Fiscal Year (FY) 2020 Inpatient Prospective Payment System (IPPS) Proposed Rule Webinar

AAMC Presenters:
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Brooke Kelly, bkelly@aamc.org

May 20, 2019

Comments are due **June 24, 2019**.

AAMC IPPS Resources: [https://www.aamc.org/initiatives/patientcare/277442/hospitalpaymentandquality.html](https://www.aamc.org/initiatives/patientcare/277442/hospitalpaymentandquality.html).

Proposals would take effect October 1, 2019 (Federal FY 2020) unless otherwise noted.
Major Policy Proposals

- Standard Operating Payment Update
- Proposals Addressing Wage Index Disparities
- Urban to Rural Reclassification Applications and Cancellations
- Disproportionate Share Hospital (DSH) and Uncompensated Care Payment Methodology Update
- Outlier Payment and Methodology Update
- Graduate Medical Education (GME) Training at Non-Provider Sites and Available Section 5506 Slots (Round 14)
- New Technology Add-on Payments (NTAPs) Calculation and Application Criteria
- Chimeric Antigen Receptor T-Cell (CAR-T) Therapy Payment
- Extracorporeal Membrane Oxygenation (ECMO) Diagnosis-Related Group (DRG) Reassignment
- Severity Level and O.R. Procedure Codes
- Quality & Promoting Interoperability Programs
Payment Updates
Proposed Payment Rate Update

Market Basket Update: +3.2%
Multifactor Productivity Adjustment: -0.5%
Documentation & Coding: +0.5%

FY 2020 Payment Update*: 3.2%

Overall Impact:
All Hospitals: 3.5%
Major Teaching Hospitals: 3.5%

*Only hospitals that successfully report quality measures and are meaningful users of electronic health records (EHR) receive the full payment update.
Wage Index Changes
Background & FY 2020 Proposed Changes to the Wage Index

➢ Background
  ➢ Wage index adjusts IPPS payments for differences in hospital-reported wages across geographic areas

➢ Wage Index Proposals
  ➢ Reduce wage index for high wage index hospitals
    ➢ 5% cap on any decrease to a hospital’s wage index between FY 2019 and FY 2020 – effective only one year (FY 2020)
    ➢ Apply budget neutrality adjustment to FY 2020 standardized amount (-0.17 %)
  ➢ Raise wage index for low wage index hospitals
    ➢ Retain policy for 4 years to allow low wage hospitals to raise wages
    ➢ CMS may extend policy for more than 4 years if necessary

➢ Rural Floor Calculation Proposal
Proposal to Reduce Wage Index for High Wage Hospitals

➢ Highest quartile wage index hospitals (75th percentile)
   ➢ 75th percentile wage index value is 1.0351
➢ Reduce wage index by 4.3% of difference between hospital’s wage index and 75th percentile wage index value
   ➢ Misprinted as “3.4%” in the text of the proposed rule
Example of Reduced Wage Index (see 84 Fed. Reg. 19396)

➢ Hospital Wage Index: \(1.7351\)

➢ Difference from 75\(^{th}\) Percentile: \(1.7351 - 1.0351 = 0.700\)

➢ Multiply by 4.3\%: \(0.700 \times 0.043 = 0.0301\)

➢ Reduced Wage Index: \(1.7351 - 0.0301 = 1.7050\)
Proposal to **Raise** Wage Index for Low Wage Hospitals

- Lowest quartile wage index hospitals (25\textsuperscript{th} percentile)
  - 25\textsuperscript{th} percentile wage index value is 0.8482
- Raise wage index by **half** the difference of hospital’s wage index and the 25\textsuperscript{th} percentile wage index value
Example of Raised Wage Index *(see 84 Fed. Reg. 19395)*

