

Centers for Medicare & Medicaid Services
Hospital
Open Door Forum
Moderator: Jill Darling
April 25, 2018
2:00 p.m. ET

Operator: Good afternoon. My name is (Amy) 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 Open Door Forum.

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

I would now like to turn the call over to Ms. Jill Darling. You may begin your conference.

Jill Darling: Thank you, (Amy). Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications. And thanks for joining us today for the hospital open door forum.

Before we dive into today's agenda, I have one brief announcement, 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 do have any inquiries, please contact CMS at press@cms.hhs.gov.

So first, we have some of the proposed rulemaking for IPPS and LTCH. So first, we have Don Thompson.

Don Thompson: Thanks, Jill. Yesterday on April 24th, CMS issued the Medicare Hospital Inpatient Prospective Payment System and Long-Term Acute Care Hospital

Prospective Payment System Proposed Rule. The proposed rule will be open for comment for 60 days. The comment period will close on Monday, June 25th. The instructions for how to submit comments are available in the beginning part of the rule and the rule can be accessed from the CMS website.

Also on the CMS website is a fact sheet that discusses the major provisions of the proposed rule and we're going to touch on a few of the highlights here on the call today and then open it up for questions.

The proposed policies in the IPPS and the LTCH PPS Proposed Rule further advance the agency's priorities with respect to creating a patient-centered health care system to achieve greater price transparency, interoperability, and significant burden reduction. We want to allow hospitals to operate with better flexibilities and patients to have the information they need to become active healthcare consumers.

Along those lines, one of the things we wanted to highlight in the rule has to do with price transparency. Under current law, hospitals are required to establish and make public a list of their standard charges in an effort to further encourage greater price transparency and improve public accessibility to charge information.

CMS is updating its guidelines in this area to specifically require hospitals to make a public a list of their standard charges on the internet. So right now, hospitals have to make it public but it is not specifically required that be available via the internet. We are updating our guidelines to say it has to be made public via the internet and it also has to be in a machine readable format to allow third parties to aggregate and access the data in a way that might be beneficial to the public.

In addition, connected with the price transparency initiatives, we're still concerned that even with these changes challenges continue to exist for patients due to insufficient price transparency. Such examples might include patients being surprised by out-of-network bills that they get from physicians at in-network hospitals and patients being surprised by facility fees and physicians' fees in emergency room visits. So we're seeking information from

the public regarding barriers that prevent providers from informing patients of their out-of-pocket cost, what changes we need to make to support greater transparency around patient obligations and what can be done to better inform patients of these obligations. In addition, what role providers should play in this entire initiative? We're considering making information regarding hospital non-compliance with these requirements public and we also intend to consider additional enforcement mechanisms in future rulemaking.

So that's one of the major initiatives with respect to price transparency in the rule. There also are the usual payment updates under the IPPS and the LTCH PPS. And so, for this year, with respect to some of the payment rate changes, the proposed increase in operating payments for IPPS hospitals is 1.75 percent, this reflects the projected Hospital Market Basket update of 2.8 percent, reduced by 0.8 percentage point productivity adjustment. This also reflects a proposed plus of 0.5 percentage point adjustment that's required by the law as well as a minus 0.75 percentage point adjustment to the update that's required by the Affordable Care Act.

Taking those all into account, you end up with a 1.75 update. Taking into account additional changes, including in uncompensated care payments, capital payments, and changes to low-volume hospitals, we expect an additional 1.6 percent. And that would lead to a total increase in IPPS payments of approximately 3.4 percent.

Additional payments that will occur as in the past are penalties for excess readmissions as well as a penalty for hospitals in the worst-performing quartile under the Hospital-Acquired Condition Reduction Program, and changes upward and downwards to the hospital update for specific hospitals based on the Hospital Value-Based Purchasing Program.

All in all, we expect to spending; on inpatient hospital services including capital to increase by about \$4 billion in fiscal 2019.

I mentioned one portion of the increase has to do with Medicare uncompensated care payments. CMS distributes a prospectively determined

amount to Medicare Disproportionate Share Hospitals based on their relative share of uncompensated care nationally. As required under the law, we set that amount equal to 75 percent of what would have been paid as Medicare disproportionate hospital share payments and we adjust that for the rate of change in the uninsured individuals and other factors.

