Centers for Medicare & Medicaid Services
Hospital & Hospital Quality
Open Door Forum
Moderator: Jill Darling
Tuesday, September 11, 2018
2:00 p.m. ET

Operator: Good afternoon. My name is (Jessa) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services Hospital & Hospital Quality Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you'd like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you.

Ms. Jill Darling, you may begin your conference.

Jill Darling: All right, thank you, (Jessa), and good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications and welcome to today's Hospital Open Door Forum.

One brief announcement for me and then we'll just dive right into today's agenda. This Open Door Forum is not intended for the press, and the remarks are not considered on the record. 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.

So our first speaker is (Jessica Wright).

(Jessica Wright): Thank you, Jill. As Jill said, my name is (Jessica Wright), and I am a Nurse Consultant in the Division of Health Information Technology at CMS. On August the 2nd, 2018, CMS released its updates to the fiscal year 2019 Medicare Prospective Payment policies and rates under the Inpatient Prospective Payment System and the Long-Term Care Hospital Payment System final rule.

Today, I will be reviewing the updates, the IPPS, and LTCH final rule made to the Promoting Interoperability Program for eligible hospitals and critical access hospitals or CAHs. Prior to the rule being finalized, we issued communication that the program's name was changed from the Medicare and Medicaid EHR Incentive Programs to the Medicare and Medicaid Promoting Interoperability Programs. We used the final rule as an opportunity to reiterate this.

We made the name change because the former name, EHR Incentive Programs, did not adequately reflect the current status of the programs as the incentive payments under Medicare have ended, with the exception of Subsection (d) Puerto Rico Hospitals, which will end under Medicaid in 2021. We believe the new name highlights the enhanced goals of the program and better aligns with the focus of the measures and objectives of the program.

In addition, the new program reflects a change in how we view patient data in a safe transmission in electronic health record systems. The rule reiterated that beginning with the EHR reporting period in calendar year 2019, participants of the Promoting Interoperability Programs are required to use the 2015 addition of Certified Electronic Health Record Technology also known as CEHRT. We are requiring this because the 2014 Edition certification criteria are out of date and insufficient for provider needs in the evolving health IT industry. In addition, we believe that it's beneficial to help IT developers and healthcare providers to move to more up-to-date standards and functions that better support interoperable exchange of information and improved clinical work flows.

One of the major improvements of the 2015 Edition is the functionality of application programming interfaces or APIs. API functionality supports

healthcare providers and patients in having electronic access to health information. It also contributes to quality improvement and offers greater interoperability between systems.

The 2015 Edition also includes certification criterion specifying a core set of data known as the Common Clinical Data Set that healthcare providers have noted are critical to interoperable exchange and can be exchanged across a wide variety of settings and use cases. It aims to support a common set of data classes that are required for interoperable exchange, and identify the predictable transparent and collaborative process for achieving those goals.

For new and returning participants of the Promoting Interoperability Programs attesting to CMS or their state Medicaid agency, we are finalizing an EHR reporting period of a minimum of any continuous 90-day period in both calendar years 2019 and 2020. The applicable incentive payment year and payment adjustment years for the EHR reporting period in 2019 and 2020, as well as the deadlines for attestation and other related program requirements are remaining the same. The continuous 90-day EHR reporting period will provide flexibility while eligible hospitals and CAHs are transitioning to the 2015 Edition CEHRT and provides additional time to adjust to the new scoring methodology.

For the Promoting Interoperability Program, we finalized the new performance-based scoring methodology that has fewer objectives and measures, and that moves away from threshold-based methodology that we currently use. The performance-based scoring methodology includes the combination of new measures as well as the existing stage three measures, broken into a smaller set of four objectives, which include Electronic Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange.

Eligible hospitals and CAHs must report on all required measures and earn a minimum total score of 50 points in order to satisfy the requirement to report on objectives and measures of meaningful use, which is one requirement for an eligible hospital or CAHs to be considered a meaningful user of the EHR and earn an incentive payment and/or avoid a Medicare payment reduction.