- Hospital Wage Index: \[0.6663\]
- Difference from 25\textsuperscript{th} Percentile: \[0.8483 - 0.6663 = 0.1819\]
- Half difference: \[0.1819 / 2 = 0.0910\]
- Raised Wage Index: \[0.0910 + 0.6663 = 0.7573\]
Rural Floor Calculation Proposal

Background
➢ By law, an urban hospital’s wage index cannot be lower than the wage index applicable to rural hospitals in the same state
➢ Some urban hospitals with high wages have reclassified as rural to increase the rural floor wage index

Proposal
➢ Will not include the urban-to-rural reclassified hospitals’ wages to calculate the rural floor that applies to urban hospitals not reclassified as rural
➢ CMS will still include urban to rural reclassified hospital’s wages to calculate the rural wage index
# Impact of Proposed Changes to Wage Index

## 2. Estimating the Impact of Proposed Changes to Wage Index

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<tr>
<th></th>
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<tbody>
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### Impact on IPPS Payments

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*Note: FY2019 Wage Index and FY2020 Payment Rates.
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Urban-to-Rural Reclassifications
Proposed Changes to Urban-to-Rural Reclassification Applications and Cancellations

Applications

• Currently, hospitals seeking to reclassify from urban to rural (42 CFR 412.103) must submit an application by mail to the CMS Regional Office.

• Proposal: Allow hospitals to submit applications electronically or by fax to the CMS Regional Office.

Cancellations

• Currently, hospitals that have reclassified from urban to rural (42 CFR 412.103) must be paid as rural for at least one 12-month cost reporting period.

• Proposals: Eliminate the requirement to be paid as rural for one 12-month cost reporting period (rule now obsolete as a result of litigation decided against CMS).
  ➢ Create uniform requirements for cancelling rural reclassifications:
    ▪ Switch from cost reporting period to federal fiscal years.
    ▪ Cancellation must occur at least 120 days before end of federal fiscal year.
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)**
  - Adjusted – 75% of 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%
DSH Uncompensated Care Payment (UCP)

**Factor 1:** $12.643 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:** 67.14%

- Reduces the amount of Factor 1 by uninsured pre-ACA to uninsured post-ACA
- FY 2020 Proposed UCP Amount: $8.489 billion**

**Factor 3:** Determines Hospitals’ % of UCP

- A hospital’s UCP amount over set time period compared to UCP for all qualifying hospitals over the same time period.

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*Office of the Actuary (OACT) uses December 2018 Medicare DSH estimates to determine Factor 1.

**CMS uses National Health Expenditure Accounts (NHEA) estimates to determine Factor 2
Factor 3 Methodology Changes – Time Period and Data Source

- Continue using Worksheet S-10 data
- Not using low income insured proxy data
- Moving from three (3) years of data to one (1) year of data for FY 2020
- Would use single year (FY 2015) of **audited** Worksheet S-10 data for some hospitals, unaudited for others
- Seeking comments on whether **unaudited** FY 2017 data would be more appropriate
## Impact of Proposed Use of FY2015 S-10 vs Alternative Proposal of Using FY2017 S-10

### Estimating Your Share in Uncompensated Care Payment Pool Using S-10 Data: 2015 Data (Proposed) vs 2017 Data (Alternative Proposal)

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<tr>
<td>UCP Pool Amount in FY2020</td>
<td>$8,488,517,726</td>
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</tr>
<tr>
<td>Your Share of the UCP Payment Pool (Factor 3)¹</td>
<td>0.033500%</td>
<td>0.054839%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your Estimated UCP Payment</td>
<td>$2,843,653</td>
<td>$4,655,027</td>
<td>$1,811,373</td>
<td>64%</td>
</tr>
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**Notes:** For FY2020, CMS proposed to fully transition into using uncompensated costs reported on Medicare cost report worksheet S-10 in determining UCP adjustment for Factor 3. Instead of averaging 3 cost report years, CMS proposed to use 1 year of cost report data. As specified in the FY2018 IPPS final rule, uncompensated care costs are extracted from Line 30 of worksheet S-10, which is defined as the sum of net charity care costs (S-10, Line 23) and bad debt costs (S-10, Line 29). To convert charity care charges (S-10, Line 20, Column 3) and bad debt charges (S-10, Line 28) to costs, CMS used hospital cost to charge ratios (CCR) reported on S-10, Line 1. If a hospital’s CCR is more than three standard deviations from the national geometric mean, then the statewide average CCR (urban/rural) will be used to calculate the hospital’s uncompensated care costs. To address potentially aberrant FY2015 and FY2017 worksheet S-10 data, CMS will continue to examine the ratio of uncompensated care costs to total operating costs. CMS will also continue to annualize uncompensated care costs if a hospital’s cost report does not equal 12 months.

