td>
</tr>
</tbody>
</table>

Round 12: Baylor Scott & White Medical Center – Garland, TX

<table>
<thead>
<tr>
<th>CCN</th>
<th>Provider name</th>
<th>City and state</th>
<th>CBSA code</th>
<th>Terminating date</th>
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<th>Direct GME FTE resident cap (including +/- MMA Sec. 422(^1) and ACA Sec. 5503(^2) adjustments)</th>
</tr>
</thead>
<tbody>
<tr>
<td>450280</td>
<td>Baylor Scott &amp; White Medical Center Garland.</td>
<td>Garland, TX ....</td>
<td>19124</td>
<td>February 28, 2018.</td>
<td>3.91 + 12.96 - 0.05 sec. 422 reduction - 4.99 sec. 5503 reduction = 12.52 (^a)</td>
<td>3.91 + 14.09 - 1.88 sec. 422 reduction - 2.59 sec. 5503 reduction = 13.53 (^a)</td>
</tr>
</tbody>
</table>
Applying for Available Slots

• Application Information:
  
  • Access the Application at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/Section-5506-Application-Form.pdf.
  
  • Submit hard copy applications to CMS Central Office.
  
  • Applications must be RECEIVED (NOT POSTMARKED) by CMS by July 23, 2018.
Email Follow-up After Application Submission

• CMS is encouraging hospitals to notify the CMS Central Office of the mailed application by sending an email to: ACA5506application@cms.hhs.gov

• In the email, the hospital should state:
  • On behalf of [insert hospital name and Medicare CCN#], I, [insert your name], am sending this email to notify CMS that I have mailed to CMS a hard copy of a section 5506 application under Round [11 or 12] due to the closure of [Affinity Medical Center or Baylor Scott & White Medical Center Garland]. If you have any questions, please contact me at [insert phone number] or [insert your email address].”
Urban to Rural Reclassification
Proposed Urban to Rural Reclassification

CMS proposes that the **IME Cap Adjustment** will only be applicable to these teaching hospitals if both the main campus and remote location(s) are BOTH rural.

- Main Campus
- 1 or More Remote Locations
- Provide Services and Bill Under IPPS
- Both Facilities Meet Provider-Based Criteria (42 CFR 413.65)
Inpatient Admission Requirements
Proposal for Inpatient Admission Orders

Currently

• Inpatient admission orders required to be present in medical record for Part A payments.
• Technical discrepancies (i.e., missing signature, signature timing) prevent payments despite medical necessity and reasonableness.

Proposal

• Revises 42 CFR 412.3(a) to remove language requiring physician order in the medical record.
• Medical reviews to focus primarily on medical necessity and reasonableness.
• CMS claims intent was never to have payments denied for services that were, otherwise, medically necessary.
Physician Certification of Claims
Proposed Revisions to Physician Certification for Claims

Current Language*

• Lists requirements for physician statements certifying and recertifying medical necessity.
• Specifies that when supporting info is available elsewhere, no need to repeat so long as it indicates where it can be found.
• Claims denied when location not specified, even when apparent to reviewer.

Proposed Change*

• CMS proposes to eliminate the language requiring the physician to state the precise location of the supporting information.
• CMS seeks to reduce duplicative and burdensome measures.
• Searchable EHR making current requirement obsolete.

*42 CFR 424.11
Post-Acute Care Transfer
Proposed Post-Acute Care Transfer Policy

**Background**
- Discharge from hospital to rehab hospital/unit, psych hospital/unit, SNF, or HHA.
  - Prior to geometric mean length of stay.
  - Payment based on one of two methodologies.

