Centers for Medicare & Medicaid Services

Open Door Forum: Hospital Quality Initiative

Tuesday, April 18, 2023

2:00 pm ET

Coordinator: Welcome. Thank you everyone, for standing by. Participants are in a listen only mode until the question and answer session of today's event. At that time, you may press star 1 on your touchtone phone if you would care to ask a question. Today's conference is being recorded. If you have any objections, please disconnect now. And I'd like to turn the conference over to your host, Ms. Jill Darling. Thank you very much, ma'am. You may begin.

Jill Darling: Great. Thank you, (Fran). Good morning and good afternoon, everyone. Welcome to today's Hospital Quality Initiative Open Door Forum. I'm Jill Darling in the CMS Office of Communication. Welcome. We greatly apologize for the huge delay. You know, we do have a huge agenda for today, so trying to get many of our speakers on as well as all of you coming on to listen what we have going on today. So, I will just say my remarks, and then we'll pass it to our new chair, Joseph Brooks.

So, this open door forum is open to everyone. But if you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at Press@cms.hhs.gov and I'll hand it off to Joseph Brooks.

Joseph Brooks: Thanks, Jill. Hi everyone. And thank you for joining us today. I'll be brief as we have a pretty packed agenda. For those of you that don't know me, my

name is Joe Brooks, and I'm the new chairperson of the open door forum. I also work in the hospital and ambulatory policy group in the division of acute care. I would like to just take a quick moment to say thank you to Emily Forrest for her leadership as the previous chair of the hospital open door forum. Today we'll be covering two important Medicare payment rules for fiscal year 2024.

The IPPS/LTCH PPS proposed rule, and the inpatient psychiatric facility, IPF PPS proposed rule. We'll also try to reserve some time at the end to take questions on the issues presented today. So, without further ado, I'll turn it over to Michael Treitel, to get us started with the IPPS/LTCH PPS proposed rule. Michael?

Michael Treitel: Thanks, Joe. So, the first thing I'll be discussing is the proposed payment updates for the IPPS and long term care hospitals. So, for the IPPS hospitals, CMS is proposing in the FY 2024 proposed rule, to increase the operating payments by 2.8% for fiscal year 2024, for hospitals that successfully participate in the hospital inpatient quality reporting program, and are meaningful EHR users. The proposed 2.8% increase reflects a projected hospital market basket update of 3.0%, reduced by a 0.2% productivity adjustment.

CMS expects that the proposed increase in operating in capital payments will increase IPPS hospital payments by approximately $3.3 billion in fiscal year 2024. In addition, we also project that the Medicare dish payments and uncompensated care payments combined, will decrease by approximately $115 million. For the LTCH payment rates, for long-term care hospitals, CMS

is proposing to increase the standard federal payment upgrade by 2.9% for fiscal year 2024, which reflects a projected market basket update of 3.1%, reduced by a 0.2% productivity adjustment.

For fiscal year 2024 we also expect LTCH PPS payments to the standard payment rate cases to decrease approximately 2.5% or $59 million. The expected decrease is primarily due to projected significant reduction in high cost outlier payments. As required by law, CMS sets the outlier threshold for standard federal payment rate cases so that outlier payments are estimated to be 7.975% of total payments for the fiscal year. And for our stimulation, we show that the average cost for discharges for these cases have risen considerably in recent years.

We estimate that fiscal year 2023 outlier payments will be approximately 12.77% of total payments, which would exceed our target by 4.7%. So therefore, we are proposing a substantial increase in the outlier threshold to return estimated outlier payments to their required levels in fiscal year 2024. And we are seeking comment on the methodology used to determine that threshold. I'll turn it over now to my next topic, which is the IPPS wage index. And I'll be discussing two proposals associated with the wage index for IPPS hospitals.

The first proposal is related to a proposed change in methodology for determining the wage index of rural hospitals and the equivalent wage index which sets the rural floor for urban hospitals. Due to relevant court decisions, we are proposing to interpret Section 1886 (d) (8) (E), instructing CMS to treat reclassified hospitals the same as geographically rural hospitals for

purposes of calculating the wage index. And beginning in 2024, we are going to include the data of all 412.103 urban to rural reclassification hospitals in the calculation of the rural wage index, which will set the rural floor as well. In the past, this policy only included those hospitals who had a 412.103 class with no other reclassification. But now this policy will include hospitals that have a dual re-class as well.

