AAMC
Tomorrow's Doctors, Tomorrow's Cures

Learn
Serve
Lead

FY 2016 Inpatient PPS Proposed Rule Teleconference

May 12, 2015

AAMC Staff:
Allison Cohen, acohen@aamc.org
Lori Mihalich-Levin, lmlevin@aamc.org
Jessica Walradt, jwalradt@aamc.org
Scott Wetzel, swetzel@aamc.org
Mary Wheatley, mwheatley@aamc.org

Association of
American Medical Colleges

Important Info on Proposed Rule

- In *Federal Register* on April 30 – available at http://www.gpo.gov/fdsys/pkg/FR-2015-04-30/pdf/2015-09245.pdf
- Comments due **June 16, 2015**
- Save the Date: **May 21, 2015**

Detailed call for quality/performance proposals from noon – 1:00 PM Eastern. Additional information will be available at www.aamc.org/hospitalpaymentandquality

AAMC

AAMC Resources

Individual Institution Reports

- AAMC Hospital Medicare Inpatient Impact Report (mbaker@aamc.org)
- AAMC Hospital Compare Benchmark Report (swetzel@aamc.org)
- AAMC Report on Medicare Inpatient Quality Programs (*In development)*

General Resources

- AAMC IPPS & OPPS Regulatory Page - Contains previous IPPS webinars and comment letters (www.AAMC.org/hospitalpaymentandquality)
- AAMC Quality Spreadsheet – To be updated this week (https://www.aamc.org/download/412838/data/aamcqualitymeasuresspreadsheet.xlsx)

AAMC

Topics for Today's Teleconference

Topic	FR Pages (April 30, 2015)
Payment Updates	24477- 24478
Documentation & Coding	24342
Wage Index & Occupational Mix Adjustment	24463- 24477
Outliers	24631-24634
Penalty for failing to meet MU	24477-24478
Medicare DSH ACA Changes	24481-24488
2 Midnight Rule and Short Stays	24523
Expanding the Bundled Payments for Care Improvement (BPCI) Program	24414-24418
New Technology Payments	24418- 24463
Transition to ICD-10	24405

AAMC

Payment Topics for Today's Teleconference

Topic	FR Pages (April 30, 2015)
Rural Referral Centers	24479-24480
Hospital Acquired Conditions Program	24509-24514
Hospital Readmissions Reduction Program	24488-24498
Inpatient Quality Reporting Program	24555-24588
Value Based Purchasing Program	24498-24509
LTCH Site Neutrality	24535-24541

AAMC

FY 2016 IPPS Proposed Rule – Key Takeaways

- 1.1% hospital payment update (overall impact on all hospitals is 0.3%, and impact on major teaching hospitals is also 0.3%)
- Documentation and Coding: -0.8% reduction for ATRA Recoupment Updated occupational mix adjustment using new data
- **NO** GME changes
- Two-Midnight rule and payment for short inpatient hospital stays, long observation stays, and the -0.2% IPPS payment adjustment will be addressed during OPPS rulemaking

AAMC

FY 2016 IPPS Proposed Rule – Key Takeaways Continued

- UC DSH: To continue to implement ACA DSH cuts, CMS proposes a $1.28 billion decrease in total UC DSH payments (16.7% reduction)
- Bundled Payments for Care Improvement Initiative: For planning, CMS seeks comments on potential future expansion of BPCI
- Hospital Quality Programs: CMS proposes a significant expansion in the patient population for the pneumonia readmissions and mortality measures, a requirement for electronic reporting of core measures, and requests feedback on using EHR derived clinical data elements to help risk-adjust outcome measures
- LTCH payments: CMS proposes to implement the Pathways for SGR Reform Act, which requires an alternative site neutral payment rate for Medicare inpatient discharges from LTCHs that fail to meet certain statutorily defined criteria

AAMC

Agenda for Today's Teleconference

- Payment update
- Documentation and Coding
- Wage Index
- Outliers
- Penalty for failing to meet MU
- Medicare DSH
- 2 Midnight Rule and Short Stays
- Expanding the Bundled Payments for Care Improvement (BPCI) Program
- New Technology Payments
- Transition to ICD-10
- Rural Referral Centers
- Hospital Quality Programs
- LTCH Site Neutrality

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Payment Updates

Association of
American Medical Colleges

FY 2016 Market Basket Update

- Market basket projected increase = 2.7 percent
  - Less multi-factor productivity adjustment = -0.6 percent
  - Less ACA adjustment = -0.2 percent
  - Less documentation and coding recoupment required by ATRA = -0.8 percent
  - Less quality (1/4 reduction to MB) and meaningful use (1/2 reduction to MB) adjustments, if requirements not met

FY 2016 Payment Update: 1.1%

However, other factors may affect your payments…

AAMC

Additional Factors Affecting Aggregate Payments – FY 2016

Policy	Impact
FY 2015 increase in payment rates (from Slide 7)	+1.1%
DSH UC Payment Pool Reduction	-1.0%
Frontier Wage Index Floor	+0.1%
FY 2015 Outlier Payments at 5.1% (compared to FY 2014 outlier payments at 4.88%)	+0.2%
Impact Including Additional Factors	+0.3%*

Impact on Major Teaching = +0.3%

*Note: total impact between 0.3 and 0.4%; differences due to rounding

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Documentation & Coding

Association of
American Medical Colleges

Documentation & Coding

Two types of adjustments:

- **Retrospective**
  - Recoup overpayments that were already made as a result of documentation and coding improvements
  - ATRA requires $11B retrospective for FY 2010 - FY 2012 overpayments
- **Prospective**
  - Eliminate the effects of documentation and coding changes on future payments