**Expansion to Hospice**
- Patient Discharge Status codes 50 and 51 subject to the policy.
  - CMS will return inpatient claims without discharge status codes 50 and 51 billed on the same day as the hospice.
Cost Report Submissions
Proposed Revisions to Requirements for Cost Report Submission

Effective October 1, 2018*

- **IRIS Data**: IRIS data must match GME and IME FTE counts reported.
- **Medicare Bad Debt Reimbursement**: Bad debt listing must match reported bad debt amounts.
- **DSH Payment Adjustment**: Detailed list of Medicaid eligible days listing must match reported Medicaid eligible days.
- **Charity Care and Uninsured Discounts**: Detailed listing of CC/UD must match amount claimed in cost report.
- **Home Office Allocations**: Home Office Cost Statement must correspond to amounts allocated from the home office to the provider’s cost report.
- **Cost Reimbursement Questionnaire**: No longer states that cost report will be rejected for lack of Provider Cost Reimbursement Questionnaire. Questionnaire now part of OPO and Histocompatibility Laboratory cost report.

*Cost reports without this new documentation will be rejected*
Chimeric Antigen Receptor
T-Cell (CAR-T) Therapy
Chimeric Antigen Receptor (CAR) T-Cell Therapy

Request for new technology add-on payment

- KYMRIAH™ and YESCARTA™
  - CD-19 directed T-cell immunotherapies

Proposal to assign CAR T-cell therapy cases to MS-DRG 016

- ICD-10-PCS codes – XW033C3 and XW043C3

Proposing revision to MS-DRG 016

- Autologous Bone Marrow Transplant with CC/MCC or T-cell Immunotherapy
CAR T-Cell Therapy Payments

CMS seeking feedback on how to pay for new therapies

- Use cost-to-charge ratio (CCR) of 1.0 rather than the drug-specific CCR (0.196 proposed for FY 2018) to determine the MS-DRG relative weight, new technology add-on payment and outlier payment

- Create new MS-DRG
  - New MS-DRGs must be budget neutral
  - Redistributive effects of budget neutrality, effect on payment for core services, cost-shifting
  - No need for new technology add-on payment

- Higher outlier payment threshold

- Impact on total health care delivery system
  - Comparability between inpatient and outpatient
Public Listing of Hospital Standard Charges
Proposed Hospital Price Transparency Requirements

ACA required hospitals to publicly report standard charges for items / services including DRGs.

CMS concerned hospitals not providing sufficient information about hospital prices to patients:

- Out-of-network bills
- Patients’ financial responsibility

CMS updating guidelines to require hospitals to make available lists of current standard charges on the hospital website in a machine readable format.
CMS Seeks Public Comment on Hospital Cost Transparency

Definition of standard charges

- Chargemaster, average contracted rate or some combination

Types of information most beneficial to patients

- Use of charge / cost information in patient decision-making

Role of providers in educating patients on cost

- Informing patients of OOP costs, including patients with Medigap

CMS enforcement of price transparency
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 & EHR Incentive Programs
AAMC Quality Resources

**Individual Institution Reports**

- AAMC Hospital Medicare IPPS Impact Report (mbaker@aamc.org)
- AAMC Hospital Compare Benchmark Report (pramsey@aamc.org)
- AAMC Medicare Pay-for-Performance Inpatient Quality Programs Report (mbaker@aamc.org)

**General Resources**

- AAMC IPPS & OPPS Regulatory Page - Contains previous IPPS webinars and comment letters (www.aamc.org/hospitalpaymentandquality)
- AAMC Quality Measures/Timeline Spreadsheet (https://www.aamc.org/download/412838/data/aamcqualitymeasuresspreadsheet.xlsx)
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.
FY 2019 Inpatient Quality Summary

6.0% at risk in FY 2019 for performance

- **IQR**
  - 25% reduction of market basket update for not reporting

- **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 in VBP until FY 2021

- **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 (peer grouping)

- **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 – until FY 2021

Promoting Interoperability Program
- 2.175% reduction for not-reporting

Hospital Compare
- Measures must be publicly reported at least 1 year before being including in VBP

E-measures
FY 2019 IPPS Proposed Rule Key Takeaways

**Hospital Readmissions Reduction Program**
- Implements previously adopted proposed methodology (21st Century Cures) to adjust penalties beginning FY 2019 by dual-eligible peer groups
- No new measures proposed