The second proposal is to continue the low wage index policy which was first adopted in fiscal year 2020. Under this policy, we increase the wage index for hospitals with a wage index value below the 25th percentile wage index value. This policy increases these wage values by half the difference between our otherwise applicable wage index value and the 25th percentile wage index value. Since there is a 4-year lag in the wage data, and we only have one year of wage data from fiscal year 2020 to evaluate the impact of this policy. Therefore, we are proposing to continue this policy and wait until we have additional data for additional fiscal years, in order to evaluate this policy further. Therefore, we are proposing to continue to apply this low wage policy for fiscal year 2024 in the proposed rule. We may decide to take a different approach in the final rule, depending on public comments or the developments in pending litigation.

One other note with regard to the wage index; what I just spoke about was the proposals in the FY 2024 proposed rule, but now I would like to discuss the wage index timeline and the cost report data that's used to compute the FY 2024 wage index. April 28, 2023 is going to be the posting of the latest public use file for hospitals to check the most recent wage data CMS has available for use in the final rule. The files will be available, as they always are, on the internet. Hospitals should review the PUF for identifying any potential data

entry or transmission errors made by CMS, or the MAC. This is not for the initiation of a new revision request. So, hospitals should look for that file that will be posted at the end of the month, on April 28th. And hospitals will have until May 26, 2023 to send any requests for corrections to their MAC. All information is, as always, in the wage index timeline that is posted on the internet. I think that's all my topics for today. And I'll turn it back to Joe.

Joseph Brooks: Thank you, Michael. And I believe the REH GME proposal topic is next, with (Renate Dombrowski).

(Renate Dombrowski): Hi. Good afternoon. I'm going to be discussing the REH GME proposal. This proposal has to do with how Medicare may pay for physician residency training at rural emergency hospitals or REHs. In response to the proposed rule for the new provider type rural emergency hospitals, or REHs, CMS received the request to treat REHs similar to critical access hospitals for graduate medical education payment purposes.

Consistent with this request and to support the flexibility for training residents in rural areas, we are proposing to treat REHs similar to critical access hospitals for graduate medical education payment purposes. We are proposing, effective October 1, 2023, an REH can function as a non-provider site, in which case a hospital can send residents to train at an REH and be paid GME payments for those residents, if the hospital pays the residents' salaries and benefits, or the REH can choose to receive payments at 100% of reasonable costs, for the direct costs incurred in training those residents.

I'm now going to pass it on to Michael, to discuss the safety net hospital RFI.

Michael Treitel: Thank you, (Renate). The proposed rule contains a request for information in which we solicit a broad range of public feedback on the nature of, and the challenges faced, by safety net hospitals. As we observe in the rule, there is currently a lack of consensus about how safety net hospitals should be defined, but it is generally agreed that safety net hospitals furnish a substantial share of services to low income and uninsured patients.

As such, safety net hospitals play a crucial role in the advancement of health equity, by making essential services available to these and other populations that face barriers to accessing healthcare. However, because they serve a greater share of low income and uninsured patients, safety net hospitals may also experience greater financial challenges compared to other providers. We note that the financial position of safety net hospitals is one of the topics discussed by MedPAC in its recent reports to the Congress.

MedPAC observes that safety net hospitals may have trouble competing with other providers for resources and technology, and are also at higher risk for closure. MedPAC also discusses a safety net index, which is a metric that it has developed for the purpose of identifying safety net hospitals. In the proposed rule CMS seeks public feedback on the unique challenges faced by safety net hospitals, and potential approaches to help these hospitals meet their challenges.

Finally, we also seek input on whether MedPAC's safety net index, or some other metric, would be appropriate to use for the purpose of identifying safety

net hospitals. I will now turn it over to Adina Hersko, to discuss new technology.