¹ For FY2020, CMS proposed to use FY2015 uncompensated care cost data reported on S-10 in determining Factor 3 because CMS has concluded audits of the FY2015 Worksheet.
Outlier Payments
Proposed Outlier Fixed Loss Cost Threshold

- Prospective Payment Rate for MS-DRG
- IME Payments
- Empirically Justified DSH Payments
- Estimated Uncompensated Care Payments
- Indirect Medical Education & New Technology Add-On Payments
- FY 2020 Fixed Loss Amount ($26,994)

Proposed FY 2020 Outlier Fixed Loss Cost Threshold
Graduate Medical Education (GME)
Counting Residents Training in Critical Access Hospitals (CAHs)

➢ Urban hospitals may count full-time equivalent (FTE) residents training at non-provider sites in its FTE count if the hospital incurs costs of salary and fringe benefits*

➢ CAH would be considered “non-provider” site

➢ Allow urban hospitals to include FTE residents training at CAHs in its FTE count

➢ Effective October 1, 2019

* “Non-provider” requirements found at: 42 CFR 413.78(g)
Available Section 5506 Resident Slots: Teaching Hospital Closure

Round 14: Good Samaritan Hospital – Dayton, OH

<table>
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<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)</th>
<th>Direct GME FTE resident cap (including +/- MMA sec. 422)</th>
</tr>
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<tr>
<td>360052</td>
<td>Good Samaritan Hospital</td>
<td>Dayton, OH</td>
<td>19380</td>
<td>July 23, 2018</td>
<td>55.60 + 7.00 sec. 422 increase = 62.60.(^1)</td>
<td>58.89 + 3.14 sec. 422 increase = 62.03.(^3)</td>
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\(^1\) Section 422 of the MMA, Public Law 108–173, redistributed unused IME and direct GME residency slots effective July 1, 2005.

\(^2\) Good Samaritan Hospital’s 1996 IME FTE resident cap is 55.60. Under section 422 of the MMA, the hospital received an increase of 7.00 to its IME FTE resident cap: 55.60 + 7.00 = 62.60.

\(^3\) Good Samaritan Hospital’s 1996 direct GME FTE resident cap is 58.89. Under section 422 of the MMA, the hospital received an increase of 3.14 to its direct GME FTE resident cap: 58.89 + 3.14 = 62.03.
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 Central Office **by July 22, 2019**.
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 14 due to the closure of Good Samaritan Hospital. If you have any questions, please contact me at [insert phone number] or [insert your email address].”
Section 5506 Application Criteria

Demonstrated Likelihood Criteria
- No room under cap but will establish new residency program
- No room under cap but will take over all or part of existing residency program; expand existing residency program
- Part of GME affiliated group agreement with the closed hospital

Level Priority
- Same or contiguous core-based statistical area (CBSA)
- Same state
- Same region
- Section 5503 (“Distribution of Additional Residency Positions”)

Ranking Criteria
- Eight criteria
- Addresses why the hospital is requesting the increase in FTE cap(s) (assuming the closed hospital, affiliated hospital, took in residents, etc.)
New Technology Add-on Payments
NTAP Applications for FY 2020

Discontinued: 3 technologies

➢ Defibrotide, Stelara®, ZINPLAVA™

Continued: 12 technologies

➢ KYMRIAH® and YESCARTA®

➢ Comment solicitation: Are KYMRIAH® and YESCARTA® substantially similar to each other?