**Value-Based Purchasing Program**
- Measure Changes:
  - Removal of PSI-90 (version 6.0), AMI Payment, HF Payment, and PN Payment in FY 2019, prior to implementation in the program.
  - Removal of PC-01, CAUTI, CLABSI, Colon Surgery/Abdominal Hysterectomy SSI, MRSA, and CDI starting FY 2021
  - No new measures proposed
- Removal of Safety domain and name domain name change (Clinical Outcomes domain)
- Proposed domain weighting with increased weight to Clinical Outcomes due to the proposed removal of the Safety domain starting FY 2021
FY 2019 IPPS Proposed Rule Key Takeaways, continued

Hospital Acquired Condition Reduction Program
• No new measures proposed
• New HACRP processes to collect, validate, and publicly report measure data beginning in January 2019 (analogous to current IQR processes)
• Proposed scoring changes – remove domains and weight measures equally

Inpatient Quality Reporting Program
• Measure Changes:
  o Removal of 39 measures between FY 2020 and FY 2023 payment determinations.
  o No new measures proposed
• Change in requirements for eCQMs

EHR Incentive Programs – now “Promoting Interoperability Programs”
• Require 2015 Edition of CEHRT
• Proposed scoring changes
• Proposed measure changes
Response to Feedback on Social Risk Factors

Potential Next Steps for CMS:

- Increase transparency of disparities shown by quality measures
  - Potential stratification of IQR outcome measures
- Convening a Technical Expert Panel (TEP) “in the Spring of 2018” to solicit feedback from stakeholders on approaches to stratification for the IQR.
- Continue work with ASPE, the public, and stakeholders to identify policy solutions that improve health equity while minimizing unintended consequences
Hospital Readmissions Reduction Program
Hospital Readmissions Reduction Program Updates

**FY 2019 Updates**

- No new measures added to HRRP in this rule
- HRRP Hospital-Specific Reports for FY 2019 expected to be available in late Summer 2018
- Implementation of SDS provisions mandated by 21st Century Cures legislation and finalized last year
- 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 Timeline

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

**FY 2018**
(July 1, 2013 – June 30, 2016)

**FY 2019**
(July 1, 2014 – June 30, 2017)
- SDS provisions go into effect
- Peer Grouping by Proportion of Dual Eligible beneficiaries

**FY 2020**
(July 1, 2015 – June 30, 2018)
- Only ICD-10-CM and ICD-10-PCS codes
- ICD-9-CM codes no longer applicable

**FY 2021**
(July 1, 2016 – June 30, 2019)
Impact of CMS’s Payment Adjustment Formula

- AAMC estimates that COTH hospitals will see savings of approximately $2.5 million ($11,000 per hospital)
- Savings or loss varies by current dual eligible quintile
- More details will be provided in the hospital-specific AAMC Impact Report (to be released later this month)

<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>$327,700</td>
<td>$25,915</td>
</tr>
<tr>
<td>2</td>
<td>$712,399</td>
<td>$60,757</td>
</tr>
<tr>
<td>3</td>
<td>$351,959</td>
<td>$15,887</td>
</tr>
<tr>
<td>4</td>
<td>$390,101</td>
<td>-$22,992</td>
</tr>
<tr>
<td>5 - Low SES</td>
<td>$463,945</td>
<td>-$95,157</td>
</tr>
<tr>
<td>Total</td>
<td>$450,123</td>
<td>-$11,104</td>
</tr>
</tbody>
</table>
Value-Based Purchasing (VBP) Program
Proposed Updates to VBP Program

FY 2019 Updates

• Measure removals proposed to end duplication with other programs

• Proposal to remove safety domain entirely, and re-weight remaining domains

• Hospitals have up to 2% of their base DRG payments at risk to fund incentive pool
  • Amount estimated at risk is $1.9 billion
  • CMS expects to release final FY 2019 VBP payment adjustment factors in the Fall (Table 16B)
# Proposed Measures for Removal from VBP

