Centers for Medicare & Medicaid Services

Open Door Forum: Hospital/Quality Initiative

August 31, 2021

2:00 pm ET

Coordinator: Welcome, and thank you for standing by. At this time, all participants are in a listen-only mode until the question-and-answer session of today's conference. At that time, you may press Star 1 on your phone to ask a question. I would like to inform all parties that today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the conference over to Jill Darling. Thank you. You may begin.

Jill Darling: Great. Thank you, (Courtney). Good morning, and good afternoon, everyone. I'm Jill Darling, in the CMS Office of Communications, and welcome to today's Hospital Quality Initiative Open Door Forum. Before we get into the agenda items today, I have one brief announcement.

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 now, I would like to hand the call off to Emily Forrest.

Emily Forrest: Thanks, Jill, and thanks, everyone, for joining us today. We have a full agenda. We'll be providing an overview of the final policies in the fiscal year 2022 IPPS and LTCH PPS final rule, along with an update regarding PAMA

reporting for hospital labs. I'm just going to ask that each speaker state the topic that you're briefing on prior to going into your remarks, because we do have several topics to cover today.

I also wanted to flag, in regards to the proposals that were included in the IPPS/LTCH PPS proposed rule, but were not addressed in the final rule, I wanted to highlight that due to the nature and number of comments received, specifically on implementation of Sections 126, 127, and 131, of the Consolidated Appropriations Act, those were related to payments to hospitals for direct graduate medical education, and also indirect medical education costs, along with proposals related to disproportionate share hospital payments, and organ acquisition costs, that those will be addressed, and those public comments associated with those issues will be addressed in future rulemaking.

So, did want to flag that before the onset of the call.

Just also want to thank those of you who have participated in our previous weekly COVID officer hour calls over the last couple of months. We've transitioned those calls from - those weekly calls to now taking COVID-related questions in these open door forums, including this one.

So, as I mentioned, we do have a full agenda, but we'll reserve some time at the end to take some questions, along with those COVID questions. So, without further ado, I will pass off to Sarah Harding to talk about the PAMA reporting for hospital labs.

Sarah Harding: Thank you so much. Good afternoon. My name is Sarah Harding, and I work with the division that is responsible for collecting data under the Protecting Access to Medicare Act. We are entering our second reporting period from laboratories.

This includes laboratories that bill Medicare Part B either under their own MPI, or for hospital outreach laboratories that bill Medicare Part B using the Type of Bill 14x. This is important because this data reporting period is beginning January 1st, 2022, and will last until the end of March 2022.

Laboratories that meet the definition of an applicable laboratory, will be required to submit their data to CMS. This is data that they would have collected during 2019. All of the resources, definition, information that is relevant to this, I don't want to spend the time on the call today, but if you have questions about whether your laboratory meets the definition of applicable laboratory, what information needs to be reported, where you report it, the easiest thing to do is to go to CMS.gov, and in the search feature, search PAMA, P-A-M-A. This will bring you to our PAMA regulations page.

This information has any of the updates that have been made since the last time we collected data, which was back in 2017 and 2018. It has the information of what is to be collected, where to report it. We do have a dedicated data reporting system that labs should be registered for.

That is something that you can be doing this fall to register with a username and password, so that you will be able to enter the data, as well as, as I mentioned, all the necessary definitions and information on whether your lab

needs to report. There are also email addresses where you may submit your questions, depending on what they are, whether they're system-related or policy-related.

So, once again, the main point is that this data reporting period is coming up beginning January 1st, 2022, and will run until March 31, 2022. So, thank you very much. I'm happy to take questions at the end of the call or by email. Again, my name is Sarah Harding. But for right now I will pass the call to Jim Mildenberger. Thank you very much.