Reviewed New Applications: 17 applications
Proposed Change to Calculation of NTAP

• Effective October 1, 2019, NTAP would be raised to the lesser of:
  1. 65% of the costs of the new technology, or
  2. 65% of the amount by which costs exceed the standard DRG payment

• CMS indicates current NTAP policy may not provide sufficient incentive for the use of new technology

• NTAP not budget neutral
Request for Information and Potential Revisions to the NTAP “Substantial Clinical Improvement” Criterion

Would apply to IPPS (NTAP) and OPPS (transitional pass-through payment policy)

Request for Information on the Substantial Clinical Improvement (SCI) Criterion

➢ Role of SCI in discouraging appropriate utilization?
➢ How to determine appropriate existing tech for comparison?
➢ Should CMS provide clarity on acceptable evidence for SCI?
➢ Instances where SCI can be inferred?
➢ Evidence based on off-label use acceptable?

Potential Revisions Adopted in Regulation or Subregulatory Guidance

➢ Broad adoption among patients and providers
➢ Different clinical outcomes from existing tech
➢ Real world evidence accepted
➢ Peer-reviewed journals not required as supporting information
➢ Beneficiary subsets used to demonstrate improvement
➢ FDA Pathway status not a bar to application
NTAP Pathway for Transformative New Devices

Applies to medical devices that are part of the FDA’s “Breakthrough Devices Program”

➢ Qualifying devices would be considered “new” and not “substantially similar” to existing technologies for NTAP applications under IPPS
➢ Would not need to demonstrate substantial clinical improvement over existing technologies (exempt from requirement at 42 CFR 412.87(b)(1))
➢ Still required to meet cost criterion (at 42 CFR 412.87(b)(3))

CMS requests comments on:

➢ Balancing benefits of beneficiary access to risks, such as adverse events
➢ Whether a “newness period” of 1 to 2 years would be sufficient before requiring demonstration of substantial clinical improvement for a 3rd year of NTAP

Effective FY 2021 and beyond
Chimeric Antigen Receptor T-Cell (CAR-T) Therapy
Chimeric Antigen Receptor (CAR) T-Cell Therapy

No modifications to current MS-DRG assignment for FY 2020

- MS-DRG 016 (Autologous Bone Marrow Transplant with CC/MCC or T-cell Immunotherapy)
- ICD-10-PCS codes – XW033C3 and XW043C3

FY 2020 Proposal: Increase NTAP to 65% -- $242,450
Comment Solicitation: CAR T-Cell Therapy

Payment alternatives for CAR T-cell therapies

- Impact on access to care and incentives that encourage lower drug prices

Creation of a new MS-DRG for CAR T-cell therapies

- Relative weight of a new MS-DRG
- Geographic payment adjustments
- Exclusion of add-on payments (e.g. IME, DSH)
- Specific cost-to-charge ratio (CCR)
Peripheral Extracorporeal Membrane Oxygenation (ECMO)
Peripheral Extracorporeal Membrane Oxygenation Proposal

In response to stakeholder feedback

➢ Reassign back to PRE-MDC MS-DRG 003 (ECMO or Tracheostomy with Mechanical Ventilation >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R. Procedure)

CMS maintains peripheral ECMO is not an O.R. procedure

➢ Central ECMO is considered an O.R. procedure
Severity Level and O.R. Procedure Codes
Changes to Severity Level Codes and Review of O.R./Non-O.R. Codes

Would change severity level designation codes for 1,492 ICD-10-CM diagnosis codes

➢ Result of comprehensive analysis of “complication or comorbidity” (CC) and “major complication or comorbidity” (MCC) codes

➢ Most would receive lower severity level codes

CMS plans a comprehensive review of O.R. and non-O.R. procedure codes

➢ Requests comments on what criteria should be used in designating a procedure as O.R.

