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Inpatient Prospective Payment System
FY 2017 Proposed Rule

May 2, 2016

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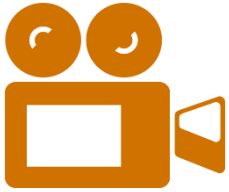

Recording

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Faculty

- **Danielle Lloyd, MPH**
  VP, policy and advocacy,
  Deputy director, D.C. office,
  Premier Inc.

- **Aisha Pittman, MPH**
  Director, quality policy and analysis
  Premier Inc.

Agenda

- Payment Updates
- MS-DRGs
- Documentation and Coding
- Two-Midnights
- New Technology
- DSH Adjustment
- Readmissions
- Value-Based Purchasing
- Hospital-Acquired Conditions
- Quality Reporting Programs
- LTCH Changes

FY 2017 proposed Inpatient PPS Rule

- Released April 18, published in April 27, *Federal Register*
- Market basket increase of 2.8%, but 0.9% final update
  - 0.5% *decrease* due to productivity cut from ACA
  - 0.75% market basket *reduction* due to ACA
  - 1.5% *reduction* due to documentation and coding offset
  - 0.8% *increase* due to two-midnights adjustment
- 0.3% *reduction* due to DSH/uncompensated care payments
- Average payments will increase by 0.7% compared to FY 16
- 61 total IQR measures for FY 19 payment, removes 15 measures, requires 15 eCQMs, and adds 4 measures
- New VBP measures for FYs 21, and 22 including new measures in the efficiency domain
- Modifies HAC Reduction Program scoring, performance periods, and measures
- **Comments due June 17, 2016**

FY 2017 proposed IPPS- How to Submit a Comment

- CMS proposed rule for the Physician Fee Schedule
  - Comments due 60 days from the date of display (June 17, 2016)

1. Go to proposed rule
2. Click “Submit a Formal Comment”, the green button on the right-hand side of the page below the title.

OR

1. Go to http://www.regulations.gov
2. Type “CMS-1655-P” into the search box
3. Find “Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates, etc” (should be first selection)
4. Click on “Comment Now”, the blue button to the right of the title.

Payment Updates
Proposed Changes

Operating Payment Impact

Contributing Factor	National % Change
Market Basket (for successful IQR/MU participation)	+2.8%
ACA MB cut	-0.75%
ACA Productivity cut	-0.50%
SUBTOTAL: FY 2017 payment rate increase	1.55%
Documentation and Coding Adjustment	-1.50%
Two-midnights adjustment reversed	+0.80%
SUBTOTAL: net increase before budget neutrality adj	**+0.85%***
Frontier hospital wage index floor and outmigration	+0.10%
Outlier payments (expect will overpay in FY 2016)	-0.2%
TOTAL: average per case increase	+0.70%**

* CMS displays 0.85% as 0.90%

** Average increase in payments is 0.7% rather than 0.75% due to rounding and interactions

*** the 0.7% does not include reductions such as DSH, HRRP, HAC and sequestration

Additional Payment Impacts

- The effects of several significant policies are not included in the rule's impact analysis:
  - **Medicare DSH and uncompensated care-** payments will be $168 million lower than in FY 2016.
  - **Hospital Readmissions Reduction Program (HRRP)-** would reduce FY 2017 payments by $523 million - $100 million more than FY 2016.
  - **HAC Reduction Program-** would reduce payments by 1 percentage point to an estimated 774 hospitals.
  - **HAC payment provision-** No discussion of the impact.
  - **New technology add-on-** no estimates provided on 9 applications, but expiration of 4 technologies is estimated to decrease payments in FY 2017 by $50 million.
  - **IME/GME-** payments for rural training tracks at urban hospitals as $1 million over 10 years.
  - **Net aggregate effect-** is a reduction in payments of $318 million compared to FY 2016.

Updates with and without Quality Reporting and/or MU

FY 2017	Submit IQR and a MU	Submit IQR but Not a MU	MU but no IQR submitted	No IQR, Not a MU
Market basket rate-of-increase	2.8	2.8	2.8	2.8
MFP adjustment under section 1886(b)(3)(B)(xi) of the Act	-0.5	-0.5	-0.5	-0.5
Statutory adjustment under section 1886(b)(3)(B)(xii) of the Act	-0.75	-0.75	-0.75	-0.75
Adjustment for failure to submit quality data under section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	-0.7	-0.7
Adjustment for failure to be a meaningful EHR user under section 1886(b)(3)(B)(ix) of the Act	0.0	-2.1	0.0	-2.1
Final applicable % increase applied to standardized amount	1.55	-0.55	0.85	-1.25

¼ MB=0.7; ¾ MB=2.1

Capital Payment Update

Capital Input Price Index*	**1.2**
Intensity	0.0
Net Case-Mix Adjustment	0.0
Subtotal	**1.2**
Effect of FY 2015 Reclassification and Recalibration	0.0
Forecast Error Correction	-0.3
Total Update	**0.9**
GAF/DRG Adjustment Factor	-0.07
Outlier Adjustment	0.1
Permanent 2-midnight Policy Adjustment Factor	0.2
One-time 2-midnight Policy Adjustment Factor	0.6
Total Net Rate	**1.73**

*The capital input price index is based on the FY 2010-based CIPI

Documentation and Coding Offset

	ATRA				SGR Reform Offset					
Status	Final	Final	Final	Tentative	Final	Final	Final	Final	Final	Final
FY	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
CUT	-0.8%	-0.8%	-0.8%	-0.8%	+0.5%	+0.5%	+0.5%	+0.5%	+0.5%	+0.5%
		-0.8%	-0.8%	-0.8%		+0.5%	+0.5%	+0.5%	+0.5%	+0.5%
			-0.8%	-0.8%			+0.5%	+0.5%	+0.5%	+0.5%
				-1.5%				+0.5%	+0.5%	+0.5%
									+0.5%	+0.5%
										+0.5%
TOTAL	**-0.8%**	**-1.6%**	**-2.4%**	**-3.9%**	**-3.4%**	**-2.9%**	**-2.4%**	**-1.9%**	**-1.4%**	**-0.9%**

- ATRA requires $11B cut between 2014-2017
- Cut would have been restored to base payments in 2018 in total, but instead is phased in over 6 years due to the SGR legislation MACRA
- The expected -0.2% cut will now be -0.9% and remain into perpetuity
- The phase-in results in a $15.1B cut between 2018-2023

MS-DRGs changes

- Numerous proposed changes that will be detailed in written summary
- Of note, stakeholders concerned within the effect on CJR and BPCI programs
  - Considered splitting ankle replacements out of DRGs 469 and 470, but CMS believes the volume is too low to warrant new DRG
  - Also considered splitting fractures out of DRGs 469 and 470, but will not do so as the costs are similar to other procedures included in the DRGs
- No additions to the replaced devices policy

