Welcome Advisor Live: May 8, 2019

Our Presentation:

Inpatient Prospective Payment System FY 2020 Proposed Rule

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Agenda

- Payment Updates
- Documentation and Coding
- Wage Index
- Other payment policies
- New Technology
- DSH Adjustment
- Quality Reporting Programs
- EHR Incentive Program
- Interoperability

FY 2020 Proposed Inpatient PPS Rule

- Released April 23, 2019. Published in the *Federal Register* May 3, 2019. **Comment period closes June 24, 2019**.
- Rates estimated to increase average of 3.5% (market basket = 3.2%). Total estimated increase in operating and capital payments = $4.7 billion.
- Proposes to use only FY 2015 Worksheet S-10 to distribute uncompensated care payments rather than 3 years of cost report data.
- Raises payment for new technology add-on and makes it easier for breakthrough technology to qualify.
- Increases the wage index for certain low wage index hospitals. Reduces wage index for certain high wage index hospitals. Caps wage index reductions at 5%.

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Payment Updates

Operating Payment Impact Table

Contributing Factor	National % Change
Market Basket (for successful IQR/MU participation)	+3.20%
ACA MB cut	0
ACA Productivity cut	-0.50%
Documentation and Coding Adjustment	+0.5%
SUBTOTAL: FY 2019 payment rate increase	3.2%
Average Payment Increase[1]	3.1%
Frontier hospital wage index floor and outmigration	+0.10%
Residual (outlier, other variables not quantified)	+0.30%
TOTAL:	+3.5%

[1]Average increase is slightly lower than 3.2% (3.1%) because hospital-specific rates do not reflect the documentation and coding adjustment.

Additional Payment Impacts

- Impact of several policies not included in operating payments impact table:
  - **Uncompensated care –** $216 million increase.
  - **Hospital Readmissions Reduction Program (HRRP) –** Reduces FY 2020 payments by $550 million.
  - **New Technology Add-On Payment (NTAP) –**
    - 17 applications for FY 2020.
    - Payments will expire for 3 technologies and continue for 9.
    - If CMS finalizes proposal to increase NTAP payment from 50% to 65% and approves all 17 applications, estimated payment increase is $110 million.
  - **Value-based purchasing –** Budget neutral but will redistribute $1.9 billion based on hospital quality scores.
  - **Low Volume Hospital Adjustment –** Increases payment by $25 million in FY 2020.
  - **IPPS Capital –** Payments per case will increase 1.9 percent.

Updates based on MU and IQR

FY 2020	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	3.2	3.2	3.2	3.2
Adjustment for Failure to Submit Quality Data	0.0	0.0	-0.8	-0.8
Adjustment for failure to be a meaningful EHR user	0.0	-2.4	0.0	-2.4
MFP adjustment under	-0.5	-0.5	-0.5	-0.5
Full /Reduced Update*	2.7	0.3	1.9	-0.5

*Does not include the +0.5% for documentation and coding.

¼ MB=0.8; ¾ MB=2.4

Capital Payment Update

Capital Input Price Index*	**1.5**
Intensity	**0.0**
Case-Mix Adjustment Factors:	
Real Across DRG Change	**+0.5**
Projected Case-Mix Change	**-0.5**
Subtotal	**1.5**
Effect of FY 2018 Reclassification and Recalibration	**0.0**
Forecast Error Correction	**0.0**
Total Update	**1.5**
GAF/DRG Adjustment Factor	**0.9976**
Outlier Adjustment	**0.9971**
Total Net Rate Change	**0.96**

*The capital input price index is based on the FY 2014-based CIPI

Establishes a $463.81 capital rate for FY 2020, a 0.96 percent increase in the capital rate compared to FY 2019.

Documentation and Coding

	ATRA				SGR Reform and Cures Offset					
Status	Final	Final	Final	Final	Law	Law	Law	Law	Law	Law
FY	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
CUT	-0.8%	-0.8%	-0.8%	-0.8%	+0.4588%	+0.4588%	+0.4588%	+0.4588%	+0.4588%	+0.4588%
		-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%**	**-3.4412%**	**-2.9412%**	**-2.4412%**	**-1.9412%**	**-1.4412%**	**-0.9412%**

- ATRA required CMS to recoup $11 billion between FYs 2014-2017.
- 3.2% would have been restored to the base in FY 2018, but instead MACRA phased in a 3.0% increase over 6 years (0.5% annually from FY 2018 through FY 2023) with a permanent 0.2% percentage point cut.
- After MACRA was enacted, CMS changed the FY 2017 reduction from 0.8% to 1.5%.
- This increase lead to an additional 0.7% percentage point permanent reduction.
- Cures bill returned 0.4588% instead of 0.5% in 2018 resulting in a slightly larger permanent reduction.