Adina Hersko: Thank you. In order to increase transparency, facilitate public input, and improve the review process, we're proposing modifications to the eligibility requirements for NTAP applications, that applicants must have already submitted an FDA market authorization request before submitting an application for new technology add-on payments, in order to be eligible for consideration for NTAP. For these purposes, this would mean that for technologies that are not already FDA market authorized, applicants have a complete and active FDA market authorization request at the time of new technology add-on payment application submission.

Applicants also would be providing documentation of FDA acceptance or filing to CMS at the time of application submission. We believe these changes would significantly improve our ability to evaluate whether a technology is eligible for new technology add-on payments.

In addition, we're proposing a modification to the deadline by which technologies must receive FDA approval or clearance in order to be eligible for consideration for NTAP from July 1, the current deadline, to May 1 of the year prior to the beginning of the fiscal year for which the application is being considered, except for applications submitted under certain alternative pathways.
This is due to increased complexity and volume of applications in recent years. We believe this May deadline will strike a balance between providing adequate time to fully evaluate applications, while also continuing to preserve

flexibility for manufacturers. I'll now turn it over to Marge Watchorn, to talk about social determinants of health. Thank you.

Marge Watchorn: Thank you, Adina. Today I wanted to talk about social determinants of health diagnosis codes. As you know, IPPS payment is made based on the use of hospital resources in the treatment of a patient's severity of illness, complexity of service, and/or consumption of resources. Generally, a higher severity level designation of a diagnosis code, results in a higher payment, reflect the increased hospital resource use.

After review of our data analysis of the impact on resource use generated using claims data, CMS is proposing to change the severity designation of the three ICD-10 CM diagnosis codes describing homelessness, from noncomplication or comorbidity, or non-CC, to complication or comorbidity, CC, based on the higher average resource costs of cases with disease diagnosis codes compared to similar cases without these codes. And now I'll turn it over to Meredith Larson, to speak about physician-owned hospitals.

Meredith Larson: Thank you. As Marge said, I will be discussing proposals related to physician-owned hospitals under the physician self-referral law. And as a reminder, the physician self-referral law prohibits a physician from making a referral for certain designated health services to an entity with which the physician or an immediate family member of the physician, has a financial relationship.

In addition, the entity is prohibited from billing Medicare or any other party for designated health services that it furnishes pursuant to a prohibited referral. For a hospital to submit claims and receive Medicare payment for

services referred by a physician owner or investor, or a physician whose family member is an owner or investor, a hospital must satisfy all of the requirements of either the whole hospital exception or the rural provider exception to the physician self-referral law.

To use the rural provider or whole hospital exception, a hospital may not increase the aggregate number of operating rooms, procedure rooms, and beds above that for which the hospital was licensed on March 23, 2010, or in the case of a hospital that did not have a provider agreement in effect as of March 23, 2010, but did have a provider agreement in effect on December 31, 2010, the effective date of such agreement, unless CMS has granted an exception to the prohibition on expansion.

A hospital may request an exception to the prohibition on expansion of facility capacity using the process established in the Calendar Year 2012 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System final rule. In the 2024 IPPS/LTCH PPS proposed rule, CMS is proposing to revise the regulations to clarify that CMS will only consider expansion exception requests from eligible hospitals, clarify the data and information that must be included in an expansion request, identify factors that CMS will consider when making a decision on an expansion request, and revise certain aspects of the process for requesting an expansion exception.

In addition, CMS is proposing to reinstate, with respect to hospitals that meet the criteria for high Medicaid facilities, program integrity restrictions on the frequency of expansion exception requests, maximum aggregate expansion of a hospital, and location of expansion facility capacity that were removed in

the calendar year 2021 OPPS ASC final rule. And with that, I will pass it to John Green.

John Green: Thank you. I will start first today with a cross program proposal for quality updates for the IQR program, TCHQR program, and LTCHQRP. We are proposing to modify the existing COVID-19 vaccination among healthcare personnel measure, to reflect the CDCs definition of up to date, to accommodate the latest guidance on booster doses. Moving now to the hospital IQR program proposals, as a reminder, the hospital IQR program is a pay for reporting program for acute care hospitals. We are proposing to adopt three measures, modify three measures, and remove three measures.