In this rule, we're proposing to distribute about \$8.25 billion in uncompensated care payments in fiscal 2019, an increase of approximately 1.5 billion from the fiscal 2018 amount. And that is due to the two factors, one is how much we otherwise would have paid for DSH in the absence of the uncompensated care program, as well as updated estimates of the change in uninsured individuals based on the latest available data.

In order to distribute that uncompensated care pool, CMS is proposing to continue to incorporate the uncompensated care data from Worksheet S-10 into the methodology, specifically for fiscal 2019, we're proposing to use Worksheet S-10 data from fiscal 2014 and fiscal 2015 cost reports in combination with insured low-income days from fiscal 2013 cost reports. So last year, we had used one year of the Worksheet S-10 data and two years of the insured low-income days data and in fiscal 2019, we're proposing to use two years of the Worksheet S-10 data and one year of insured low-income day's data.

Also in the proposed rule, we wanted to highlight, there is a request for comment with respect to the CMS wage index, which is how we geographically adjust the Medicare payments. As we discuss in the rule, there've been numerous studies, analysis and reports on the disparities between the wage index values for individual hospitals and the wage index values on different geographic areas, as well as on ways to improve the Medicare wage index. There has been some time that has elapsed since those studies were done. So we're inviting the public to submit comments, suggestions, and recommendations for policy changes that we might be able to make to the Medicare wage index to address some of these issues. We would welcome appropriate supporting data and specific recommendations. And

also, if there are any novel legal questions raised by the suggestions from the public, we'd also invite legal analysis as well.

So, with that, I'm going to turn it over to Michele Hudson to talk a little bit about the long-term care hospital update.

Michele Hudson: Thanks, Don. In the proposed rule, CMS is proposing a 1.15 percent annual update to the long-term care hospital standard federal rate for 2019. This is the rate – payment rate that's applicable to long-term care hospital patients that meet the statutory patient criteria under the dual rate payment system required by fact sheet that began in 2016.

Similar to the proposed IPPS update, the long-term care hospital rate update is based on our estimate of the long-term care market basket increase for inflation of 2.7 percent, our estimate of the statutory adjustment for productivity of 0.8 percent. And, a statutory reduction of 0.75 percent as required by the Affordable Care Act.

In addition to our usual budget neutrality adjustment for proposed changes to the area wage adjustment, for 2019, we're also proposing to apply a one-time budget neutrality factor of approximately 0.9 percent to the long-term care hospital standard federal rate to ensure that our proposed elimination of the 25 percent threshold policy is budget neutral and I'll talk more about the 25 percent policies proposals in a minute.

Overall, based on the changes included in this proposed rule, we project that long-term care hospital, PPS payments, we've decreased by approximately a (10) percent or \$5 million in 2019. This estimate is based on the rate update and adjustments I just described but also reflects the continued phasing of the dual rate payment system under the statute, which was recently extended through 2019 by the Budget Act of 2018.

Prior to the passage of that recent legislation, the dual rate LTCH PPS System was the phasing under the statute over two years, first in 2016 and 2017. During that phasing period, long-term care hospital cases that don't meet the statutory patient criteria received a blended payment.

The provisions of the Bipartisan Budget Act extended this blended payment for an additional two years in 2018 and 2019. In addition, the Budget Act also include a provision that reduces the IPPS comparable payment amount option under the site neutral rate for the cases that don't meet the statutory patient criteria, reduces that amount by 4.6 percent for fiscal years 2018 through 2026.

These changes to the LTCH PPS payments for 2018 that were in accordance with the provisions of the Bipartisan Budget Act were implemented in the Medicare claims processing systems in the beginning of April and Medicare administrative contractors are working to reprocess those claims for 2018.

Back to the proposed rule for 2019, the proposed rule also contains proposals related to the 25 percent threshold policy. This is the payment adjustment under the LTCH PPS that's applied, if the number of patients to an LTCH from the same referring hospital are in excess of a threshold, generally 25 percent.

Since that policy was enacted over 10 years ago, several laws have the latest implementation until 2018 and then in last year's rulemaking, we implemented an additional one-year regulatory delay while we consider – to consider stakeholder feedback, or whether or not the 25 percent policy is still needed.

In light of the significant changes to LTCH admission practices, as well as the changes to the long-term care hospital PPS payment structure that have occurred since the 25 percent policy was originally introduced, including those new patient statutory patient criteria that began in 2016, we recognize that the policy concerns that led to the adoption of that policy have been ameliorated. So in the proposed rule, we included a proposal to eliminate the 25 percent threshold policy.