Updates to Wage Index Methodology

- Wage index is based on hospital reported data (Worksheet S-3 of the hospital cost report).
- CMS argues that:
  - Higher wage index hospitals can pay higher wages to continue a high wage index.
  - Lower wage areas cannot afford to pay wages that would allow their hospitals to approach median wage index.
  - Over time, hospital reported data has widened the gap between high and low wage indexes.

Proposal 1

Allow Time for Low-Wage Hospitals to Raise Wages

- Increases the wage index values for hospitals with a wage index in the lowest quartile.
    - Increase is one-half the difference between the hospital's wage index and the 25th percentile wage index.
    - CMS will update the 25th percentile wage index based on FY 2020 final rule data.
- Policy would be effective for at least 4 years in order to allow employee compensation increases implemented by these hospitals sufficient time to be reflected in the wage index calculation.
    - CMS intends to revisit the duration of the policy in future rulemaking.

Proposal 2

Make Proposal Budget Neutral by Lowering Wage Index for High Wage Hospitals

- Maintains budget neutrality for increases to low wage index hospital through an adjustment to the wage index of high wage index hospitals
- A uniform reduction of 4.3 percent* would be applied to the portion of a hospital's wage index above the 75th percentile
- Based on proposed rule data, the 75th percentile wage index value is 1.0351.
    - Under CMS' proposal, the portion of a hospital's wage above 1.0351 will be reduced by 4.3 percent to maintain budget neutrality for the proposed wage index increases.

* The rule presents this figure as 3.4% but CMS confirmed it is 4.3%

Proposal 3 and 4

Wage index of urban hospitals reclassified as rural will no longer be included in in determining rural floor wage index.

- Rural floor does not allow urban hospitals to have a lower wage index than rural hospitals in the same state.
- Benefited 366 urban hospitals in FY 2018 at the expense of a -0.67% adjustment to all hospital wage indexes.
- Proposal will result in 166 hospitals receiving the rural floor in FY 2020—87 fewer than in FY 2019.
- CMS: Raises all urban hospital wage indexes to wage index of other urban hospitals in the state, not rural hospitals.

CMS will cap reduction to the wage index in FY 2020 to 5%. Cap will not apply in FY 2021.

Other Wage Index Provisions

- **Outmigration –** Continues 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

- **Occupational Mix –** Uses 2016 data for 2020 AWI.