<table>
<thead>
<tr>
<th>Measure</th>
<th>Proposed Removal Year</th>
<th>Proposed End of Data Collection</th>
<th>Retained in Other Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC-01 Elective Delivery</td>
<td>FY 2021</td>
<td>12/31/2018</td>
<td>IQR</td>
</tr>
<tr>
<td>NHSN CAUTI</td>
<td>FY 2021</td>
<td>12/31/2018</td>
<td>HACRP</td>
</tr>
<tr>
<td>NHSN CLABSI</td>
<td>FY 2021</td>
<td>12/31/2018</td>
<td>HACRP</td>
</tr>
<tr>
<td>NHSN MRSA</td>
<td>FY 2021</td>
<td>12/31/2018</td>
<td>HACRP</td>
</tr>
<tr>
<td>NHSN CDI</td>
<td>FY 2021</td>
<td>12/31/2018</td>
<td>HACRP</td>
</tr>
<tr>
<td>Colon/Abdominal Hysterectomy SSI</td>
<td>FY 2021</td>
<td>12/31/2018</td>
<td>HACRP</td>
</tr>
<tr>
<td>PSI-90</td>
<td>FY 2023</td>
<td>n/a</td>
<td>HACRP</td>
</tr>
<tr>
<td>AMI Payment</td>
<td>FY 2021</td>
<td>n/a</td>
<td>IQR</td>
</tr>
<tr>
<td>HF Payment</td>
<td>FY 2021</td>
<td>n/a</td>
<td>IQR</td>
</tr>
<tr>
<td>PN Payment</td>
<td>FY 2022</td>
<td>n/a</td>
<td>IQR</td>
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</tbody>
</table>
## VBP Timeline

### FY 2020

<table>
<thead>
<tr>
<th>4 Domains (each 25%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person &amp; Community Engagement: HCAHPS</td>
</tr>
<tr>
<td>Efficiency &amp; Costs Reduction: MSPB</td>
</tr>
<tr>
<td>Clinical Outcomes: Mortality – AMI, HF, PN</td>
</tr>
<tr>
<td>Complications – THA/TKA</td>
</tr>
<tr>
<td>Safety: CAUTI, CLABSI, SSI, CDI, PC-01</td>
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</tbody>
</table>

### FY 2021

<table>
<thead>
<tr>
<th>3 Domains</th>
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</thead>
<tbody>
<tr>
<td>Person &amp; Community Engagement (25%): HCAHPS</td>
</tr>
<tr>
<td>Efficiency &amp; Costs Reduction (25%): MSPB</td>
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<tr>
<td>Clinical Outcomes (50%): Mortality – AMI, HF, PN, COPD</td>
</tr>
<tr>
<td>Complications – THA/TKA</td>
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### FY 2022

<table>
<thead>
<tr>
<th>3 Domains</th>
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</thead>
<tbody>
<tr>
<td>Person &amp; Community Engagement (25%): HCAHPS</td>
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<tr>
<td>Efficiency &amp; Costs Reduction (25%): MSPB</td>
</tr>
<tr>
<td>Clinical Outcomes (50%): Mortality – AMI, HF, PN, COPD, CABG</td>
</tr>
<tr>
<td>Complications – THA/TKA</td>
</tr>
</tbody>
</table>
Proposed VBP Domain Weighting Beginning in FY 2021

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

The full list of VBP measures, baseline, and performance periods can be found at www.aamc.org/hospitalpaymentandquality
Potential Impact of CMS’s Proposed Re-Weighting in FY 2021

![Bar chart showing mean COTH performance on mortality measures in HVBP FY2018.](chart.png)
Hospital Acquired Condition (HAC) Reduction Program
Proposed Updates to the HAC Program

FY 2019 Updates

• Proposal to adopt administrative processes similar to IQR to collect, validate, and publicly report quality measure data independent of the IQR

• Proposal to adjust scoring methodology to remove domains and assign equal weights to measures in the program

• Requests feedback on future measure inclusion of additional measures, including eCQMs

• HACRP Hospital-Specific Reports (HSRs) for FY 2019 expected to be available in late Summer 2019
Proposal for Data Collection

