



MLN Connects®

National Provider Call Transcript



**Centers for Medicare & Medicaid Services
Hospital Inpatient and LTCH PPS FY 2016 Final Rule
MLN Connects National Provider Call
Moderator: Amanda Barnes
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Contents

Announcements and Introduction 2

Presentation 2

 Changes to Payment Rates under the IPPS..... 3

 LTCH PPS System Changes 3

 Medicare DSH Payments and Documentation and Coding Adjustment 4

Keypad Polling 5

Presentation Continued 5

 Changes to the Quality Reporting and Value-Based Purchasing Programs..... 5

 Reporting Changes for PPS-Exempt Cancer Hospitals 8

 Updates to the Hospital Readmission Reduction Program..... 9

 Updates to the Hospital-Acquired Conditions Readmission Program..... 10

 Updates to the LTCH Quality Reporting Program 11

 Data Submission Deadlines..... 12

 Measures Proposed This Year and Policy Updates 13

Question-and-Answer Session 17

Additional Information 23

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Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Amanda Barnes. Thank you, you may begin.

Announcements and Introduction

Amanda Barnes: Thank you Kalia. I am Amanda Barnes from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on the Hospital Inpatient and Long-Term Care Hospital Prospective Payment System Fiscal Year 2016 Final Rule. MLN Connects Calls are part of the Medicare Learning Network®.

On July 31st, CMS issued a final rule to update the fiscal year 2016 Medicare payment policies and rates under the Inpatient Prospective Payment System, or IPPS, and the LTCH PPS. During this call, CMS subject matter experts will provide information on the major provisions in the final rule. The call also provides details on the quality initiatives included in the final rule.

Before we get started, I have a couple of announcements. You should have already received a link to today's slide presentation. If you have not already done so, you may view or download the presentation from the following URL, www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the web page, select National Provider Calls and Events, then select the date of today's call from the list. You will also find a resources file that is available for download as well.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to [the MLN Connects Calls](http://theMLNConnectsCalls) website. Registrants will receive an email when these materials become available.

Lastly, registrants were given the opportunity to submit questions. We thank you all for submitting those.

At this time, I'd like to call — turn the call over to Sara Vitolo.

Presentation

Sara Vitolo: Hi everybody. Thanks for participating. In this — on this call, we're going to talk about changes to payment rates under the Hospital Inpatient Prospective Payment System and the Long-Term Acute Care Prospective Payment System, Medicare Disproportionate Share Hospital payments, documentation and coding adjustment, and Hospital Inpatient Quality Reporting, Electronic Health Record Incentive, Hospital Value-Based Purchasing, and PPS-Exempt Cancer Hospital Quality Reporting programs.

As background, on July 31st, CMS issued a final rule to update the FY '16 Medicare payment policies and rates under the Inpatient and Long-Term Acute Care Hospital Prospective Payment System. This final rule appeared in the *Federal Register* on August 17th, and it will affect discharges occurring on or after October 1st, 2015. The final rule includes policies that move Medicare and the health care system towards paying providers based on quality of care. And this presentation, as I mentioned, discusses the major provisions in the FY '16 IPPS and LTCH final rules.

Changes to Payment Rates under the IPPS

So changes to payment rates under the IPPS. With changes in operating payment rates for general acute care hospitals is 0.9 percent. That's for hospitals that successfully participate in the Hospital Inpatient Quality Reporting Program and demonstrate Meaningful Use's electronic health record technology. So we get to the 0.9 percent with a plus 2.4 percent hospital market basket update, a minus 0.5 percent multifactor productivity adjustment, a minus 2 percent Affordable Care Act adjustment, and a minus 8 percent — minus 0.8 percent documentation and coding recoupment adjustment required by the American Taxpayer Relief Act.

Hospitals that don't successfully participate in the hospital IQR Program and do not submit required quality data will be subject to one-quarter reduction in the market basket update. And any hospital that's not a meaningful user of electronic health records, the update is reduced by one-half of the market update in FY '16.

Other payment adjustments include a minus 1 percent penalty for hospitals in the worst performing quartile under the HAC Reduction Program, continued penalties for readmissions, and continued bonuses and penalties for Hospital Value-Based Purchasing. These and other payment adjustments are discussed in detail later in this presentation

LTCH PPS System Changes

Under the Long-Term Acute Care PPS, the LTCH PPS, the Pathway for SGR Reform Act of 2013 directed CMS to make significant changes in the payment system for LTCHs. The law directs CMS to establish two different types of LTCH PPS payment rates, depending on whether the patient meets certain clinical criteria. There's the — now the LTCH PPS standard Federal payment rate and a new LTCH PPS site neutral payment rate that is generally comparable to the IPPS payment rates.

In order for the LTCH to be paid at the higher LTCH PPS standard Federal payment rate and be excluded from the site-neutral payment rate, the patient discharges must not have a principal diagnosis related to psychiatric diagnosis or rehabilitation. The discharge must be immediately preceded by a discharge from an acute care hospital, and either the acute care hospital stay must have included at least 3 days in the ICU or the discharge from the LTCH must have included ventilator services for at least 96 hours.

The law provides a 2-year transition period for those discharges paid at the site-neutral payment rate. During that transition, the site-neutral payment rate cases are paid based on a 50/50 blend of the LTCH PPS standard Federal payment rate and the LTCH PPS site neutral payment rate. In the final rule, CMS is implementing these statutory requirements.