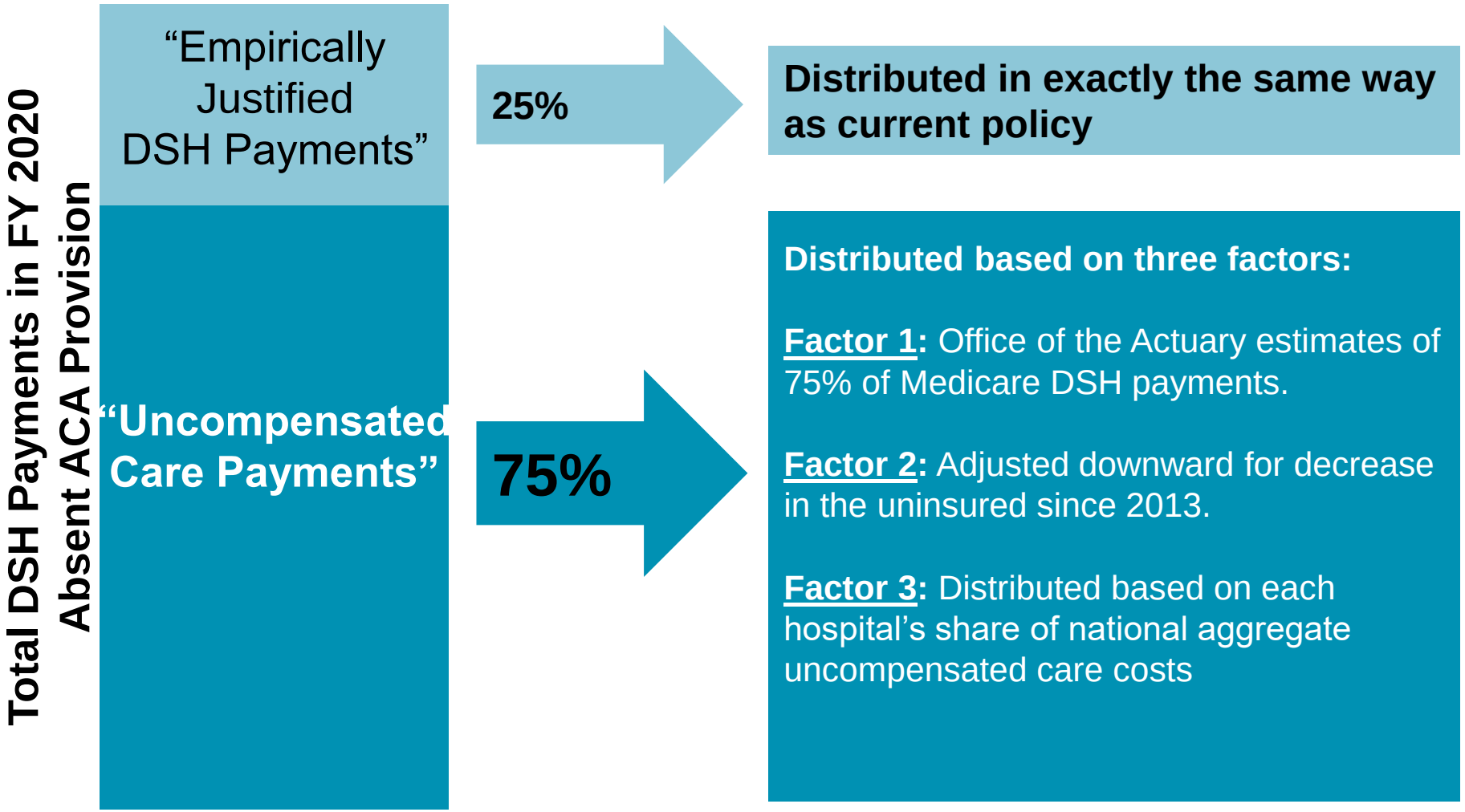
Updates to Outlier Fixed-Loss Cost Threshold

- Beginning FY 2020 CMS would incorporate an estimate of outlier reconciliation dollars based on historical cost reports
  - For FY 2020 outlier threshold, reconciliation benefits hospitals as CMS refunding money in prior year (FY 2014) to hospitals.

- Beginning in FY 2020, CMS is making a minor change to the charge inflation factor used to estimate outlier payments. Using less recent fiscal year rather than calendar year data. However, data is more complete and publicly available and will allow public to replicate CMS calculations.

- Fixed-loss cost threshold increasing to $26,994 for FY 2020 from $25,743 in FY 2019.

Medicare DSH: Uncompensated Care DSH Payment



Proposed FY2020 Factor 1 Numbers

- **Factor 1 – Total DSH Payments**
  - Total DSH pool December 2018 estimate ($16.857 billion) which is based on the September 2018 update to HCRIS and FY 2019 final rule impact file
  - 75% of $16.857 = **$12.643 billion** (compared to $12.254 billion for FY 2020)

Proposed Updates to Factor 2

FY2020 Proposed Data Source		
NHEA (National Health Expenditure Accounts) estimate reflects the percent uninsured in the U.S. **across all age groups and residents** (not just legal residents)		
NHEA estimate of the rate of the uninsured:	**FY 2013**	14%
	FY 2019	9.4%
	FY 2020	9.4%

Factor 2 – Change in the Uninsured Percent

1 – 67.14% (compared to 67.51% for FY 2018)

FY 2020 proposed uncompensated care payments = **$8.489 billion***

($12.643 billion x 0.6714 = $8.489 billion)

**This is a 2.6 percent increase over FY 2019.

Proposed Changes to Factor 3 Calculation

- For FY 2019, Worksheet S-10 data was used for the FY 2014 and FY 2015 cost reporting periods and low-income insured days proxy was used for the FY 2013 cost reporting period.
- For FY 2020, CMS expected to propose using 3 years of Worksheet S-10 data (FY 2014 – FY 2016).
- CMS actually proposed to use a single year of Worksheet S-10 data from FY 2015 cost reports to calculate Factor 3 because of concerns about using partially audited data for one year and unaudited data for the other two.
- CMS seeks comment on using the FY 2017 cost report instead of FY 2015 because of improved instructions for lines 20-22 regarding reporting charity care charges
- Continues to define uncompensated care (Worksheet S-10, line 30) as the sum of charity care (line 23) and non-Medicare bad debt and non-reimbursable Medicare bad debt (line 29).

