AAMC
Tomorrow's Doctors, Tomorrow's Cures

FY 2015 Inpatient PPS Proposed Rule Teleconference

Learn
Serve
Lead

May 27, 2014

AAMC Staff:
Allison Cohen, acohen@aamc.org
Lori Mihalich-Levin, lmlevin@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 May 15 – available at http://www.gpo.gov/fdsys/pkg/FR-2014-05-15/pdf/2014-10067.pdf
- Comments due **June 30, 2014**

Save the Date:
Detailed call for quality/performance proposals on Monday, June 2, 3-4 PM Eastern. Additional information will be available at www.aamc.org/hospitalpaymentandquality

AAMC

Topics for Today's Teleconference

Topic	FR Pages (May 15, 2014)
Payment Updates	28086-28088
Documentation & Coding	27995-27996
Wage Index & Occupational Mix Adjustment	28054-28070
GME Provisions	28144-28164
Medicare DSH ACA Changes	28094-28105
2 Midnight Rule and Short Stays	28169-28170
Outliers	28321-28324
New Technology	28028- 28054
Hospital Acquired Conditions Program	28134-28144
Value Based Purchasing Program	28117-28134
Hospital Readmissions Reduction Program	28105-28117
Inpatient Quality Reporting Program	28218-28253

AAMC

FY 2015 IPPS Proposed Rule – Key Takeaways

- 1.3% hospital payment update (overall impact on all hospitals is 0.8%, but impact on major teaching hospitals is -1.3%)
- Documentation and Coding: -0.8% reduction for ATRA Recoupment (defers -0.55% prospective adjustment)
- Update labor market areas (based on most recent Census)
- 2 Midnight Rule: open for comments on how CMS should pay for “short stays”
- Mostly technical GME changes
- Hospital Price Transparency: ACA requirement to make charges public

AAMC

FY 2015 IPPS Proposed Rule – Key Takeaways Continued

- Increased risk in pay for performance programs (approximately 5.5% at risk in FY 2015 for VBP, HRRP, & HAC)
- New quality measures proposed for VBP, HRRP, and IQR
- Changes to HAC domain weighting/scoring methodology
- CMS encouraging greater alignment between IQR and EHR Incentive Program

AAMC

Topics for Today's Teleconference

- Payment Updates/Documentation and Coding
- Price Transparency
- Wage Index Changes
- GME
- Medicare DSH
- 2 Midnight Rule and Short Stays
- Outliers
- New Technology
- ICD-10
- Quality Provisions

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Payment Updates

Association of
American Medical Colleges

FY 2015 Market Basket Update

- Market basket projected increase = 2.7 percent
  - Less 25 percent if hospital doesn't submit quality data
  - Less multi-factor productivity adjustment = -0.4 percent
  - Less ACA adjustment = -0.2 percent
  - Less documentation and coding recoupment required by ATRA = -0.8 percent

FY 2015 Payment Update: 1.3%

However, other factors may affect your payments…

AAMC

Additional Factors Affecting Aggregate Payments – FY 2015

Policy	Impact
FY 2015 increase in payment rates (from Slide 7)	+1.3%
DSH UC Payment Pool Reduction	-1.0%
Readmissions	-0.2%
Higher SCH rate update	+0.1%
Expiration of MDH Special Status	-0.1%
Frontier Wage Index Floor	+0.1%
HAC Reduction Program	-0.3%
FY 2015 Outlier Payments at 5.1% (compared to FY 2014 outlier payments at 5.79%)	-0.7%
Impact Including Additional Factors	-0.8%

Impact on Major Teaching = -1.3% (why? DSH + HAC policies)

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

Documentation & Coding Proposal

- CMS proposes a second 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
  - CMS estimates the -0.8 percent for FY 2015 will recover almost $2B. (With $1B for FY 2014, leaves $8B to recoup)
- Again postpones -0.55% prospective adjustment

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Price Transparency

Association of
American Medical Colleges

Price Transparency

- "Reminder" of ACA requirement to make charge master public
- "Guidelines" require hospitals to make public either:
  - (1) a list of their standard charges ("whether that be the chargemaster itself or in another form of their choice"), OR
  - (2) their policies for allowing the public to view a list of their charges in response to an inquiry
- Encourages "consumer friendly communication"
- Update at least annually

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Wage Index Changes

Association of
American Medical Colleges

Wage Index Changes

New Labor Market Areas

- FY 2015 CBSAs based on updated (2010) Census data
- 12 urban hospitals become rural (p. 28056)
  - Transition? 3 years
- 81 rural hospitals become urban (p. 28056-57)
- Some urban hospitals remain urban but move to different CBSA (p. 28050-60)
- Transition for hospitals w/decrease in wage index? 1 year, 50-50 blended rate

AAMC

Wage Index Changes, cont.