CMS projects that the LTCH PPS payments will decrease by approximately 4.6 percent, or \$250 million, for FY '16. This estimated decrease is primarily attributable to the statutory decrease in the payment rates for site-neutral payment rate cases that do not meet the clinical criteria to qualify for the standard Federal payment rate. Cases that do not — cases that do qualify for the higher standard Federal payment rate and successfully submit quality data under the LTCH Quality Reporting Program will see increase in payment — will see an increase in that payment rate of 1.7 percent.

Medicare DSH Payments and Documentation and Coding Adjustment

The Hospital Inpatient LTCH final rule also discusses Medicare Disproportionate Share Hospital Payments and uncompensated care payments. Beginning in FY '14, the Affordable Care Act changed the way Medicare pays for disproportionate share. Hospitals now receive 25 percent of the amount they previously would have received under the statutory DSH formula.

The remainder, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH, is aggregated nationally, adjusted for decreases in the rate of uninsured individuals and other factors, and then distributed to hospitals based on their relative share of the total amount of uncompensated care. In this rule, CMS is distributing \$6.4 billion in uncompensated care payments in FY '16. This is a decrease of \$1.2 billion from the estimate for FY '15, and that decrease is primarily attributable to continued declines in the number of uninsured individuals since the passage of the Affordable Care Act.

The Inpatient Rule also talks about documentation and coding adjustment. Section 631 of the American Taxpayer Relief Act of 2012 requires CMS to recover \$11 billion by 2017 to fully recoup documentation and coding overpayments related to the transition to the MS-DRGs that began in FY '08.

For FY '16, CMS is continuing the approach begun in FY '14 by making another negative 0.8 percent adjustment.

Amanda Barnes: Thank you Sara. At this time, we will pause for a few moments for keypad polling. Kalia, we're ready to start.

Keypad Polling

Operator: CMS appreciates that you minimize the Government’s teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Please continue to hold while we complete the polling. Please continue to hold while we complete the polling. Please continue to hold while we complete the polling. Please continue to hold while we complete the polling. Please continue to hold while we complete the polling.

Thank you for your participation. I would now like to turn the call back over to Amanda Barnes.

Presentation Continued

Amanda Barnes: Thank you so much Kalia. We’ll now turn the call over to Cindy Tourison. Cindy?

Cindy Tourison: Thank you.... on the final project? Can you tell me the number that we’re starting on? It should be the Quality Reporting Program slide.

Amanda Barnes: Yes, that’s correct, slide 12.

Changes to the Quality Reporting and Value-Based Purchasing Programs

Cindy Tourison: OK, thank you. Slide 12. OK. So today, I’m going to be reporting changes in the final rule related to our Quality Reporting Programs and Value-Based Purchasing Programs.

Next slide. We will review — so this year we finalized the removal of nine measures under Hospital Inpatient Quality Reporting, either in their entirety or just their chart-abstracted form for FY 2018 payment determination and subsequent years. We finalized removal of the chart-abstracted versions of STK-01, 06, 08; VTE-1, 2, and 3 on the basis of the measures being topped out. However, we are retaining STK-06, 08; VTE-1, 2, and 3 as electronic Clinical Quality Measures to allow our program to align with the EHR Incentive Program.

For IMM-1, we are removing, based on the continued lack of readiness for the ability to collect comprehensive patient-level immunization data by hospital staff and the continued infeasibility to implement or align this measure with current clinical guidelines or practice — so we are removing this from IQR.

We are — have also finalized the removal of AMI-7a, the chart-abstracted measure, because performance on this measure does not result in better patient outcomes. In addition, we believe that the burden of requiring all hospitals to report data on this measure when only a few facilities report enough cases to be publicly reported outweighs the benefit of retaining the chart-abstracted version of this measure. However, we did finalize to retain AMI-7a at this time as an eCQM, again for alignment to the EHR Incentive Program.

We also finalized the removal of AMI-7a, as the measure does not result in better patient outcomes and does align with current clinical guidelines or practices, and publicly reporting of this measure leads to negative or unintended consequences and patient harm.

****Post-Call Clarification: We also finalized the removal of AMI-7a, as the measure does not result in better patient outcomes and it creates a large burden for hospitals to report and yields too few relevant cases for public reporting for most hospitals.****

Next slide, also for FY 2018, which is equivalent to calendar year 2016 for most of the measures, a hospital will be required to submit the eight listed chart-abstracted measures to meet IQR requirements. Now I want to highlight this slide because there has been quite a bit of questions on this slide. In the original proposed rule, we had proposed that hospitals would have a choice to submit these in their chart-abstracted form or in electronic clinical quality form for those measures that have electronic Clinical Quality Measures. However, based on public comments, we have finalized that these chart-abstracted measures will be required for the entire year in their chart-abstracted form for FY 2018 payment determinations. So regardless of the eCQMs that you select, all of the measures on this slide are required for a full year's worth of data in their chart-abstracted form.

Next slide, entitled New Measures for FY 2018 and Subsequent Years. So in the proposed rule, we had proposed to add eight new measures — seven claims and one structural measure to IQR for FY '18 payment determination in subsequent years. After consideration of public comments received, we are finalizing adoption of six of these measures, including the structural measure to survey patients' basic safety culture and also the claims-based measures on AMI/heart failure excess days for — also for the '18 payment determination. In addition, we finalized a total hip/total knee arthroplasty payment for this payment year as well.

Next slide. After consideration of public comments, we finalized the modification to our original proposal on the episodic payment measures. We finalized three of the four measures, as listed on this slide. We did not finalize the Lumbar Spine Fusion/Refusion Clinical Episode-Based Payment measure. Additionally, we are postponing the implementation of the Kidney/UTI, Cellulitis, and GI payment measures for the FY 2019 payment determination. We will provide hospitals with confidential hospital-specific

feedback reports, which contain performance data on these three measures, during the FY 2018 payment determination prior to inclusion for public reporting.

