

Centers for Medicare & Medicaid Services
Hospital, Hospital Quality
Open Door forum
Moderator: Jill Darling
May 16, 2017
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, 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 would 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. I would now like to turn the call over to Ms. Jill Darling, you may begin.

Jill Darling: Thank you (Amy). Good morning and good afternoon everyone, I'm Jill Darling in the CMS Office of Communication. We have a pretty good agenda today for you so just one brief announcement from me and then we'll – and then I'll hand it off to our chair Tiffany.

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 enquiries please contact CMS at press@cms.hhs.gov. I'll now hand it off to Tiffany.

Tiffany Swygert: Hi everyone, this is Tiffany Swygert. I'm the acting director of the division of outpatient care here at CMS and I'm very pleased to be able to have – to be able to host this hospital open door forum today. As Jill mentioned we do have a rather full agenda. I just wanted to give a couple of reminders.

The fiscal year 2018 inpatient prospective payment system and long term care -- acute care hospital proposed rule is the bulk of what we'll be talking about today. That rule was displayed in the federal register on April 14th and is subject to a 60 day public comment period which is scheduled to end on June 13th of 2017.

All comments that are submitted through the channels that are outlined in the proposed rule itself will be considered and the final rule will be where those final decisions and determinations are made based on the public comments received.

So I just wanted to give a reminder that the purpose of today's call is to give an overview of some of the high level proposals that were included in the rule. But since we're in the middle of rulemaking we're not able to go into further detail about any specific proposals other than what was already publicly communicated in the proposed rule itself.

Also while it wasn't on the agenda, we will also be covering an item that was included in the inpatient rehab facility proposed rule as well that'll be a little bit later on the call. But we look forward to having the opportunity to talk about the proposals that were in both of those rules today and to hear the questions that you have.

But again I would encourage you to the extent that you have comments whether they're in support or not for the proposals that are made that you submit those public comments through one of the avenues that is mentioned in the proposed rule itself. And again for the inpatient and long term care rule you have until June 13th, 2017 to submit a timely public comment. With that I will turn it over to Mr. Donald Thompson the director of the division of acute care to begin talking about the inpatient rule.

Donald Thompson: Thanks Tiffany. One of the center pieces of the fiscal 2018 inpatient prospective payment system NPRM is a request for information. And what that is, we're looking for ideas for either regulatory, sub regulatory, policy, practice, or procedural changes to help us improve the payment systems.

This is a very wide open request so we're looking for broad ideas. If people want to also provide data and specific examples that would be welcome as well as clear and concise proposals. If there are novel legal questions or analysis we would also welcome those relating to some of the issues.

The idea is that we would use this to plan out future regulatory or sub regulatory action, depending on the concept that's provided to us, related inpatient and long term care hospitals. We would do anything through regulation would be in future guidance that we would provide through rulemaking.

So in addition to that centerpiece of the IPPS rule we also have some of the usual proposals and information that's contained in the IPPS, one of which is what the update, the proposed update is for fiscal 2018.

And so based on the information that we have right now for the NPRM, some of which will be updated for the final rule, the market basket update for inflation is 2.9 percent and then there are a number of adjustments, statutory and/or regulatory adjustments that occur to that 2.9 percent, the first of which is a minus 0.4 tenths of a percent adjustment for multifactor productivity.

The multifactor productivity adjustment is provided for in the statute and the current estimate of it is four tenth of a percent. The second factor was discussed in prior rulemaking and that is a minus 0.6 percent adjustment related to the two-midnight policy and the adjustments that were put in place for that.

Last year we had increased the rates by six tenths of a percent related to the two-midnight adjustment and that was a onetime adjustment that we were making. And so now we're reducing the rate by six tenths of a percent to remove that one time plus six tenths of a percent that we had put in place last year.