HACRP process to receive NHSN measure data beginning with January 1, 2019 infection events

No change from IQR Program policies for:

- Quarterly reporting requirements
- Deadlines
- Data submission (CDC collection system)
- Measure exception (CLABSI, CAUTI, and SSI)
- Quarterly updates on NSHN measures via QualityNet secure portal

HACRP review/correction process for program scoring renamed the “Scoring Calculations Review and Correction Period”
Proposal for Data Validation

- HACRP validations begin with Q3 2019 discharges for FY 2022 payment

- 400 randomly selected hospitals & up to 200 targeted hospitals; including all subsection (d) hospitals

- Change to penalty for failing validation: hospital assigned the maximized Winsorized z-score only for the set of measures that CMS validated (and not for the entire domain)
## Proposed Scoring Adjustment

<table>
<thead>
<tr>
<th>Domain 1 (Patient Safety):</th>
<th>Current Weight</th>
<th>Proposed</th>
<th>Alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>- CMS PSI-90</td>
<td>15%</td>
<td>Equal measure weights (removes domains) Each measure with a score has the same weight; can vary from 16.7% (all measures have a score) to 100% (only 1 measure has a score).</td>
<td>Variable domain weights (retain domains, assign weight dependent upon the number of measure scores a hospital has in each domain). Domain weights would vary by hospital.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 2 (NHSN HAIs):</th>
<th>Current Weight</th>
<th>Proposed</th>
<th>Alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>- CAUTI</td>
<td>85%</td>
<td></td>
<td>Domain 2 could range from 0-100%, each measure ranging from 60% to 20%</td>
</tr>
<tr>
<td>- CDI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- CLABSI</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- SSI</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- MRSA Bacterium</td>
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</tbody>
</table>
## Estimated Impact on % of Hospitals in Worst-Performing Quartile by Hospital Group

<table>
<thead>
<tr>
<th>Hospital Group</th>
<th>Equal Measure Weights</th>
<th>Variable Domain Weights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching hospitals: 100 or more residents (N = 248)</td>
<td>2.4%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Urban hospitals: 400 or more beds (N = 360)</td>
<td>2.2%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Hospitals with 100 or fewer beds (N = 1,169)</td>
<td>-1.8%</td>
<td>-0.9%</td>
</tr>
</tbody>
</table>

Source: CMS, FY 2019 IPPS Proposed Rule (83 FR 20436)
Request for Feedback on Future Measures, including eCQMs

CMS has requested feedback and suggestions for additional measures in the HAC Reduction Program, with specific focus on eCQMs and whether they would be a benefit to the program in the future.

- Would eCQMs improve measurement of processes, observations, treatments, and outcomes?
- Would eCQMs reduce burden? Are they less resource intensive? Less likely to produce error?

What are your recommendations?
Inpatient Quality Reporting (IQR) Program
Proposed Updates to the IQR Program

Measure Removals:
- FY 2020 Payment Determinations – 19 measures removed
  - 17 claims-based measures and 2 structural measures
- FY 2021 Payment Determinations – 10 measures removed
  - 8 chart-abstracted measures and 2 claims-based measures
- FY 2022 Payment Determinations – 9 measures removed
  - 1 chart-abstracted measure and 7 eCQMs
- FY 2023 Payment Determinations – 1 measure removed (claims-based)

Request for Feedback:
- Possible Future Hospital IQR Program Measures
- General Adoption of eCQMs
## Measures Removed FY 2020