Changes to the Calculation of the Inpatient New Technology Add-On Payment

- Current calculation of the new technology add-on payment is based on the cost to hospitals for new medical service or technology
  - If the costs of the discharge exceeds the full DRG payment CMS will make an add-on payment equal to the lesser of (1) 50 percent of the costs of the new medical technology; or (2) 50 percent of the amount by which the costs of the case exceed the standard DRG payment.
  - Beginning October 1, 2019 increases the add-on payment from the current 50 percent to 65 percent
  - Would increase the maximum add-on payment from $186,500 to $242,450 for CAR-T products approved for new technology add-on payments in FY 2019.
- Beginning in FY 2021: New policies for medical device approved by the FDA as breakthrough technologies:
  - Would be considered new and not substantially similar to an existing technology for purposes of the new technology add-on payment.
  - Would not have to meet the substantial clinical improvement criterion.
  - Would only have to meet the cost criterion.

FY 2020 Status of Existing New Technology Add-On Payment - Proposed Discontinuation

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

- **Stelara®** is a FDA approved biologic for IV-induction therapy for Crohn's disease

- **ZINPLAVA™** is a human monoclonal antibody that neutralizes *Clostridium difficile* (*C-diff*) Toxin B and reduces recurrences of *Clostridium difficile* infection (CDI)

FY 2020 Status of Existing New Technology Add-On Payment - Proposed Continuation

- ✓ **AndexXa™ (Andexanet alfa)** antidote used to tread patients who are receiving treatment with an oral Factor Xa inhibitor who suffer a major bleeding episode and require urgent reversal of direct and indirect Factor Xa anticoagulation
  - The maximum new technology add-on payment amount for a case using AndexXA™ would be $18,281.25 for FY 2020.
- ✓ **The AQUABEAM System (Aquablation)** indicated for the use in the treatment of patients experiencing lower urinary tract symptoms caused by a diagnosis of benign prostatic hyperplasia (BPH)
  - The maximum new technology add-on payment amount for a case using AQUABEAM would be $1,625 for FY 2020
- ✓ **GIAPREZA™** a synthetic human angiotensin II administered through IV infusion to raise blood pressure in adults who have been diagnosed with septic or other distributive shock
  - The maximum new technology add-on payment amount for a case using GIAPREZA™ would be $1,950 for FY 2020

FY 2020 Status of Existing New Technology Add-On Payment - Proposed Continuation

- ✓ **KYMRIAH™ and YESCARTA®** Autologous T-cell immune therapy indicated for use in the treatment of patients with relapsed/refractory (R/R)Diffuse Large B Cell Lymphoma (DLBCL) not eligible for autologous stem cell transplant (ASCT).
  - Maximum new technology add-on payment amount for case involving KYMRIAH® and YESCARTA® would be increased to $242,450 for FY 2020
- ✓ **remedē® System** transvenous phrenic nerve stimulator for the treatment of adult patients who have been diagnosed with moderate to severe central sleep apnea
  - The maximum new technology add-on payment amount for a case using the remedē® System would be $22,425 for FY 2020
- ✓ **Cerebral Protection System (Sentinel® Cerebral Protection System)** embolic protection (EP) device to capture and remove thrombus debris while performing transcatheter aortic valve replacement (TAVR) procedure
  - ✓ The maximum new technology add-on payment amount for a case using the Sentinel® Cerebral Protection System would be $1,820 for FY 2020

FY 2020 Status of Existing New Technology Add-On Payment - Proposed Continuation

- ✓ **VABOMERE™** beta-lactamase combination antibiotic for cUTIs
  - The maximum new technology add-on payment amount for a case using VABOMERE™ would be $7,207.20 for FY 2020
- ✓ **VYXEOS™** nano-scale liposomal formulation containing a fixed combination of cytarabine and daunorubicin in a 5:1 molar ratio used for treatment of Acute Myeloid Leukemia
  - The maximum new technology add-on payment amount for a case using VYXEOS™ would be $47,353.50 for FY 2020
- ✓ **ZEMDRI™ Plazomicin** aminoglycoside antibiotic with enhanced activity against many multi-drug resistant (MDR) gram-negative bacteria
  - The maximum new technology add-on payment amount for a case using ZEMDRI™ would be $3,539.25 for FY 2020