Two-midnights cut reversed

- In FY 2014, CMS created the “Two-Midnight” policy where a patient expected to stay across two consecutive midnights (or has an “inpatient only” service) will be presumed appropriate for Part A payment.
- CMS applied a -0.2 percent adjustment to IPPS rates to account for the estimated $220 million in increased inpatient expenditures in FY 2014-2016.
- After a pending law suit, CMS has agreed to pay back the cut by adjusting payment rates by a one-time +0.8 percent
  - 0.6% will reverse the FY 2014, 2015, and 2016 cuts
  - 0.2% will correct the base going forward

Notification Procedures for Outpatient Observation

- Implements the NOTICE Act effective August 6, 2016 for all hospitals and CAHs as a condition of participation.
- Standardized written notice called the Medicare Outpatient Observation Notice (MOON) explaining:
  - the individual was an outpatient—not an inpatient
  - the reason for outpatient status (i.e., the individual doesn't currently need inpatient services but requires observation to decide whether to admit or discharge)
  - the implications of receiving observation services as an outpatient (i.e. cost-sharing and eligibility for skilled nursing facility care)
- Provide the explanations in plain language
- Include a blank for additional information
- Include a dedicated signature area to acknowledge receipt and understanding of the notice

Notification Procedures for Outpatient Observation (cont'd)

- Guidance for the oral notification in forthcoming Medicare manual provisions.
- Deliver to *all* Medicare beneficiaries receiving treatment as outpatients and receiving observations services for more than 24 hours.
- Given no later than 36 hours after observation services begin, but sooner if transferred, discharged or admitted.
- English language version of the MOON was submitted to OMB for approval, and a Spanish language version will also be made available.
- If CMS reviewer denies a claim for inpatient services as not medically necessary, no requirement to issue MOON.
- The NOTICE Act does not afford appeal rights to beneficiaries regarding the notice.

New Technology Add-on Payments

- Code freeze over October 1, 2016
- Created new component within ICD-10 PCS codes, labeled Section “X” (analogous to outpatient C codes).
- Will be used to identify and describe new technologies and services (drugs, biologicals, and newer medical devices being tested in clinical trials).
- Section intended to assist in identifying and tracking new technologies and related inpatient services for add-ons.
- Component available October 1, 2015.
- Applications for “X” codes will be same as others through Coordination and Maintenance Committee.
- More information available on CMS Web site at: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD9-CM-C-and-M-Meeting-Materials.html

New Technology Add-on Payments—proposed denied extensions

- **Kcentra™**, a replacement therapy for fresh frozen plasma for patients with an acquired coagulation factor deficiency due to warfarin and who are experiencing a severe bleed; (ICD-10 code: 30283B1)
- **Argus® II System**, an implantable device that provides electrical stimulation of the retina to induce visual perception in patients who are profoundly blind due to retinitis pigmentosa; (09H005Z or 08H105Z)
- **MitraClip® System**, a transcatheter mitral valve system designed to perform reconstruction of the insufficient mitral valve for high risk patients who are not candidates for conventional valve surgery; (02UG3JZ); and
- **Responsive Neurostimulator System (RNS®),** an implantable device for treating persons with epilepsy whose partial onset seizures have not been adequately controlled with antiepileptic medications. (0NH00NZ, 00H00MZ)

New Technology Add-on Payments—proposed continuation

- ✓ **CardioMEMS™ HF System** is an implantable pulmonary artery hemodynamic monitoring system for the management of heart failure; (02HR30Z, 02HQ30Z)
- ✓ **BLINCYTO™** is a bi-specific T-cell engager used for treatment of Philadelphia chromosome-negative relapsed or refractory B-cell precursor acute-lymphoblastic leukemia; (XW03351 or XW04351)
- ✓ **LUTONIX® and IN.PACT™ Admiral™** Both of these technologies are drug coated balloon percutaneous transluminal angioplasty for patients with peripheral artery disease; (codes in the notes)

New Technology Add-on Payments—new applications

1. **MAGEC®** Spinal Bracing and Distraction System treats children with severe spinal deformities, such as scoliosis.

2. **MICRODERM** is a non-crosslinked acellular wound matrix that is derived from the porcine liver and is processed and stored in a phosphate buffered aqueous solution.

3. **Idarucizumab** is a humanized fragment antigen-binding molecule, which specifically binds to PRADAXA® (an oral direct thrombin inhibitor) to deactivate the anticoagulant effect.

4. **Titan Spine Endoskeleton ®** is a nanotechnology-based interbody medical device with a dual acid-etched titanium interbody system used to treat patients diagnosed with degenerative disc disease.

New Technology Add-on Payments—new applications

5. **Andexanet Alfa** is an antidote used to treat patients who are receiving an oral Factor Xa inhibitor who suffer a major bleeding episode and require urgent reversal.

6. **Defitelio®** a treatment for patients with hepatic veno-occlusive disease with evidence of multi-organ dysfunction.

7. **EDWARDS INTUITY Elite™ Valve System** uses a rapid deployment valve system and serves as a prosthetic aortic valve insert via surgical aortic valve replacement.

8. **GORE EXCLUDER ® Iliac Branch Endoprosthesis** for the repair of common iliac or aortoiliac aneurysms.

9. **Vistoguard™** is an antidote to Fluorouracil toxicity in patients treated with the chemotherapeutic agent 5-fluorouracil for solid tumors.

Wage Index

- Geographical “delineations” based on 2010 census data (OMB bulletin published July 15, 2015).
- Same labor market areas used in FY 2016 to calculate wage indexes and transition periods except:
  - Garfield County, OK, with principal city Enid, OK, which was a Micropolitan (geographically rural) area, now qualifies as an urban new CBSA 21420 called Enid, OK.
  - The county of Bedford City, VA, a component of the Lynchburg, VA CBSA 31340, changed to town status and is added to Bedford County. Therefore, the county of Bedford City (SSA State county code 49088, FIPS State County Code 51515) is now part of the county of Bedford, VA (SSA State county code 49090, FIPS State County Code 51019). However, the CBSA remains Lynchburg, VA, 31340.
  - The name of Macon, GA, CBSA 31420, as well as a principal city of the Macon-Warner Robins, GA combined statistical area, is now Macon-Bibb County, GA. The CBSA code remains as 31420.

Wage Index

- Third year of transition to 2010-based OMB delineations
  - If going from urban to rural delineation:
    - » Keep old CBSA in which physically located in FY 2014 until 2017, ***if*** not reclassified/redesignated (or closest labor market area if old area no longer exists)
    - » Considered rural for all other policy purposes
  - For Lugar hospitals (designated as urban, but revert to rural)
    - » Keep old CBSA in which physically located in FY 2014 until 2017, ***if*** not reclassified/redesignated (or closest labor market area if old area no longer exists)
- Proposes budget neutrality adjustment for transition
- In 2018, they will move to the statewide rural wage index absent reclassifications or redesignations

Wage Index

- Outmigration- continue to use data from custom tabulation of the American Community Survey (ACS), 2008-2012 Microdata with no changes in methodology
- Frontier Floor- applies 1.0 floor in MT, ND, NV, SD, WY
- Imputed Floor- continues for 1 year the imputed rural floor for all-urban states (NJ, DE) and alternative method for RI
  - No effect this year on DE
- Occupational Mix- will be surveyed in 2016 for 2019 AWI
- Urban to rural reclassification- proposes a “lock in” date of the second Monday in June, meaning applications must be received 70 days in advance
  - If received before lock in, effective upon application
  - If after, it will not take effect until the fiscal year *following* the next fiscal year