AAMC

Documentation & Coding Proposal

- CMS proposes a third year of a -0.8 percent recoupment adjustment to the $11 billion required by the ATRA
  - ATRA requires the full adjustment ($11B) to be completed by FY 2017. CMS is phasing in these cuts w/cumulative reductions
  - CMS estimates the -0.8 percent for FY 2016 will recover almost $3B. (With $6B for FYs 2014 and 2015 combined, leaves $2B to recoup)

AAMC

MACRA Documentation & Coding

- Medicare Access & CHIP Reauthorization Act of 2015 (aka SGR Fix) Sec. 414 also affected Doc & Coding:
  - Instead of getting cumulative 3.2% reduction back in 2018 when recoupment is over, replaces 3.2% increase with 0.5% increase for 6 years (FYs 2018-2023)
  - Removes CMS's authority to adjust for discharges occurring during FY 2010 (the 0.55% CMS had been deferring)

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Wage Index Changes

Association of
American Medical Colleges

Wage Index Changes

- FY 2016 wage index uses FY 2012 cost report data
- 1.02% increase in national hourly wage (lower than last year's increase, so some hospital wage indices will go down)
- Reminder: FY 2015 CBSAs based on updated (2010) Census data,
  - Urban-to-rural has 3-year transition (FY 2016 is 2nd year)
  - During transition, CMS uses FY 2014 urban wage index of CBSA where hospital physically located

AAMC

Wage Index Changes, cont.

Occupational Mix Adjustment

- Data from new 2013 Occupational Mix Survey will be used for FYs 2016, 2017, and 2018

Temporary Imputed Floor

- "Floor" for states with no rural counties
- Extended 1 more year (through 9/30/16)
- NJ and RI benefit this year (but not DE)

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Outlier Payments

Association of
American Medical Colleges

Outlier Payments

- **For FY 2016, target for total outlier payments continues to be set at 5.1% of total operating DRG payments**
  - Estimate of actual outlier payments for FY 2014 = 5.34% of actual total MS-DRG payments
  - Estimate of actual FY 2015 outlier payments = 4.88% of actual total MS-DRG payments

AAMC

Outlier Threshold

- **For FY 2016**, CMS proposes an outlier fixed-loss cost threshold equal to the proposed prospective payment rate for the MS-DRG, plus any IME, empirically justified DSH payments, estimated uncompensated care payment, and any new technology add-on payments, plus **$24,485**.
- Note: proposed threshold is $141 less than FY 2015 threshold.
  - CMS explanation? Decrease in FY 2016 charge inflation factor (compared to FY 2015)

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Penalty for Failure to Meet Meaningful Use

Association of
American Medical Colleges

Penalty for Failing to Meet MU

- Hospitals that did not meet MU in FY 2014 (and didn't qualify for hardship exception) subject to ½ reduction of market basket
  - Start with MB rate of 1.35% (instead of 2.7%) and receive overall update of -0.25%
- Exception for NEW meaningful users:
  - If first time for MU is 2015, no FY 2016 penalties
    - Must attest to continuous 90-day period that ends by 7/1/15
  - New attestation period proposed in MU rules would be 1/1/16 – 2/29/16. Timing may require reconciling penalties.

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Medicare DSH

Association of
American Medical Colleges

DSH - ACA Sec. 3133

- **Sec. 3133 of the ACA requires changes** to Disproportionate Share Hospital (DSH) payments and applies to all hospitals that are currently eligible for DSH payments

- **Aggregate DSH payments will again be reduced in FY 2016**

AAMC

DSH Payment Overview

DSH payments were split into 2 separate payments: "Empirically Justified" and the "Uncompensated Care Payment."

25% of DSH Payments ("Empirically Justified") are paid the same way they have been paid.

75 % of DSH payments will be used toward the uncompensated care (UC DSH) payment.

This 75% (UC DSH payment pool) will be reduced as the uninsured population decreases.

This reduced pool will be redistributed based on each hospital's relative share of uncompensated care costs determined using a proxy of low income days.

AAMC

CMS Estimates for Factor 1 (the UC DSH Pool)

- For the proposed rule, CMS' estimate for:
  - **Total DSH payments for FY 2016** = **$13.338 B** (this is the pool we are starting with).
  - **Empirically justified DSH payments = $3.335 B** (25% of original DSH payments that is paid the same)
  - **Factor 1:** Total DSH payments – Empirically Justified DSH payments = **$10.003 B** (75% of original DSH payments that will be redistributed as UC DSH payments)

AAMC

CMS Estimates for Factor 2 (The Pool Reduced by the % Insured)

- CMS proposes to use:
  - The CBO estimate from March 2010 (**18 percent**) as the estimate of the uninsurance percentage for the baseline year of 2013.
  - The CBO's most recent estimate of the rate of insurance coverage in CY 2015 (**87 percent**).
  - The CBO's most recent estimate of the rate of insurance coverage in CY 2016 (**89 percent**).
- CMS will normalize these estimates for CYs to correspond with the appropriate FYs. **The FY 2016 rate of insurance coverage** = (87% x .25) + (89% x .75) **= 88.5%** so the **% of individuals without insurance for FY 2016 (weighted average) = 11.5%**.
- **Factor 2 =** 1 minus the % change in the % of uninsured individuals < age 65 minus 0.2 percentage points.
- **So Factor 2 =** 1 - |[0.115-0.18)/0.18]| = 1 – 0.3611 = 0.6389 (63.89%) – 0.002 **= 0.6369 (63.69%)**

AAMC

CMS Proxy for Factor 3

- **CMS does not propose to use the S-10 data** for purposes of redistributing UC DSH payments, but suggests it will be used in the future.
- Again, **CMS proposes to base Factor 3** on the most recent available data on utilization of insured low-income patients => **Inpatient days of Medicaid patients + inpatient days of Medicare SSI patients.**
- Hospitals have until **June 16 to review proposed rule tables** listing Factor 3 levels and notify CMS in writing of any changes.
- After the final rule is published, hospitals will have until Aug. 31 to review and submit comments on the accuracy of the tables.