Jim Mildenberger: Good afternoon. So, I'm Jim Mildenberger, and I'll be presenting a few different topics from the fiscal year 2022 IPPS and LTCH PPS final rule. The first topic I'll be discussing is the payment updates for IPPS hospitals. In this rule, we finalized our proposal to set IPPS payment rates for fiscal year 2022, using data from prior to the COVID-19 PHE.

For 2022, ordinarily, we would use data from 2020 to approximate inpatient utilization in 2022. However, the 2020 data reflected shifts in inpatient utilization that were driven by the COVID-19 PHE. And therefore, we finalized our proposals used 2019 data to approximate utilization when determining rates for 2022.

As for the rates, the increase in operating payment rates for hospitals paid under the IPPS that successfully participate in the hospital inpatient quality reporting program, and are meaningful electronic health record users, is approximately 2.5%. This reflects the projected hospital market basket update

of 2.7%, reduced by a 0.7 percentage point productivity adjustment, an increase by a 0.5%point adjustment required by legislation.

Before taking into account Medicare additional uncompensated care payments, the increase in hospital payments for fiscal year 2022 due to increases in the operating payment rates, capital, and new medical technologies payment, and other changes, is 3.7 billion or 3.1%.

We project Medicare additional uncompensated care payments to decrease in fiscal year 2022 by approximately 1.4 billion. Overall, CMS estimates hospital payments will increase by 2.3 billion. Under this final rule, CMS will distribute roughly $7.2 billion in uncompensated care payments for fiscal year 2022, which is a decrease of approximately 1.1 billion from fiscal year 2021. CMS will a single year of data on uncompensated care costs from hospitals' fiscal year 2018 cost reports to distribute these funds.

The next topic I'll be discussing is the payment update for long-term care hospitals. Similar to the IPPS, we primarily use data from fiscal year 2019 to determine the LTCH rates for fiscal year 2022. As was the case for IPPS hospitals, we found that LTCH utilization patterns were meaningfully impacted by the COVID-19 PHE in 2020, and believe that data from 2019 will be a better approximation of 2022 utilization.

We apply the 1.9% annual update to the LTCH PPS standard federal payment rate. This is based on our current estimate of the fiscal year 2022 LTCH market basket increase for inflation of 2.6%, and a 0.7 percentage point adjustment for productivity. We are estimating that overall LTCH PSS

payments in fiscal year 2022, would increase by approximately 1.1% or approximately $42 million.

This estimated change reflects an estimated increase in payments to LTCH PPS standard federal payment rate cases of approximately $31 million, an estimated increase in payments to LTCH site-neutral payment rate cases of approximately $11 million.

I'll lastly be discussing two policies related to the IPPS wage index that were implemented in this final rule, the first of which is the permanent reinstatement of the imputed floor for all urban States, as required by Section 9831 of the American Rescue Plan Act. The imputed floor sets the minimum wage index amount for hospitals in all urban states.

Section 9831 of the act also defines all urban states and exempts the resulting higher payments resulting from the imputed floor from budget neutrality under the IPPS. Both the original and alternative methodologies for calculating an imputed floor that were in effect in 2018 before CMS ended the imputed floor, were reinstated permanently.

Based on final rule data for fiscal year 2022, the all-urban states of New Jersey, Rhode Island, Delaware, Connecticut, and the District of Columbia, are eligible to receive an increase in their wage index due to application of the imputed floor. CMS estimates that this provision will increase fiscal year 2022 Medicare payments to hospitals located in those states by approximately $0.2 billion.

The second wage index policy I'll be discussing is the extension of the fiscal year 2021 wage index transition policy. In 2021, in conjunction with our adoption of the OMB delineations and OMB bulletin 1804, we adopted a policy to place a 5% cap for fiscal year 2021 on any decrease in hospitals wage index from 2020.