Next slide, entitled IQR eCQM Reporting Requirements. So now I'm moving on to the section of IQR related to electronic Clinical Quality Measures, or eCQMs, and this is the portion that aligns with the EHR Incentive Program. We had proposed to require 16 of 28 measures for hospitals to report third and fourth quarters of calendar year 2016. We believe that requiring hospitals to report a minimum of four is reasonable because it significantly reduces burden for hospitals from the 16 proposed, but it still allows for the collection of data derived from the EHR to further plan electronic data collection and validation.

Further, instead of requiring hospitals to report two quarters of data within 2 months following the reporting period, we changed so that hospitals will be required to report four eCQMs for just one quarter, either quarter three or quarter four of calendar year 2016, also referred to as FY 2018 payment determination. The submission deadline for these measures reported from either third quarter or fourth quarter will be February 28th, of 2017. We believe this allows more time for hospitals to overcome vendor issues, such as mapping and testing. And in addition, instead of requiring that a hospital select and report eCQMs across three NQS domains, as originally proposed, we have finalized our policy to not require any of the four eCQMs to fall under any particular NQS domain. We've removed that requirement.

Next slide, Available eCQMs. There are currently 29 eCQMs available under the EHR Incentive Program; however, only 28 of these measures are available to be submitted for Hospital Inpatient Quality Reporting. The third measure — or the 29th measure, rather, is ED-3. This is an outpatient measure and, therefore, not applicable to IQR. So in order to select four of these measures in order to satisfy the eCQM requirement for IQR as well as for the EHR Incentive Program requirement, you'll need to not include ED-3.

Next slide. So we are retaining a variety of eCQMs in order to ensure that hospitals have flexibility and choice in determining which electronic measures they report in 2016. We believe that the collection of electronic Clinical Quality Measure data will enable hospitals to capture and calculate data efficiently. We will make note of the reasons for our removal when we propose them in next year's rule; however, we just wanted to be transparent and let everyone know that we intend to remove these in next year's rule.

Next slide, please, entitled Public Reporting of eCQMs. We previously proposed that measures reported under eCQMs would be marked as a footnote on Hospital Compare. However, instead we finalized that data submitted electronically will not be posted on Hospital Compare at this time. Public reporting of electronic data will be addressed in next year's rulemaking as well, following the conclusion and assessment of our ongoing eCQM validation pilot.

Next slide, please, entitled Future Considerations for Electronically Specified Measures. We did also make some proposals on our — on developing our goals in using data derived from Electronic Health Records, so, where feasible, we are considering the use of core clinical data elements derived from EHRs for use in future quality measures (for example, in the risk adjustment of outcome measures, the collection of additional administrative linkage variables to a patient's episode of care from an EHR with administrative claims data, and use of content exchange standards). We anticipate that EHRs will continue to improve capturing relevant clinical data. We also anticipate further expansion of core clinical data elements in future rule proposals.

Next slide, entitled FY 2018 HVBP Program Domains. The scoring methodology for HVBP for FY 2018 program year was finalized in this year's rule. We continue our adoption of the four domains listed on this slide. Each of the domains for FY 2018 will be equally weighted at 25 percent of the total performance score. We also maintain our policy that a hospital must receive scores in at least three of four domains in order to be eligible to incur payment adjustments under Value-Based Purchasing.

Additionally, all Hospital 30-day All Cause, following COPD Hospitalization, is a risk-adjusted NQF-endorsed mortality measure, monitoring mortality rates following COPD hospitalization. We finalized the addition of the measure to the Clinical Care domain for the FY 2021 program year.

Next slide. So this slide shows those measures added, removed, and moved for the FY 2018 payment determination. We finalized the addition of the CTM-3 — the Three-Item Care Transition Measure because the Patient and Caregiver-Centered Experience of Care Coordination domain, which increases the total HCAHPS dimension from eight to nine dimensions. We will look a little more at that later on in the presentation.

Two measures removed for FY 2018 were AMI-7a and IMM-2, which were formerly under the Clinical Care Process domain, and we also talked about removing those from IQR a little earlier. The remaining measure in the Clinical Care Process domain, the PC-01, was actually moved to the Safety domain. The MAP Hospital Workgroup has included PC-01 as an obstetrical adverse event measure in its safety family of measures. So we think it's appropriate to move this measure to the Safety domain. And due to that move, there would be no measures remaining in the Clinical Care Process subdomain, so we finalized the removal of the subdomain, and the Clinical Care domain now only includes the three 30-day mortality measures.

Reporting Changes for PPS-Exempt Cancer Hospitals

Next slide. This reporting will end by fourth quarter 2015 discharges. This slide is actually specific to PPS-exempt cancer hospitals. So the measures that are shown on this

screen will end in — at the fourth quarter of 2015 discharges. No further data submissions will be required.

Next slide, also finalized for the 2018 program year for PCHQR were these new NHSN HAI measures, including NQF number 1717, which addresses C. diff, and NQF 1716, which is our MRSA measure. Both of these are outcome measures with the rate for the entire hospital being monitored and reporting. The third measure is NQF number 0431, which is our Influenza Vaccination Coverage among Health Care Personnel, or HCP, and this is the first HCP introduction into the PCHQR Program. It, too, is an outcome measure.