Proposed New Time Period to Determine Low-income Patient Days

- For FY 2016, CMS proposes to hold constant cost report years used to calculate Medicaid days and to again use data from the 12-month 2012 or 2011 cost reports
- But CMS would use cost report data for these years from the most recent HCRIS database available for FY 2016 rulemaking
- CMS proposes to use the FY 2013 SSI ratios when they become available to determine Medicare days for the final rule. The SSI ratios will be published at: http:/www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html.

AAMC

How to Figure Out Your UC DSH Payment

The UC Payment Pool= 75% x $13.338 = $10.003 B

The Pool is Reduced by the Percentage Insured = $10.003 B x 63.69% = $6.3712 B (about $1.28 billion less than FY 2015)

UC Payment = $6.3712 B x [(Your Hospital Medicaid Days + SSI Days) ÷ (Medicaid Days + SSI Days for All DSH Eligible Hospitals)] = YOUR UC DSH PAYMENT

AAMC

UC DSH for Hospitals that Merge

- CMS will publish tables with the proposed and final rules with a list of known mergers and the UC payment for each merger.
- Hospitals have until June 16 for the proposed rule and Aug. 31 for the final rule to review and submit comments on the accuracy of these tables.

AAMC

AAMC
Tomorrow's Doctors, Tomorrow's Cures

Learn
Serve
Lead

2 Midnight Rule and Short Stays

Association of
American Medical Colleges

2 Midnight Rule and Short Stays

- CMS will include **further discussion** of the issues related to short inpatient hospital stays, long outpatient observation stays and the related -0.2% payment adjustment **in the CY 2016 OPPS proposed rule**.

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Expanding the Bundled Payments for Care Improvement (BPCI) Initiative

Association of
American Medical Colleges

AAMC as Facilitator Convener

- ✓ Advocacy
- ✓ Policy Analysis
- ✓ Project Management
- ✓ Data Analysis

DataGen

SINGLETRACK ANALYTICS

Your Partners in Health Care Data Analysis and Interpretation

AAMC

CMMI BPCI Participants May Choose from 48 Episodes

- Acute myocardial infarction
- AICD generator or lead
- Amputation
- Atherosclerosis
- Back & neck except spinal fusion
- Coronary artery bypass graft
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Cellulitis
- Cervical spinal fusion
- Chest pain
- Combined anterior posterior spinal fusion
- Complex non-cervical spinal fusion
- Congestive heart failure
- Chronic obstructive pulmonary disease, bronchitis, asthma
- Diabetes
- Double joint replacement of the lower extremity
- Esophagitis, gastroenteritis and other digestive disorders
- Fractures of the femur and hip or pelvis
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Hip & femur procedures except major joint
- Lower extremity and humerus procedure except hip, foot, femur
- Major bowel procedure
- Major cardiovascular procedure
- Major joint replacement of the lower extremity
- Major joint replacement of the upper extremity
- Medical non-infectious orthopedic
- Medical peripheral vascular disorders
- Nutritional and metabolic disorders
- Other knee procedures
- Other respiratory
- Other vascular surgery
- Pacemaker
- Pacemaker device replacement or revision
- Percutaneous coronary intervention
- Red blood cell disorders
- Removal of orthopedic devices
- Renal failure
- Revision of the hip or knee
- Sepsis
- Simple pneumonia and respiratory infections
- Spinal fusion (non-cervical)
- Stroke
- Syncope & collapse
- Transient ischemia
- Urinary tract infection

AAMC

BPCI Background: Model 2

- 48 clinical episodes
- Episode length: Index hospital admission + 30, 60, or 90 days post-discharge
- Small set of clinical and patient-specific exclusions
- Target price set using Medicare claims from baseline period (2009 – 2012) trended to performance period + 2-3% discount
- Retrospective reconciliation

AAMC

BPCI Background: Model 2

- 48 clinical episodes
- Episode length: Index hospital admission + 30, 60, or 90 days post-discharge
- Small set of clinical and patient-specific exclusions
- Target price set using Medicare claims from baseline period (2009 – 2012) trended to performance period + 2-3% discount
- Retrospective reconciliation

AAMC

Comment Areas

1. Breadth/scope of expansion
2. Episode definitions
3. Models for expansion
4. Roles of organizations and relationships necessary for/beneficial to care transformation
5. Setting bundled payment amounts
6. Mitigating the risk of high-cost cases

AAMC

Comment Areas

7. Administering bundled payments (retrospective vs. prospective)
8. Data needs
9. Use of health information technology
10. Quality measurement and payment for value
11. Transition from Medicare FFS → bundled payments
12. Other issues

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

New Technology Add-On Payments

Association of
American Medical Colleges

New Technology Add-On Payments

Update on FY 2014 New Technologies

New Tech	Continued for FY 2016?	Max Add-On per Case
Voraxaze®	No	N/A
CardioMESH™	Yes	$8,8075
Zenith® F. Graft	No	N/A
Kcentra™	Yes	$1,587.50
Argus® II System	Yes	$72,028.75
Zilver® PTX®	No	N/A

AAMC

New Technology Add-On Payments

Update on FY 2014 New Technologies

New Tech	Continued for FY 2016?	Max Add-On per Case
MitraClip®	Yes	$15,000
Responsive Neurostimulator (RNS®) System	Yes	$18,475

AAMC

New Technology Add-On Payments

FY 2016 Applications for New Technology Add-On Payments:

- Angel Medical Guardian® Ischemia Monitoring Device
- Blinatumomab (BLINCYTO™)
- Ceftazidime Avibactum (AVYCAZ)
- DIAMONDBACK 360®
- CRESEMBA® (Isavuconazonium)
- Idarucizumab
- LUTONIX® Drug Coated Balloon (DCB) Percutaneous Transluminal Angioplasty (PTA) and IN.PACT™ Admiral™ Paclitaxel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter
- VERASENSE™ Knee Balancer System (VKS)
- WATCHMAN® Left Atrial Appendage Closure Technology

AAMC

New Technology Add-On Payments

- CMS solicits comments on the use of **supplemental threshold values** when the coding to identify a new technology is reassigned to a new MS-DRG that does not have a threshold value in Table 10.
- CMS created a new section within the ICD-10-PCS codes, labeled **Section "X" codes**, to identify new medical services and technologies that are not usually captured by coders, or do not have the desired specificity w/in the current ICD-10-PCS structure required for new technology.
- The FY 2016 ICD-10-PCS Section "X" codes will be posted in June on the CMS website at http://www.cms.gov/Medicare/Coding/ICD10/index.html

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Transition to ICD-10

Association of
American Medical Colleges

Transition to ICD-10

- With **ICD-10-CM scheduled to go into effect on Oct. 1, 2015**, CMS proposed to adopt ICD-10-CM and ICD-10-PCS as the base code set for all MS-DRGs
- **Proposed changes:**
  - There are no new, revised, or deleted ICD-10-CM diagnosis codes for FY 2016
  - There are new ICD-10-PCS procedure codes. See Table 6B (Procedure Codes) released with the proposed rule

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Rural Referral Centers (RRCs)

Association of
American Medical Colleges

Revised Criteria for RRC Status

- **Beginning on/after Oct. 1, 2015**, CMS proposes that a rural hospital with < 275 beds available for use must:
  - Have a **CMI value** for FY 2014 that is at least:
    - 1.6075, or
    - The median CMI value (not transfer adjusted) for urban hospitals (excluding hospitals with approved teaching programs) calculated by CMS for that hospital's census region
  - Have as the **# of discharges** for its cost reporting period that began during FY 2013 at least:
    - 5,000 (3,000 for an osteopathic hospital) or
    - The median # of discharges for urban hospitals in the census region in which the hospital is located

AAMC

Quality Programs in IPPS

AAMC

AAMC IPPS Quality Webinar

- AAMC will host a webinar covering just the hospital quality performance and reporting programs outlined in the FY 2016 IPPS Proposed Rule on Thursday, May 21 from Noon to 1 EST.
- This webinar will cover updates on:
  - Hospital Acquired Conditions Reduction Program,
  - Hospital Value-Based Purchasing Program,
  - Hospital Readmissions Reduction Program, and
  - Inpatient Quality Reporting Program.
- To register, please visit https://aamc1.webex.com/aamc1/onstage/g.php?MTID=ee8b053086ea63d44d95f21555f47c01e

CMS Webinar:

CMS today held a webinar on the hospital reporting and quality programs. The slides can be found here: http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/Acute-Care-Quality-MLN.pdf

AAMC

Quality Summary- FY 2016

5.75% at risk in FY 2016 for performance

Hospital Compare

IQR
25% reduction of market basket update for not reporting

E-measures

EHR Incentive Program

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

VBP
1.75% of base DRG
(goes up to 2% in FY2017)

- 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

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 2016 IPPS Proposed Rule Key Takeaways

Hospital Acquired Condition Reduction Program

- No new measures proposed
- Proposed Increase in weighting for Domain 2 (CDC NHSN) to 85 percent starting FY 2017
- Medical/Surgical ward CLABSI and CAUTI data inclusion and "new standard population data" starting FY 2018
- Proposed extraordinary circumstance waiver

Value Based Purchasing Program

- Addition of one new measure in FY 2018 and one new measure in FY 2021; removal of two measures in FY 2018
- Removal of Clinical Care – Process measure domain
- Medical/Surgical ward CLABSI and CAUTI data inclusion and "new standard population data" starting FY 2019

Readmissions Reduction Program

- Expansion in denominator for pneumonia readmissions measure starting FY 2017 (also proposed for IQR in FY 2017)
- Proposed extraordinary circumstance waiver

Inpatient Quality Reporting Program

- Mandatory electronic measure reporting for core measures
- Seven new claims measures added (episodes of payment, excessive days in acute care, patient safety culture survey)
- Expansion in denominator for pneumonia readmissions and mortality measures
- CMS requests feedback on EHR derived clinical data

AAMC

CDC NHSN Measure Updates

Expansion of CLABSI and CAUTI Beyond ICU

- CMS proposes to use expanded data collection beyond the ICU for CLABSI and CAUTI for VBP (payment year FY 2019) and HACRP (payment year FY 2018)
  - For IQR Program, NHSN definitional changes started January 2015

Change in SIR Baselines

- CDC is updating the HAI national baselines (referred to as "standard population data") to ensure that the number of predicted infections more accurately reflects national infection levels today.
- Updated baselines will affect how your standardized infection ratios (SIR) are calculated
- Current and new NHSN measure baselines are below. We will discuss how this affects VBP and HACRP during the webinar

	Calculation for "Current Standard Population Data" Based on Collection Period:	Calculation for "New Standard Population Data" will be Based on Collection Period:
CAUTI	CY 2009	CY 2015
CLABSI	CYs 2006 – 2008	CY 2015
SSI	CYs 2006 – 2008	CY 2015
MRSA	CYs 2010 – 2011	CY 2015
C. diff	CYs 2010 – 2011	CY 2015