After consideration of public comments, we are applying an extended transition to the fiscal year 2022 wage index for IPPS hospitals. Specifically, for IPPS hospitals that received the transition in fiscal year 2021, we are continuing a wage index transition for fiscal year 2022, under which a 5% cap on any decrease in the hospital's wage index, compared to its wage index for fiscal year 2021, will be applied to mitigate significant negative impacts of the CMS decision to adopt the revised OMB delineations in OMB bulletin 1804.

So, now, I'll turn it over to Emily Forrest, who will discuss the repeal of the market-based DRG data collection policy. Thank you.

Emily Forrest: Thanks, Jim. And yes, I will be talking about the repeal of the market-based MS-DRG relative weight policy. As you may recall, in the proposed rule, we proposed to repeal the requirement that hospitals report to CMS market-based data that a hospital negotiated with its Medicare Advantage organizations for each MS-DRG for cost reporting periods ending on or after January 1 of 2021.

We also proposed to repeal the market-based MS-DRG relative weight methodology, which would use that market-based data to establish hospital payments effective for payments beginning in fiscal year 2024. In this year's

rule, we finalized these proposals, and we are and we have repealed both the requirement that a hospital report on the Medicare cost report of this data, and the market-based MS-DRG relative weight methodology.

As such, we will continue using the existing cost-based methodology for calculating the MS-DRG relative weight to set Medicare payments for inpatient stays for 2024 and in subsequent fiscal years. I wanted to note that had hospitals been required to comply with this data collection requirement, that it would have resulted in approximately 64,000 hours of administrative burden.

The repeal of these policies does not delete CMS's commitment to hospital price transparency. And I also want to flag that repealing this market-based policy, does not in any way remove the requirement CMS has previously finalized under the hospital price transparency final rule, or the transparency in coverage final rule.

To repeat, hospitals are still required to comply with the hospital price transparency requirements, regardless of this market-based policy. So, with that, I will turn it over to Heather for the Medicare Shared Savings Program changes.

Heather Grimsley: Thanks, Emily. This is Heather Grimsley. The Medicare Shared Savings Program has a basic track participation arrangement, which includes a glide path that allows ACOs to participate under progressively increasing levels of risk. ACOs have indicated that they modify their care coordination strategies

in response to the public health emergency, and requested relief from taking on additional risk while under the public health emergency.

So, we finalized the policy, which allows ACOs participating under a glide path agreement to elect to freeze their level of participation in the Medicare Shared Savings Program for performance year 2022. And then for the following year, which would be performance year 2023, an ACO that elected to freeze, will participate at the level of the basic track glide path that they would have participated under, absent the election to freeze. I'm going to now turn it over to Grace Snyder, to talk about Medicare Promoting Interoperability Program update.

Grace Snyder: Thanks very much, Heather, and good afternoon. This is Grace Snyder, and I'll be providing an update on the Medicare Promoting Interoperability Program for eligible hospitals and critical access hospitals. So, in this final rule, we made finalized several updates to the program.

First of all, we finalized to continue the EHR reporting period of a minimum of any continuous 90 days for new and returning eligible hospitals and critical access hospitals for calendar year 2023, and also to increase the EHR reporting period to a minimum of any continuous 180-day period for hospitals, beginning with calendar year 2024.

We also finalized maintaining the electronic prescribing objectives query of prescription drug monitoring program measure as an optional measure, and increasing the available bonus points from five points to 10 points. We have also added a new health information exchange bidirectional exchange measure

as a yes or no attestation, beginning with the calendar year 2022 reporting period. And also, for this objective, that the two existing measures are an alternative to reporting the measure.

We have also updated the measures for the Public Health and Clinical Data Exchange objective to require a yes response for four of the existing measures, syndromic surveillance reporting measure, immunization registry reporting measure, electronic case reporting measure, and the electronic reportable laboratory result reporting measure. And the other two measures in this objective remain available for additional bonus points.

We have also adopted a new measure for the attestation of an annual assessment of all nine guides in the SAFER Guides measure, and this is under the Protect Patient Health Information objective. The SAFER Guides were established by the Office of the National Coordinator for Health IT, and identifies recommended practices to optimize the safety and safe use of EHRs.