Other Payment Policies

Low Volume Adjustment

- ACA criteria extended by MACRA through Sept 30, 2017
  - » At least 15 miles from another hospital
  - » Less than 1,600 Medicare Part A discharges
  - » Sliding scale payment between 25% for ≤ 200 and 0% ≥ 1,600 discharges

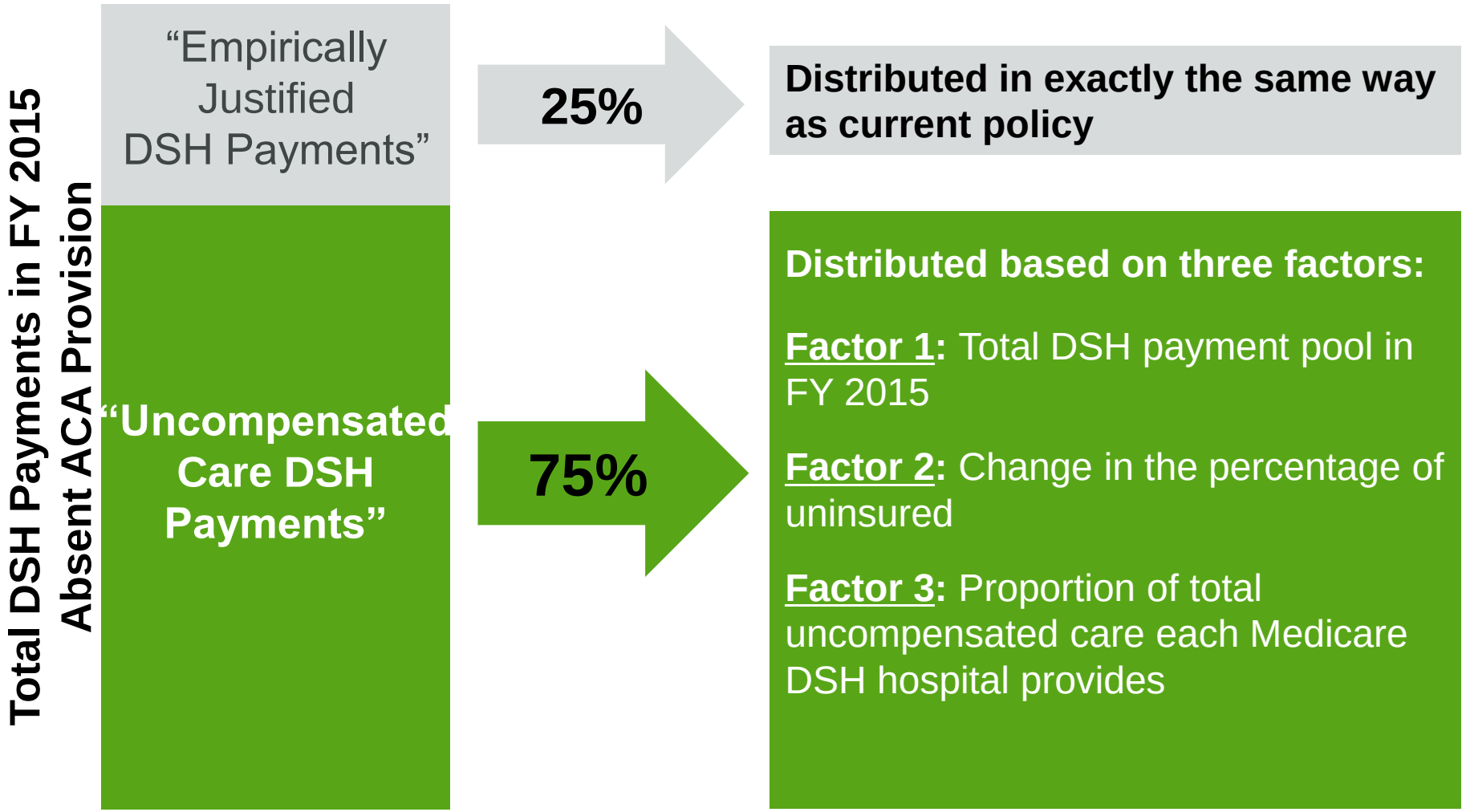
Medicare Dependent Hospitals

- MACRA extends through Sept 30, 2017

Outliers

- Increased fixed loss threshold from $22,538 in FY 2016 to $23,681 in 2017
  - » CMS spent 4.68% in FY 2015
  - » CMS is estimated to spend 5.3% in 2016

Medicare DSH: Uncompensated Care DSH Payment



Proposed values of Factors 1, 2 and 3

- Factor 1 – Total DSH Payments
  - Total DSH pool March 2016 estimate ($14.227 billion) which is based on the December 2015 update to HCRIS and FY 2016 final rule's impact file
  - 75% of $14.227 = **$10.671 billion**
- Factor 2 – Change in the Uninsured Percent
  - Required to use CBO estimate from March 20, 2010, which is **18%**, as the baseline number of uninsured in 2013
  - FY 2017 percent uninsured based on CBO's March 2015 estimate (CY 2016 and CY 2017 weighted average **10.25%**)
  - (1 – percent change in uninsured) = 56.94%, but available portion is **56.74%**
  - **Pool is $6.054 billion, a reduction of $352 million (5.5%) from FY 2016**
- Factor 3 – Uncompensated Care Proportion
  - CMS will continue to use proxy to calculate uncompensated care proportion for FY 2017, but will use a three-year rolling average instead of one year

$$\frac{\text{Hospital's Medicare SSI Days + Medicaid Days}}{\text{Total DSH Hospitals' Medicare SSI Days + Medicaid Days}}$$

Proposed Changes to Factor 3 Calculation

- FY 2017 – keep using proxy measure, but use three-year rolling average (FY 2011, FY 2012, and FY 2013 cost reports for Medicaid days and FY 2012, FY 2013, and FY 2014 for SSI days)

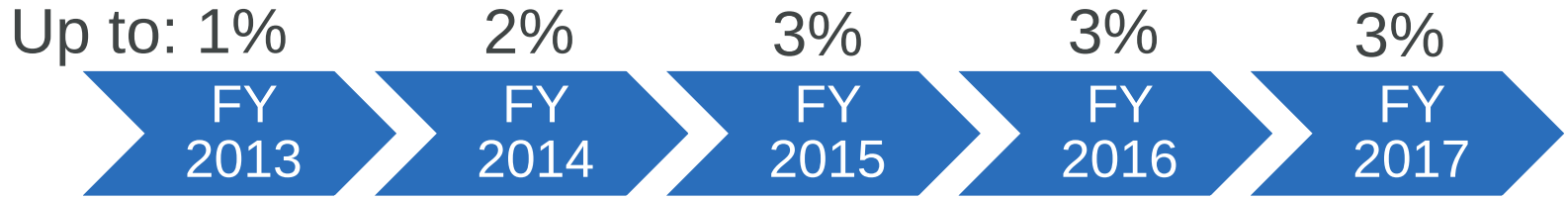
$$\frac{\text{Hospital's Medicare SSI Days + Medicaid Days}}{\text{Total DSH Hospitals' Medicare SSI Days + Medicaid Days}}$$