We believe this change is more flexible and less burdensome, and allows eligible hospitals and CAHs to put their focus back on patients, meaning that the performance-based scoring methodology will encourage hospitals to push themselves, on measures that are most applicable to how they deliver care to patients instead of increasing threshold on measures that may not be as applicable to the individual hospitals.

For the EHR reporting period beginning in calendar year 2019, the new performance-based scoring methodology applies to eligible hospitals and CAHs that submit an attestation to CMS under the Medicare Promoting Interoperability Programs. This would include Medicare only and dual-eligible hospitals and CAHs.

With regard to the objectives of measures, we have changed the following name -- the Patient Electronic Access to their Health Information Objective is now the Provider to Patient Exchange Objective. The current measure within this objective, which was titled Provide Patient Access Measure, is changed to Provide Patients Electronic Access to Their Health Information.

We are not making any changes to the name of the Health Information Exchange Objective. But we are changing the name of the Sending Summary of Care Measure to Support Electronic Referral Loops by Sending Health Information. The Public Health and Clinical Data Registry Reporting Objective is being renamed to the Public Health and Clinical Data Exchange Objective. We are maintaining the e-Prescribing Objective name and the Measures of the Public Health and Clinical Data Exchange Objective with the modification to the reporting requirements only.

We are removing measures from the Promoting Interoperability Program, which we feel do not emphasize interoperability and the electronic exchange of health information. This includes removal of the Coordination of Care through Patient Engagement objective and (the) associated measures, including view, download, and transmit measure; the patient generated health data measure, and the secure messaging measure. We are also removing the patient specific education measure within the provided patient electronic

access to their health information objective. We found this measure increased burden and did not further interoperability or the advancement of the health IT.

We are also removing the individual measures of the request Request/Accept Summary of Care and the Clinical Information Reconciliation Measures and combining their functionality into a new measure, which is called the Support Electronic Referral Loops by Receiving and Incorporating Health Information Measure.

We are finalizing two new measures related to the electronic prescribing of opioids. The measures are the Query of Prescription Drug Monitoring Program or PDMP and Verify Opioid Treatment Agreement. The Query of PDMP Measure is optional in calendar year 2019 and worth five bonus points. Having the measure be optional in 2019 will allow additional time to develop, test, and refine certification criteria and standards, and also workflows, while taking an aggressive stand to combat the opioid epidemic.

Because the measure is optional in calendar year 2019, there are no exclusions available. The Query of PDMP measure will be required beginning in calendar year 2020 and will be worth up to five points. However, since the measure is a required measure in 2020, there will be exclusions available for those who meet the criteria.

The Verify Opioid Treatment Agreement is optional for both calendar years 2019 and 2020, and worth five points for each year. We believe that extending the optional reporting status will allow healthcare providers additional time to research and implement methods for verifying the existence of an opioid treatment agreement, expansion of the use of such agreements in practice, and development of system changes in clinical workflows. However, we've planned to reevaluate the measure for calendar year 2021.

As discussed previously, we are also finalizing a new measure for the Health Information Exchange objective titled, Support Electronic Referral Loops by Receiving and Incorporating Health Information. This measure builds upon and replaces the existing Request/Accept Summary of Care and Clinical

Information Reconciliation measures. We are finalizing the public health and clinical data exchange objective requirements with modification from our proposal so that eligible hospitals in CAHs may report on any two measures (listed) in this objective.

Lastly, we are removing the exclusion criteria from all of the stage three measures retained except for the e-Prescribing measure, the Public Health and Clinical Data Exchange, and the new measure Support Electronic Referral Loops by Receiving and Incorporating Health Information.

For the Promoting Interoperability in calendar year 2019, there are no changes to the reporting requirements for Clinical Quality Measures, also known as CQM or eCQM. Beginning in calendar year 2020, we are removing eight of the 16 eCQMs from the Medicare and Medicaid Promoting Interoperability Programs to align with the Hospital IQR Program. We believe this will reduce the certification burden on hospitals; improve the quality of reported data by enabling eligible hospitals and CAHs to focus on a smaller, more specific subset of CQMs, while still allowing some flexibility to select which eCQMs to report that best reflect their patient populations; and support internal quality improvement efforts.