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Hospital Acquired Condition (HAC) Reduction Program

Association of
American Medical Colleges

HAC Reduction Program FYs 2016 – 2018 Updates

FY 2016

- Second year of the HAC Reduction Program
- First year that SSIs included for payment determination (MRSA and C. diff will start FY 2017)
- PSI-90 is undergoing NQF review. Current measure still used for Domain 1
- Proposed inclusion of extraordinary circumstance waiver

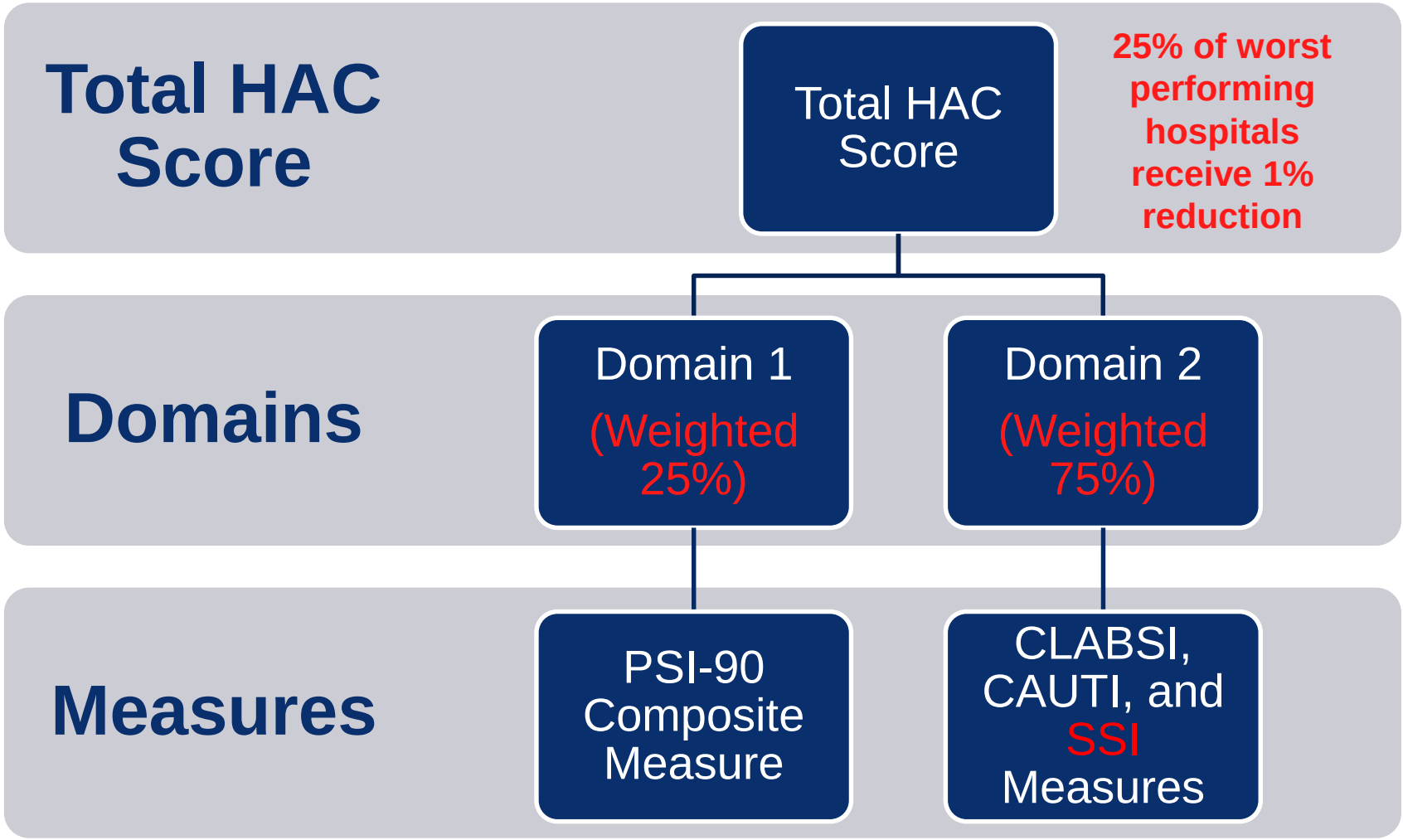
FYs 2017 & 2018

- Proposed changes:
  - Requirement to submit data for all Domain 2 measures starting FY 2017
  - Increase in Domain 2 weight to 85%; decrease in Domain 1 to 15% starting FY 2017
  - CLABSI and CAUTI data collection beyond ICU used for payment determination starting FY 2018
  - New CDC measure infection baselines will be incorporated into the HACRP starting FY 2018

- CMS predicts that 42.3 percent of major teaching hospitals will be penalized in FY 2016.
- FY 2016 HACRP Hospital Specific Reports expected to be available in late Summer 2015