Another adjustment that we're putting in place has to do with the provision in the Cures Act. The Cures Act specifies that we increase the fiscal 2018

update by 0.4588 and that number is directly in the law. The reason for that it's related to adjustments that were made for documentation and coding that originated beginning back in fiscal year 2008 and over the intervening years there have been a variety of regulatory and statutory changes, the latest of which is the provision in the Cures Act indicating that we should increase the update by 0.4588 for next year and then in the following years there are other provisions in the law that will increase the update by 0.5 percentage points for the four years after that.

Another adjustment occurring for fiscal 2018 is an adjustment that's provided for in the Affordable Care Act and that's a minus 0.75 percentage point adjustment. So, taking the 2.9 minus the four tenths of a percent for multifactor productivity minus the 0.6 for the two-midnight plus the 0.4588 for the Cures Act minus the 0.75 for the ACA and you end up with an update of 1.6 percentage points, a proposed update of 1.6 percentage points for fiscal year 2018. And again some of those, the ones that are not specified in statute such as the multifactor productivity or the market basket, will be updated for the final rule based on the most recently available data.

When you combine that rate increase, that 1.6 percent, with the other proposed changes in the IPPS rule you end up with an overall change in operating payments of 1.7 percent. And then on top of that there are some changes I'm going to talk about in a little more detail in a second related to uncompensated care and the amount of money available for Medicare uncompensated care payments. That's going to add about an additional 1.2 percent to the update so taking the 1.7 percent and increasing it by the 1.2 for the uncompensated care we project that the operating payments will go up 2.9 percent.

There will be other additional payment adjustments that could be hospital specific such as adjustments for excess readmissions, a one percent penalty for hospitals in the worst performing quartile under the hospital acquired condition program, and there'll be continued upward and downward adjustments under the hospital value based purchasing program. We expect

the total Medicare spending on inpatient hospital services, including capital, will increase by \$3.1 billion in fiscal 2018, that's our current projection.

I talked a little about Medicare uncompensated care payments. As I mentioned we expect to be able to distribute additional money this year compared to – in fiscal 2018 compared to fiscal 2017.

The way the Medicare uncompensated care program payments work is that first we estimate what, and this is under the statute, first we estimate what we would have spent under the Medicare disproportionate share hospital program what we would have spent prior to some changes that came about because of the ACA.

Seventy-five percent that, of what amount we estimate we would have spent at Medicare disproportionate share hospital payments, is set aside for uncompensated care payments but that number is then adjusted for a number of factors one of which is the change in the uninsured individuals, the change of the rate of uninsured individuals.

Another thing that's changing in terms of the size of the pool that's available for fiscal 2018 is that for the first time in 2018 we're allowed to update some of the estimates with respect to the uninsured rate. Prior to 2018 the number that we were to use was specified in the statute and in particular what the uninsured rate was for some of the more historical years. We now have beginning in 2018 the ability to use updated information for that.

We are proposing to use information on the uninsured that the office of the actuary had calculated for the national health expenditure accounts. So we intend to use that for this purpose as described in the proposed rule.

Taking all that into account, what we otherwise would have paid for DSH, taking 75 percent of that, updating the information on the uninsured, we expect an increase of approximately \$1 billion in what we can spend in fiscal 2018 for uncompensated care payments up from about 6 billion estimated in 2017.

Another big change in uncompensated care has to do with the way we distribute that money. So we have an estimated uncompensated care amount as I mentioned of about \$7 billion for fiscal 2018 and we are proposing to begin to use the Worksheet S-10 data on uncompensated care from the fiscal 2014 cost reports combining that with insured low income days, which is how we used to distribute it prior to 2018.

Combining that with insured low income days from the two preceding cost reporting years and putting those three things together so the two years of the preceding cost reporting periods based on low income days, one year from the Worksheet S-10 data, and we've proposed to use that to distribute that \$7 billion in uncompensated care payments. And again we're seeking comments on all those proposals.

We have not made a proposal for fiscal 2019 so the proposal we have made is for fiscal 2018 but of course we're welcoming comments both on the fiscal 2018 proposal and if people had thoughts on what we might be – what we should do for 2019 in terms of moving that forward.