Reminder re: Contract Housekeeping & Dietary

- Some hospitals aren't consistently providing documentable salaries, wages, and hours
- Contractors instructed to use reasonable estimates of wages and hours

Occupational Mix Adjustment

- New data required for FY 2016
- 2013 surveys due to MAC by July 1, 2014

Temporary Imputed Floor

- "Floor" for states with no rural counties
- Extended 1 more year (through 9/30/15)
- Affects DE (new this year), NJ, RI

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Graduate Medical Education (GME)

Association of
American Medical Colleges

GME Provisions – Affect You If:

- You train residents in a rural hospital that is now considered urban, and the rural hospital is in the middle of building a new program
  - Rule says: rural hospital can finish building its cap for the new program
    - All new programs had to have started while hospital was rural
- You train residents in a rural training track (RTT) program, and one of your rural hospitals is now considered urban
  - Rule says: 2 year transition period (formerly rural must classify back to rural & only get IME, or urban must find a new rural partner)
    - If in middle of RTT cap-building period, can keep building that cap

AAMC

GME Provisions – Affect You If:

- You had a jurisdictionally proper appeal pending on DGME or IME payments as of March 23, 2010, and you are appealing nonprovider site FTE count
  - Rule says: CMS "clarifying" ACA Sec. 5504 prohibits reopening
    - Talk to your appeals lawyers…

AAMC

GME Provisions – Affect You If:

- You are considering applying for Sec. 5506 slots from closed hospitals in rounds announced on or after 10/1/14
  - Rule says:
    - No more cap relief option
    - No more "seamless" requirement for RC #1 and #3
      - But still have to show commitment to permanent expansion
    - Emergency GME affiliation agreement now counts for RC #2

GME Provisions – Affect You If:

- You are considering applying for Sec. 5506 slots from closed hospitals, cont.:
  - Rule says: Slot effective dates for rounds announced on or after 10/1/14:
    - RC #1 & 3:
      - No temporary slots: date of closure
      - Yes, temporary slots: after residents graduate
    - RC #2:
      - Date of closure
    - RC #4-8:
      - No temporary slots: when you prove to MAC you filled them
      - Yes, temporary slots: later of either graduation or prove to MAC you filled them

AAMC

GME Provisions – Affect You If:

- You train residents in an FQHC or RHC that receives DGME money
  - Rule says: As with teaching hospital, if FQHC or RHC incurs cost of resident stipends/benefits, it can claim nonhospital clinical training time
- You are working with a new teaching hospital to build a cap under the 5-year window
  - Rule says: cap, 3 year rolling average, and IRB ratio cap go into effect at beginning of cost reporting period preceding 6th year

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Medicare DSH

Association of
American Medical Colleges

Medicare DSH Impact of Proposed New Labor Market Areas

- **Maximum DSH Payment Adjustment:** DSH payment adjustment can't exceed **12% for rural hospitals with < 500 beds** unless they are rural referral centers (RRCs)
- If a **hospital is currently in an urban county that would become rural** under the proposed new labor market areas and does not become an RRC, it would become **subject to this maximum DSH payment adjustment for the empirically justified DSH payments (NOT for the UC DSH)**

AAMC

Transitional Period After Hospital Loses Urban Status

If a hospital will receive lower DSH payments because it loses its urban status, current regulations allow for additional payments for 2 years to transition to the lower payment.

- Year 1: hospital receives 2/3 of the difference b/w its DSH payments before redesignation and DSH payments after redesignation
- Year 2: hospital receives 1/3 difference b/w its DSH payments before redesignation and DSH payments after redesignation

DSH - ACA Sec. 3133

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

- **Aggregate DSH payments will again be reduced in FY 2015**

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 2015** = **$14.205 B** (this is the pool we are starting with).
  - **Empirically justified DSH payments = $3.551 B** (25% of original DSH payments that is paid the same)
  - **Factor 1:** Total DSH payments – Empirically Justified DSH payments = **$10.654 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 uninsurance in CY 2014 (**16 percent**).
  - The CBO's most recent estimate of the rate of uninsurance in CY 2015 (**14 percent**).
- CMS will normalize these estimates for CYs to correspond with the appropriate FYs. **The FY 2015 rate of insurance coverage** = (84% x .25) + (86% x .75) **= 85.5%** so the **% of individuals without insurance for FY 2015 = 14.5%**.
- **Factor 2 =** 1 minus the % change in the % of uninsured individuals < age 65 minus 0.2 percentage points.
- **So Factor 2 =** 1 - |[0.145-0.18)/0.18]| = 1 – 0.19444 = 0.80556 (80.556%) – 0.002 **= 0.8036 (80.36%)**