<table>
<thead>
<tr>
<th>Measure</th>
<th>Retained in Another Program?</th>
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<tbody>
<tr>
<td>Survey on patient culture safety</td>
<td></td>
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<tr>
<td>Safe surgery checklist</td>
<td></td>
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<tr>
<td>PSI-90 patient safety composite</td>
<td>HAC</td>
</tr>
<tr>
<td>AMI Readmissions</td>
<td>HRRP</td>
</tr>
<tr>
<td>CABG Readmissions</td>
<td>HRRP</td>
</tr>
<tr>
<td>COPD Readmissions</td>
<td>HRRP</td>
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<tr>
<td>HF Readmissions</td>
<td>HRRP</td>
</tr>
<tr>
<td>PN Readmissions</td>
<td>HRRP</td>
</tr>
<tr>
<td>THA/TKA Readmissions</td>
<td>HRRP</td>
</tr>
<tr>
<td>Stroke Readmissions</td>
<td></td>
</tr>
<tr>
<td>AMI Mortality</td>
<td>VBP</td>
</tr>
<tr>
<td>HF Mortality</td>
<td>VBP</td>
</tr>
<tr>
<td>Medicare Spending per Beneficiary (MSPB)</td>
<td>VBP</td>
</tr>
<tr>
<td>Cellulitis payment episode</td>
<td></td>
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<tr>
<td>GI hemorrhage payment episode</td>
<td></td>
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<tr>
<td>Kidney/UTI payment episode</td>
<td></td>
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<tr>
<td>Aortic Aneurysm payment episode</td>
<td></td>
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<tr>
<td>Chole/CDE payment episode</td>
<td></td>
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<tr>
<td>Spinal fusion payment episode</td>
<td></td>
</tr>
<tr>
<td>Measure</td>
<td>Retained in Another Program?</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------------------------------</td>
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<tr>
<td>NHSN CDI</td>
<td>HAC</td>
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<td>NHSN CLAUTI</td>
<td>HAC</td>
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<td>NHSN CLABSI</td>
<td>HAC</td>
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<tr>
<td>NHSN MRSA</td>
<td>HAC</td>
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<tr>
<td>Colon/Abdominal hysterectomy SSI</td>
<td>HAC</td>
</tr>
<tr>
<td>COPD mortality</td>
<td>VBP</td>
</tr>
<tr>
<td>PN mortality</td>
<td>VBP</td>
</tr>
<tr>
<td>Influenza immunization</td>
<td></td>
</tr>
<tr>
<td>ED-1 Median ED arrival to departure time admitted patients</td>
<td>Similar measure in OQR</td>
</tr>
<tr>
<td>VTE-6 Potentially preventable VTE</td>
<td>*2 eCQMs, VTE-1 &amp; VTE-2, would be retained in IQR</td>
</tr>
</tbody>
</table>
# Measures Removed FY 2022 and FY 2023

<table>
<thead>
<tr>
<th>Measure</th>
<th>Retained in Another Program?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CABG Mortality</td>
<td>VBP</td>
</tr>
<tr>
<td>ED-2 Admit decisions time to ED departure</td>
<td>*eCQM version would be retained in IQR</td>
</tr>
<tr>
<td>AMI-8 eCQM primary PCI received within 90 minutes</td>
<td></td>
</tr>
<tr>
<td>CAC-3 eCQM home management plan of care</td>
<td></td>
</tr>
<tr>
<td>ED-1 eCQM version</td>
<td></td>
</tr>
<tr>
<td>EHDI-1a eCQM hearing screening</td>
<td></td>
</tr>
<tr>
<td>PC-01 eCQM elective delivery</td>
<td>*chart-abstracted version would be retained in IQR</td>
</tr>
<tr>
<td>STK-08 eCQM stroke education</td>
<td></td>
</tr>
<tr>
<td>STK-10 eCQM assessed for rehabilitation</td>
<td></td>
</tr>
<tr>
<td>FY2023: THA/TKA Complications</td>
<td>VBP</td>
</tr>
</tbody>
</table>
Proposed Changes to eCQMs for IQR

Reporting eCQMs for CY 2019 Reporting (FY 2021 Payment):

• Proposes to extend 2018 reporting and submission requirements – 4 eCQMs for 1 self-selected quarter of data

Certification Requirements for CY 2019 Reporting (FY 2021 Payment):

• Proposal to require hospitals to use 2015 Edition ONLY for 2019 reporting period.