We did say in the rule obviously one expectation would be that we could go to two years of using the cost reporting data, so the fiscal 2014 and the fiscal 2015 could be part of the calculation in 2019 and we would use one year of the low income insured days as we roll everything forward and people can comment on that as well.

Switching gears a little bit over to the long term care hospital prospective payment system, so we are continuing to phase in the dual rate payment system under the LTCH proposed rule. What the dual rate payment system does is that there are some clinical criteria in the statute for when patients should get the higher federal rate LTCH payment. And patients that don't meet that criteria are paid a lower site neutral payment under the LTCH PPS. That has been phased in over the last couple of years and that phase in will continue.

Mainly as a result of that phase in we expect that overall LTCH PPS payments will decrease by approximately 3.75 percent in fiscal 2018. That's about \$173

million. But for the LTCH standard federal payment rate cases the update for that is specified in statute at one percent. So overall the system we expect a decline of 3.75 percent or \$173 million in fiscal 2018 as a result of the phasing of the new system, where some cases are going to be paid at this lower rate, but for the cases that are paid at that higher standard federal payment rate we expect those to go up by about one percent.

Another provision in the rule has to do with the 96 hour rule for critical access hospitals, the 96 hour certification requirement. That requirement is in statute and the law requires that a physician certify that an individual may be reasonably expected to be discharged or transferred to another hospital within 96 hours after admission to the CAH.

Although there's nothing we can do in regulation with respect to that, the existence of that requirement, based on feedback from stakeholders what we have done reviewing this from a medical review standpoint is we've made it a very low priority for medical record reviews conducted on or after October 1st, 2017 and this is described in greater detail in the proposed rule. What that means is that absent concerns of fraud, waste or abuse that contractors will not be conducting medical record reviews for the 96 hour certification requirement.

Another thing going on related to the IPPS has to do with the fiscal 2018 wage index. So in the fiscal 2018 wage index, we have with respect to that, we have recently put up on April 28th we put up the final 2018 wage index and occupational mix data public use files on the webpage on our website. Hospitals have about a month to verify their data and submit correction requests. So just a reminder at this point in the process that the correction requests are limited to mistakes that CMS or the MAC made as a result of mishandling the final wage index and occupational mix data and the deadline is May 30th for you to submit those requests to us. And again, there's more information on our website on the wage index page.

I also wanted to mention although not related to the fiscal 2018 wage index timeline, we're already started work on the fiscal 2019 wage index and on

May 19th we'll be releasing the preliminary fiscal 2019 wage index files and that has the unaudited fiscal 2015 wage data from Worksheet S-3.

We note we'll be using the occupational mix data from 2016, and since hospitals are supposed to submit this data, the first public use file containing the occupational mix data will be posted on the CMS website on July 12th, 2017. Also wanted to remind folks that hospitals have until September 1st, 2017 to review and request revisions to the posted wage and occupational mix data. And that's it for IPPS. I'm going to turn it over to Jill.

Jill Darling: All right, thanks Don. Next we have Steven Johnson who will talk about the EHR Incentive Program.

Steven Johnson: Thanks Jill. So I wanted to provide an update on what changes we are proposing in EHR Incentive Program. For 2018 we're proposing to modify the EHR reporting period from the full calendar year to a minimum of any continuous 90 days for new and returning participants in the Medicare and Medicaid EHR Incentive Program.

There were a couple of requirements on the 21st Century Cures Acts. The first requirement that we are proposing in the rule is to add a new exception from the Medicare payment adjustment for eligible professionals, eligible hospitals and critical access hospitals who are unable to comply with requirements for being a meaningful user because their certified EHR technology has been decertified under the office of the national coordinator health IT certification program. Qualified, qualifications for this exception will require the completion of an application.