FY 2020 Proposed New Applications for New Technology Add-On Payment

- ✓ **AZEDRA® (Ulratace® iobenguane Iodine-131) Solution** a drug solution formulated for IV use in the treatment of patients diagnosed with iobenguane avid malignant and/or recurrent and/or unresectable pheochromocytoma and paragangliona
- ✓ **CABLIVI® (caplacizumab-yhdp)** a humanized bivalent nanobody13 administered through IV and subcutaneous (SC) injection to inhibit microclot formation in adult patients diagnosed with acquired thrombotic thrombocytopenic purpura (aTTP).
- ✓ **CivaSheet®** a “sealed source” intended to be placed into a body cavity or tissue for the delivery of radiation therapy.
- ✓ **CONTEPO™ (Fosfomycin for Injection)** for treatment of (cUTIs caused by multi-drug resistant (MDR) pathogens in hospitalized patients.
- ✓ **DuraGraft® Vascular Conduit Solution** a solution used for vein graft storage and prevention of vascular graft disease (VGD) and vein graft failure (VGF) which reduces the clinical complications associated with graft failure.

FY 2020 Proposed New Applications for New Technology Add-On Payment

- ✓ **Eluvia™ Drug-Eluting Vascular Stent System** implantable endoprothesis and a stent delivery system (SDS) indicated for improving luminal diameter in the treatment of peripheral artery disease (PAD) with symptomatic de novo or restenotic lesions in the native superficial femoral artery (SFA) and or proximal popliteal artery (PPA) with reference vessel diameters (RVD) ranging from 4.0 to 6.0 mm and total lesion lengths up to 190 mm.
- ✓ **ELZONRIS™ (tagraxofusp, SL-401)** a targeted IV therapy for treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN), a rare, highly aggressive hematologic malignancy, previously known as blastic natural killer (NK) cell leukemia/lymphoma
- ✓ **Erdafitinib** an oral pan-fibroblast growth factor receptor (FGFR) tyrosine kinase inhibitor being evaluated in Phase II and III clinical trial is patients with advanced urothelial cancer
- ✓ **ERLEADA™ (Apalutamide)** an oral drug that is an androgen receptor inhibitor indicated for the treatment of patients diagnosed with non-metastatic castration-resistant prostate cancer (nmCRPC).

FY 2020 Proposed New Applications for New Technology Add-On Payment

- ✓ **SPRAVATO (Esketamine)** a drug administered through a nasal spray for the treatment of treatment-resistant depression (TRD)
- ✓ **XOSPATA® (gilteritinib)** an oral small molecule FMS-like tyrosine kinase 3 (FLT3) used for the treatment of adult patients with r/r acute myeloid leukemia (AML) with a FLT3 mutation as detected by an FDA-approved test.
- ✓ **GammaTile™** a brachytherapy technology for use in the treatment of patients diagnosed with brain tumors using cesium-131 radioactive sources embedded in a collagen matrix
- ✓ **Imipeneum, Cilastatin, and Relabactam (IMI/REL) Injection** an antibiotic indicated for the treatment of patients 18 years of age and older diagnosed with complicated intra-abdominal infections (cIAI) and cUTIs, including pyelonephritis, caused by susceptible gram-negative microorganisms where limited or no alternative therapies are available.