- FY 2018 – begin phase-in of Worksheet S-10 uncompensated care costs (defined as charity care + non-Medicare bad debt) using FY 2014 cost report data
  - Definition will not include Medicaid payment shortfalls to be consistent with definitions used by other gov't agencies and key stakeholders
  - By FY 2020, Worksheet S-10 will be used exclusively to determine Factor 3 (three-year phase-in)

Hospital Pay-for-Performance Quality Programs
Proposed Changes

Hospital Readmissions Reduction Program (HRRP)

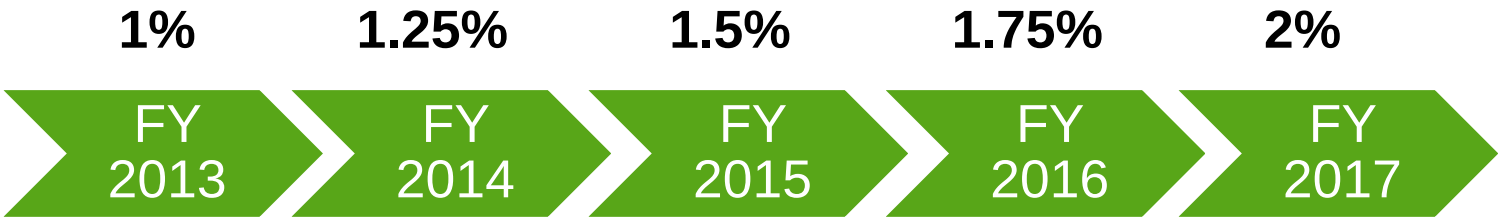
- Hospital-specific payment adjustment factors were applied to inpatient claims beginning Oct 1, 2012.



- 30-day AMI, HF, expanded PN, COPD, THA/TKA (Hip/Knee), and CABG measures based on 3 years of data (July 1, 2012 - June 30, 2015) for FY 2017 payment. PN expansion and CABG finalized in earlier rules.
- Applies to wage-adjusted base operating DRG payment amount (includes new tech add-on payment only, no adjustments for DSH, IME, outlier, or low volume)
- For SCHs the adjustment will only apply to the national portion of the rates, not the additional payment due to the hospital-specific rates but for MDHs, applies also to the hospital specific add-on

Inpatient Value-Based Purchasing (VBP)

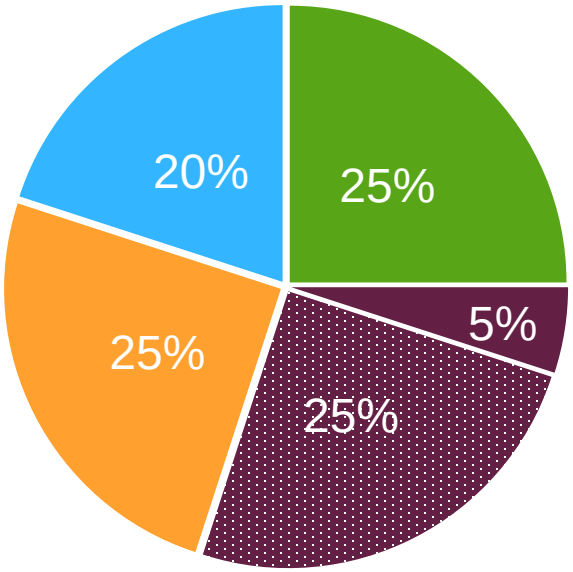
- A percent of inpatient base operating payments are at risk based on quality and efficiency metric performance



- A budget neutral policy (redistributes $1.7B), where hospitals must fail to meet targets for bonuses to be generated for others. Rewards for achievement or improvement
- Quality measures from Hospital Compare measure set
  - 20 measures (12 process/8 HCAHPS dimensions) in FY 2013,
  - Adds 3 outcome measures (3 mortality) in FY 2014,
  - Adds 2 outcome measures and 1 efficiency measure in FY 2015,
  - Removes 5 process and adds 1 process, 2 outcome measures in FY 2016,
  - Removes 6 process and adds 1 process, 2 “safety” measures in FY 2017 and
  - Removes 2 process and adds 1 patient experience in FY 2018.
- Inpatient Quality Reporting measures are “on deck” for VBP.

Inpatient VBP FY 2017 Recap

FY 2017 Finalized Revision

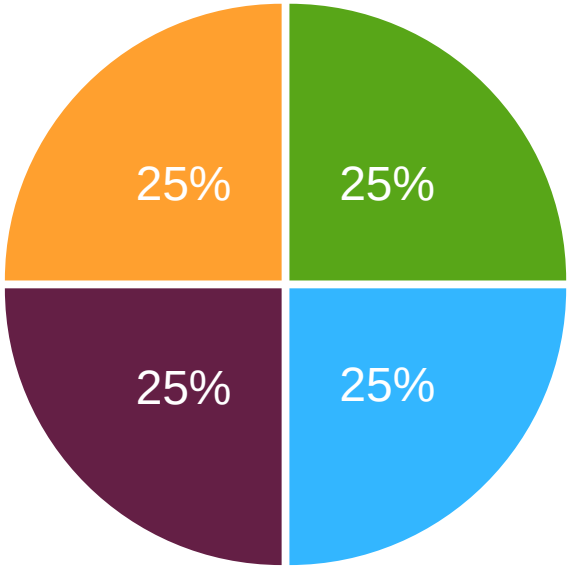


- Clinical Care
  - Process (**5%**)
  - Outcomes (25%)
- Patient and Caregiver Experience
- Efficiency and Cost Reduction
- Safety (**20%**)

Measure ID	NQS-Based Domain
AMI-7a	Clinical Care – Process
IMM-2	Clinical Care – Process
PC-01 *NEW*	Clinical Care – Process
MORT-30-AMI	Clinical Care – Outcomes
MORT-30-HF	Clinical Care – Outcomes
MORT-30-PN	Clinical Care – Outcomes
HCAHPS	Patient and Caregiver Centered Experience of Care / Care Coordination
CAUTI	Safety
CLABSI	Safety
MRSA *NEW*	Safety
C. Diff *NEW*	Safety
PSI-90	Safety
SSI	Safety
MSPB-1	Efficiency and Cost Reduction

Inpatient VBP FY 2018 Recap

FY 2018 Final



- Clinical Care (**25%**)
- Patient and Caregiver Experience (25%)
- Efficiency and Cost Reduction (25%)
- Safety (**25%**)

Measure ID	NQS-Based Domain
~~AMI-7a~~	~~Clinical Care – Process~~
~~IMM-2~~	~~Clinical Care – Process~~
PC-01	Safety
MORT-30-AMI	Clinical Care
MORT-30-HF	Clinical Care
MORT-30-PN	Clinical Care
HCAHPS	Patient and Caregiver Centered Experience of Care / Care Coordination
CTM-3	
CAUTI	Safety
CLABSI	Safety
MRSA	Safety
C. Diff	Safety
PSI-90	Safety
SSI	Safety
MSPB-1	Efficiency and Cost Reduction