AAMC

HAC Reduction Program Framework for FY 2016



AAMC

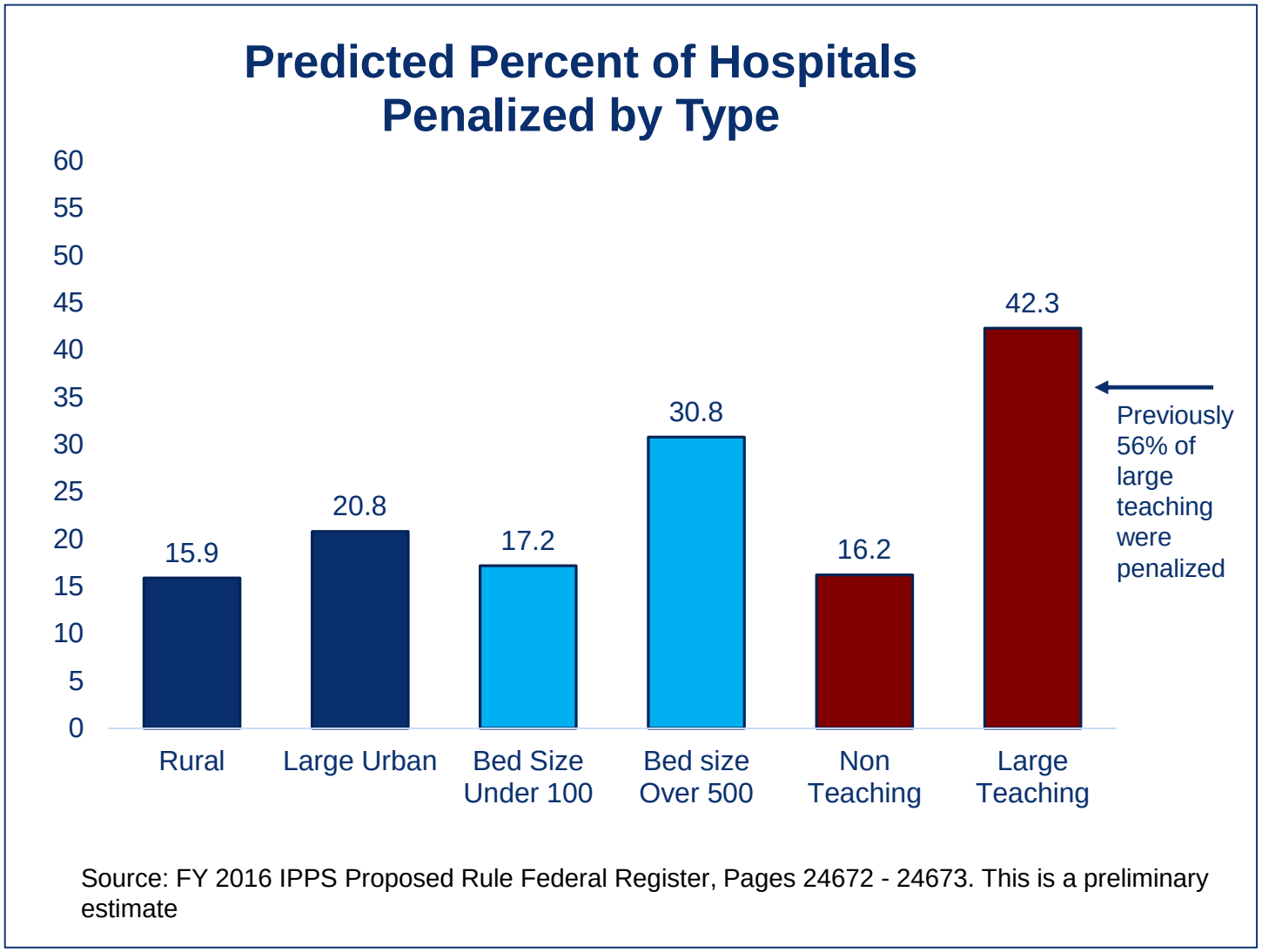
HACRP Measures and Domain Weights Through FY 2017

	FY 2015	FY 2016	FY 2017
Domain 1 performance period	July 2011 – June 2013	July 2012 – June 2014	July 2013 – June 2015
Domain 2 performance period	CYs 2012 – 2013	CYs 2013 – 2014	CYs 2014 - 2015
Domain 1 Weight	35%	25%	15% *(Proposed)*
• PSI 90*	x	x	x
Domain 2 Weight	65%	75%	85% *(Proposed)*
• CLABSI	x	x	x
• CAUTI	x	x	x
• SSI *(New for FY 2016)*		x	x
• MRSA			x
• C. diff			x

*PSI-90 Composite could expand (currently under NQF review). Any changes to the measure would go through rulemaking before it is used in a reporting or performance program

AAMC

Breakdown of Hospitals Affected By HAC Reduction Program for FY 2016



Source: FY 2016 IPPS Proposed Rule Federal Register, Pages 24672 - 24673. This is a preliminary estimate

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Readmissions Reduction Program

Association of
American Medical Colleges

Hospital Readmissions Reduction Program Updates

- No new measures proposed for HRRP
- However, CMS has proposed a significant expansion of the pneumonia readmissions measure for FY 2017 HRRP payment adjustment
- Proposed extraordinary circumstance waiver
- Proposed Performance period for FY 2016: July 1, 2011 through June 30, 2014

Proposed Expansion of the PN Readmissions Measure FY 2017

Current Pneumonia Cohort

Pneumonia
(Principal diagnosis viral or bacterial)

OR

Proposed Expansion of Pneumonia Cohort

Aspiration Pneumonia
(principal diagnosis)

OR

Sepsis or Respiratory Failure
(principal diagnosis)

AND

Pneumonia
(secondary diagnosis)

- CMS predicts the inclusion of these diagnosis codes could expand the measure denominator by over 630,000 patients (from 976k to 1.6 million -- a 65% increase)
- Expanded measure has **not** been NQF reviewed and does **not** adjust for SES
- **What is the effect of this expanded population for teaching hospitals?**

AAMC

HRRP Measures FYs 2013 - 2017

	FY 2013 (July 1, 2008 – June 30, 2011)	**FY 2014** (July 1, 2009 – June 30, 2012)	**FY 2015** (July 1, 2010 – June 30, 2013)	**FY 2016** (July 1, 2011 – June 30, 2014)	**FY 2017** TBD**
AMI	X	X	X	X	X
HF	X	X	X	X	X
PN	X	X	X	X	X *(Expanded Population)**
CODP			X	X	X
THA/TKA			X	X	X