Next slide, entitled Public Reporting Requirements for PCHQR. Initially for FY 2014, two cancer-specific measures were displayed on Hospital Compare, and starting with October 2015 Hospital Compare release, a third cancer-specific measure, the Adjuvant Hormonal Therapy, will also be publicly reported. No later than 2017, two of the HAI measures, CLABSI/CAUTI, will also be displayed on Hospital Compare, making a total of five PCHQR measures that will be displayed publicly.

Updates to the Hospital Readmission Reduction Program

Next slide, entitled Pneumonia Readmission Measure Cohort Expansion. So one of the main updates made to our Hospital Readmissions Reduction Program in this final rule was finalizing an expansion for the Pneumonia Readmission Measure. We currently have a Pneumonia Readmission Measure in the Hospital Readmissions Reduction Program. So this is a modification to the specification for that measure. The modifications will come into effect in the FY 2017 program year. This will affect the measure results and will be reported in the hospital-specific reports that will become available to hospitals in the summer of 2016.

What we finalized in the rule is actually a modified version of what we had proposed. So just to clarify, the current pneumonia measure includes patients with a principal discharge diagnosis of pneumonia. With the modification to this measure, we will also include patients with a principal discharge diagnosis of aspiration pneumonia and also patients with a principal discharge diagnosis of sepsis with a secondary diagnosis of pneumonia present on admission. However, this will not include patients that are coded as having severe sepsis or septic shock.

What has been proposed but not finalized in this rule is including a patient with a respiratory failure or, as I mentioned, severe sepsis. We finalized an update to this measure in response to changing trends in hospital coding practices and to address the potential coding variation that we've seen. We believe that by including more pneumonia patients in the Readmission measure, it will provide a more complete picture for the hospital performance on readmission with respect to pneumonia patients.

Updates to the Hospital-Acquired Conditions Readmission Program

Next slide. Another update to the Hospital Readmissions Reduction Program that we also made for our Hospital-Acquired Condition Program is the extraordinary circumstance exception policy, which will go into effect, again, beginning October 1st of 2016. This policy will allow a hospital that has experienced an extraordinary circumstance, such as a major hurricane, severe flood, to request a waiver of certain periods of data from inclusion and calculations of its excess readmission ratio for a given fiscal year. An extraordinary circumstance might also affect its ability to accurately or timely submit all claims data.

Soon there will be a revision to the extraordinary circumstance exception and exemption, which will become available on QualityNet, that will also include the HRRP and HACRP Program. It is going to be the same form that we use for many of our other programs, including IQR, HVBP, ASC, and OQR.

Next slide, the applicable time period for fiscal year 2017, for our HAC Reduction Program for FY 2017, has been finalized. The Domain 1 measure, PSI-90 Composite Measure, will be from July 1st through June 30th, 2015. For our CDC NHSN measures, including CLABSI, CAUTI, SSI, MRSA, and C. diff., the applicable time period will be calendar years 2014 and 2015.

Additionally, we have revised our approach to how we calculate the Domain 2 score. In our current rule, we assign a score for each Domain 2 measure, and the measure scores are averaged to provide a Domain 2 score. In the fiscal year 2016 final rule, we will treat each Domain 2 measure independently when determining if a score of 10 should be assigned to the measures.

Next slide. In the fiscal year 2016 final rule, we finalized changes to the domain weight for fiscal year 2017 HAC Reduction Program, including the reduction of Domain 1 to 15 percent and the increase of Domain 2 to 85 percent of the total HAC score. The changes in domain weight were finalized in response to stakeholder recommendations and the addition of MRSA and C. diff into Domain 2.

Next slide. In the FY 2016 final rules, two measures-related updates for the fiscal year 2018 HAC Reduction Program were finalized. The first measure refinement includes the inclusion of nonintensive care unit locations for CDC NHSN measures CLABSI and CAUTI. In addition to data from adult and pediatric ICU locations, the HAC Reduction Program includes data from pediatric and adult medical wards, surg. wards, and medical/surgical wards.

As mentioned earlier for HVBP, beginning in 2015, CDC will collect data in order to update the standard populations for all NHSN measures. However, unlike VBP, the HAC Reduction Program will use CDC new standard population data beginning in fiscal year 2018.

Updates to the LTCH Quality Reporting Program

Next we'll move into our LTCH Quality Reporting Program. CMS has adopted 13 quality measures for our LTCH Quality Reporting Program. Three of those quality measures are for data collection and reporting for fiscal year 2014 and 2015 payment update determination. We adopted two additional measures for our FY '16 payment update determination, three additional measures for FY 2017 payment update determination, and a total of five additional measures for the FY 2018 payment update determination.

Next slide. So I'm going to cover all of the measures that are currently reported under the requirements of the LTCH Quality Reporting Program. You'll notice that some of the measures are highlighted. The highlighted measures are the ones that were proposed and finalized in this year's final rule. The first is the Percent of Patients or Residents with Pressure Ulcers That Are New or Worsened. This is NQF number 0678. This measure was actually repropose this year to establish its use as a cost-setting measure that satisfies requirement of the IMPACT Act of 2014. Beyond that, LTCHs should be currently collecting the NHSN Catheter-Associated Urinary Tract Infection Outcome and NHSN CLABSI, which is an outcome measure.

Next slide, which should read, "LTCH Quality Reporting Program Overview — 3." LTCHs should currently be reporting the Percent of Residents or Patients Who Were Assessed Appropriately Given the Seasonal Flu — the Influenza Vaccine, or the short stay measure. The Influenza Vaccination Coverage among Health Care Personnel, NQF 0431, should currently be collected between the dates of October 1 and March 31 of each year, which is considered the influenza vaccination season.