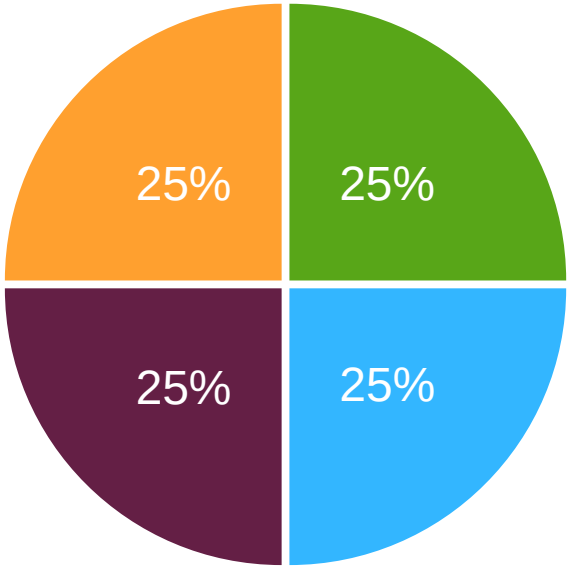
Inpatient VBP FY 2018 Baseline and Performance Periods

Domain	Baseline Period	Performance Period
Safety • PSI-90 • PC-01 and NHSN (CAUTI, CLABSI, SSI, C. diff, MRSA)	July 1, 2010 - June 30, 2012* January 1, 2014 - December 31, 2014	July 1, 2014 - September 30, 2015 January 1, 2016 - December 31, 2016
Clinical Care – Mortality measures*	October 1, 2009 - June 30, 2012	October 1, 2013 – June 30, 2016
Efficiency and Cost Reduction (MSPB-1)	January 1, 2014 – December 31, 2014	January 1, 2016 – December 31, 2016
Patient and Caregiver – Centered Experience of Care/Care Coordination (HCAHPS, CTM-3)	January 1, 2014 – December 31, 2014	January 1, 2016 – December 31, 2016

* Previously adopted baseline and performance periods

Inpatient VBP FY 2019 Proposals

FY 2019 Proposed



- Clinical Care (**25%**)
- *Person and Community Engagement* (25%)
- Efficiency and Cost Reduction (25%)
- Safety (**25%**)

Measure ID	NQS-Based Domain
~~AMI-7a~~	~~Clinical Care – Process~~
~~IMM-2~~	~~Clinical Care – Process~~
PC-01	Safety
MORT-30-AMI	Clinical Care
MORT-30-HF	Clinical Care
MORT-30-PN	Clinical Care
HCAHPS	Patient and Caregiver Centered Experience of Care / Care Coordination
CTM-3	
CAUTI	Safety
CLABSI	Safety
MRSA	Safety
C. Diff	Safety
PSI-90	Safety
SSI	Safety
MSPB-1	Efficiency and Cost Reduction

Inpatient VBP: Other Proposed Changes

- FY 2019
  - Expand CAUTI and CLABSI measures to include non-ICU locations beginning with program year FY 2019
  - Domain name change to Person and Community Engagement
  - Immediate jeopardy citations
- FY 2021
  - Additional Efficiency and Cost Reduction Measures
    - » Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI) (NQF #2431)
    - » Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Heart Failure (HF) (NQF #2436)
    - » Use same scoring methodology as MSPB (alternatives discussed)
  - Update to Pneumonia Mortality
    - » Expand to include patients with a principal discharge diagnosis of aspiration pneumonia and patients with a principal discharge diagnosis of sepsis (excluding severe sepsis) with a secondary diagnosis of pneumonia coded as present on admission
- FY 2022
  - Add Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery (NQF #2558)

Inpatient VBP

FY 2019 - 2021 Baseline and Performance Periods

Measure	Baseline Period	Performance Period
FY 2019 Hospital VBP Program		
HCAHPS, CTM-3, PC-01, NHSN, MSPB	January 1- December 31 2015	January 1- December 31 2017
Mortality Measures*	July 1, 2009 – June 30, 2012	July 1, 2014 – June 30, 2017
THA/TKA*	July 1, 2010 – June 30, 2013	January 1, 2015 – June 30, 2017
AHRQ PSI 90	July 1, 2011 – June 30, 2013	July 1, 2015 – June 30, 2017
FY 2020 Hospital VBP Program		
Mortality Measures*	July 1, 2010 – June 30, 2013	July 1, 2015 – June 30, 2018
THA/TKA*	July 1, 2010 – June 30, 2013	July 1, 2015 – June 30, 2018
AHRQ PSI 90*	July 1, 2012 – June 30, 2014	July 1, 2016 – June 30, 2018
FY 2021 Hospital VBP Program		
Mortality Measures (AMI, HF, PN, and COPD)*	July 1, 2011 – June 30, 2014	July 1, 2016 – June 30, 2019
THA/TKA *	April 1, 2011 – March 31, 2014	April 1, 2016 – March 31, 2019
Payment- AMI and HF	**July 1, 2012- June 30, 2015**	**July 1, 2017- June 30, 2019**

* Previously adopted measurement periods

Hospital-acquired Condition (HAC) Reduction Program

- HAC Reduction program reduces **total** payments by 1% for worst performing quartile of hospitals starting in FY 2015
- Two domains:
  1. Agency for Healthcare Research and Quality measure
  2. Centers for Disease Control and Prevention National Healthcare Safety Network (NHSN) measures
- FY 2017 reports released in late summer via QualityNet, hospitals have 30 days to review

[Note: No proposed changes to the ongoing policy where certain HACs can't qualify a case for a higher paying DRG tier]

Overlapping Medicare HAC policies

Hospital-acquired conditions (HACs)	Not eligible higher payment (FY 08 ongoing)	IP VBP (FY 13 ongoing)	HAC Reduction Program (Starting FY 2015)
Catheter associated UTI	X	Finalized FY 16	Finalized FY 15
Surgical Site Infections	X*	Finalized FY 16	Finalized FY 16
Vascular cath-assoc. infections	X**	PSI-90/ CLABSI	PSI-90/ CLABSI
Foreign object retained after surgery	X		
Air embolism	X		
Blood incompatibility	X		
Pressure ulcer stages III or IV	X	PSI-90 FY 2015	PSI-90 FY 2015
Falls and trauma	X***	PSI-90 FY 2015	PSI-90 FY 2015
DVT/PE after hip/knee replacement	X	PSI-90 FY 2015	PSI-90 FY 2015
Manifestations of poor glycemic control	X		
Iatrogenic pneumothorax	X	PSI-90 FY 2015	PSI-90 FY 2015
Methicillin resistant Staph. aureus (MRSA)		Finalized FY 17	Finalized FY 17
Clostridium difficile (CDAD)		Finalized FY 17	Finalized FY 17

*SSI includes different conditions. ** Vascular Catheter is broader than the CLABSI measure. Proposed adoption of revised PSI-90 would remove this indicator from HACRP for FY 2018 and beyond *** Hip Fracture in PSI-90