And finally, the rule formalizes the Promoting Interoperability Program for eligible hospitals in Puerto Rico, which had previously been implemented through guidance in 2016. We are aligning the requirements for eligible hospitals in Puerto Rico with the requirements of eligible hospitals in the Medicare PI Program.

Thank you for your time today, and I will now turn it over to Robert Morgan.

Robert Morgan: Thank you. This is Robert Morgan. I'm the measure's lead for The Hospital Inpatient Quality Reporting Program and the Hospital Value-Based Purchasing Program in the Division of Quality (Measurement) here at CMS.

The Hospital Inpatient Quality Reporting Program finalizes proposal to move 39 measures consistent with our commitment to producing a smaller set of more meaningful measures, including 18 measures beginning with CY 2018

reporting that address process of care, readmissions, and mortality following specific inpatient procedures and condition-specific payment; five measures beginning with CY 2019 reporting that address process of care mortality following specific inpatient procedures; 14 measures beginning with CY 2020 reporting that address healthcare-associated infection, process of care (by) subset of the program's electronic clinical quality measures and mortality following specific inpatient procedures; and lastly, one measure beginning with CY 2021 reporting that addresses complications following a specific inpatient procedure. And for a full breakdown of these measures, in the interest of time, I refer you to the final rule.

The remaining program measures provide valuable information critical to improvement of quality of care and patient outcomes. We also finalize a proposal to adopt a new measurable factor that is the costs associated with the measure outweigh the benefit of its continued use in the program. For the CY 2019 reporting period, we also finalize our proposal to continue using the same reporting requirements that were previously finalized for the CY 2018 reporting period, such that hospitals submit one self-selected calendar quarter of discharge data for four self-selected eCQMs in the Hospital IQR Program measure set. These reporting requirements were finalized in alignment with the electronic reporting requirements of eCQMs in the Promoting Interoperability Program for Hospitals.

Lastly, the CY 2019 reporting period required the use of a 2015 Edition of Certified Electronic Health Record Technology for (eCQM reported), which was discussed previously. Combined, these finalized policies amount to a $38.3 million cost reduction and over a million dollar reduction annual burden hours across approximately 3,300 IPPS hospitals.

And with that, I'll pass it to Lorraine.

Lorraine Wickiser: Thank you, Robert. My name Lorraine Wickiser and I'm the Long-Term Care Hospital Quality Reporting Program Coordinator in the Department of DCPAC here at CMS. Just a brief overview, I'm going to give you the updates in the fiscal year final rule 2019.

So the Long-Term Care Hospital Quality Reporting Program began collecting data in 2012. We continue collecting that data, and any LTCH that does not summit this data is subject to 2% reduction in their annual payment update.

This year, in the final rule, we proposed to remove the National Healthcare Safety Network measure, MRSA or the methicillin-resistant Staphylococcus aureus. We also removed another National Healthcare Safety Network measure, the Ventilator-Associated Event Outcome Measure. And we also removed the measure percent of residents or patients who were assessed and appropriately given the seasonal influenza vaccine measure. So we removed three measures from the QRP program.

We also added a measure removal factor, and that's factor eight. We did use that factor for the measures that we removed this year in the rule. We clarified policies for the provider which gave provider notification about non-compliance within the LTCH QRP. And that consisted of notifying the providers using at least one method that includes the QIES ASAP System, United States Postal Service, and also the Medicare Administrative Contractor or the MAC. So we will notify LTCHs in writing of our final decision regarding any reconsideration request using the same notification process.

That's what we proposed this year and finalized. And with that, I'm going to turn it over to (Katie Brooks) who will now review the IRF QRP.

(Katie Brooks): Thank you so much, Lorraine. My name is (Katie Brooks) and I am the Coordinator for the Inpatient Rehab Facility Quality Reporting Program in the Division of Chronic and Post-Acute Care here at CMS. So I'm just going to give you a few updates on the IRF final rule that pertained to the Quality Reporting Program.