The next measure, which is an All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from a Long-Term Care Hospitals, is highlighted in yellow. This measure was, again, repropose this year in the proposed rule. We finalized it in this year's final rule, and this is proposed to establish the NQF-endorsed version of the measure. This measure was endorsed by NQF in December of 2014.

Next slide, overview slide 4. Continuing with the quality measures that are currently reported in the Quality Reporting Program, there's the NHSN Facilitywide Inpatient Hospital Onset MRSA, also the Onset C. Diff Outcome Measure and the NHSN Ventilator-Associated Event Outcome Measure. Reporting for this measure actually will not begin until January 1st of 2016, but this measure has been previously finalized and adopted into the program.

Next slide, overview 5 slide. The Percent of Residents Experiencing One or More Falls with Major Injury is in the long stay measure, NQF number 0674. This measure was repropose this year in order to establish its use as a cost-setting measure that also satisfies the IMPACT Act of 2014 requirement.

Beginning in April 1st of 2016, LTCHs will begin collecting functional outcome measure, Change in Mobility among Long-Term Care Hospital Patients Requiring Ventilator Support. This is NQF number 2632. And also, a Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function NQF number 2631.

This year, we also proposed the measure that is highlighted at the bottom of this slide, which is the Application of Percent of Long-Term Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function. This measure, as an application, is a bit different from the previous measure I mentioned in that it uses a subset of those items and reestablishes this measure's use as a cost-setting measure that satisfies also the IMPACT Act of 2014 requirement.

Next slide, the LTCH CARE Data Set. The LTCH CARE Data Set must be completed for all patients admitted and discharging from an LTCH. It is used to collect and submit all data on all quality measures that are assessment-based.

So let's go over each measure that we've seen in the LTCH CARE Data Set. The first version was 1.01, and LTCHs began using this October 1st of 2012, and a Pressure Ulcer Measure was the only measure collected using that version of the item set.

We moved on to 2.01, and LTCHs began using that version on July 1st, 2014, when we added a Patient Influenza Vaccination Status Measure to the Pressure Ulcer Measure for the data set. Beginning in April 1st of 2016, we'll move to version 3 of the LTCH CARE Data Set. That version will contain not only the Pressure Ulcer measure and the Patient Influenza Vaccination Status measure, but will additionally add Falls with Major Injury Measure to that data set.

Next slide, CDC — entitled, CDC NHSN. The other use of the LTCH CARE Data Set number measure, as submitted via CDC's NHSN. And NHSN is a mechanism of submission for CAUTI, CLABSI, MRSA, CDI, Influenza Vaccination Coverage among Health Care Personnel. As of January 1, 2016, the CDC's NHSN will also be the data submission mechanism for the Ventilator-Associated Event Outcome Measure. You can find further information on data collection and submission for these measures at [CDC's website](#).

Data Submission Deadlines

Next slide. I'm now going to review the data submission deadlines for payment update determinations in detail. I'm going to go over some of this information. But currently, LTCHs must submit quality data for each year — each quarter by the established quarterly data submission deadline. Data submitted after the quarterly submission deadline will not be accepted for LTCH Quality Reporting Program compliance determination. Missing one or more of these deadlines may lead to filing of noncompliance.

I would like to note that for the Influenza vaccine —Vaccination Coverage among Health Care Personnel, the extension of the quarterly submission deadlines, which took place in this rule, is not applicable. The data submission deadline will remain May 15th of each year for quality data related to this measure.

Next slide. Now I'm going to cover the newly adopted data submission deadlines for LTCH Quality Reporting Program, which was finalized in this year's rule. So beginning with quarter four, which is October 1st through December 31st, of 2015, the data submission deadlines for quality measures, except the Influenza Vaccination Coverage among Health Care Personnel, have been expanded to give facilities additional time to submit, review, and correct data. These deadlines apply for payment determinations for the fiscal year 2017, 2018, and subsequent years. LTCHs will have 4 ½ months, or approximately 135 days, after the end of each quarter to submit required quality data to CMS. The current submission deadlines allow LTCHs to submit data within 1 ½ months, which is approximately 45 days after the end of each quarter.

Next slide, please. In this year's rule, we also adopted policy related to public reporting of LTCH Quality Reporting program. The public reporting of this quality data is scheduled to begin in the fall of 2016 and includes a period of review and correction of quality data prior to public display and performance data. Initial data that we display will include the following four measures:

- The Percent of Residents with Pressure Ulcers That Are New or Worsened,
- The NHSN CAUTI measure,
- The NHSN CLABSI measure, and finally
- The All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from an LTCH.

Next slide. This year for LTCHs, we also adopted a policy to post a list of LTCHs that successfully meet with the reporting requirements for the applicable payment determination. Once finalized, we will publish this list on the LTCH Quality Reporting website. We will, of course, update that list following the end of the reconsideration process on an annual basis.

Measures Proposed This Year and Policy Updates

Next slide. Now I'm going to talk about the measures that were proposed this year, or shall I say at least re-proposed for various reasons and finalized again this year, for the FY 2018 payment determination and subsequent years. We re-proposed two quality measures. The first, which is the All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRF. We re-proposed this measure in order to establish the use of NQF-endorsed version of this measure. This measure was endorsed by NQF in December of 2014.

The second reproposal was the application of Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened. Our point of reproposing this measure was to establish it for use as a cost-setting measure that satisfies requirements for the IMPACT Act of 2014.