*Proposed
**FY 2017 HRRP data collection time period has not yet been proposed

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Value Based Purchasing (VBP) Program

Association of
American Medical Colleges

Updates to VBP Program

FY 2016 Payments

- Reduction in base DRGs increased from 1.5% to 1.75% to fund incentive pool
- Amount at risk is $1.49 billion
- CMS expects to release final FY 2016 VBP payment adjustment factors in October (Table 16B)

ICD-10

- CMS did not discuss how the transition to ICD-10 will affect the VBP Program in this rule

Proposed Changes to Measures in VBP Program

Measures Proposed to be Removed

FY 2018

- IMM-2: Influenza Immunization
- AMI-7a: Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival

Measures Proposed to be Added

FY 2018

- CTM-3: 3 Item Care Transition Measure

FY 2021

- Hospital 30-Day, All-Cause, Risk Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease

Domain Shift

- CMS proposes to shift PC-01: Elective Delivery from the Clinical Care – Process domain to the Safety domain

AAMC

VBP Domain Weighting FYs 2017 - 2018

- **CMS Proposes to Increase Safety Domain and Remove Clinical Care – Process Domain Starting FY 2018**

	FY 2017 (Finalized)	FY 2018 *(Proposed)*
Safety	**20%**	**25%***
Clinical Care	**30%** (Outcomes = 25%, Process = 5%)	**25%** (Outcomes = 25%, Process removed)
Efficiency and Cost Reduction	**25%**	**25%**
Patient Experience	**25%**	**25%**

* Includes PC01: Elective Delivery measure (proposed for Safety Domain starting FY 2018

AAMC

CDC Data Collection Proposals - VBP

- FY 2019 will be the first year that CAUTI and CLABSI non-ICU data (Medical/Surgical wards) will be used for payment determination
- CDC will also calculate new baselines (new standard population data) for all NHSN measures starting CY 2015
  - In order to accurately compare baseline and performance periods, CMS proposes to start using “new standard population data” in payment year FY 2019, as shown below:

VBP Payment Year	FY 2017	FY 2018	FY 2019
	⇩	⇩	⇩
Performance Year	CY 2015 Current Standard Population data	CY 2016 Current Standard Population data	CY 2017 New Standard Population data
Baseline Year	CY 2013 Current Standard Population data	CY 2014 Current Standard Population data	CY 2015 New Standard Population data

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Inpatient Quality Reporting (IQR) Program

Association of
American Medical Colleges

IQR Program Proposals

- Required electronic reporting starting in CY2016 for FY 2018
- Updated CDC measures (with new baselines) starting CY 2016
- Significant expansion of the pneumonia readmissions and mortality measures would be publicly reported on Hospital Compare in 2016
- CMS requesting feedback on EHR derived core clinical data elements
- Changes to measures for FY 2018:
  - CMS proposes removal of nine measures, while retaining six for electronic reporting
  - Proposed addition of eight measures (seven claims based measures, and one structural measure)

Proposed Removal of Measures From IQR Starting FY 2018

6 Chart Abstracted Specified Measures Proposed for Removal, but Retained as Electronic Clinical Quality Measures
STK-06: Discharged on Statin Medication
STK-08: Stroke Education
VTE-1: VTE Prophylaxis
VTE-2: ICU VTE Prophylaxis
VTE-3: VTE Patients with Anticoagulation Overlap Therapy
AMI-7a: Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival

3 Measures Proposed for Removal
STK-01: VTE Prophylaxis
IMM-1: Pneumococcal Immunization
SCIP-Inf-4: Cardiac Surgery Patients with Controlled Postoperative Blood Glucose

AAMC

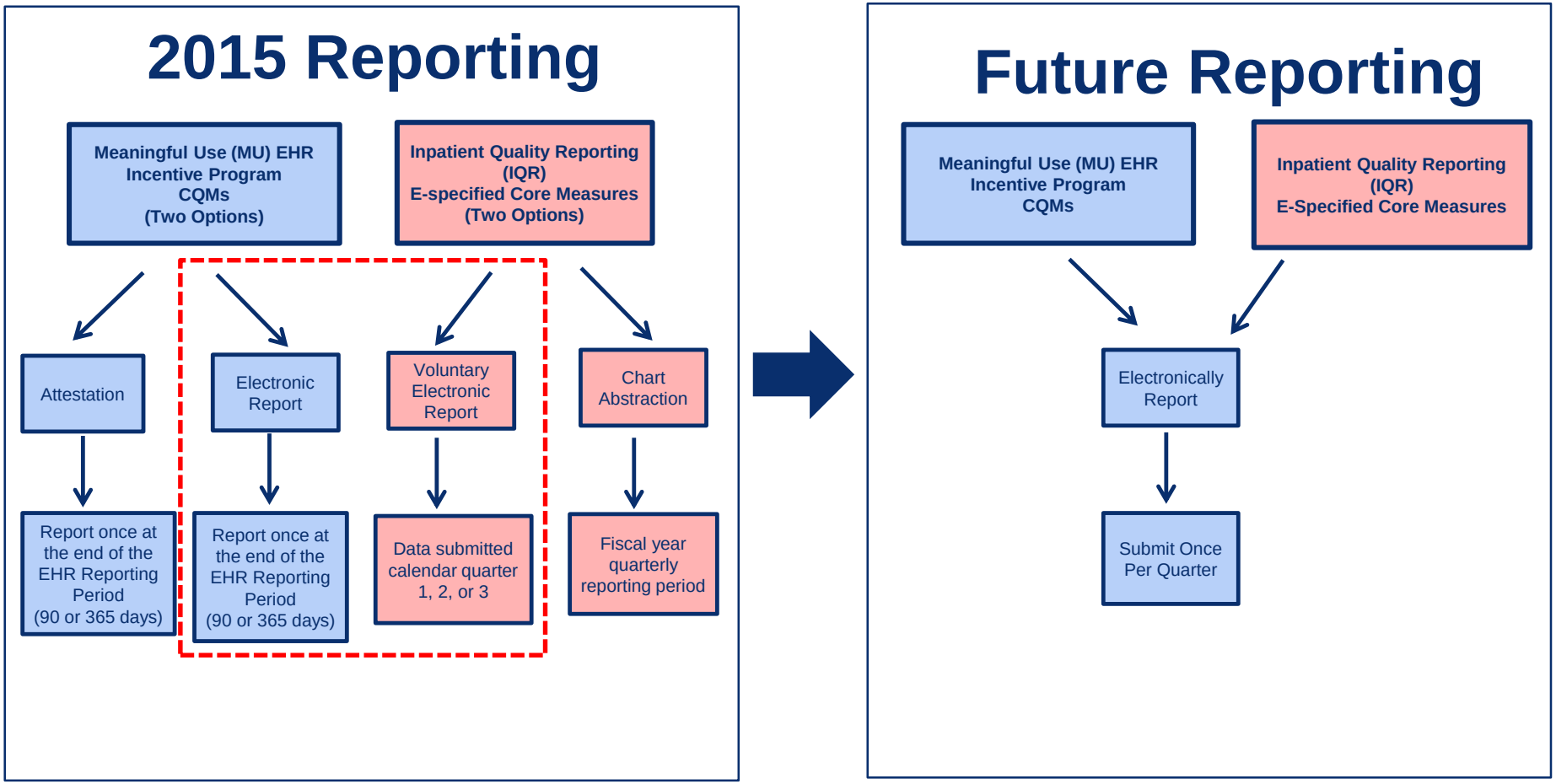
New Measures Proposed for IQR Starting FY 2018