As part of that proposal, we also included a proposal that the elimination would be done in a budget neutral manner, so that there would be no change to aggregate long-term care hospital PPS payments as a result of this proposed change. Because the policy goal of this proposed elimination of the 25

percent policy is to remove the specific regulations now that the concerns underlying the creation of the policy have been addressed and is – it's not to increase Medicare payments to LTCH PPS aggregate payments under the system.

So we estimate without further adjustments eliminating the 25 percent threshold policy would increase aggregate LTCH spending by about \$36 million. So to offset that projected increase in payments, we propose to include a one-time adjustment to the federal rate of 0.9 percent in 2019.

That includes the provisions that were in the proposed rule for IPPS and LTCH PPS but before – payment provisions. Before I turn it over for a discussion on the quality provisions, I also wanted to note that on – yesterday, CMS also issued a notice in the Federal Register to implement to the extender provisions, IPPS extender provisions that were included in the Bipartisan Budget Act, the one for the extension of payment adjustment for low-volume hospitals and also the extension of the Medicare Hospital Dependent program or MDH program.

So in that notice, it provided additional detail on our implementation of the extension of the low-volume payment adjustment for 2018. The original lead temporary increases to that payment policy had expired on September 30th 2017 and this legislation extended those payment provisions into 2018. Similar to the long-term care hospital blend extension, the systems changes that are needed has been put in place but this notice announces the process that we're using to implement this increase in low-volume hospital payments under that statutory provision.

Consistent with past practice, in the notice, we announced the process for requesting a low-volume hospital adjustment for 2018 – for F.Y. 2018 payments. Hospitals would need to notify their MACs in writing and provide documentation that they continue to meet the mileage criterion by sending a written notification that's received by the MAC no later than 30 days from the issuance of that notice which is May 24th. And that includes – that would include whatever documentation is required to indicate that the hospital meets the mileage criteria.

If the written documentation request isn't received by the MAC by that deadline, then the adjustment will be made prospectively effective 30 days from the date that the MAC makes the low-volume hospital determination.

In addition, that notice also includes information about the extension of the Medicare Hospital Dependent program. That extension continues from 2018 through 2022. In general, hospitals that had previously qualified as an MDH don't have to do anything to have that status reinstated back to October 1st, 2017.

However, as also described in that notice, it's a Medicare – former Medicare Dependent Hospital has subsequently become classified as the Sole Community Hospital or canceled, its rural reclassification status on or after October 1st, 2017. Those hospitals will need to work with their MACs in their regional office and may have to reapply for such statuses in order to return to being a Medicare Dependent Hospital.

And, that covers what's in the extender's notice for 2018 team. So I'll hand it over to Grace Snyder.

Grace Snyder: Thanks, Michele. So, with respect to our hospital quality programs, as part of our commitment to reducing burden and using a smaller set of measures that are more meaningful to patients and their providers, we took a close, hard look at the measures in our five hospital quality reporting and value-based purchasing programs. These programs are, the Hospital Inpatient Quality Reporting Program, the Hospital Value-Based Purchasing Program, the Hospital-Acquired Condition Reduction Program, the Hospital Readmissions Reduction Program, and the PPS-Exempt Cancer Hospital Quality Reporting Program.

At a very high level, our proposals seek to remove a total of 25 measures from these programs and would de-duplicate another 21 measures while still maintaining meaningful measures of hospital quality and patient safety. And by de-duplication, we mean to remove a measure from one program where the same measure is also used in another program.

Overall, our goal with these proposals is to streamline the measure sets, and to reduce the amount of time that clinicians and providers spend on reporting measures to CMS, so they can spend more time with patients. We estimate that the removal of these measures over – across the five hospital quality programs would result in over 2 million hours of burden that are reduced and saving approximately \$75 million.

So, please keep an eye out for Listserv messages about upcoming webinars where we'll be able to go into more detail about the specific proposed changes to our hospital quality programs.

Thank you. And now, let me turn it over to (Steven Johnson).

(Steven Johnson): Thank you, Grace. So in this (rule), as you probably all heard about, the new name change for the Medicare and Medicaid EHRs in a program. As a result of the overall in trying to focus more interoperability, we have announced that in this rule, that we are now called the Medicare and Medicare Promoting Interoperability Programs. Now, this is effective in 2018. It's not a proposal but it is more of announcement into rule.