Next slide. The IMPACT Act of 2014 requires that CMS adopt quality measures that satisfy the following quality domains. First, Domain 1 is the skin integrity and changes in skin integrity. In order to satisfy that domain, we repropose and adopted the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened. And then the second domain is functional status, cognitive function, and changes in function and cognitive function. In order to satisfy that requirement, we proposed and finalized the measure Percent of Long-Term Care Hospitals with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function. That measure is currently under review in NQF.

Lastly, Domain 3 is incidence of major falls. In order to satisfy that required domain, we propose an application of Percent of Residents Experiencing One or More Falls with Major Injury.

Next slide. In addition to those measures, we proposed four additional functional outcome measures. The four adopted functional outcome measures are as follows:

- Change in Self-Care for Medical Rehabilitation Patients. That measure is currently under review at NQF.
- Change in Mobility Score for Medical Rehabilitation Patients, also under review at NQF,
- Discharge Self-Score for Medical Rehabilitation Patients, which is NQF number 2635, and
- Discharge Mobility Score for Medical Rehabilitation Patients, which is NQF number 2636.

Next slide. This year we adopted a new policy related to data collection timeframe for the IRF Quality Reporting Program. Previously, IRF data collection has been based on the fiscal year. However, we have proposed and now finalized that the policy that states the data collection timeframes will be based on the calendar year unless there's a clinical reason for an alternative date — data collection timeframe. An example of this would be the two influenza vaccination measures that are tied to the influenza vaccination season.

When additional quality measures that use the IRF-patient assessment instrument, or the IRF-PAI, as data collection mechanism are adopted for future use in the IRF QRP, the

first data collection timeframe for those newly adopted measures will be only 3 months, October through December. Subsequent data collection period would follow the calendar year collection timeframe. So for example, IRF-PAI is always released in October, so any new measures that begin with that release will only be collected for the first 3 months related to the APU that year.

For example, the next year — for calendar year 2016, you will be collecting data as usual. On October 1st, 2016, a new IRF-PAI will be released and the new data items related to the newly finalized measures. So for fiscal year 2017, APU ...

Background female: Good, how are you doing?

Cindy Tourison: ... or fiscal year 2018 APU for those measures will only be based on the first 3 months of data collection, which will be October through December.

Crosstalk

Cindy Tourison: Could you please mute your phone if you're not speaking?

Background female: No, it's no bother.

Cindy Tourison: For all of the new IRF-PAI quality measures that we finalized in this year's final rule, IRF-PAI version 1.4 will be used, and this version of IRF-PAI will be effective October 1st of 2016. It specifically includes the modified pressure ulcer items, which will be collected at admission and discharge; the new fall items, which will be collected at discharge; the new self-care and mobility functional status items, collected at admission and discharge; and the new risk factor items for self-care and mobility measures, collected at admission. You can find the new version of IRF-PAI on the IRF-Quality Reporting website, and the link is listed at the bottom of the slide.

This year, we also finalized the policy related to newly opened IRFs. When a IRF opens midyear, there's always a question as to when they should begin reporting quality data. So in order to ensure that all IRFs have a minimum amount of time to prepare to submit quality data to CMS under the requirements of the IRF Quality Reporting Program, the new policy states that a new IRF is required to begin reporting quality data by no later than the first day of the calendar year, subsequent to 30 days after the date on a CCN notification letter.

So again, IRFs are required to begin reporting quality data under the IRF Quality Reporting Program no later than the first day of the calendar year quarter subsequent to 30 days after the date of the CCN. For example, if you get a notification letter on March 15th of 2016, you would add 30 days to —30 days to that, which would take you to April 15th. You would then be required to begin reporting quality data beginning on the first day of the calendar year quarter that follows that date. The next calendar year

quarter following April 15th would be calendar year quarter three, which would begin July 1st of 2016. So if you got your letter on March 15th, you would then be required to begin reporting quality data to CMS on July 1st.

Next slide. We also have finalized a policy that states that we are going to suspend the implementation of a process to validate the data that's submitted for the quality purposes. We originally finalized this policy under FY 2015 IRF PPS final rule. So data accuracy validation will have no bearing on the applicable fiscal year annual increase factor reduction for FY 2016 and subsequent years, unless and until we propose to either reenact this policy or to propose a new validation policy in future rulemaking.

We'll tell you that we are working to develop a more comprehensive data validation policy that is aligned across all post-acute care quality reporting programs, reducing labor and burden and cost on IRFs in comparison to our previously finalized policy.

Next slide, a few other policy updates. CMS has finalized its proposal to codify data submission exception and extension requirements for IRF as CMS will continue using the IRF Quality Reporting Program reconsideration and appeals procedures that were adopted in FY 2015 final rule. The exact citation is listed here for you, if you would like to look that up. For FY 2017 payment determination and subsequent years, with the addition of notifying noncompliant IRF providers, the IRF Program is using the Quality Improvement Evaluation System in addition to the U.S. Postal Service.

So previously, when we communicated with providers regarding compliance determinations and reconsideration determinations, we only used U.S. Postal Service and sent out a certified letter. So that beginning in FY 2017, in addition, we will be posting your letters electronically inside of your system folders that are located within the QIES System, and we'll be releasing a lot more detail related to this policy, of course, on our Quality Reporting Program website, and you can continue to check for updates.

We also have finalized the policy for public reporting related to IRF Quality Reporting Program. CMS will display performance information regarding the quality measures required in the IRF Quality Reporting Program by the fall of 2016. Display will be on CMS website after a 30-day preview period. The initial display is going to contain provider performance data on three measures, including Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened, the NHSN CAUTI Outcome Measure, and the All-Cause Unplanned Readmission Measure for 30 Days Post -Discharge from IRF.