CMS is proposing parallel changes to the Meaningful Use requirements for reporting eCQMs.
Request for Feedback re: Possible Future IQR Program Measures (83 FR 20489-20493)

Hospital-Wide, All-Cause Risk Standardized Mortality Measure 2 versions: claims-only and hybrid, claims with EHR enhanced risk-adjustment. CMS is seeking specific feedback on:

- The service-line division structure of the measures
- Input on the measure testing approach
- How measure results might be presented to the public (specifically how to report more than “no different from national average”)

Hospital-Harm – Opioid Related Adverse Events eCQM

- Whether to initially introduce the measure as voluntary?
- Adopt the measure into the existing eCQM measure set?
- Adopt the measure as mandatory for all hospitals to report?

What are your thoughts and recommendations?
Request for Feedback re: General Adoption of eCQMs (83 FR 20494-20495)

• What aspects of the use of eCQMs are most costly to hospitals and health IT vendors?

• What program and policy changes, such as improved regulatory alignment, would have the greatest impact on addressing eCQM costs?

• What are the most significant barriers to the availability and use of new eCQMs today?

• What specifically would stakeholders like to see CMS do to reduce costs and maximize benefits of eCQMs?

• How could CMS encourage hospitals and health IT vendors to engage in improvements to/testing new eCQMs?

• Would hospitals and health IT vendors be interested in or willing to participate in pilots or models?

• What ways could CMS incentivize or reward innovative uses of health IT?

What are your thoughts and recommendations?
Medicare and Medicaid Promoting Interoperability Programs (PI Programs; rebranded EHR Incentive Program)
Rebranding the Programs

New approaches to focus the programs on:

• Increasing interoperability
• Increasing patient access to health information
• Reduce burden
Proposed Updates to the PI Programs

- Require 2015 Edition of CEHRT for EHR reporting period beginning CY 2019
  - Reporting periods for 2019 and 2020: any continuous 90-day period during the CY
- The reduction (for failure to demonstrate meaningful use [MU] of EHR) is estimated 2.1 percentage points to update factor for FY2019
- Requirement for increasingly stringent MU measures was removed by the Bipartisan Budget Act of 2018
- Changes to MU for Medicare PI program scoring system beginning in CY 2019:
  - Fewer measures
  - Eliminates the threshold-based methodology
- MU measure updates;
  - Remove 6 existing measures
  - Add 3 new measures
- Align eCQM reporting requirements with the IQR Program
## Proposed MU Scoring System Changes

<table>
<thead>
<tr>
<th>Current Stage 3 Methodology</th>
<th>Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 6 objectives</td>
<td>- 4 objectives</td>
</tr>
<tr>
<td>▪ Protect Patient Health Information</td>
<td>▪ E-Prescribing</td>
</tr>
<tr>
<td>▪ E-Prescribing</td>
<td>(1 to 3 measures, 5 to 15 points)</td>
</tr>
<tr>
<td>▪ Patient Electronic Access to Health Information</td>
<td>▪ Health Information Exchange</td>
</tr>
<tr>
<td>▪ Coordination of Care through Patient Engagement</td>
<td>(2 measures, 40 points)</td>
</tr>
<tr>
<td>▪ Health Information Exchange</td>
<td>▪ Provider to Patient Exchange</td>
</tr>
<tr>
<td>▪ Public Health &amp; Clinical Data Exchange</td>
<td>(1 measure, 35 to 40 points)</td>
</tr>
<tr>
<td>- 16 measures</td>
<td>- 6 measures minimum</td>
</tr>
</tbody>
</table>

Pass/fail scoring on objectives
Performance thresholds must be met for most measures unless an exclusion is claimed

Points awarded for individual measures based on performance or participation
Score of 50 points+ would satisfy MU requirement

If CMS doesn’t finalize the new scoring methodology, the current Stage 3 methodology would continue, but the new opioid measures would be added
## Proposed MU Measure Changes

