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Inpatient Prospective Payment System FY 2018 Final Rule

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Inpatient Prospective Payment System
FY 2018 Final Rule

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Agenda

- Payment Updates
- Documentation and Coding
- Wage Index
- Other payment policies
- DSH Adjustment
- New Technology
- Readmissions
- Value-Based Purchasing
- Hospital-Acquired Conditions
- Quality Reporting Programs

FY 2018 Final Inpatient PPS Rule

- Published in August 14 *Federal Register*
- Market basket of 2.7%, but 1.3% average payment increase
- Total estimated increase in operating and capital of $2.4B
  - $1.7 billion increase in operating payments
  - $0.2 billion increase in capital payments
- Transitioning to Worksheet S-10 from low income patient days for uncompensated care payments
- Accounts for percentage of dual-eligibles in scoring of Hospital Readmission Reduction Program
- No new IQR measures; changes to HCAHPS pain questions and stroke mortality measure
- Adds 1 VBP measure for FY 22 and adopts modified PSI-90 for FY 23

Payment Updates

Operating Payment Impact Table

Contributing Factor	National % Change
Market Basket (for successful IQR/MU participation)	+2.70%
ACA MB cut	-0.75%
ACA Productivity cut	-0.60%
SUBTOTAL: FY 2018 payment rate increase	**1.35%**
Documentation and Coding Adjustment	+0.4588%
Two-midnights adjustment reversed	-0.60%
SUBTOTAL: net increase before budget neutrality adj	**+1.2088%**
Frontier hospital wage index floor and outmigration	+0.10%
Expiration of MDH Status	-0.10%
Residual (outlier payment)	+0.10%
TOTAL:	**+1.30%**

Additional Payment Impacts

- Impact of several policies not included in operating payments impact table:
  - **Medicare DSH and uncompensated care-** payments will be $1.1 billion higher than in FY 2017 ($300 million DSH and $800 million uncompensated care).
  - **Hospital Readmissions Reduction Program (HRRP)-** reduces FY 2018 payments by $556 million – $24 million more than FY 2017.
  - **New technology add-on-** Payments in FY 2018 estimated to be $47 million.
  - **Value-based purchasing-** is budget neutral but will redistribute $1.9 billion based on hospital quality scores
  - **Low Volume Hospital Adjustment – Decreases spending $300 million.**
  - **Other policies-** such as volume decrease adjustment will decrease payment modestly
  - IPPS capital payments increasing $0.2 billion
- **Net aggregate effect**- of these policies is an increase of $2.4 billion compared to FY 2017.

Updates based on MU and IQR

FY 2018	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	2.7	2.7	2.7	2.7
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	-0.675	-0.675
Adjustment for failure to be a meaningful EHR user under section 1886(b)(3)(B)(ix) of the Act	0.0	-2.025	0.0	-2.025
MFP adjustment under section 1886(b)(3)(B)(xi) of the Act	-0.6	-0.6	-0.6	-0.6
Statutory Adjustment under Section 1886(b)(3)(B)(xii) of the Act	-0.75	-0.75	-0.75	-0.75
Final applicable % increase applied to standardized amount	1.35	-0.675	0.675	-1.35

¼ MB=0.675; ¾ MB=2.025

Capital Payment Update

Capital Input Price Index*	**1.3**
Intensity	**0.0**
Case-Mix Adjustment Factors:	
Real Across DRG Change	**0.5**
Projected Case-Mix Change	**0.5**
Subtotal	**1.3**
Effect of FY 2015 Reclassification and Recalibration	**0.0**
Forecast Error Correction	**0.0**
Total Update	**1.3**
GAF/DRG Adjustment Factor	**0.9986**
Outlier Adjustment	**0.9484**
Removal of One-time 2-midnight Policy Adjustment Factor	**1/1.0060**
Total Net Rate	**1.61**

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

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 $11B cut between 2014-2017
- 3.2% would have been restored to the base in 2018, but instead MACRA phased in a 3.0% increase over 6 years with a permanent 0.2%pts cut
- A cut of 0.8% was expected in 2017, but increased to 1.5% to reach $11B
- This increase in recoupment lead to an additional 0.7%pts permanent cut
- Cures bill returned 0.4588% instead of 0.5% in 2018 resulting in ~1% cut

Wage Index

- 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
- Imputed Floor- extends the temporary imputed floor policy for one additional year which will expire effective October 1, 2018.
- Occupational Mix- using 2013 data for 2018 AWI; 2016 data for 2019 AWI. Survey deadline was July 3, 2017.
- Urban to rural reclass- No changes. Applications must be received 70 days in advance of the second Monday in June to be effective upon application
- Rural Referral Centers – Rule clarifies that application is in last quarter of cost reporting period to be effective in the first quarter of the next cost reporting period.