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Quality & Promoting Interoperability Programs
FY 2020 IPPS Proposed Rule Key Takeaways

➢ Hospital Inpatient Quality Reporting (IQR) Program
  • Measure removals (1)
  • Measure additions (3)
  • Minor changes to eCQM reporting

➢ Medicare & Medicaid Promoting Interoperability Programs
  • Measure additions (2), removals (1), modifications (1)
  • Mirror changes to eCQM reporting for IQR
  • Lots of Requests for Information (RFIs)!

➢ Hospital Quality Performance Programs (HRRP, VBP, HACRP):
  • No measure or scoring methodology changes
  • Largely technical changes
Inpatient Quality Reporting Program
FY2020 IQR

Measure Areas:
- Chart-Abstracted Process Measures
- eCQMs
- HAIs
- Claims-Based Measures
- Patient Experience of Care

25% of FY2020 Market Basket Update: 0.8 percent

Measure performance periods vary across measures
IQR Proposals

- 3 New Measures
- 1 Measure Removal
- 3 *Potential* Future IQR Program Measures
- Confidential Reporting of Stratified Data for Hospital Quality Measures – *expanding to 5 additional measures*
- eCQM Reporting Requirements for FY2022 through FY2024 (CY2020 through CY2022 reporting)
Proposed New IQR Measures

➢ Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e)
  • Calculates the proportion of patients 18+ who are prescribed 2 or more opioids/1 opioid & benzodiazepine concurrently at discharge from a hospital-based encounter, including observation stays and ED.
  • Begin with FY2023 (CY2021 reporting)

➢ Hospital Harm – Opioid-Related Adverse Events eCQM (not NQF endorsed)
  • Proportion of patients with an opioid-related adverse event during an admission as indicated by the administration of naloxone.
  • Begin with FY2023 (CY2021 reporting)

➢ Hybrid Hospital-Wide Readmissions (NQF #2879)
  • Same as claims-based measure, plus used data from EHR for risk adjustment and hospital service adjustment
  • Voluntary reporting expanded 2 years; Mandatory reporting would begin with FY2026 (7/1/2023 - 6/30/2024 reporting)
Proposed Measure Removal

- Claims-based Hospital-Wide Readmissions
  - CMS Proposes removal effective FY2026, contingent on the adoption of the hybrid HWR measure
Potential Future IQR Measures

- **Hospital Harm – Severe Hypoglycemia eCQM** *(not NQF-endorsed)*
  - Measures proportion of patients who experience a low glucose test result of less than 40mg/dL within 24 hours of the administration of an antihyperglycemic agent

- **Hospital Harm – Pressure Injury eCQM** *(not NQF endorsed)*
  - Measures the rate at which new hospital-acquired pressure injuries occur during a hospitalization

- **Cesarean Birth (PC-02) eCQM** *(not NQF endorsed)*
  - Assesses the rate of nulliparous women (those who have never previously given birth) with a term singleton baby in a vertex position delivered by cesarean birth.
Confidential Reporting of Stratified Data

➢ Currently - CMS provides reports of PN Readmission measure using 2 disparity methods:
   • Within-hospital comparing readmission rates for dual eligible and other Medicare beneficiaries within a hospital, and
   • Across hospital comparing performance in care for dual eligible across hospitals

➢ Expand to include 5 additional measures in Spring 2020:
   ➢ AMI Readmissions
   ➢ CABG Readmissions
   ➢ COPD Readmissions
   ➢ HF Readmissions
   ➢ THA/TKA Readmissions
eCQM Reporting FY2022 through FY2024

- FY2022 (CY2020) and FY2023 (CY2021)
  - Continue current reporting requirement: one self-selected quarter for four self-selected eCQMs