We have also finalized removal of attestation statements two and three from the program's prevention of information blocking attestation requirements to help reduce stakeholder confusion. And we have finalized the increase in the minimum required scoring threshold for the program from 50 points to 60 points to be considered a meaningful EHR user.

Additionally, we have adopted two new electronic clinical quality measures for the program, and also finalized the removal of three existing electronic clinical quality measures from the program. All right. And then now, I will turn to updates for the hospital quality programs that are also in the final rule.

So, first of all, for acute care hospitals, PPS-exempt cancer hospitals, and also long-term care hospitals, we have finalized the adoption of the COVID-19 vaccination coverage among healthcare personnel measure. And reporting on that measure would start with the fourth quarter 2021 reporting period, with an initial submission deadline in May of 2022, and for the measure to be reported to the CDC's National Health Care Safety Network, which is a web-based surveillance system for quarterly data reporting deadlines.

Also, due to the significant impact of the COVID-19 public health emergency on - impacting performance on the quality measures, and the impact of that performance on the hospital pay-for-performance programs, we have finalized the measure suppression policy. And how that policy applies specifically to each of the performance programs is as follows.

So, for the hospital readmissions reduction program, we are suppressing the pneumonia readmission measure for the fiscal year 2023 payment adjustments. And for the other readmission measures that are used in the program, we are removing the COVID-19 diagnoses from the measured calculations.

For the hospital-acquired condition reduction program, we're suppressing the use of 2020 data in calculation of measure performance and scoring, in order to reduce the impacts of the COVID-19 Public Health Emergency.

And for the Hospital Value-Based Purchasing Program, because so many measures in that program would need to be suppressed because of impacts of

COVID-19, we have also finalized a special scoring policy for fiscal year 2022 payment adjustments, so that no hospital would be receiving a total performance score, or a positive or negative payment adjustment.

Instead, each hospital in the program would be receiving a - would have a net neutral payment adjustment, meaning there would be essentially a 2% withhold as required by the statute for then to have the full 2% return. So, for again, a net neutral adjustment.

And then finally, there are some additional measures, new measures that we have adopted for the inpatient quality reporting program for hospitals, in addition to the COVID-19 vaccination measure. And these measures, first of all, there's a maternal and morbidity structural measure that will assess hospital participation in a statewide or national perinatal quality improvement initiative.

Also, we are adopting a hospital-wide mortality measure, and then two electronic clinical quality measures, one that focuses on severe hypoglycemia, and a complementary measure that focuses on severe hypoglycemia. So, that concludes my updates and thank you. I will turn it back over to Jill.

Jill Darling: Thanks, Grace, and thank you to all of our other speakers. (Courtney), will you please open the lines for Q&A?

Coordinator: Thank you. We will now begin the question-and-answer session. If you would like to ask a question, please press Star 1, unmute your phone and record your name clearly. Your name is required to introduce your question. If you need to

withdraw your question, press Star 2. Again, to ask a question, please press Star 1. Our first question comes from Tim Walters. Your line is open.

Tim Walters: Yes, thank you. As part of the Medicare DSH calculations, every year, CMS will post a listing of SSI percentages for hospitals. The last couple of years, this cover would have been posted in the spring. It's been at different times over the years. So, I'm just curious, it hasn't been posted yet. And I was wondering if there was an update on when we could expect that SSI listing to be released by CMS.

Don: So, this is Don. We'll issue instructions when we release that file, but we have not released it yet.

Tim Walters: Okay. I don't know if you had any - my cost report period is such that I'll be filing costs for next month and I wanted to know if you had any idea if it's going to come out sooner or later, or any guess at all on the anticipated timing on that. I was wondering if you had any …

Don: Yes. I don't have a firm date on when that file will be released.

Tim Walters: Okay, thank you.