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. **CMS invites comments on when it would be appropriate to use the S-10.**
- 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.**
- The FY 2015 proposed rule is accompanied by **tables listing Factor 3 levels. Hospitals have 60 days (until June 30) to review the tables and notify CMS in writing of any changes.**

AAMC

How to Figure Out Your UC DSH Payment

The UC Payment Pool= 75% x $14.205 = $10.654 B

The Pool is Reduced by the Percentage Insured = $10.654 B x 80.36% = $8.562 B (about $500 million less than FY 2014)

UC Payment = $8.562 B x [(Your Hospital Medicaid Days + SSI Days) ÷ (Medicaid Days + SSI Days for All DSH Eligible Hospitals)] = YOUR UC DSH PAYMENT

AAMC

How UC Payments Will Be Made

- Interim UC Payments will be made on an per discharge basis
- Estimated per discharge amount (same for every discharge for a hospital) = UC payment CMS calculates for a hospital for a fiscal year ÷ average number of discharges/claims in the most recently available 3 fiscal years of the Medicare claims dataset
- For FY 2015 payments => average number of claims from MedPAR claims data for FY 2011, 2012 and 2013

AAMC

Cost Report Settlement

- Will not include reconciliation of the values of Factors 1, 2, and 3.
- Only will include adjustments for changes in whether the hospital is eligible to receive empirically justified DSH payments.
- CMS will pay UC DSH payments on the basis of the federal fiscal year and will reconcile that amount on the cost report that begins the respective federal fiscal year.

AAMC

UC DSH for Hospitals that Merge

- Proposed rule includes **new** policies for addressing hospital mergers. CMS proposes:
  - For FY 2015, to **incorporate data from both merged hospitals' separate CCNs until data for the merged hospital become available under the surviving CCN.**
  - **To identify hospitals that merged after the period from which data are being used to calculate Factor 3** (for FY 2015, after 2012 and 2011 cost reports) but before publication of the final rule.

AAMC

UC DSH for Hospitals that Merge

- **CMS proposes to treat hospitals that merge after the development of the final rule as new hospitals are treated:**
  - **Interim UC payments would be based only on the data of the surviving hospital's CCN** at the time of the preparation of the final rule.
  - But, **at cost report settlement, CMS would determine the newly merged hospital's final UC payments based on the Medicaid days and SSI days reported on the cost report used for the applicable fiscal year** (revising the numerator of Factor 3 to reflect the low income days reported on the cost report).
  - **CMS invites comments on these proposals.**

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 requests comments on **alternative payment approaches under the Medicare program for short hospital stays.**
- CMS is soliciting comments on:
  - **How the short stay payment methodology would be designed,**
  - **How short or low cost stays would be defined, and**
  - **What the appropriate payment would be for these short stays.**

AAMC

2 Midnight Rule and Short Stays

- CMS provided **examples** of possible alternative short stay payment policies for commenters to consider, such as **a per diem payment model (such as that used for transfer cases).**
- **CMS is interested in input on the impact** of a per diem payment model or another payment methodology on cases under the OPPS and IPPS.
- **The AAMC is interested in your feedback!**

AAMC

AAMC Recommendations and Request for Input on Alternative Short Stay Payment Models

- **House Ways & Means Health Subcommittee Hearing** on reimbursement for short stays and the 2 midnight rule.
- The **AAMC** submitted written testimony with the following **recommendations**:
  - Keep the part of the rule that would make all medically necessary stays > 2 midnights inpatient stays.
  - **For stays lasting < 2 midnights, return to the policy in place for short stays prior to Oct. 1, 2013, along with simple reforms to the RAC process** (e.g., reverse the policy requiring that a denied inpatient claim may only be re-billed under Part B within 12 months of the date of service).

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Outliers

Association of
American Medical Colleges

Outlier Payments

- **For FY 2015, target for total outlier payments continues to be set at 5.1% of total operating DRG payments**
  - Current estimate is that actual outlier payments for FY 2013 were 4.81% of actual total MS-DRG payments
  - Currently estimate is that actual FY 2014 outlier payments will be 5.79% of actual total MS-DRG payments (about 0.69 percentage points higher than the 5.1% projected).

AAMC

Outlier Threshold

- **For FY 2015**, 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 add-on payments for new technology, plus **$25,799**.
- CMS attributes the **higher FY 2015 threshold** to a charge inflation factor that is higher than FY 2014.