HAC Reduction Program –Proposed Changes

- FY 2017 Proposed Changes/Clarifications
  - Must have 12 months or more of data to have complete data for PSI-90
  - Must submit CDC NHSN HAI data even when not required to do so for IQR
- FY 2018- Propose to Adopt revised AHRQ PSI-90
  - Change name to Patient Safety and Adverse Events Composite
  - Removes PSI 07 Centra Venous Catheter-related Blood Stream Infection Rate
  - Adds PSI 09 Postoperative Hemorrhage Or Hematoma Rate
  - Adds PSI 10 Physiologic And Metabolic Derangement Rate
  - Adds PSI 11 Postoperative Respiratory Failure Rate
  - Re-specifies PSI 12 Perioperative Pulmonary Embolism Or Deep Vein Thrombosis Rate
  - Re-specifies PSI 15 Accidental Puncture Or Laceration Rate
  - Weighting changed to account for harms associated with adverse events and number of adverse events
  - Uses a 15-month performance period (FY 2018 only) to account for ICD-10 conversion (July 1, 2014- September 30, 2015)
- FY 2018- Scoring
  - Replaces decile-based scoring with “Winsorized Z-Score Method”
  - New method creates continuous scores
  - Helps hospitals with only a PSI-90 score

HAC Reduction Program: Measures

Domain 1: AHRQ Patient Safety Indicators (PSI-90 Composite)	
FY 2015 and onward	PSI-3 Pressure Ulcer Rate
FY 2015 and onward	PSI-6 Iatrogenic Pneumothorax Rate
FY 2015 and onward	PSI-7 Ctrl Venous Catheter-Related Blood Stream Infection Rate *Proposed Removal for FY 2018*
FY 2015 and onward	PSI-8 Postoperative Hip Fracture Rate
Proposed FY 2018	PSI 09 Postoperative Hemorrhage Or Hematoma Rate
Proposed FY 2018	PSI 10 Physiologic And Metabolic Derangement Rate
Proposed FY 2018	PSI 11 Postoperative Respiratory Failure Rate
FY 2015 and onward	PSI-12 Postoperative PE/DVT rate *Re-specified for FY 2018*
FY 2015 and onward	PSI-13 Postoperative Sepsis Rate
FY 2015 and onward	PSI-14 Wound Dehiscence Rate
FY 2015 and onward	PSI-15 Accidental puncture and laceration rate *Re-specified for FY 2018*
Domain 2: CDC NHSN Measures	
FY 2015 and onward	Central Line-associated Blood Stream Infection (CLABSI)
FY 2015 and onward	Catheter-associated Urinary Tract Infection (CAUTI)
FY 2016 and onward	Surgical Site Infection (SSI) following Colon Surgery or following Abdominal Hysterectory
FY 2017 and onward	Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia
FY 2017 and onward	*Clostridium difficile*

Hospital Inpatient Quality Reporting (IQR) Changes

Hospital Inpatient Quality Reporting Program Data Collection
Summary

Measure Category	CY 2016 Count	Changes	CY 2017 Count
Chart-Abstracted	8	Remove 2 chart abstracted	6
eCQMs	28 4 Required	Require All Remove 13	15 Required
HAI / NHSN	6	No change	6
30 day Mortality	6	No change	6
30 day Readmission	8	No change	8
AHRQ	2	No change	2
Hip/Knee Complications	1	No change	1
Efficiency	7	Previously finalized to add 3 Propose to add 4	14
Structural	4	Remove 2	2
HCAHPS	1	No change	1
Totals	43 (68)		61

IQR FY 2019 Removal of Measures

Measure #	Measure Name
AMI-2	Aspirin Prescribed at Discharge for AMI (NQF #0142)
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
AMI-10	Statin Prescribed at Discharge
HTN	Healthy Term Newborn (NQF #0716)
PN-6	Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients (NQF #0147)
SCIP-Inf-1a:	Prophylactic Antibiotic Received within 1 Hour Prior to Surgical Incision (NQF #0527)
SCIP-Inf-2a:	Prophylactic Antibiotic Selection for Surgical Patients (NQF #0528)
SCIP-Inf-9:	Urinary Catheter Removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with Day of Surgery Being Day Zero
STK-4:	Thrombolytic Therapy (NQF #0437) *(remove chart-abstracted and eCQM)*

IQR FY 2019 Removal of Measures

Measure #	Measure Name
VTE-3:	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy (NQF #0373)
VTE-4:	Venous Thromboembolism Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram)
VTE-5:	Venous Thromboembolism Discharge Instructions *(remove chart-abstracted and eCQM)*
VTE-6:	Incidence of Potentially Preventable VTE *(remove eCQM; retain chart-abstracted version)*
Structural Measure	Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care
Structural Measures	Participation in a Systematic Clinical Database Registry for General Surgery

IQR FY 2019 Proposed Changes and Additions

- Proposed Changes to Current Measures
  - Refinement to 30-Day Pneumonia Payment Measure
    - » Add patients with a Principal Diagnosis of
      - Aspiration Pneumonia
      - Sepsis (excluding severe sepsis) with secondary diagnosis of Pneumonia present on admission
    - » Previously changed for 30-Day Readmission and Mortality Pneumonia Measures
  - Adoption of Modified PSI 90: Patient Safety and Adverse Composite Measure
- Proposed New Measures
  - Aortic Aneurysm Procedure Clinical Episode-Based Payment (AA Payment) Measure
  - Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment (Chole and CDE Payment) Measure
  - Spinal Fusion Clinical Episode-Based Payment (SFusion Payment) Measure
  - Excess Days in Acute Care after Hospitalization for Pneumonia

Future Measure Considerations

- Changes to Stroke Mortality
  - Inclusion of strove severity in risk adjustment
- Add NHSN Antimicrobial Use Measure (NQF #2720)
- Addressing Behavioral Health
  - Measures to add to IQR
  - Adoption of Inpatient Psychiatric Facility Measures
- Public Reporting Changes
  - Stratify measures by race, ethnicity, sex and disability

Changes to Data Submission and Validation

- Require All (15) eCQMs

Discharge Reporting Period	Submission Deadline
Jan 1, 2017 – December 31, 2017	February 28, 2018

- CEHRT Editions
  - Hospitals can report using either 2014 or 2015 edition of CEHRT for CY 2017 reporting/FY 2019 payment
  - Must use 2015 edition of CEHRT for CY2018 reporting/FY2020 payment
- eCQM Validation (CY 2018 reporting/FY 3030 payment)
  - Continue to select 600 hospitals for validation of chart-abstracted measures
  - Select additional 200 hospitals for validation of eCQMs
    - » Exclude hospitals selected for chart-abstracted measures
    - » Exclude hospitals granted ECE exception for eCQMs
    - » Validation score based on timely submission of at least 75% of sampled eCQMs, not accuracy
- Extraordinary Circumstances and Exemptions (ECE)
  - Extend non-eCQM request deadline from 30 days to 90 days following extraordinary circumstance
  - eCQM deadline April 1 of calendar year (e.g., April 1, 2018 for CY 2017 reporting)