And that concludes our updates on our Quality Reporting Program.

Amanda Barnes: Thank you so much Cindy.

Question-and-Answer Session

At this time, our subject matter experts will take your questions about the final rule. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. If you could please state your name and the name of your organization once your line is open. In an effort to get to as many participants as possible, we also ask that you limit your question to just one.

Kalia, we're ready to start our first question, please.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Chuck Bruster.

Chuck Bruster: Yes, quick question. Any idea when the transmittal summarizing all the IPPS updates will be posted on CMS's website?

Donald Thompson: We're — it's currently in the sort of final stages of clearance, so we do expect that to be out in the near future, but I don't have an exact date for you.

Chuck Bruster: OK. Because the case mix summary — case mix factor that's being used within the HSP calculation is only published in that transmittal, so it's kind of important that we get it soon.

Amanda Barnes: Thank you for your question.

Operator: Your next question comes from the line of Lisa Poehls.

Lisa Poehls: Hi, this is Lisa Poehls from Optum.

My question is in regards to the new LTCH site-neutral rules. As was mentioned that there're some claims that can be excluded from the site-neutral payment, and in order to figure out if a claim can be excluded, a payer needs to know if the patient just came from an acute care hospital, and if so, if that stay included at least 3 days in the ICU. Today, you know, that information isn't put onto the LTCH claim. So then the provider — the payers have to, you know, go through claims history to figure out if that site-neutral payment applies or not. Do you know if CMS is planning on issuing instructions to the LTCH facilities to provide, you know, that data, the hospitalization

dates, and if there are any ICU days, so that the appropriate reimbursement can be calculated without having to access, you know, the claims history?

Donald Thompson: We've —under our claims process — the Medicare claims processing system, what we are intending to do is to have the claims processing system check the IPPS claim for the prior — prior to the LTCH stay, and we also sort of encourage LTCH to sort of work closely with their IPPS referral partners in order to make this as seamless as possible. But currently there is — there are no operational plans to have that information on the LTCH claims.

Amanda Barnes: Thank you.

Lisa Poehls: OK.

Operator: Your next question comes from the line of Cynthia Healy.

Cynthia Healy: Hi, it's Cindy Healy from Orlando Health. I just had a question about the excess stays and then securing the inpatient. Is there also one plan for pneumonia as well?

Amanda Barnes: Could you repeat your question? We have a little bit of trouble hearing you.

Cynthia Healy: Yes, on the Inpatient program, the Excess Stays in Acute Care Measure that's new, is there not one plan for pneumonia as well?

Cindy Tourison: Yes, that's right, there is. But I must have missed that in my presentation.

****Post-Call Clarification: We did not propose nor finalize Excess Day PN measure for FY 18.****

Cynthia Healy: OK, I just wanted to make sure because I heard that was coming in as well for fiscal year '18.

Cindy Tourison: You are correct.

Cynthia Healy: Thank you very much. All right.

Operator: If you would like to ask a question, press star 1 on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key. Your next question comes from the line of Maureen Gaus.

Maureen Gaus: Yes, hi. Do you have a slide that lists the HCAHPS indicators, or are they the same as last year? And also with the Joint Commission, do you know the comparisons? I know they have the three options if we're able to submit the same populations for e-measure and electronic measures, I'm not sure if you're able to answer that, abstract any e-measures.

Amanda Barnes: Cindy, will you be able to help her?

Operator: Could you please repeat the question?

Maureen Gaus: Yes, the first question is, do you have a list of the HCAHPS indicators for the next year or are they the same as the previous year? That's the first question.

Cindy Tourison: So is that — can you tell me that's in the context of which program of IQR or HVBP?

Maureen Gaus: For IQ — for the Value-Based Purchasing with HCAHPS.

Cindy Tourison: OK, yes. So we've added — we've added a ninth dimension, which is the three items of care transition, which adds three questions to the survey. And that's already been collected under IQR and posted on Hospital Compare for a year.

Maureen Gaus: Do you have a slide with all the HCAHPS indicators because I looked through the presentations and no one has that?

Cindy Tourison: No, we can certainly get you that information at the end of the call. We'll make a note to send that to you.

Maureen Gaus: OK.

Amanda Barnes: We have a resource box, the resource slide, a separate document. You could actually send your question into one of those resource boxes and they can help you up from there.

Maureen Gaus: OK, thank you.

Amanda Barnes: You're welcome.

Operator: Your next question comes from the line of Doreena Volvo-Kalenova.

Doreena Volvo-Kalenova: Hi, our question is — we have a little bit of confusion with the influenza vaccine. It seems that we were told that influenza vaccine would be removed from manual chart abstraction in calendar year 2016. But in your PowerPoint, it says that it will be for the Value-Based Purchasing in FY 2018. Can you clarify that please?

Cindy Tourison: Yes, so that's because FY 2018 of HVBP correlates to calendar year 2016 from a data collection perspective.

Doreena Volvo-Kalenova: So that would mean that we still have to collect manually in 2016 for influenza?

Cindy Tourison: No, it does not. It's being removed at that point.

Doreena Volvo-Kalenova: OK.

Cindy Tourison: So if you take a look at — and I'm sorry. I don't know if my slide numbers match. But if you take a look at the slide that has the pie graph on it, you'll notice ...

Doreena Volvo-Kalenova: Right, but then the ...

Cindy Tourison: ... that the immunization measure is not listed there.