Additionally, in the 2019 IPPS rule, we have provided that in 2019, all stakeholders as well as (hospital) cost, as well as EPs in a Medicaid EHR – in the Medicaid Promoting Interoperability Program have to attest to stage three of the meaningful use program using the 2015 edition of CERT. Additionally, we proposed a minimum of (any 20) days in 2019 and 2020 in order to make sure that we continue with the agency's mission of reducing burden and providing flexibility.

We also – in conjunction with the name change and in conjunction with our goal to move forward, is making sure every patient has access to their care, we have proposed a new scoring methodology. We are moving away from an all-or-none approach more to one that focuses on letting providers of (hospice and costs) choose what measures are most appropriate for their practices.

This includes three measures in e-prescribing, two measures in health information exchange objective, one measure to provider patient exchange, and one measure in the public health and clinical data exchange and additional measure as well, additional information regarding the specifics of the proposed scoring methodology along with the breakdown (will be provided in) future webinars.

We also are proposing two new opioid measures, North Carolina with HHS and agency mission of tackling the opioid epidemic. These two new measures are the query to prescription drug monitoring program and the new verified opioid treatment agreement.

We're also aligning our proposals with the IQR – hospital IQR program. They're reducing the number of CQMs, Clinical Quality Measures available from 16 to 8, and we're beginning to encourage hospitals to submit their Clinical Quality Measures electronically through the Hospital IQR Program.

Additionally, in this rule, they're proposing to formalize the Medicare Promoting Interoperability Program for eligible hospitals in – hospitals in Puerto Rico. This is previously implemented in 2016 through guidance and in this proposal, we are aligning the requirements with the requirements for the eligible hospitals in the Medicare Promoting Interoperability Program.

At this time, I would like to pass it over to (Lorraine Wickiser).

(Lorraine Wickiser): Thank you, (Steven). So I'm just going to follow up my colleagues and talk about the quality reporting program within the IPPS LTCH PPS Proposed Rule. Briefly, the LTCH QRP began collecting quality measures in 2012. Currently, there are 20 measures that are adopted within this program. Last year in the fiscal year '18, we finalized the removal of two measures. This year, we're going to propose the removal of three more measures to address the Meaningful Measures Initiative and to achieve the goals of a parsimonious measure set that focuses on the most critical quality issues with the least burden to the clinicians and providers.

So the three measures that we're proposing this year for removal include patient influenza vaccination measure, two CDC measures including MRSA which is the methicillin-resistant Staph aureus, and the ventilator-associated events measure. If these proposals are adopted, we foresee that there will be a reduction in burden related to data collection as well as administrative related burden. We're seeking public comment on the removal of these measures.

Thanks. And back to you, Jill.

Jill Darling: All right, thank you, (Lorraine).

Next, we have Bill Lehrman who has an announcement on an HCAHPS podcast.

Bill Lehrman: Thank you, Jill. Just changing the tone a bit here, I'd like to announce today and hopefully encourage interest in a new podcast on our HCAHPS online website. HCAHPS, as probably all you know, is the Patient Experience of Care Survey that's administered by over 4,200 hospitals.

This year, we have been adding podcast to our HCAHPS online website to encourage hospitals especially to become more involved and more aware of what they're doing and what the survey vendor might be doing.

This new podcast, which we debuted this month, is about improving response rates of HCAHPS hospitals. The link length to the actual podcast is in the invite, so you should be able to click on it and see the podcast but I'd like to give a little plug for that podcast today.

We recommend that hospitals, first of all, are aware of the response rate they get on the survey. And secondly, maybe talk to the survey vendor about improving the response rate. The response rate for HCAHPS is published on HCAHPS – I'm sorry, on the Hospital Compare website.

I should probably mention what response rate means, and that's essentially the number of people who were surveyed who actually complete the survey. Currently, the national response rate is about 28 percent or 29 percent. Some

hospitals are a lot higher, some hospitals are a lot lower. We especially encourage hospitals that have lower response rates to investigate with their vendor what they might be able to do to improve that response rate.

Having a high response rate means having more efficient data collection. You're contacting fewer patients to get more responses. The higher the response rate, the more reliable the scores on HCAHPS Survey and the more representative of the sample of the patients, your patients, who answered the survey.

In particular, the podcast talks about a number of techniques that hospitals and survey vendors should investigate and perhaps employ to a greater degree. And I'll just briefly go over what those techniques are.