Starting first with new measure adoptions, all three proposals here are patient safety related electronic clinical quality measures that we're proposing to begin collecting in the calendar year 2025 reporting period. The first two are hospital harm-related measures. The first is hospital harm pressure injury. This measures the proportion of inpatient hospitalizations for patients 18 and over, who develop a new stage 2, stage 3, stage 4 deep tissue or unstageable pressure injury.

The next measure is hospital harm acute kidney injury. This measures the proportion of inpatient hospitalizations for patients 18 and older, who have an acute kidney injury that occurs during the encounter as evidenced by a substantial increase in serum care and team value, or by the initiation of kidney dialysis. The third new measure is the excessive radiation dose or inadequate image quality for diagnostic CTs, ECQM. This measure will provide a standardized method for monitoring the performance of diagnostic

CT, discourage unnecessarily high radiation doses while preserving image quality.

This measure is the percentage of eligible CT exams that are out of range based on having either excessive radiation, dose, or inadequate image quality relative to evidence-based thresholds based on the clinical indication for the exam, while diagnostic CT exams of specified anatomic sites performed in an inpatient hospital care setting are eligible. There are three measure modifications. The first, as I mentioned, is the update to the COVID-19 healthcare personnel vaccination measure, to include boosters recommended by the CDC.

There are two other measure modifications in hospital IQR. These are the hybrid hospital library admissions and hybrid hospital wide mortality measures. We are proposing to add Medicare Advantage patients to the population. In hospital IQR we are removing three measures or proposing to remove three measures - PCO-1, which is elective delivery before 39 weeks. We are proposing to remove this measure because it's been topped out for six years. We previously had not proposed this measure for removal because it did not have other - we did not have other maternal health related measures.

But since we have finalized two new ECQMs last year for severe obstetric complications and C-sections, we feel that it is appropriate to remove PCO-1 at this time. The next two removals - Medicare spending per beneficiary and hospital level risk standardized complication rate following elective primary total hip anthroplasty and or total knee anthroplasty, are related to replacing older versions of these measures in HVBP.

As a reminder, each hospital VBP has a statutory requirement to publicly report measures for a year in IQR, before being able to move into HVBP. So, whenever we want to modify an HVBP measure, we have to put the updated version in IQR first. These measures have been reported for the required amount of time, and we are proposing to move them in HVBP. Lastly, I want to mention an administrative proposal in hospital IQR related to the HCAP survey measure.

We are proposing some changes to the form and the manner in which we collect the HCAPs measure; not any changes to the measure itself. Those changes include adding three new Web first modes of survey implementation, extending the resource period, allowing patient proxies to fill out the survey, and requiring that the official Spanish language HCAP survey be used for patients whose preferred language is Spanish. I'd now like to hand it over to my colleague, (Ora).

(Ora Dawedeit): Thanks, John. I will be giving you information about the PPS exempt cancer hospital program, also known as PCHQR. As John stated, we will also have the COVID-19 update in PCHQR, as well as the HCAPS survey measure update, as John just stated. For PCHQR specifically, we will begin public display of the surgical treatment complications for localized prostate cancer measure. We will also be adding four new measures for the PCHQR program - facility commitment to health equity, screening for social drivers of health, screen positive rate for social drivers of health, and documentation of goals of care discussions among cancer patients.

These will all begin in fiscal year 2026 program year. And at this time, I think I'm passing it over to (Ariel) or (Lorraine).

Ariel Cress: Yes. Thank you, (Aura). For the fiscal year rule for the LTCH QRP, we will be proposing the addition of two new measures - one measure update, two measure removals, one administrative and one public reporting policy. The first measure is the COVID-19 vaccine percent of patients/residents who are up-to-date measure, which is calculated using a raw rate for the number of patients who are up-to-date with the COVID-19 vaccination within a facility.

The second measure is the cross-setting function discharge measure, which is a cross setting function outcome measure that assesses functional status by looking at the percentage of patients who meet or exceed an expected discharge function score. Our proposed measure update is the modification to the COVID-19 vaccination coverage among healthcare personnel measure, which was previously mentioned by John.

Our proposed measure removals are the application of the percent of LTCH patients with an admission and discharge function assessment and a care plan that address function and the percent of LTCH patients with an admission and discharge function assessment, and a care plan that addresses function. Additionally, we are proposing to increase the LTCH QRP data completion threshold from 80% to 90%. And we are proposing to publicly report the transfer of health information to the provider measure and to the patient measure, which began data collection October 1, 2022.