Additionally the 21st Century Cures Act is proposing to implement a policy which payment estimates will be made for eligible professionals who furnish substantially all of their covered professional services in an ambulatory surgical center. This exception is applicable for 2017 and 2018 Medicare payment adjustments.

We are requesting public comment of two proposed alternative definitions to identify the minimum percentage of an eligible professional's covered

professional services that must be furnished in an ambulatory surgical center to be considered substantially all of their covered professional services. The first definition proposes 75 percent or more of covered professional services and alternative of 90 percent or more of their covered professional services.

Additionally we're proposing to use (placement) service code 24 to identify the services furnished in an (ASC) and we're requesting public comment on where the point of – placement service code 24 or other mechanisms should be used to identify sites of service in addition to or lieu of placement service code 24.

Additionally we not necessarily propose but (part of logical outgrowth) of say we work with (OMC) to monitor deployment and implementation status of certified electronic health record technology certified to 2015 additions.

And if we identify a change in current trends and significant issues with certification deployment of the 2015 addition we will consider flexibility in the use of certified EHR technology in 2018. This will be for all participants in the Medicare and Medicaid electronic health record incentive programs. I'd like to turn it back over to Jill. Thanks Jill.

Jill Darling: You're welcome. Thanks Steve. Next we have (Lorraine Wickiser) who we're going over LTCH QRP Proposals.

(Lorraine Wickiser): Good afternoon. As Jill said I'm (Lorraine Wickiser), I'm the Long Term Care Hospital Quality Reporting Program Coordinator at CMS. As Tiffany has already mentioned the Rule (display) date and also that the public comment that will end on June 13th for the-IPPS/ LTCH PPS proposed rule.

In this year's rule we have a few proposals. The first one is the modification of the measure percent of residents or patients with pressure ulcers that are new (or worsened) which includes additional types of pressure related wounds and data collection methodologies and are aimed at reducing the burden by removing certain data elements that are no longer required for the calculation of the modified measure.

And it also helps improve the reporting of these pressure ulcers. We're also proposing to sunset the current measure percent of residents or patients with pressure ulcers that are (newer or worsened) if this measure is to be finalized.

In this measure we're also proposing two companion ventilator measures. The first one is the process measure that includes the compliance of spontaneous breathing trial including tracheostomy collar or continuous positive air wave pressure breathing trial by day two of the LTCH stay. The second measure is an outcome measure which is a ventilator liberation rate measure. Also the LTCH QRP we're proposing to sunset the measure Potentially Preventable 30 day Post discharge Readmission measure for Long Term Care Hospital Quality Reporting Program and replace it with Potentially Preventable Readmission 30 day post discharge measure.

Also, we're proposing modifications to the assessment instruments specific to the post acute care setting. For the fiscal year 2019 we are proposing the submission of standardized assessment data to satisfy the data reporting elements of the categories of medical conditions, and to meet these conditions we're proposing the submission of this standardized assessment data that's already collected on the pressure ulcer measure and are used to calculate this quality measure.

We're also proposing to follow the existing pattern established through previous rulemaking for the data submission that would be calendar year quarter two, through quarter four of the new data elements for the APU determination year, the first year followed by a full calendar year schedule for all new assessment based measures and standardized data submission for all subsequent APU years.

We're also having the expansion of all previously finalized policies associated with measures to include these standardized assessment data submission procedures and policies. And for the LTCH QRP this year we're proposing to remove the program interaction items from the LTCH care data set. And that's it.

Jill Darling: All right, thank you (Lorraine). Next we have (Christine Grose) who will go over the IRF QRP proposals.

(Christine Grose): Thank you Jill. The Inpatient Rehabilitation Facility Prospective Payment System Proposed Rule is now on display in the federal register. The deadline for receipt of public comments is June 26th. I'll be sharing some of the proposals related to the IRF QRP portion of this rule.