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

New Technology

Association of
American Medical Colleges

New Technology Add-On

Update on FY 2014 New Technologies

New Tech	Approved for FY 2015?	Max Add-On per Case
Voraxaze®	Yes	$45,000
DIFICID™	No	$868
Zenith® F. Graft	Yes	$8,171.50
Kcentra™	Yes	$1,587.50
Argus® II System	Yes	$72,028.75
Zilver® PTX®	Yes	$1,705.25

AAMC

New Technology Add-On

FY 2015 Applications for New Technology Add-On Payments:

- **Dalbavacin**
- **Heli-FX™ EndoAnchor System**
  - Applicant submitted two applications:
    - For treatment of abdominal aortic aneurysms (AAA)
    - For treatment of thoracic aortic aneurysms (TAA)
- **WATCHMAN® Left Atrial Appendage (LAA) Closure Device**
- **CardioMEMS™ HF (Heart Failure) System**
- **MetraClip® System**
- **Responsive Neurostimulator (RNS®) System**

ICD-10

AAMC

ICD-10

ICD-10 Compliance Date

- The Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) enacted April 2014 said **HHS may not adopt ICD-10 prior to October 1, 2015.**
- **ICD-10 not in proposed rule.** May 1st, CMS announced it expects to release an interim final rule soon. The rule will:
  - Include a new compliance date that would require the use of ICD-10 beginning October 1, 2015.
  - Require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.
- **July ICD-10 End-to-End Testing Canceled: Additional Testing Planned for 2015.**

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

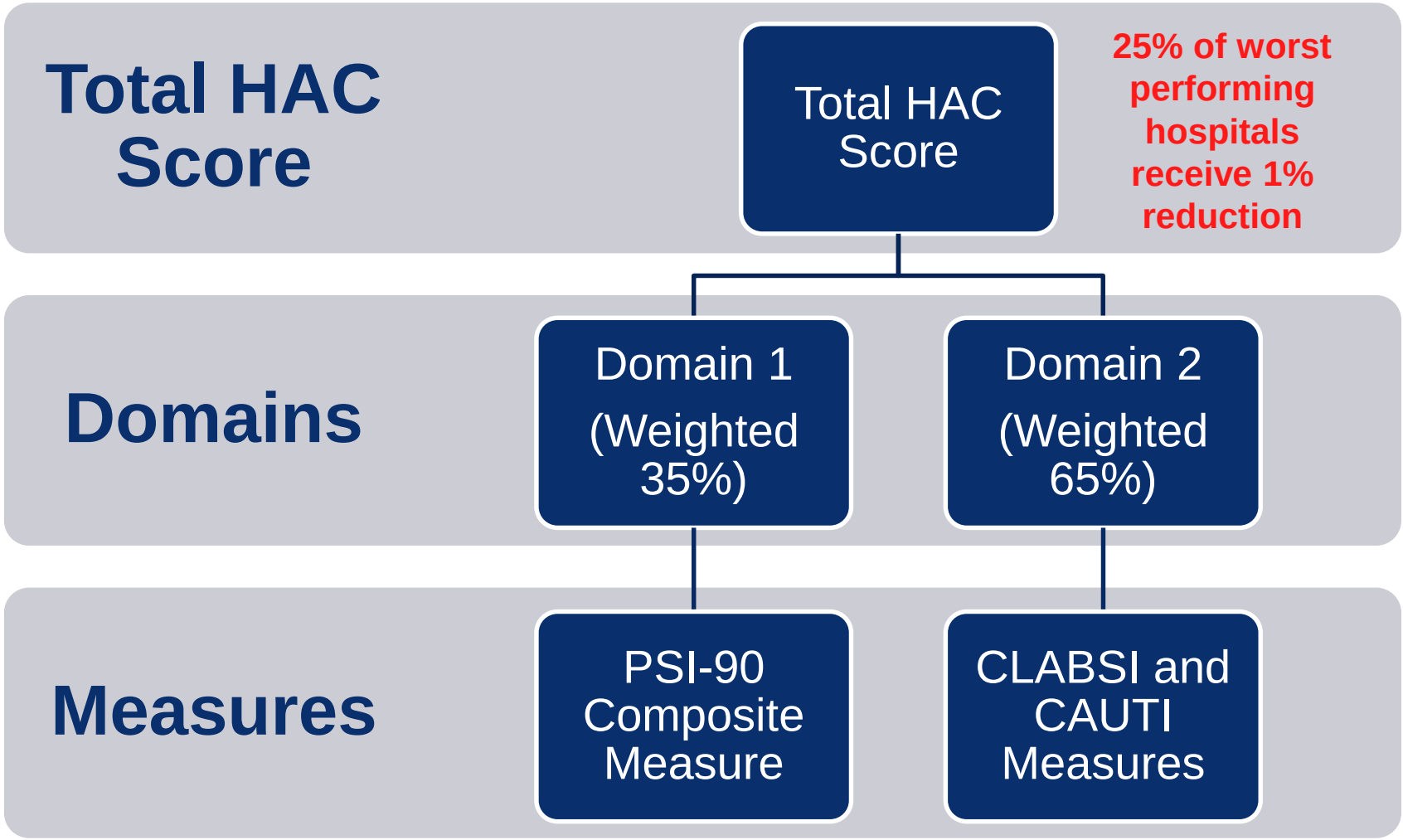
Hospital Acquired Condition (HAC) Reduction Program