Coordinator: Our next question comes from Becky Keen. Your line is open.

Becky Keen: Hi. My question is about the value-based purchasing. Where can we find the net neutral payment adjustment that so we can record those calculations in our figures?

Grace Snyder: Sure. So, this is Grace Snyder. So, before the end of the year, we will be issuing for each hospital, a percentage payment summary report. I think we - normally each year, we issue that around August 1st. this year, because of the COVID-related proposals, that timeframe has been delayed.

But my suggestion would be to keep an eye out for when that report becomes available. And we will be putting out like listserv communications to also notify everyone when it becomes available. But that report would have the information in there. I think also in past years normally, we would post a table 16B that would also have the payment adjustments included.

For this year only, we will not be doing that because essentially everybody's payment adjustment would be zero. So, it wouldn't really be useful information in that sense. But the percentage payment summary report, the hospital-specific report, will have that information available, and we'll be issuing that a little bit later this year. Unfortunately, I don't have a more definitive timeframe for you right now, but it will be before the end of this year.

Becky Keen: So, are the current payments still going to use our last year's rate until October 1 or until it's released?

Grace Snyder: Until October 1, that's correct. So, for - I guess right now, it would be the fiscal year 2021 payment adjustment. And then beginning with October 1, 2021 discharges for the next fiscal year, it would be a neutral payment adjustment. That's correct.

Becky Keen: All right. Thank you.

Coordinator: Our next question comes from Amy Couch. Your line is open.

Amy Couch: Yes. I've missed on when will the reporting here for the new ECQ measures for hypoglycemia and hyperglycemia begin?

Grace Snyder: Oh, sure. This is Grace Snyder. It will be beginning with the calendar 2023 reporting period. So, there'll be a little bit of time to implement those new measures for 2023.

Amy Couch: Thank you.

Coordinator: I'm showing no further questions at this time, but as a reminder, please press Star 1 if you'd like to ask a question.

Jill Darling: We'll just give it one minute if any questions come up.

Coordinator: Our next question comes from Karen Miska. Your line is open.

Karen Miska: Hi. Good afternoon. Thanks for taking my questions. It's related to the lab PAMA reporting. I was wondering, with the continuation of the public health emergency and all the attention to that and labs reporting related to COVID, if there's been any consideration given to a further delay of the lab PAMA reporting until after the PHE has ended.

Sarah Harding: Yes. This is Sarah Harding. Thank you for that question. To our knowledge, no, there has been no movement to delay. We have already delayed the reporting twice. And so, we are in the sort of third time's a charm to get the data in. And - but so it could certainly happen. The very first delay happened in the latter part of the year, but to our knowledge, no, there's been no conversation about another delay.

Karen Miska: Okay, thank you. What is for consideration of that with maybe a quick turnaround time, if you are going to delay? The reporting is often very manual and time-consuming. So, you know, if there's going to be a delay, it would be helpful - and to know about that as soon as possible, would be helpful so people don't divert work from COVID to the collection.

Sarah Harding: Absolutely. And that's understood. The nuts and bolts of a delay, though, would be that it would have to be congressionally mandated. That's not something that CMS can decide, because PAMA is a statutory requirement for CMS to collect the data. So, that's why I said we have not heard anything, but it's also not, at least as I understand, that's sort of where the delay would need to be directed from.

Karen Miska: Okay. Thank you.

Sarah Harding: Thank you.

Coordinator: I'm showing no further questions at this time.

Jill Darling: All right, everyone. Well, we thank you for calling in and listening and having some questions for us. If you do have further questions, please email the hospital ODF email. It's listed on the agenda, but it is also - I'll say it here, it's Hospital_ODF@cms.hhs.gov. This will conclude today's call, and thank you for joining, and have a great day.

Coordinator: That concludes today's conference. Thank you for participating. You may disconnect at this time. Speakers, please allow a moment of silence and stand by for your post-conference.

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