FY 2020 Proposed New Applications for New Technology Add-On Payment

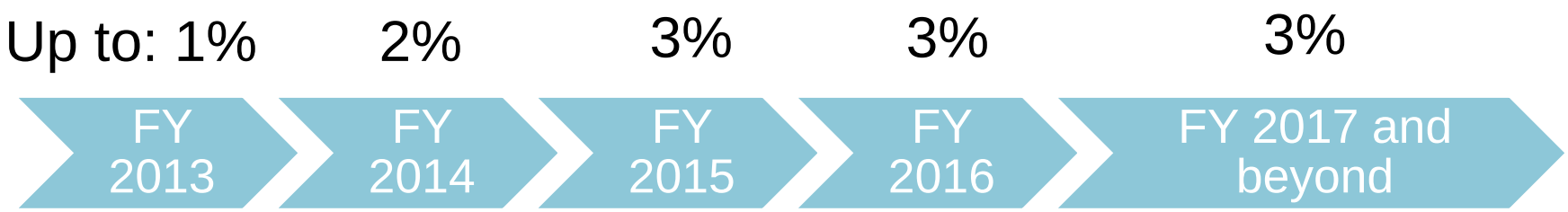
- ✓ **JAKAFI™ (Ruolitinib)** an oral Janus-associated kinase (JAK) inhibitor for the treatment of acute graft-versus-host-disease (aGVHD) in patients with an inadequate response to corticosteroids
- ✓ **Supersaturated Oxygen (SSO2) Therapy (DownStream® System)** an adjunctive therapy designed to ameliorate progressive myocardial necrosis by minimizing microvascular damage in patients receiving treatment for an acute myocardial infarction (AMI)
- ✓ **T2Bacteria® (T2 Bacteria Test Panel)** a multiplex disease panel that detects five major bacterial pathogens (Enterococcus faecium, Escherichia coli, Klebsiella pneumoniae, Pseudomonas aeruginosa, and Staphylococcus aureus) associated with sepsis
- ✓ **VENCLEXTA® (venetoclax)** an oral anti-cancer drug. VENCLEXTA® was previously approved by the FDA for the treatment of patients diagnosed with chronic lymphocytic leukemia (CLL) with 17p deletion, as detected by am FDA-approved test, who had received at least one prior therapy

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. Adjustments are either zero or payment reductions – HRRP includes no rewards



Adjustment 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 applies only 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

For FY 2020 payment, the 30-day AMI, HF, expanded PN, COPD, THA/TKA (Hip/Knee), and CABG measures will be based on data for July 1, 2015 - June 30, 2018

HRRP: Proposed FY 2020 Changes

- No changes proposed to HRRP measures or formula
- Proposes adoption of 8 factors to determine whether to remove a measure; same factors previously adopted for the Inpatient Quality Reporting and the Inpatient Value-Based Purchasing programs.
- Proposes subregulatory process to make nonsubstantive changes to HRRP components; parallel to process for making nonsubstantive changes to measures
  - e.g., names and locations of data files and other minor discrepancies
  - Minor technical change proposed to definition of dual eligible that would not require rulemaking under the proposed policy
- Following past policy, for FY 2022, HRRP measurement period ("applicable period") would be July 1, 2017 – June 30, 2020.
- Confidential hospital-specific stratified readmissions data will be made available beginning in spring of 2020
  - Within-hospital and across-hospital methods; different from HRRP stratification

* CMS preferred methodology

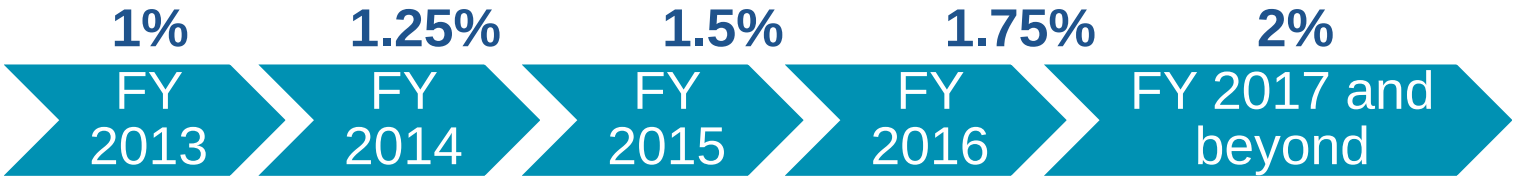
Measure Removal Factors

Measure removal factors adopted for IQR and VBP programs, proposed for HRRP:

1. Measure is topped out
2. Measure does not align with current clinical guidelines or practice
3. Measure more broadly applicable or more proximal in time to desired outcomes is available
4. Performance improvement does not result in better outcomes
5. Measure more strongly associated with desired patient outcome is available
6. Collection or public reporting leads to negative unintended consequences other than patient harm
7. It’s not feasible to implement measure specifications
8. The costs associated with the measure outweigh the benefit

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 $1.9B), where hospitals must fail to meet targets for bonuses to be generated for others