Association of
American Medical Colleges

Background on HAC Reduction Program

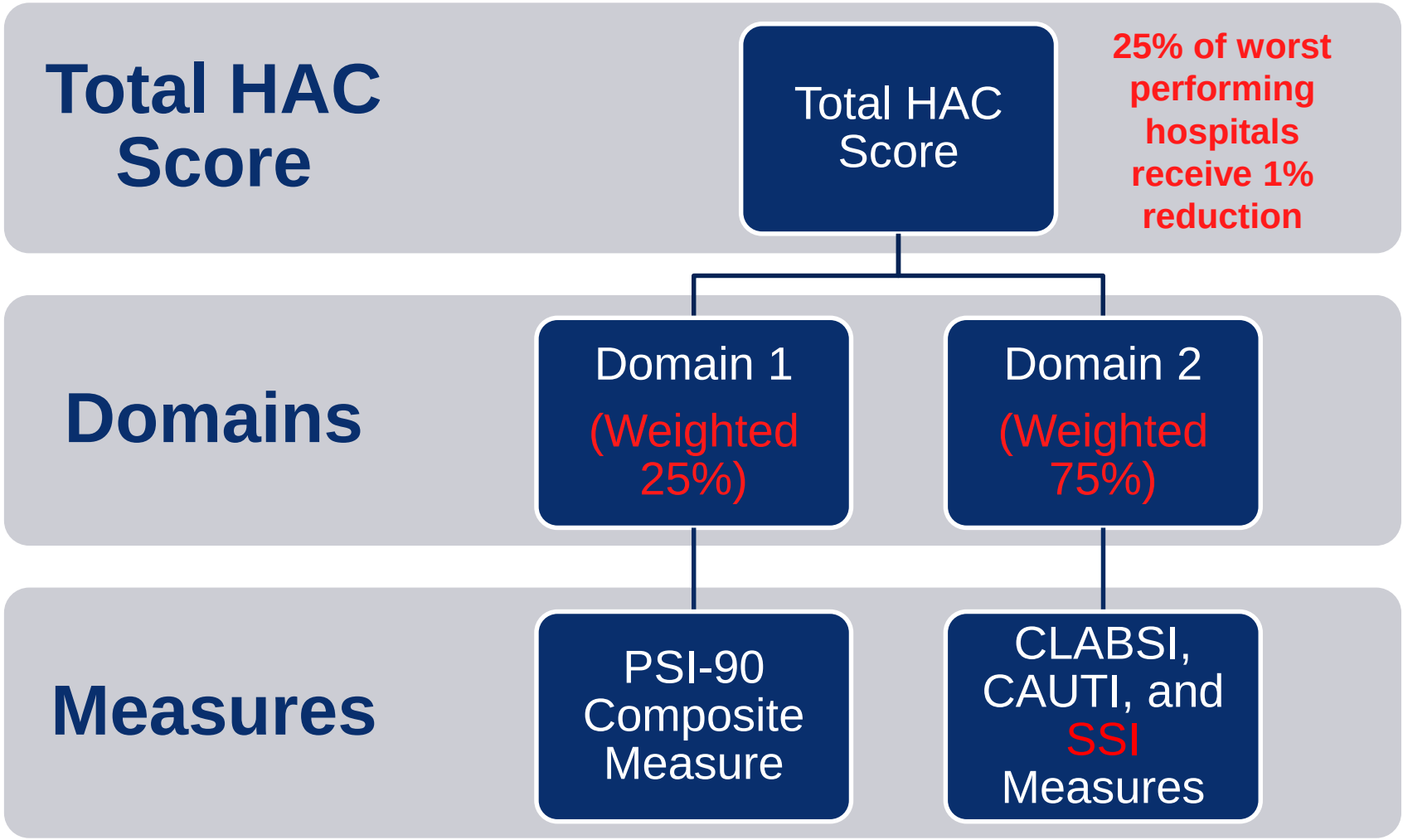
- HAC Reduction Program starting FY 2015
- Hospitals in the worst performance quartile of HACs will face a 1 percent reduction in all payments (including IME and DSH)
- HAC reductions will be applied after adjustments for the VBP and the Readmission Reduction Programs
- Teaching hospitals disproportionately affected by HAC Program

HAC Reduction Program Framework Finalized for FY 2015



AAMC

HAC Reduction Program Framework Proposed for FY 2016



AAMC

HAC Domains and Measures

Domain 1
(AHRQ PSI-90 Composite)