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) FY 2018

PCHQR Measures for FY 2019

Measure	Public Display
NHSN SSI (NQF #0753)	
NHSN CDI (NQF #1717)	
NSHN MRSA bacteremia (NQF #1716)	
NHSN Influenza vaccination coverage among health care personnel (NQF #0431)	
Adjuvant chemotherapy is considered or administered within 4 months of surgery for certain colon cancer patients (NQF #0223)	2014
Combination chemotherapy is considered or administered within 4 mos. of diagnosis to certain breast cancer patients (NQF #0559)	2014
Adjuvant hormonal therapy for certain breast cancer patients (NQF #0220)	2015
Oncology: Plan of Care for Pain (NQF #0383)	2016
Oncology: Pain Intensity Quantified (NQF #0384)	2016
Prostate Cancer-Avoidance of Overuse Measure-Bone Scan for Staging Low-Risk Patients (NQF #0389)	2016
Prostate Cancer-Adjuvant Hormonal Therapy for High-Risk Patients (NQF #0390)	2016
HCAHPS	2016
External Beam Radiotherapy for Bone Metastases (NQF#1822)	2017 proposed

PCHQR Proposed Changes for FY 2019

Current Measures- Changes to Public Reporting Timeline	Public Display
NHSN CLABSI (NQF #0139)	2017 defer
NHSN CAUTI (NQF #0138)	2017 defer
External Beam Radiotherapy for Bone Metastases (NQF#1822)	2017 proposed

Measure Changes and Additions	Public Display
Oncology-Radiation Dose Limits to Normal Tissues (NQF #0382) Propose to update to recently NQF-endorsed version; cohort expanded to include patients undergoing 3D conformal radiation therapy for breast or rectal cancer	2016
Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy Assesses inpatient admissions and ED visits within 30 days of each outpatient chemotherapy encounter for certain qualifying diagnoses: anemia, dehydration, diarrhea, emesis, fever, nausea neutropenia, pain, pneumonia, or sepsis	

Long-Term Care Hospital Quality Reporting Program (LTCH QRP) FY 2018

LTCHQR Previously Adopted Measures for FY 2018

Measure Title	FY 2017	FY 2018	Public Repoting
NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)	X	X	X
NHSN Central line-associated Blood Stream Infection (CLABSI) Outcome Measure (NQF #0139)	X	X	X
Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)	X	X	X
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)	X	X	P
Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)	X	X	P
NHSN Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)	X	X	P
NHSN Facility-Wide Inpatient Hospital-onset Clostridium Difficile Infection (CDI) Outcome Measure (NQF #1717)	X	X	P
All-Cause Unplanned Readmissions for 30 Days Post Discharge from LTCHs (NQF #2512)	X	X	X
Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (Application of NQF #0674)		X	
Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)		X	
Change in Mobility among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632)		X	
NHSN Ventilator Associated Event Outcome Measure		X	

LTCHQR Proposed Measures

- FY 2018
  - Medicare Spending Per Beneficiary MSPB-PAC LTCH
    - » Similar to MSPB measure used for hospitals
    - » Standard and site-neutral episodes are compared separately
    - » Episode is admission- 30 days after discharge
    - » Score calculated as comparison to national average
  - Discharge to Community PAC LTCH
    - » Assesses “successful” discharge to the community from an LTCH
    - » Success defined as no unplanned hospitalizations in an acute hospital or LTCH and no death in the 31 days following discharge
    - » Community is defined as home or self-care, with or without home health services
  - Preventable Readmissions 30 Days Post LTCH Discharge
    - » Risk-standardized readmission rate of potentially preventable readmissions for Medicare beneficiaries within 30 days of discharge from an LTCH
- FY 2020
  - Drug Regimen Review Conducted With Follow-Up
    - » The percentage of patient stays in which a drug regiment review was conducted at the time of admission and timely follow-up with a physician occurred each time potentially clinically significant medication issues were identified during the stay
    - » Derived from LTCH CARE data set

LTCHQR: Future Measure Topics Under Consideration

- Transfer of health information and care preferences when an individual transitions
- Patient Experience of Care
- Percent of Patients with Moderate to Severe Pain
- Advance Care Plan
- Ventilator Weaning (Liberation) Rate
- Compliance with Spontaneous Breathing Trial (SBT) (including Tracheostomy Collar Trial (TCT) or Continuous Positive Airway Pressure (CPAP) Breathing Trial) by Day 2 of the LTCH Stay
- Patients Who Received an Antipsychotic Medication
- Venous Thromboembolism Prophylaxis

Inpatient Psychiatric Facilities Quality Reporting (IPFQR) FY 2018

IPFQR Previously Adopted Measures for FY 2019

Measure ID	Measure Name
HBIPS-2	Hours of Physical Restraint Use (NQF #0640)
HBIPS-3	Hours of Seclusion Use (NQF #0641)
HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (NQF #0560)
FUH	Follow-Up After Hospitalization for Mental Illness (NQF #0576)
SUB-1	Alcohol Use Screening (NQF #1661)
SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered and the subset, Alcohol Use Brief Intervention (NQF #1663)
TOB-1	Tobacco Use Screening (NQF #0651)
TOB-2 and TOB-2a	Tobacco Use Treatment Provided or Offered and the subset, Tobacco Use Treatment (during the hospital stay) (NQF #1654)
TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and the subset, Tobacco Use Treatment at Discharge (NQF #1656)
IMM-2	Influenza Immunization (NQF #1659)
N/A	Transition Record with Specified Elements Received and Discharged Patients (NQF #0647)
N/A	Timely Transmission of Transition Record (NQF #0648)
N/A	Screening for Metabolic Disorders
N/A	Influenza Vaccination Coverage Among Healthcare Personnel
N/A	Assessment of Patient Experience of Care
N/A	Use of an Electronic Health Record (EHR)

FY 2019 Payment Proposed Measure Changes

- Changes to Existing Measures
  - Screening for Metabolic Disorders
    - » Exclude patients with a length of stay over less than 3 days or more than a year
- New Measures
  - Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge (SUB-3) /Measure Alcohol & Other Drug Use Disorder Treatment at Discharge (SUB-3a) (NQF #1664)
  - 30-Day All Cause Readmission Following Psychiatric Hospitalization in an IPF.

Faculty

- **Danielle Lloyd, MPH**
  VP, policy and advocacy; Deputy director, D.C. office, Premier Inc.

- **Aisha Pittman, MPH**
  Director, quality policy and analysis Premier Inc.