Rewards for achievement or improvement

Measures selected from IQR program

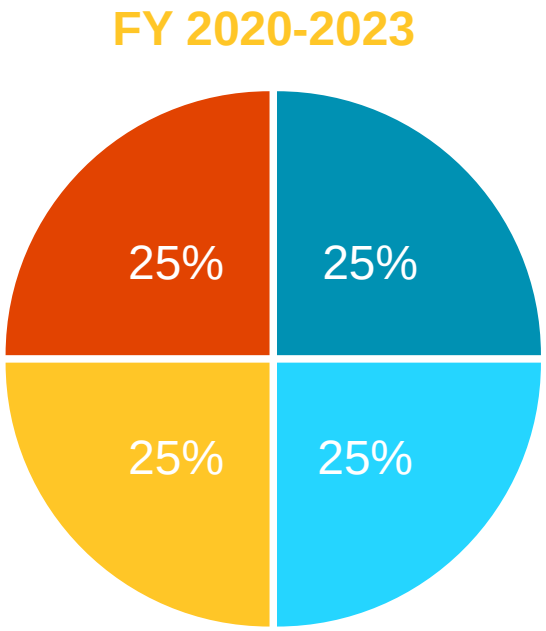
Focuses on four domains:

- Clinical Outcomes
- Patient and Caregiver Experience
- Healthcare Costs
- Safety

Inpatient VBP: FY 2020 Proposed Changes

- No measure additions or removals proposed
- No changes to VBP scoring proposed
- Proposal to use the same CDC National Healthcare Safety Network (NHSN) Healthcare Associated Infection (HAI) data for the VBP Program that is used for the Hospital-Acquired Condition (HAC) Reduction Program, beginning with January 1, 2020 data collection when these measures will be removed from the IQR Program
- 12 measures previously finalized for FY 2020, with measure changes in FYs 2021, 2022 and 2023
  - FY 2021: Elective delivery < 39 weeks (PC-01) removed
  - FY 2022: COPD 30-day mortality rate added
  - FY 2023: Patient Safety and Adverse Events composite added

Inpatient VBP FY 2020-2023 (Previously finalized)



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

Measure ID	NQS-Based Domain
MORT-30-AMI	Clinical Outcomes
MORT-30-HF	Clinical Outcomes
MORT-30-PN	Clinical Outcomes
MORT-30-COPD	Clinical Outcomes (Begins FY 2021)
MORT-30-CABG	Clinical Outcomes (Begins FY 2022)
THA/TKA	Clinical Outcomes
HCAHPS	Person and Community Engagement
CTM-3	Person and Community Engagement
CAUTI	Safety
CLABSI	Safety
MRSA	Safety
C. Diff	Safety
SSI	Safety
PC 01	Safety (removed after 2020)
Patient Safety and Adverse Events Composite	Safety (Begins FY 2023)
MSPB-1	Efficiency and Cost Reduction

HAC Reduction Program

HAC Reduction program reduces **total** payments by 1% for worst performing quartile of hospitals starting in FY 2015

- Equal weighting of six measures*
- Beginning with January 1, 2020 infectious events, data collection and validation policies for NHSN measures transferred from IQR program

FY 2020 Measures

- Patient Safety and Adverse Events composite
- Central Line Associated Blood Stream Infection (CLABSI)
- Catheter Associated Urinary Tract Infection (CAUTI)
- Surgical Site Infection (Colon, Abdominal hysterectomy)
- Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia
- Clostridium Difficile Infection (CDI)

*Prior to FY 2019, measures were sorted into 2 domains

HAC Reduction Program Proposed Changes

- No changes proposed to measures or scoring
- Changes proposed to provide flexibility in selecting hospitals for the HAC reduction program validation beginning in 2020
  - *Up to* 200 hospitals would be chosen for HAC validation from 400 in IQR validation pool (previously set to *equal* 200)
  - To identify CLABSI and CAUTI "true events," cases for which cultures were collected on days 1 or 2 following admission would be eliminated from validation pool
- Performance period ("applicable period") for FY 2022
  - July 1, 2018-June 30, 2020 for Patient Safety composite
  - Calendar years 2019 and 2020 for NHSN measures

IQR Program Changes

- FY 2019 final rule removed 39 measures across FYs 2020-2023; no further removals proposed
- Proposes addition of 2 new opioid-related electronic clinical quality measures (eCQMs)
  - Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e)
  - Hospital Harm – Opioid Related Adverse Events eCQM
- Current eCQM policy -- requirement to report 4 of 8 eCQMs for 2020 reporting (FY 2022 payment) for IQR program
  - Consistent with Medicare Promoting Interoperability program
- Proposal would require reporting 4 of 10 eCQMs for reporting in FY 2021 (FY 2023 payment)
- CEHRT Editions (previously finalized policies would continue)
- EHR technology must be certified to all eCQMs available
- Must use 2015 edition of CEHRT for CY2020 reporting/FY2022 payment