<table>
<thead>
<tr>
<th>Measure Status</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained from Stage 3 without modification*</td>
<td>e-Prescribing</td>
</tr>
<tr>
<td>(Security Risk Analysis measure is retained as a requirement, but is not included in the proposed scoring methodology)</td>
<td>- Immunization Registry Reporting</td>
</tr>
<tr>
<td></td>
<td>- Syndromic Surveillance Reporting</td>
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<td></td>
<td>- Electronic Case Reporting</td>
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<td></td>
<td>- Public Health Registry Reporting</td>
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<tr>
<td></td>
<td>- Clinical Data Registry Reporting</td>
</tr>
<tr>
<td></td>
<td>- Electronic Reportable Laboratory Result Reporting</td>
</tr>
<tr>
<td>Retained from Stage 3 with modifications</td>
<td>Send a Summary of Care</td>
</tr>
<tr>
<td></td>
<td>Provide Patient Access</td>
</tr>
<tr>
<td>Removed Measures</td>
<td>Request/Accept Summary of Care</td>
</tr>
<tr>
<td></td>
<td>Clinical Information Reconciliation</td>
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<td></td>
<td>Patient Specific Education</td>
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<td></td>
<td>Secure Messaging</td>
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<tr>
<td></td>
<td>View, Download or Transmit</td>
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<tr>
<td></td>
<td>Patient Generated Health Data</td>
</tr>
<tr>
<td>New Measures</td>
<td>Query of Prescription Drug Monitoring Program (PDMPs)</td>
</tr>
<tr>
<td></td>
<td>Verify Opioid Treatment Agreement</td>
</tr>
<tr>
<td></td>
<td>Support Electronic Referral Loops by Receiving &amp; Incorporating Health Information</td>
</tr>
</tbody>
</table>
Request for Feedback: Future Direction of PI Programs

- Consideration of creating a set of priority health IT activities as alternatives to traditional program measures
  - Would this direction decrease burden associated with the PI Programs?
- If additional measures were added to the program, what measures would be beneficial to add to promote CMS goals of care coordination and interoperability?
- How can CMS align the PI Programs with the Quality Payment Program?

What are your recommendations?
Request for Info: Promoting Interoperability through Possible Revisions to Requirements (83 FR 20550-20553)

CMS is requesting feedback broadly on potential changes to hospital Conditions of Participation (CoPs) to require interoperability, providing as examples:

- Require hospitals to electronically transfer medically necessary information upon patient discharge/transfer
- Require hospitals to electronically send discharge information to a community provider when possible
- Require hospitals to make information electronically available to patients, or a specific third-party application, if requested

What are your recommendations?
## FY19 IPPS Proposed Rule References (Payment)

<table>
<thead>
<tr>
<th>Payment Provisions</th>
<th>Federal Register Page #(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Operating Update</td>
<td>p. 20381 - 20382</td>
</tr>
<tr>
<td>Disproportionate Share Hospital (DSH) Payments and Uncompensated Care Payment</td>
<td>p. 20386 - 20401</td>
</tr>
<tr>
<td>IME Adjustment</td>
<td>p. 20386</td>
</tr>
<tr>
<td>IME and DGME Payments</td>
<td>p. 20438 - 20440</td>
</tr>
<tr>
<td>Inpatient Admission Requirements</td>
<td>p. 20447 - 20448</td>
</tr>
<tr>
<td>MCH Rural Reclassification Rules</td>
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<tr>
<td>Outlier Payments</td>
<td>p. 20580 - 20584</td>
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<tr>
<td>CAR - T</td>
<td>p. 20284 - 20295</td>
</tr>
<tr>
<td>Physician Certification</td>
<td>p. 20550</td>
</tr>
<tr>
<td>Public Listing of Standard Charges</td>
<td>p. 20548 - 20549</td>
</tr>
<tr>
<td>Post-Acute Care Transfer</td>
<td>p. 20377 - 20381</td>
</tr>
<tr>
<td>Cost Report Submission</td>
<td>p. 20544 - 20548</td>
</tr>
</tbody>
</table>
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.
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- Andrew Amari – aamari@aamc.org

Hospital Quality and Meaningful Use Programs

- Phoebe Ramsey – pramsey@aamc.org