Required Measures			
Measure	**Data Collection**	**MAP Recommended?**	**NQF Endorsed?**
THA/TKA payment per episode of care	Claims	Conditional support (NQF endorsement	No
Kidney/UTI clinical episode based payment	Claims	Conditional support (NQF endorsement	No
Spine fusion/refusion episode based payment	Claims	Conditional support (NQF endorsement)	No
Cellulitis clinical episode based payment	Claims	Conditional support (NQF endorsement)	No
Gastrointestinal hemorrhage clinical episode based payment	Claims	Conditional support (NQF endorsement)	No
Excess days in acute care after hospitalization for AMI	Claims	Conditional support (NQF endorsement and considered for SDS adjustment)	No
Excess days in acute care after hospitalization for HF	Claims	Conditional support (NQF endorsement and considered for SDS adjustment)	No
Patient Safety Culture	Structural	Yes	No

Electronic Reporting Proposed for FY 2018

- CMS proposes to require electronic reporting of quality measures in the IQR Program starting FY 2018 payment determination
- Hospitals would be required to submit 16 of 28 e-measures that cover three national quality strategy domains (NQS)
- For FY 2018 payment purposes, hospitals would be required to submit Q3 and Q4 data in 2016
- Greater alignment with CQM requirements in the EHR incentive program

Hospital IQR CQM and MU EHR Data Submission



AAMC

EHR Core Clinical Data

- CMS seeks feedback on use of EHR derived data elements for risk adjustment of outcome measures
- CMS envisions a system where hospitals forward EHR extracted data, and CMS would perform the measure calculations.
- CMS previously identified a set of 21 core data elements consisting of patient characteristics, first-captured vital signs, and first captured laboratory results that can feasibly be extracted from EHRs, such as:
  - Age, gender, blood pressure, hemoglobin levels
- Any requirements for using EHR derived data elements would only be for specific “hybrid” measures that are proposed through rulemaking

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

LTCH Site-Neutrality

Association of
American Medical Colleges

LTCH Site-Neutrality

- Required by Sec. 1206(a) of Pub. L. 113-67 (Pathway for Sustainable Growth Rate (SGR) Reform of 2013)
- Establishes alternate “site neutral” payment rate for LTCH discharges that fail to meet certain clinical criteria
  - = lower of IPPS comparable amount or 100% of the estimated cost of the case
- Creates dual-rate structure (standard rate cases v. site-neutral rate cases)

AAMC

LTCH Site-Neutrality, Cont.

- Criteria for a **standard** LTCH PPS payment:
  - Stay in LTCH immediately preceded by a discharge:
    - (1) from an acute care hospital that included at least 3 days in an ICU; or
    - (2) from an acute care hospital and the LTCH stay was assigned to an MS-LTC-DRG based on receipt of at ventilator services
    - Note: IPPS hospital claim must use Patient Discharge Status Codes 63 or 91
  - AND, LTCH discharge does *not* have principal diagnosis relating to psychiatric diagnosis or rehabilitation
- All the rest? Site neutral rate.

AAMC

Calculation of Site-Neutral Rate

- Proposed blended site neutral payment rate for FYs 2016 & 2017
  - 50% site neutral & 50% LTCH PPS standard Federal payment rate
- If teaching LTCH, IPPS-comparable per diem amount would include IME adjustment
  - IME cap would be imputed from DGME cap

AAMC

Questions?

AAMC

AAMC Staff

Payment Issues

- Lori Mihalich-Levin, lmlevin@aamc.org
- Allison Cohen, acohen@aamc.org

Bundling

- Jessica Walradt, jwalradt@aamc.org

Quality and Performance Programs

- Scott Wetzel, swetzel@aamc.org
- Mary Wheatley, mwheatley@aamc.org

AAMC