Finally, we have included a request for information on future measure concepts and a brief health equity update for the LTCH QRP. And with that, I'll hand it back over to John.

John Green: Thank you. I would now like to discuss the hospital value based purchasing program proposals. We are proposing a scoring methodology change in HVBP to reward hospitals who both care for a large proportion of patients who are duly eligible, but that also perform well on our existing quality measures. We propose to do this by adding bonus points to hospital total performance scores. The amount of points would be calculated by multiplying the hospital's proportion of patients that are duly eligible, and hospitals performance across all patients on the existing HVBP measures.

All hospitals would be eligible get points. The amount of bonus points available scales up as the proportion of patients that are duly eligible increases as performance on quality measures increases. We are proposing to start with dual eligibility, but also include an RFI component that seeks comment on potentially using other variables, such as area deprivation index, and receipt of low income subsidies, to further the goal of health equity.

Moving to measure updates in hospital VBP - first, as I alluded to during the IQR session, we are proposing to move two modified measures into HVBP as an update to the existing program measures. These are Medicare spending preventive per beneficiary. And as a reminder, the changes include allowing readmissions to trigger episodes and minor changes to the risk adjustment methodology. This change would begin in the fiscal year 2028 program year.

There's also the THA/TKA complication rate measure, which - and the modifications include adding 26 new codes than mechanical complications list, and risk adjustment calculations. This change would take effect starting in the fiscal year 2030 program year. The third measure update is adopting the severe sepsis and septic shock as a new measure under the hospital safety domain, starting in the fiscal year 2026 program year. This measure is currently in IQR, but we believe moving into the HVBP program, creates a stronger incentive for continued improvement in this important area.

And with that, I would like to - we'd now like to move to the IPF PPS proposed rule. And I'll hand things over to (Marissa).

(Marissa Kellam): Thank you, John. Today I will be discussing the proposed updates to the IPF payment rates. The total estimated payments to IPF are estimated to increase by 1.9% or $55 million in FY 2024, which are relative to the IPF payments in FY 2023. For FY 2024, CMS is proposing to update the IPF PPS payment rates, by 3%. This is based on the proposed market basket increase of 3.2%, reduced by 0.2 percentage points for the productivity adjustment.

Additionally, CMS is proposing to update the outlier threshold so that the estimated outlier payments remain at 2% of total payments. CMS estimates that this would result in a 1% decrease to aggregate payments due to updating the outlier threshold. I will now turn it over to Nick Brock to discuss the IPF PPS market basket and excluded psychiatric units.

Nick Brock: Thanks, (Marissa). All right. So, the first issue I'll talk about is the proposal to rebase and revise the IPF PPS market basket. For this fiscal year 2024 IPF

rule, we're proposing to rebase and revise the IPF market basket to reflect a 2021 base year. The current IPF market basket reflects a 2016 base year. About 80% of the proposed 2021 based IPF market basket cost rates are derived from Medicare cost report data from both freestanding and hospital based IPFs.

The proposed FY 2024 market basket increase using the 2021 based market basket, is currently forecasted to be the same as the market basket increase using the 2016 based market basket. And that update is 3.2% as Marissa just said. We are also proposing that if more recent data become available after the publication of the proposed rule and before the publication of the final rule, for example, a more recent estimate of market basket increase factors or the productivity adjustment, then we would use such data as appropriate, to determine the FY 2024 market basket update and the final rule.

In addition, we're proposing to determine the labor related share based on the proposed 2021 based IPF market basket. This will result in a proposed labor related share of 78.5%, which is about one percentage point higher than the FY 2023 labor related share, which was based on the 2016 based market basket. And that was 77.4%. The increase in the labor related share is due to an increase in the compensation cost weight, specifically the contract labor cost weight, which was derived using the Medicare cost support data.

Next, I will discuss the proposal regarding changes to the status of excluded psychiatric units during the cost reporting period. In response to increased mental health needs, including the need for availability of inpatient psychiatric beds, CMS is proposing changes to the regulations to allow greater flexibility

for hospitals to open and bill Medicare for new inpatient psychiatric distinct part units. Beginning in fiscal year 2024, CMS is proposing to amend the regulations at 412.25(c) to allow hospitals to open a new IPF unit at any time during the cost reporting period.