So to improve your response rate on the HCAHPS Survey, one idea is to limit the number of supplemental items you or your vendor adds to your survey. We have seen that – HCAHPS project team have seen that offering a large number of supplemental items creates a poorer response rate. It degrades its response rate. So hospitals have to carefully consider how many supplemental items they add to these surveys.

Second, know your patient population and offer the survey in a language that that population speaks. The HCAHPS Survey is offered in English, Spanish, Chinese, Russian, Vietnamese and Portuguese. If your hospital – if your patient population includes a large number of patients who speak one of those non-English languages, we strongly encourage you to work with your vendor to assure that those patients receive the survey in the language they prefer to speak.

Another technique is to schedule patient callbacks. As you know, the HCAHPS Survey is offered in mail, telephone, IVR and a mixed-mode, which is a mail survey followed by telephone follow-up calls. If you're using a telephone survey, and approximately 40 percent of hospitals do use telephone survey, we encourage, in fact, we require that if a patient is contacted and says, "This is not a good time to talk, can you call me back on Saturday

morning" that the hospital or the vendor schedules that callback at the patient's request and makes the callback at the appointed time.

It is now required in the HCAHPS protocols that telephone – patient survey by telephone who request a callback have that callback request honored by the survey vendor or the hospital, whoever is collecting the data. And we think this is increasingly necessary because something like 70 percent of American adults have smartphones, probably even more have mobile telephones. That means it's more likely they can be contacted at a time or place that's not convenient to do a survey, but they may – they should be offered the opportunity to reschedule the call at a time convenient to the patient. And we strongly encourage that, we require that, those callback requests be honored.

Another technique for improving response rate is to make sure that the patient contact information is up to date current and correct, this again is a requirement of the HCAHPS Survey. The hospital or the vendor ought to be checking the contact information before they send a survey to a patient or call the patient to make sure the contact information is correct. That obviously is going to help your response rate if the survey goes to the correct contact address or telephone number.

And finally, and a bit more ambitiously, we suggest hospitals consider using the HCAHPS mixed-mode of survey administration. Mixed-mode is a telephone – I'm sorry, a mail survey to a patient, and if it's not returned within a certain amount of time, then making telephone calls to that patient. We have found through empirical research that this method of survey administration yields the highest response rates and the most reliable data and the most representative samples.

Hospitals may argue that this probably cost more than doing either mail alone or telephone alone. But hospitals should also consider the cost of getting 300 completed surveys and how many attempts they currently make to get the 300 completes, minimum 300 completes which is required for HCAHPS. And whether perhaps a mixed-mode might even be more efficient than the current mail or telephone-only approach. That's something we'd like hospitals and their vendors to consider.

So again, the link to the new podcast is in the invite, it's on our HCAHPS online website. We will be presenting more and more podcasts through the coming year and we'll be announcing them on this hospital open door forum. And strongly encourage you to look at those podcasts and discuss the techniques or ideas with the people in your hospital who administer the survey, or monitor the survey, and your survey vendor.

With that, I'll pass it back to Jill.

Jill Darling: All right, thank you, Bill. And thank you to all of our speakers today. (Amy), we will open the lines for Q&A, please. Oh, I'm – excuse me, sorry. I'll kick it back to (Lorraine) and she has a training announcement.

(Lorraine Wickiser): Yes, thanks, Jill. Yes, shifting gears one more time. I just want to make an announcement that CMS is hosting a two-day training for the inpatient rehabilitation facility and the long-term care hospital within these Quality Reporting programs, train-the-trainer event which – for providers, that'll be May 8th through 10th in Baltimore, Maryland. May 8th will be for LTCH only, 9th will be a combined training for IRF and LTCH providers and then May 10th will just be for IRF providers. Though, you can attend all three if you want or any combination thereof.

Topics will include information on new items, public reporting, report use and resources available to assist providers in better understanding those IRF and LTCH QRPs. Details are available on the IRF and LTCH QRP respective training web pages and the links are provided in the agenda and there's also still time to sign up for the training. Thank you.

Don Thompson: Thanks very much for everybody for calling in. I encourage everyone to read the IPPS and LTCH NPRM, look at the fact sheet and the materials that we have, and we look forward to receiving the comments. Thanks.

Operator: Thank you for participating in today's Hospital Open Door Forum conference call. This call will be available for replay beginning today, April 25th, at 5:00 p.m. Eastern Time through April 27th at midnight. The conference ID

number for the replay is 32622211. 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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