Doreena Volvo-Kalenova: That's correct. But in your slide 13, it says required chart-abstracted measures for FY 2018 and influenza is listed there.

Cindy Tourison: Give me 1 second. Yeah, I think you're correct. So I will — I'll make sure that we update that. Actually, I think the difference — I think what the challenge is. So this is IMM-2, OK? And we kept IMM-2 for IQR; however, we removed IMM-2 from HVBP because of its topped-out status. So IMM-2 continues to be collected under IQR; however, it's no longer assessed under our Hospital Value-Based Purchasing Program.

Doreena Volvo-Kalenova: So to clarify, IMM-2 influenza vaccine will have to be manually abstracted in 2016. It's just not being used for Value-Based Purchasing.

Cindy Tourison: That is correct.

Doreena Volvo-Kalenova: OK.

Amanda Barnes: Great, thank you. Next question please.

Operator: Once again, if you would like to ask a question, press star 1 on your telephone keypad. To withdraw your question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

Your next question comes from the line of Tony Cawiezell.

Tony Cawiezell: Yeah, hi. On the documentation and coding adjustment, I noticed that that's not being applied to the sole community hospital and Medicaid-dependent hospital, HSR calc. Is that true for '16 and it was '14 and '15?

Donald Thompson: That's correct. The statute only authorizes us to take that from the hospital's pay on the IPPS rate

Tony Cawiezell: OK, thanks.

Amanda Barnes: You're welcome.

Operator: Your next question comes from the line of Joseph Maggot. Joseph, your line is open. If you're on speakerphone, please pick up your handset. And that question has been withdrawn.

Your next question comes from the line of Paul Pruitt.

Paul Pruitt: Hi, so the question's relating the functional outcome measures for LTCH. Will there be a standardized tool that is required to capture that information for reporting?

Amanda Barnes: Cindy, are you able to answer that?

Cindy Tourison: I'm sorry, I thought maybe we have Mary Pratt on the line who could help answer that question for us.

Mary Pratt: Yeah, I'm sorry. Can you repeat the question? Sorry about that.

Paul Pruitt: Sure. It's regarding the functional outcome measures for quality measures for the LTCH. Will there be a standardized tool that will be required for us to capture that data so that we can submit it — submit it so it's all standardized?

Mary Pratt: Yes, that's correct.

Paul Pruitt: Do you have ...

Mary Pratt: The information to collect the data will be in the LTCH care data set and we will — if we haven't already posted, I believe the specifications and the items are on our cms.gov website under the Long-Term Care — yes, [the Long-Term Care Hospital Quality Reporting Program](#) website, and I think we could ...

Paul Pruitt: So.

Mary Pratt: Go ahead.

Paul Pruitt: I was going to say, so will there be a tool such as the FIM, the Functional Independent Measurement, or will it be something different, do you know?

Mary Pratt: It's something different but similar.

Paul Pruitt: OK, thank you.

Mary Pratt: Sure.

Operator: Your next question comes from the line of Krista Akins.

Krista Akins: Yes, our question is about LTCH reimbursement and the discharge code 61. Do you all know anything about that?

Donald Thompson: In the final rule?

Krista Akins: Yes, um-hum.

Donald Thompson: I think Michelle is not on the call. I'm not sure we have any of our billing folks on, so this is may be one we have to follow up on.

Krista Akins: OK.

Amanda Barnes: Yes, if you could send your questions into one of the resource boxes, ...

Krista Akins: OK.

Amanda Barnes: That would be very helpful.

Krista Akins: OK, which one? Like the question-and-answer tool, that box?

Michelle Hudson: I'm on the call, can you remind me what the 61 is?

Krista Akins: It is the discharge. We think it's the discharge to LTCH code that short-stay hospital would have to put in.

Michelle: Oh, the patient discharge status code?

Krista Akins: Yes.

Michelle Hudson: Yes, that was included in our original proposal as part of our definition of immediately proceeding. And in response to comments, we determined that that wouldn't be necessary, and so we didn't finalize that proposal.

Krista Akins: OK.

Michelle Hudson: So it will not be necessary as this point for the 61 or the 93 patient discharge status codes to be on the inpatient hospital claim in order for it to be a qualifying LTCH stay.

Krista Akins: OK. So that is not – that is — we don't have to worry about that then.

Michelle Hudson: Correct. Not at this time.

Krista Akins: OK. All right, thank you.

Michelle Hudson: Sure.

Operator: Your next question comes from the line of Karen Holland.

Karen Holland: Thank you for taking my call. I know there's been a lot of controversy about the new set-1 measure that's goes live October 1st, a lot of discontent with the makeup of the measure, especially from the Hospital Association, people like that. I don't know if you could tell me, is there any hope of it being revised or repealed at all?

Cindy Tourison: I can tell you, at this point in time, we intend to move forward with data collection beginning with October 1 discharges.

Karen Holland: OK. Thank you.

Operator: There are no further questions in queue.

Additional Information

Amanda Barnes: OK, fantastic. An audio recording and written transcript of today's call will be posted to [the MLN Connects website](#). We will release an announcement in the [MLN Connects Provider eNews](#) when these are available.

On slide 53 of the presentation, you will find information and the URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary, and we hope you will take a few moments to evaluate your call experience.

Again, my name is Amanda Barnes and I'd like to thank our presenters. And also, thank you for participating in today's MLN Connects Call on the Final Rule for Hospital Inpatient and LTCH PPS final year — fiscal year, excuse me, 2016. Have a great day, everyone.

Operator: This concludes today's call. Presenters, please hold.

This document has been edited for spelling and punctuation errors.

-END-