Your questions

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For more information, contact:

Anna Vordermark, Advisor Live®

anna_vordermark@premierinc.com 704-816-5599

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Appendix

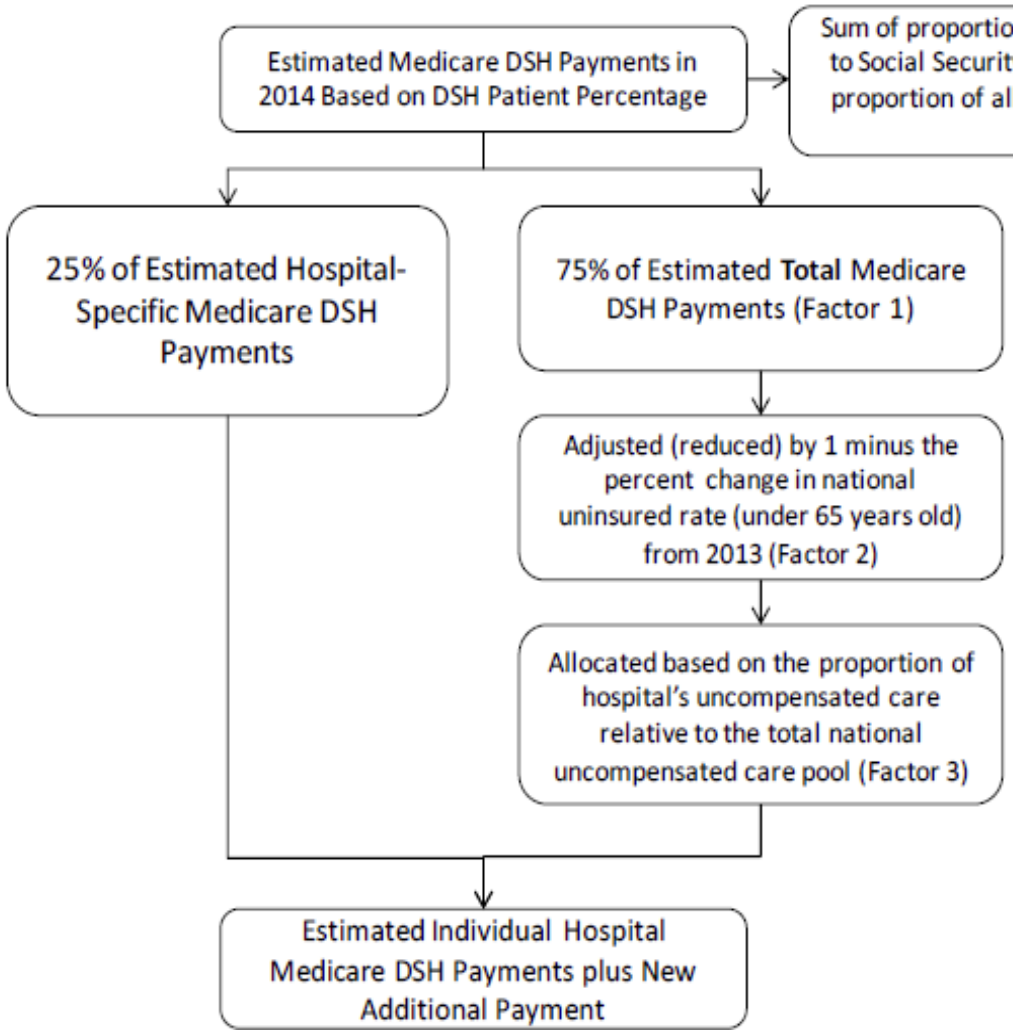
Medicare DSH: "Empirically Justified" DSH Payment Adjustment

- Primary method for qualifying for DSH adjustment: Disproportionate Patient Percentage (DPP)

$$\frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid Days}}{\text{Total Patient Days}}$$

  - Hospital's DPP must equal or exceed a specified threshold amount
  - Varies by hospital size, urban/rural designation, and Rural Referral Center designation
- Alternative method ("Pickle" hospitals)
  - Hospitals located in an urban area and have 100 or more beds
  - Have 30 percent of their total net inpatient care revenues come from State and local government sources for indigent care (other than Medicare or Medicaid)
  - Receive a 35 percent DSH adjustment

Medicare DSH: Review of Section 3133 of ACA



Implementation requires estimates of:

(1) Total estimated Medicare DSH payments

(2) The change in the uninsured rates

(3) Each hospital's share of uncompensated care using a Section 3133 definition of uncompensated care for each hospital and a national pool

Medicare DSH: Uncompensated Care Payment Eligibility

- No proposed changes in eligibility from FY 2014
- Only affects *operating* DSH, not *capital* DSH
- Only IPPS hospitals receiving a DSH payment adjustment can receive an “uncompensated care payment”
- Hospitals in Puerto Rico and those participating in the Bundled Payments for Care Improvement Initiative are *included*
- Maryland hospitals and hospitals participating in the Rural Community Hospital Program are *excluded*
- Sole Community Hospitals (SCHs) paid under their hospital-specific rates will be *excluded*
- All Medicare Dependent Hospitals (MDHs) are *included*, payments will be pro-rated based on current expiration of this status

Medicare DSH: Uncompensated Care Payment Operations

- **Payments for uncompensated care will be made on a per discharge basis**
  - Uncompensated care payments will be determined in final rule each year and will not be updated with newer data
  - "Empirically justified" DSH paid on a per discharge basis (same as today)
  - Final determination for eligibility will be at cost report settlement – but Factor 3 will not be recalculated
  - "Empirically justified DSH payments" (25% portion) and uncompensated care payments may then be recouped if not eligible or paid out if eligible/under paid because of lower than expected volume
  - Uncompensated care payments will begin with Federal FY not hospital FY, but will be reported in hospital FY
- Estimate of Uncompensated Care DSH Payment
  - Multiply Factor 3 by total estimated pool amount (i.e., Factor 2) to calculate estimated uncompensated care DSH payment amount for your hospital. Appears on IPPS Impact file and supplemental table as well as merger data

HRRP: Adjustment Calculation for FY 2017

- **Aggregate payments for excess readmissions** = [Sum of DRG payments for AMI * (Excess Readmission Ratio for AMI – 1)] + [Sum of DRG payments for HF * (Excess Readmission Ratio for HF – 1)] + [Sum of DRG payments for PN * (Excess Readmission Ratio for PN – 1)] + [Sum of DRG payments for COPD * (Excess Readmission Ratio for COPD – 1)] + [Sum of DRG payments for Hip/Knee * (Excess Readmission Ratio for Hip/Knee – 1)]
- **Aggregate payments for all discharges** = sum of DRG payments for all discharges
- **Ratio** = 1-(Aggregate payments for excess readmissions/Aggregate payments for all discharges)
- **Readmissions Adjustment Factor** for FY 2016 proposed as the greater of the **ratio** or 0.97 (floor adjustment factor for FY 2016)

The most DRG base operating payment can be reduced on a claim due to the Readmission Adjustment Factor in FY 2016 is 3 percent

Excess Day Measures

- Excess Days in Acute Care after Hospitalization for AMI, HF, PN
  - Risk-standardized outcome comparing the number of days that patients are predicted to spend in acute care (hospital readmissions, observation stays, and ED visits) after discharge from a hospital, compared to the days expected based on their degree of illness
- Days per 100 discharges during first 30 days after discharge, compared to the of days at an average hospital
- Days calculation
  - Readmissions- Discharge date minus admission date, capped at 30 days, excludes planned readmissions
  - Observation days- hours rounded up to nearest half day
  - ED visits- treat and release is a half day
- 3 years of Part A & B claims data