- The PSI-90 Composite consists of:
- PSI-3: pressure Ulcer
- PSI-6: latrogenic pneumothorax
- PSI-7: central venous catheter-related blood stream infection rate.
- PSI-8: hip fracture rate
- PSI-12: postoperative PE/DVT rate
- PSI-13: sepsis rate
- PSI-14: wound dehiscence rate
- PSI-15: accidental puncture

Domain 2
(CDC Measures)

- **2015 (2 measures)**
  - CAUTI
  - CLABSI
- **2016 (1 additional measure)**
  - Surgical Site Infection (Colon Surgery and Abdominal Hysterectomy)
- **2017 (2 additional measures)**
  - MRSA
  - C Diff

AAMC

HAC Measure Scoring Methodology

Points will be assigned according to a hospital's performance on these measures:	
Starting FY 2015	**Starting FY 2016**
PSI-90 Composite	Surgical Site Infections (SSI)
CLABSI	CMS proposes to pool SSI for abdominal hysterectomies and colon procedures into a single standardized infection ratio (SIR) for each hospital.
CAUTI	

- The performance range for each of the measures will be divided into 10 deciles. All hospitals will receive between 1 and 10 points for each measure
- CMS will handle "ties" by assigning all hospitals with the same result the same number of points based on the lowest appropriate percentile (i.e. if 14% of hospitals score a zero on a measure, all 14% would receive 1 point)
- CMS states that the worse quartile is defined by a score > 7 points. HPA analysis of the CMS file of hospital-specific scores shows that 23% of hospitals will be penalized

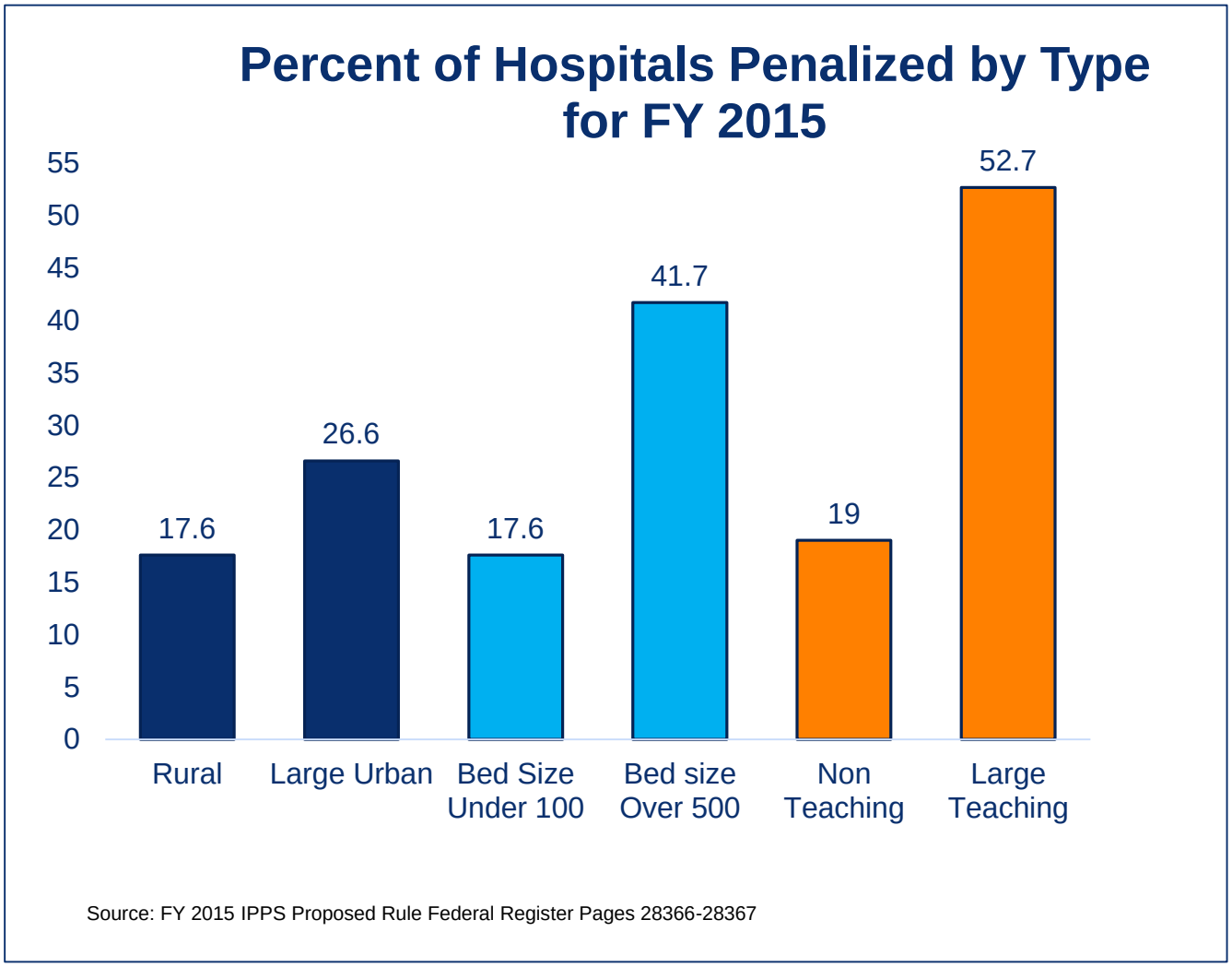
To Calculate HAC Score:

(Domain 1 Score x 35%) + (Domain 2 Score x 65%) =Total HAC Score*

*Hospitals reporting measures in 2 domains

AAMC

Breakdown of Hospitals Affected By HAC Reduction Program



Source: FY 2015 IPPS Proposed Rule Federal Register Pages 28366-28367

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 for FY 2015

- Reduction in base DRGs increased from 1.25% to 1.5% to fund incentive pool
- Amount at risk is $1.4 billion
- First year of the efficiency domain (20% of the total VBP score). Domain contains one measure: Medicare Spending Per Beneficiary (MSPB)

Six Measures Proposed for Removal Starting FY 2017

- PN-6: Initial Antibiotic Selection for CAP in Immunocompetent Patient
- SCIP-Inf-2: Prophylactic Antibiotic Selection for Surgical Patients
- SCIP-Inf-3: Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
- SCIP-INF-9: Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2
- SCIP-Card-2: Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
- SCIP-VTE-2: Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery

AAMC

Six Measures Proposed For VBP Starting 2017 & 2019

2017

- Hospital-onset Methicillin-Resistant Staphylococcus Aureas (MRSA) Bacteremia
- *Clostridium Difficile* (C.Diff) Infection
- Early Elective Deliveries (PC-01)
- Re-adoption of CLABSI (Current Measure, not the Reliability-adjusted Measure)

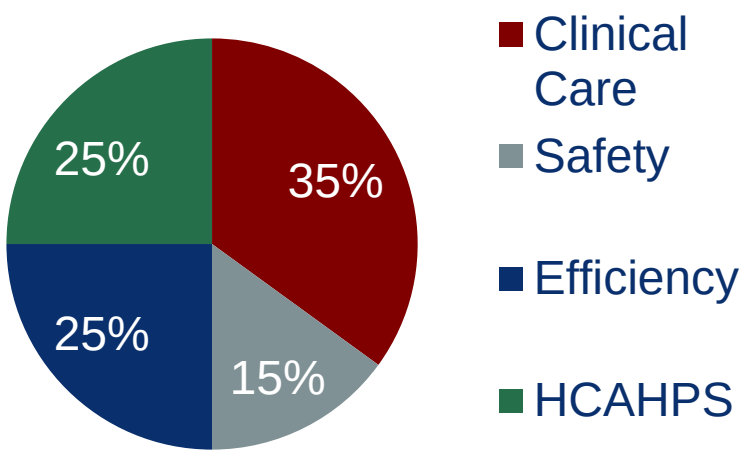
2019

- Hospital-level Risk-standardized Complication Rate (RSCR) Following Elective Hip and Knee Arthroplasty
- Re-adoption of PSI-90

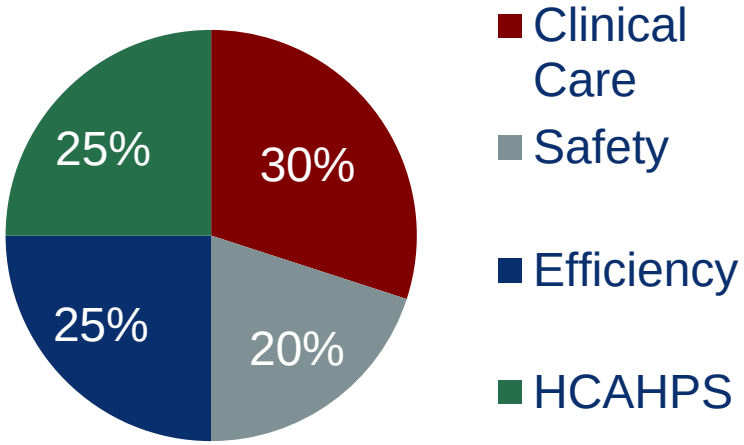
AAMC

Proposed VBP Domains for FY 2017

Previously Finalized Domain Weighting FY 2017



Proposed Domain Weighting FY 2017



AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Readmissions Reduction Program

Association of
American Medical Colleges

Updates to Hospital Readmissions Reduction Program

- Maximum penalty increases to 3% in FY 2015
- CMS proposes to add 1 new measure in FY 2017:
  - CABG
- Performance period July 1, 2010 through June 30, 2013
- Proposed changes to Planned Readmissions Algorithm (Version 3.0) and to Total Hip/Total Knee Arthroplasty methodology