So the Inpatient Rehab Facility Quality Reporting Program began collecting quality data in fiscal year 2014. Inpatient rehab facilities must submit quality measures and standardized patient assessment data or they are subject to a 2% reduction in their payment rates. There are 18 measures currently adopted in

the IRF QRP. Measures that are adopted into IRF QRP are publically reported on the Inpatient Rehab Facility Compare website.

In the Fiscal Year 2019 IRF PPS proposed rule, the IRF QRP proposed to address the Meaningful Measure's initiative to achieve the goals of a parsimonious measure set that focuses on the most critical quality issues in order to further reduce burden for clinicians and for providers. In the final rule, we've finalized the removal of two measures including the Patient Influenza Vaccination measure and the CDC Methicillin-Resistant Staph Aureus, or MRSA, Infection measure.

We also added the measure removal factor eight similar to what Lorraine mentioned for LTCH. This factor specifies that the costs associated with the measure outweighs the benefit of its continued use in the program. And also similar to the LTCH, we clarified policies for a provider notifications of non-compliance within the IRF QRP requirements. And finally, we finalized the public display for four IRF QRP functional outcome measures in Calendar Year 2020. Those four measures include the IRF Functional Outcome Measures: Change in Self-Care Score for Medical Rehabilitation Patients, Change in Mobility Score for Medical Rehabilitation Patients, Discharge Healthcare Score for Medical Rehabilitation Patients, and finally Discharge Mobility Score for Medical Rehabilitation Patients.

And that summarizes the updates for the IRF QRP. At this point, I'd like to pass it back to Robert Morgan.

Robert Morgan: Thanks. This is Robert again. So the Hospital Value-Based Purchasing Program finalized removal of four measures -- one from the safety domain that is perinatal care, PC-01; and three from the efficiency and cost reduction domain, that is AMI payment, heart failure payment, and pneumonia payment.

In addition, we adopted eight measure removal factors in alignment with Hospital IQR program; changed the name of the clinical care domain to the clinical outcomes domain, demand, beginning with the FY 2020 program (here); and we clarified that while the Hospital VBP measures will be selected

from the measure specified on the Hospital IQR Program, the Hospital VBP Program measure set will not necessarily be a subset of the Hospital IQR Program measure set. We did not finalize the proposal to de-duplicate fixed measures from the safety domain, remove the safety domain, or accordingly revise the domain waiting. At such, waiting for each of the four domains remained at 25 percent.

With that, I'll pass it to (Erin).

(Erin Patton): Thank you. Good afternoon. I'm (Erin Patton). I'm the Program Lead for the Hospital Readmissions Reduction Program. And today, I will be speaking about the HRRP Program as well as the HAC Reduction Program.

The Hospital Readmissions Reduction Program provides an incentive for hospitals to provide high quality patient care (or) reducing approval IPPS hospital payments by up to 3 percent for excess readmissions within hospital peer groups in six clinical areas. In the fiscal year 2019 IPPS Final Rule, CMS (finalized) proposals to establish the (approval) period for the FY 2019, FY 2020, and FY 2021 program years; and codify our previously finalized definitions of dual-eligible patients, proportion of dual-eligibles, and applicable period for dual eligibility. In addition, CMS specified the methodology for calculating aggregate payments for excess readmissions for fiscal year 2019. Measures under the HRRP will remain the same.

And now on to the HAC Reduction Program. The Hospital-Acquired Conditions or HAC Reduction Program establishes an incentive for hospitals to reduce hospital-acquired conditions by requiring the secretary to reduce (applicable) IPPS payment by 1% to all Subsection D hospitals that rank in worst performing 25% of all eligible hospitals.

In the FY 2019 IPPS final rule, CMS finalized the following three changes -- specified the dates of the time period used to calculate hospital performance for the FY 2021 HAC Reduction Program; adopted administrative processes to receive and validate National Healthcare Safety Network Healthcare-Associated Infection Data that is submitted by hospitals to the CDC beginning

in CY 2020; and adopted a new scoring methodology which will equally weigh all measures used in a hospital's program score.