- FY2024 (CY2022)
  - CMS Proposes to modify to one self-selected quarter for three self-selected eCQMs and one required eCQM (Safe Use of Opioids – Concurrent Prescribing)

- Continues the requirement that EHRs be certified to all available eCQMs used in the IQR Program
eCQMs in IQR – FY2022 (CY2020 Reporting)

**ED-2**  Admit Decision Time to ED Departure Time for Admitted Patients
**PC-05**  Exclusive Breast Milk Feeding
**STK-02**  Discharged on Antithrombotic Therapy
**STK-03**  Anticoagulation Therapy for Atrial Fibrillation/Flutter
**STK-05**  Antithrombotic Therapy by the End of Hospital Day Two
**STK-06**  Discharged on Statin Medication
**VTE-1**  VTE Prophylaxis
**VTE-2**  ICU VTE Prophylaxis

**Proposed for Additional Selection for FY2023 (CY2021 Reporting):**
Safe Use of Opioids & Opioid-Related Adverse Events
FY2020 Promoting Interoperability Program
aka Meaningful Use of CEHRT

Meaningful Use:
1. Report on ALL required measures across all four objectives, unless an exclusion applies*
2. Report “yes” on all required yes/no measures, unless an exclusion applies*
3. Attest to completing the actions included in the Security Risk Analysis measure*
4. Achieve a total score of at least 50 points
5. Report on eCQMs (same as IQR Program reqs)

*failure on this requirement results in a total score of 0

Four Objectives

E-Prescribing
(max. 15 points)

Health Information Exchange
(max. 40 points)

Provider to Patient Exchange
(max. 40 points)

Public Health & Clinical Data Exchange
(max. 10 points)

75% of FY2020 Market
Basket Update: 2.4 percent
Promoting Interoperability Programs Proposals

- 2 New Measures - **same as IQR Program**
- 1 Measure Removal and 1 Measure Modification
- eCQM Reporting Requirements for FY2022 through FY2024 (CY2020 through CY2022 reporting) – **same as IQR Program**
- RFIs:
  - Future Opioid Measures
  - National Quality Forum and CDC Opioid Quality Measures
  - Metric to Improve Efficiency of Providers within EHRs
  - Including Medicare Promoting Interoperability Program Data on *Hospital Compare*
  - Provider to Patient Exchange Objective
  - Integration of Patient-Generated Health Data into EHRs using CEHRT
  - Engaging in Activities that Promote Safety of the EHR
Proposed New Promoting Interoperability Program Measures

➢ Safe Use of Opioids – Concurrent Prescribing eCQM
➢ Hospital Harm – Opioid-Related Adverse Events eCQM
➢ CMS also seeks comment on whether to consider proposing the Hybrid Hospital-Wide Readmissions eCQM in future rulemaking for the Promoting Interoperability Program.
Proposed Measure Removal & Measure Modification

➢ Removal of the Verify Opioid Treatment Agreement measure
  • Remove beginning in CY2020
  • CMS proposes removal based on stakeholder feedback that measure presents significant implementation challenges, increased burden, and does not further interoperability

➢ Modifications to the Query of PDMP measure
  • Remain optional for CY2020 reporting (eligible for 5 bonus points)
  • Beginning with CY2019 reporting – change to a yes/no measure instead of a numerator/denominator measure
  • CMS proposes modifications due to unintended and unforeseen challenges with implementation and burden
eCQM Reporting FY2022 through FY2024

- FY2022 (CY2020) and FY2023 (CY2021)
  - Continue current reporting requirement: *one* self-selected *quarter* for *four* self-selected eCQMs

- FY2024 (CY2022)
  - CMS Proposes to modify to *one* self-selected *quarter* for *three* self-selected eCQMs and *one required eCQM* (Safe Use of Opioids – Concurrent Prescribing)

- Continues the requirement that EHRs be certified to all available eCQMs used in the IQR Program
Hospital Quality Performance Programs:

- Hospital Readmission Reduction Program (HRRP)
- Hospital Value-Based Purchasing (VBP) Program
- Hospital-Acquired Condition Reduction Program (HACRP)
Hospital Readmissions Reduction Program (HRRP)
Up to 3.0% of base DRG penalties for excess readmissions
no credit for improvement
payment penalties adjusted by SDS (peer grouping)

Hospital Value-Based Purchasing Program (VBP)
Up to 2.0% of base DRG rewards for good performance & penalties for poor performance
credit for improvement
no readmission measures & HAC measures included

Hospital -Acquired Conditions Reduction Program (HACRP)
1.0% of total payment automatic penalty for ¼ of hospitals deemed “worst” performers
no credit for improvement
HAC measures also in VBP
FY2020 HRRP

Measures:
- AMI Readmissions
- HF Readmissions
- PN Readmissions
- THA/TKA Readmissions
- COPD Readmissions
- CABG Readmissions

Penalty Assessed Across Peer Groups
Quintiles, based upon hospital’s proportion of Medicare/Medicaid dually-eligible patients

Measures Performance Period:
July 2015 – June 2018
HRRP Proposals

➢ Adopt the 8 factors used in the IQR, VBP, and other hospital quality reporting programs to determine whether a measure should be removed from the HRRP.

➢ Modify the definition of dual eligible beneficiary effective in FY21
  • “Dual-eligible is a patient beneficiary who has been identified as having full benefit status in both the Medicare and Medicaid programs in the State Medicare Modernization Act (MMA) files for the month the beneficiary was discharged from the hospital, except those patients who die in the month of discharge who will be identified using the previous month’s data sources from the State MMA files.”

➢ Create a subregulatory process for nonsubstantive changes to the payment adjustment factors
FY2020 VBP

MSPB

Efficiency & Cost Reduction

Clinical Outcomes

Patient Safety

Person & Community Engagement

Mortality: AMI, HF, PN
Complications: THA/TKA

CAUTI | CLABSI | C. diff
MRSA | PC-01 | SSI

HCAHPS

Measure performance periods vary across measures

Table 16 Proxy FY20 VBP Incentive Payment Adjustment Factors
VBP Proposals

➢ Adopt the same data to calculate the NHSN HAI measures for the VBP as CMS uses to calculate these measures for the HAC Reduction Program (HACRP)
  • This is the process CMS proposed and finalized in last year’s IPPS rule to address the removal of the NHSN HAI measures from the IQR effective with Jan. 1, 2020 data collection (FY2022 payment determinations) for the HACRP
FY2020 HACRP

Measures:
- PSI-90
- CAUTI
- CLABSI
- C diff
- MRSA
- SSI

Reminder! FY2020 is the first year under the Equal Measure Weights policy for calculating the Total HAC Score

PSI-90 Measure Performance Period: July 2016 – June 2018

NHSN HAI Measures Performance Period: January 2017 – December 2018
HACRP Proposals

➢ Adopt the 8 factors used in the IQR, VBP, and other hospital quality reporting programs to determine whether a measure should be removed from the HRRP.

➢ Establish data collection periods for FY2022
  • PSI-90: July 1, 2018 – June 30, 2020
  • NHSN Measures: January 1, 2019 – December 31, 2020

➢ Clarify data validation and data collection policies finalized in last year’s rule:
  • Modify the # of hospitals for targeted validation to “up to 200” hospitals instead of exactly 200 hospitals
  • Proposes a filtering method to better target “true events”
Informational Resources

❖ Past Comments to CMS
  - FY19 IPPS
  - FY18 IPPS
  - 2019 CMS Star Ratings Methodology

❖ Quality Measures Spreadsheet
  - Tracks measures implemented across hospital reporting and performance programs
  - Includes information on measure reporting baseline and performance periods
  - Available at: AAMC’s Hospital Payment and Quality Page
Questions?
# FY 2020 Proposed Rule References (Payment)

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