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Inpatient Quality Reporting (IQR) Program

Association of
American Medical Colleges

CMS Proposal to Removal IQR Measures Starting FY 2017

10 Measures Proposed for Removal from the IQR Program
AMI-1: Aspirin at Arrival (Previously Suspended)
AMI-3: ACEI or ARB for Left Ventricular Systolic Dysfunction- Acute Myocardial Infarction (AMI) Patients (NQF #0137)
AMI-5: Beta-Blocker Prescribed at Discharge for AMI (NQF#0160) (Previously Suspended)
HF-2: Evaluation of Left Ventricular Systolic Function (NQF #0135)
SCIP-Inf-3: Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time (48 Hours for Cardiac Surgery) (NQF #0529)
SCIP-Inf-4: Cardiac Surgery Patients with Controlled Postoperative Blood Glucose (NQF #03
SCIP-Inf-6: Surgery Patients with Appropriate Hair Removal (NQF #030) (Previously Suspended)
SCIP-Card-2: Surgery Patients on Beta Blocker Therapy Prior to Arrival Who Received a Beta Blocker During the Perioperative Period (NQF #0284)
SCIP-VTE-2: Surgery Patients Who Received Appropriate Venous Thromboembolism (VTE) Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery (NQF #0218)
Participation in a Systematic Database for Cardiac Surgery (NQF #0113)

AAMC

CMS Proposal to Remove IQR Measures Starting FY 2017, Cont.

10 Measures Proposed to be Removed from IQR, but Retained as a Voluntary Electronic Clinical Quality Measure
AMI-8a: Primary PCI Received Within 90 Minutes of Hospital Arrival (NQF #0163)
PN-6: Initial Antibiotic Selection for Community-acquired Pneumonia (CAP) in Immunocompetent Patients (NQF #0147)
SCIP-Inf-1: Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision (NQF #0527)
SCIP-Inf-2: Prophylactic Antibiotic Selection for Surgical Patients (NQF #0528)
SCIP-Inf-9: Urinary Catheter Removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) With Day of Surgery Being Day Zero (NQF #0453)
STK-2: Discharged on Antithrombotic Therapy (NQF #0435)
STK-3: Anticoagulation Therapy for Atrial Fibrillation/flutter (NQF #0436)
STK-5: Antithrombotic Therapy by the End of Hospital Day Two (NQF #0438)
STK-10: Assessed for Rehabilitation (NQF #0441)
VTE-4: Patients Receiving un-fractionated Heparin with Doses/labs Monitored by Protocol

Updates to Existing Measures

- Expansion of CLABSI and CAUTI to select non-ICU locations will start January 1, 2015
- CMS proposed to update the planned readmission algorithm methodology and the THA/TKA measure
- CMS clarifies that for the healthcare personnel vaccination measure (adopted for IQR and OQR), hospitals should only report a single vaccination count by CMS Certification Number (CCN).

CMS Proposal for New IQR Measures

5 Measures Proposed as IQR Required Measures

Measure	Data Collection	NQF-Endorsed?
Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery	Claims	No
Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery	Claims	No
Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia	Claims	No
Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure	Claims	No
Severe Sepsis and Septic Shock: Management Bundle (NQF# 500)	Chart-abstracted	Yes

6 Measures Proposed for Voluntary Electronic Health Reporting

Measure
Hearing Screening Prior to Hospital Discharge (NQF #1354)
PC-05 Exclusive Breast Milk Feeding and the subset 1042 measure PC-05a Exclusive Breast Milk Feeding Considering Mother's Choice (NQF #0480)
CAC-3 Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver
Healthy Term Newborn (NQF #0716)
AMI-2 Aspirin Prescribed at Discharge for AMI (NQF #0142)
AMI-10 Statin Prescribed at Discharge (NQF #0639)

AAMC

Proposals for Electronically Submitted Measures Starting FY 2017

- Providers may voluntarily report 16 of 28 measures that align with EHR Incentive Program
  - Measures must span at least 3 NQS Domains
- Must electronically report data for a full year
- Hospitals that successfully submit electronic measures would not need to submit chart abstracted data for validation purposes
- CMS had finalized a policy that electronic data would only be reported if it is “accurate enough”
  - CMS now intends to publicly report this data (without being validated) when submitted for FY 2016 payment determination
  - Data submitted for FY 2017 payment determination will also be publicly reported, but hospitals will have a preview period
- CMS intends to propose required electronic reporting for some IQR measures in next year’s rule.

AAMC

Questions?

AAMC Staff

GME, DSH, Payment Issues

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

Quality and Performance Programs

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

AAMC