Measures under the HAC Reduction Program will stay the same. In addition, retaining these measures in both the HAC Reduction and Hospital Value-Based Purchasing Programs will ensure that hospitals are incentivized to continually strive for both improvement and high-performance. It will also continue to promote transparency through public reporting of additional information about hospital performance on these measures as stakeholder will continue to be able to see both hospitals performance compared to all other hospitals and their performance improvement over time even after these measures are removed from the hospital IQR Program.

I will now turn it over to (Don Thompson).

(Don Thompson): Thanks, (Erin). The fiscal year 2019 increase in operating payment rates for the vast majority of general acute care hospitals payment with the IPPS is approximately 1.85%. That reflects the market basket of 2.9 percent, reduced by 0.8 percent productivity adjustment under the law. It also reflects a positive 0.5 percent adjustment supported by legislation, and a 0.75% adjustment to the update required by the Affordable Care Act, a reduction of 0.75 percent.

With that rate increase, together with other changes to the IPPS payment policies, we expect fiscal 2019 spending on inpatient hospital services to increase by about $4.8 billion. And that includes an increase of approximately $200 million for new technology add-on payments. CMS approved 10 of the 11 applications for the final rule for the new technology add-on applications.

Another component of that $4.8 billion are payments for Medicare uncompensated care. We distribute an amount, a pre-determined amount, to Disproportionate Share Hospitals based on their relative share of uncompensated care cost nationally. As required under law, we first estimate what would have been paid under the old Disproportionate Share Hospital Payment Program and 75% of that becomes the dollars that are available for the Medicare uncompensated care payments, and we adjust that for a change

in the rate of uninsured individuals as well as some other statutory factors. We expect to distribute approximately $8.3 billion in uncompensated care payments for fiscal 2019, and that's an increase of approximately $1.5 billion from fiscal 2018.

We're also continuing to work on the Worksheet S-10. The Worksheet S-10 data is where we get the uncompensated care cost data for hospitals in order to distribute those payments, that 8.3 billion. We have done a lot of work, with respect to the instructions for the Worksheet S-10 as well as work with individual hospitals to try to improve the data quality in the Worksheet S-10. We're continuing that work in 2018. This fall, we expect to start audits of the Worksheet S-10 data, and that would be for use potentially in fiscal year 2020 and later years.

Another aspect of the IPPS Final Rule involves updates to the wage index, the geographic adjustments we make to the payments for IPPS hospitals. We had also done a request for information about wage index disparities, between high and low wage index areas. We are reviewing all the information that we received as a result of that request for information, and we look forward to continuing to work on work on geographic payment disparities, particularly for rural hospitals to the extent permitted under current law.

With that, I'm going to turn it over to Michele Hudson to talk a little about the Long-Term Care Hospital PPS changes.

Michele Hudson: Thanks, (Don). For long-term care hospitals, we're updating the LTCH PPS Standard Federal Rate by approximately 1.35% that's based on the market basket as well as some statutory adjustments. This is the payment rate that's applicable to the Long-Term Care Hospital patients that meets the certain statutory patient criteria under the dual-rate payment system.

Overall, we're projecting Long-Term Care Hospital payments will increase by approximately nine-tenths of a percent or 40 million in 2019. And this reflects the continued phase in of the dual-rate payment system that was recently extended by law through 2019. And during that additional phase-in

time claims that long-term hospital cases that do not meet the statutory patient criteria are paid a blended federal rate instead of the full site neutral rates.

In addition, in the final rule, we also finalized our proposal to eliminate the 25% threshold policy and a budget neutral manner. To do so, we adopted the application of a budget neutrality adjustment to the Long-Term Care Hospital Standard Federal Rate. And that is a permanent adjustment of approximately nine-tenths of a percent.

Jill Darling: All right, well, thank you, everyone, for joining today's Hospital Open Door Forum. Thank you for all your questions. And if you do have any follow-up questions, you may send them into the hospital_odf@cms.hhs.gov. Thanks, everyone. Have a great day.

Operator: Thank you for participating in today's Hospital, Hospital Quality Open Door Forum Conference Call. This call will be available for replay beginning at 5:00 p.m. today until midnight on September 14th. The conference ID number for the replay is 33432065. The number to dial for the replay is 855-859-2056. This concludes today's conference call. You may now disconnect.

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