This proposal would allow a hospital unit to start being paid under the IPF PPS, as long as 30-day advanced notice is provided to the CMS regional office and Medicare Administrative Contractor. CMS believes this proposal would alleviate unnecessary burden and administrative complexity placed upon hospitals when opening new psychiatric units, helping to expand access to behavioral healthcare in line with the CMS behavioral healthcare strategy.

Now I'll pass it over to David Pope to discuss the IPF PPS data collection, and revisions required by the Consolidated Appropriations Act.

David Pope: Thank you, Nick. As part of ongoing work to refine the IPF PPS, CMS has continued to analyze more recent IPF costs and claim information. In the fiscal year 2023 IPF PPS proposed rule, CMS issued a technical report and sought comments on the results of the latest refinement analysis. New provisions in the CAA 2023, require CMS to revise payments under the IPF PPS for rate year 2025, which under the IPF PPS, is fiscal year 2025. Accordingly, CMS is including a request for information that will be used to inform future payment revisions.

CMS currently collects data through claims and cost report submissions that include ICD-10 CM codes that indicate the required intensity of behavioral monitoring. We collect relevant demographic information, such as patient age.

IPS and psychiatric units report ICD-10 PCS codes on claims, for interventions, including oncology treatment procedures and electroconvulsive therapy. This RFI would allow us to gain feedback from the public about what data and information can be collected through administrative claims and cost report data, and what additional data collection we could consider undertaking for future refinements.

I will now pass it on Lauren Lowenstein-Turner, for IPF quality reporting program proposals.

Lauren Lowenstein-Turner: Thank you, David. The IPF QR program is a pay for reporting program, and there are currently 14 measures in the program. We are proposing to adopt four new measures. First, CMS is proposing to adopt three measures related to health equity. They are the facility commitment to health equity measure, the screening for social drivers of health measure, and the screen positive rate for social drivers of health measure.

Next, CMS is proposing to add a patient experience of care measure to the IPFQR program. The psychiatric inpatient experience survey measure calculates patient experience of care for patients in IPFs across four domains. We are also proposing to modify the COVID-19 vaccination coverage among healthcare personnel measure, which is already in the program. This is the same measure and modification that John Green just described.

And next, we are proposing to remove two measures. The first measure proposed for removal is the patients discharged on multiple antipsychotic medications with appropriate justification measure for (unintelligible),

because the measure no longer aligns with current clinical guidelines. The second measure proposed for removal, is the tobacco use brief intervention provided or offered measure (unintelligible) 2, 2A, because it is duplicative of the tobacco use treatment provided or offered at discharge measure, which will remain in the program, and which similarly measures tobacco cessation interventions provided by IPFs.

That covers all of IPF QRs planned measure updates. We do have one administrative proposal to adopt a data validation pilot program. And because it is a pilot program, there would be no penalties for IPFs that participate in this program. I will now turn the call back to Jill Darling.

Jill Darling: Thanks, Lauren. And thank you to everyone for speaking today. That concludes today's presentation. And (Fran), will you please open the lines for Q&A?

Coordinator: Thank you, Ms. Darling. If you'd like to ask a question, please press star 1. Please take a moment to unmute your phone and record your name clearly when prompted. Your name is needed to introduce your question. So again, please press star 1, and you will be announced by name. Just one moment, please. Presently, I have nothing in queue.

Jill Darling: Okay. I think maybe just give it maybe like 30 more seconds just in case anyone does. And as we wait, I'll just let folks know, you can always send questions and comments into the Hospital Open Door Forum email, which is Hospital_ODF@cms.hhs.gov. And it is always listed on the agenda. And (Fran), do we have any questions?

Coordinator: No. We have no questions in queue.

Jill Darling: All right. Again, everyone, thank you for joining us. A lot of great information. Thank you to all of our speakers. Thank you to Joe Brooks, our new Chair. And you will get some time back to your day. We appreciate you taking the time out to join us. Until next time, everyone, thank you so much.

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