We are proposing to remove the current pressure ulcer measure and replace it with a modified version of the current measure called changes in skin integrity, post acute care, pressure ulcer or injury. The new measure includes unstageable pressure ulcers including deep tissue injuries and includes updated specifications to the measure calculations. To meet the requirements for reporting standardized patient assessment data we are also proposing modifications to the assessment instruments currently used in post acute care settings.

For fiscal year 2019 we are proposing to use the standardized assessment data already collected on pressure ulcers and injuries to calculate the current pressure ulcer measure percent of residents or patients with pressure ulcers that are new or worsened.

For fiscal year 2020 we are proposing that IRFs begin reporting standardized patient assessment data to meet five specified patient assessment categories representing functional status, cognitive functions, special services, treatments and interventions, medical conditions and comorbidities and impairments. We are also proposing to remove the all cause unplanned readmission measure and remove it from public reporting when the potentially preventable readmission measures are publicly reported.

We are proposing to extend all previously finalized policies related to data submission procedures and policies to the new assessment based measure and the standardized patient assessment items. In addition we are also proposing six additional measures for public reporting for calendar year 2018, two of these are assessment based and four are claims based and we refer you to the IRF PPS proposed rule for additional details. Thank you Jill.

Jill Darling: Thanks (Christine). And up next we have Grace Im, excuse me, who will go over the inpatient quality reporting and value-based programs.

Grace Im: Hi, thanks Jill and good afternoon everyone. We have proposals in the fiscal year 2018 IPPS LTCH PPS proposed rule for several of our quality reporting and value-based purchasing programs. First of all the Hospital Inpatient Quality Reporting Program is a pay-for-reporting program first established by the Medicare Prescription Drug Improvement and Modernization Act of 2003. The quality measure data we collect under this program are publicly reported on our Hospital Compare website.

In this proposed rule we're proposing to update two previously adopted measures. One, we're seeking to reword the current pain management questions in the Hospital Consumer Assessment of Healthcare Providers and Systems survey, or HCAHPS survey, to focus on hospitals' communications with patients about their pain during the hospital stay. And this would be beginning with surveys in January 2018 which would impact fiscal year 2020 payment determinations for hospitals.

We're also seeking to update the risk adjustment methodology used in the 30 day mortality rate following acute ischemic stroke hospitalization measure to include the use of ICD-10 stroke severity codes that are based on the NIH stroke scale. And to help hospitals transition to the use of the stroke severity codes, we're also proposing to start with what we call a dry run for which we would calculate the measure using claims data on discharges from October 1, 2017 through June 30, 2020 and then share confidential feedback reports with hospitals in 2021. The following year in 2022 we would publicly report the data and this would impact fiscal year 2023 payment determinations.

In this year's proposed rule we don't have any proposals to remove measures from the program or to add any new mandatory measures. However, we do have a proposal for a new voluntary measure, a hybrid hospital-wide readmission measure with claims and electronic health record data.

As the measure name suggests, we refer to this as a hybrid measure because it uses both claims data and EHR data. The EHR data elements include patient vital signs and laboratory test results along with linking variables to match the EHR data to CMS claims data. This would allow for the use of clinical data for risk adjustment and not just administrative data like we do now with our fully claims based version of the hospital-wide readmission measure.

We are also proposing a number of changes in relation to the reporting of electronic clinical quality measures, or eQMs. For the 2017 reporting period which would impact fiscal year 2019 payment determinations, we are proposing that hospitals report on six of the 15 available eQMs which is a reduction from eight eQMs as finalized last year in the fiscal year 2017 IPPS LTCH PPS final rule.

And to report data for any two quarters in 2017 which is a reduction from what we finalized last year of requiring one year or four quarters of data. The submission deadline for the eQM data would still be February 28th, 2018.

We're also proposing for the 2018 reporting period which would impact fiscal year 2020 payment determinations that hospitals report on six of the 15 available eQMs which is again a reduction from requiring eight eQMs as finalized in last year's rule and to report data for the first three quarters of 2018 which is a reduction from requiring one year or four quarters of data as finalized last year.