IQR Program Changes (cont'd)

- Hybrid Hospital-Wide Readmission measure would transition from voluntary to mandatory
  - Previous 6 month voluntary reporting period in 2018
  - 2 voluntary reporting periods July 1, 2021-June 30, 2022 and July 1, 2022-June 30, 2023
  - Mandatory measure for FY 2026, first reporting July 1, 2023- June 30, 2024
- Possible future additional eCQMs under consideration
  - Severe hypoglycemia
  - Pressure injury
  - Cesarean birth (PC-02)

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Medicare Promoting Interoperability Program for Hospitals and CAHs

Proposals for Medicare Promoting Interoperability Program

- Continuous 90-day reporting period minimum would be extended to 2021
- Actions counted in measure numerators would need to be completed during the hospital's chosen reporting period, except for Security Risk Analysis measure
- Changes proposed to 2020 reporting for two opioid-related measures adopted in FY 2019 rulemaking:
    - Query of Prescription Drug Monitoring Program (PDMP) measure would remain optional and changed to a yes/no measure (scoring adjusted)
    - Verify Opioid Treatment measure would be removed
- As previously finalized, requirement to use 2015 Edition of CEHRT beginning with CY 2019 reporting period
- eCQM proposals to align with IQR program -- 2 new measures
    - Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e)
    - Hospital Harm – Opioid Related Adverse Events eCQM

Medicare Promoting Interoperability Program Scoring for 2020 reporting

Objectives	Measures	Maximum Points	
		Current	**Proposed**
e-Prescribing	e-Prescribing	5 points	10 points*
	Query of Prescription Drug Monitoring Program (PDMP)	5 points	5 points **(bonus)**
	Verify Opioid Treatment Agreement	5 points (bonus)	Remove
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points	40 points
Public Health and Clinical Data Exchange	<u>Choose any two of the following:</u> Syndromic Surveillance Reporting Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Electronic Reportable Laboratory Result Reporting	10 points	10 points

*This change in points is conditional on CMS finalizing the Query of PDMP measure as optional.

Promoting Interoperability Program: Requests for Information

Requests for Information are included in the proposed rule

- Potential Future Opioid Measures
- National Quality Forum and CDC Opioid Quality Measures
- Metric to Improve Efficiency of Providers within EHRs
- Including Promoting Interoperability Program Data on *Hospital Compare*
- Provider to Patient Exchange Objective
- Integration of Patient-Generated Health Data into EHRs
- Engaging in Activities that Promote Safety of the EHR

Other Quality Reporting Programs in IPPS/LTCH Proposed Rule

LTCH Quality Reporting Program

- Proposals made to align reporting across post-acute care (PAC) settings
  - Same proposals also included in separate proposed rules for Skilled Nursing Facilities and Inpatient Rehabilitation Facilities; Home Health Agency proposed rule due to be published in July
- Quality measures proposed beginning with FY 2022 payment
  - Transfer of Health Information to the Provider – PAC Measure
  - Transfer of Health Information to the Patient – PAC Measure
- Proposed removal of long-term nursing facility residents from the existing Discharge to Community PAC Measure
- Proposed expansion of Standardized Patient Assessment Data Element (SPADE) reporting beginning in 2020
  - 28 SPADEs proposed for application across PAC patient assessment instruments; most are new items for LTCHs
  - Involve functional status; cognitive function and mental status; special services, treatments, and interventions; medical condition and comorbidity data; hearing and vision impairment; and new proposed category for social determinants of health

PPS-Exempt Cancer Hospital Quality Reporting Program

- Applies to 11 cancer hospitals exempt from the IPPS
- Proposed removal of Pain Management questions from Hospital Consumer Assessment of Healthcare Providers and Suppliers (HCAHPS) patient survey
  - Consistent with previous removal from IQR and Inpatient VBP programs
- Proposes removal of 1 measure and addition of 1 measure
  - Removal of External Beam Radiotherapy for Bone Metastases Measure
  - Addition of Surgical Treatment Complications for Localized Prostate Cancer Measure
- Proposed public display of performance on 5 measures
  - 4 NHSN HAI measures in 2019
  - Admissions and ED visits for outpatient chemotherapy patients in 2020

Important Links

Detailed Summary

Proposed Rule

CMS press release

CMS fact sheet

Questions

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