And the submission deadline for the 2018 eQM data would be February 28th of 2019. We'd like to note that these same proposed requirements would also apply for meeting the Medicare EHR Incentive Program requirements for electronic reporting of clinical quality measures by eligible hospitals and critical access hospitals.

For the Hospital Inpatient Quality Reporting Program we're also proposing to modify the previously finalized validation process for eQM data to reduce the number of cases required to be submitted and to include additional exclusion criteria. Please review the proposed rules for other proposed updates to our data validation process.

For the Hospital Value-Based Purchasing Program, this program adjusts payments to hospitals for inpatient services based on their performance on the measures adopted for this program. And in this proposed rule we're seeking to update the program's measure set as follows. We want to remove the current eight component Patient Safety for Selected Indicators composite measure known as PSI 90 from the safety domain beginning with the fiscal year 2019 program year and to replace it with a modified version of the PSI 90 measure that includes 10 components related to patient safety and adverse events as a composite measure, and this would be beginning with the fiscal year 2023 program year.

We're also proposing to adopt a measure for risk standardized payments associated with a 30 day episode of care for pneumonia which would be added to the efficiency and cost reduction domain beginning with the fiscal year 2022 program year. And then finally for the hospital value based purchasing program we're also proposing to revise the weighting of the measures in the efficiency and cost reduction domain as additional payment measures are being added to this domain beginning with the fiscal year 2021 program year.

The Hospital Readmissions Reduction Program requires a reduction to a hospital's base operating MS-DRG payment to account for excess readmissions associated with certain conditions. In this proposed rule we're proposing to make changes to the payment adjustment factor in accordance with the 21st Century Cures Act.

Namely to assess penalties under this program based on a hospital's performance relative to other hospitals with a similar proportion of patients who are duly eligible for Medicare and full benefit Medicaid. Specifically we're proposing one, a methodology for calculating the proportion of dual eligible patients, two, a methodology for assigning hospitals to peer groups and three, a payment adjustment formula calculation methodology.

The Hospital Acquired Condition Reduction Program creates an incentive for hospitals to reduce the incidents of hospital acquired conditions by assessing a

one percent negative payment adjustment to those hospitals that rank in the worst performing 25 percent on quality measures used in the program.

In this year's proposed rule we're proposing the specific dates of the performance period for the fiscal year 2020 program year and we're also inviting public comment on additional measures for potential future adoption in the Hospital Acquired Condition Reduction Program.

The Prospective Payment System Exempt Cancer Hospital Quality Reporting Program collects and publishes quality measure data on PPS exempt cancer hospitals. In this year's proposed rule we're proposing to add four new claims based measures that assess end of life care for cancer patients. We're also proposing to remove three chart-abstracted process measures.

And for the Inpatient Psychiatric Facility Quality Reporting Program which is a pay-for-reporting program for which we collect and publish quality measure data on inpatient psychiatric facilities, we are in this year's proposed rule we are proposing to add one new claims-based measure, a measure focusing on medication continuation following inpatient psychiatric discharges. And this would be beginning with fiscal year 2020 payment determinations. I'll turn it back over to Jill.

Tiffany Swygert: Hi, it's actually it's Tiffany Swygert again chair of the hospital open door forum. I'd just like to thank everyone for their participation today and just to give one last reminder of the comment period for the inpatient prospective payment system and long term care hospital proposed rule for fiscal year 2018. The public comment period ends on June 13th, 2017 and comments may be submitted electronically via regulations.gov. The instructions on how to submit a comment are included in the proposed rule itself.

Again we very much thank you for your participation and look forward to continued dialogue.

Operator: Thank you for participating in today's Hospital, Hospital Quality Open Door Forum conference call. This call will be available for replay beginning today at 5 pm eastern through midnight on May 18th. The conference ID number

for the replay is 58688483. The number to dial for the replay is 855-859-2056. This concludes today's conference call, you may now disconnect.

END