Other Payment Policies

- CMS will rebase capital input price index (CIPI) and IPPS market basket. CIPI goes down 0.1 percentage point in FY 2018 from change and does not change for IPPS market basket.
- Labor share revised from 69.6% to 68.3% for hospitals with a wage index > 1.0. Remains 62% for other hospitals.
- Medicare Dependent Hospitals expires Sept 30, 2017 unless extended by law.
- Outliers
  - Increased fixed loss threshold from $23,573 in FY 2017 to $26,601 in 2018

Medicare DSH: Uncompensated Care DSH Payment

Total DSH Payments in FY 2018 Absent ACA Provision

"Empirically Justified DSH Payments"

25%

Distributed in exactly the same way as current policy

"Uncompensated Care DSH Payments"

75%

Distributed based on three factors:

Factor 1: Office of the Actuary estimated of 100% of Medicare DSH payments.

Factor 2: Change in the percentage of uninsured

Factor 3: Proportion of total uncompensated care each Medicare DSH hospital provides

Finalized FY2018 Factor 1 Numbers

- **Factor 1 – Total DSH Payments**
  - Total DSH pool June 2017 estimate ($15.553 billion) which is based on the March 2017 update to HCRIS and FY 2017 final rule's impact file
  - 75% of $15.553 = **$11.665 billion**
- The finalized Factor 1 for 2018 is about $870 million more than the final Factor 1 for FY 2017.

Final Updates to Factor 2

FY2017 Data Source

CBO's (Congressional Budget Office) estimate of the uninsured rate in the **under 65 population**

CBO estimate of the uninsured rate in the under 65 population:	**FY2013**	18%
	FY2017	10%

FY2018 Finalized Data Source

NHEA (National Health Expenditure Accounts) estimate reflects the rate of uninsurance in the U.S. **across all age groups and residents** (not just legal residents)

NHEA estimate of the rate of uninsurance:	**FY2013**	14%
	FY2017	8.3%
	FY2018	8.1%

Finalized FY2018 Factor 2 Numbers

- **Factor 2 – Change in the Uninsured Percent**
  - Used NHEA data to determine the rate of uninsurance, which is 14%, as the baseline number of uninsured in 2013.
  - FY 2018 percent uninsured based on the NHEA data (8.1%)
  - 1 – (58.21% percent change in uninsured) – (0.2 percentage points for FY2018) = 58.01%

The FY 2018 Final Uncompensated Care Amount is **$6.767 billion**

($11.664 billion x 0.5801 = $6.767 billion)

- The Final FY 2018 uncompensated care payment is $800 million more than $5.977 billion payment total in FY 2017 or a 13.2% increase.

Final Changes to Factor 3 Calculation

- For FY 2018 Worksheet S-10 data will be used for the FY 2014 cost reporting period and low-income insured days proxy will be used for FY 2012 and FY 2013 cost reporting periods.
- CMS expects to carry forward the transition schedule it discussed in the proposed rule for incorporating Worksheet S-10, however, its decision in the final rule only applies to FY 2018.
- Worksheet S-10 will be subject to further review beginning with FY 2014 cost reports.
    - Hospitals can resubmit FY 2014 and FY 2015 cost reports containing Worksheet S-10 to their local Medicare Administrative Contractor(MAC).
    - Resubmission deadline is September 30, 2017.
    - Resubmitted FY 2014 Worksheet S-10 will not be used in determining a hospital's uncompensated care payments for FY 2018 but may be used in determining future year uncompensated care payments.

Additional Final Changes to Factor 3

- **Annualizing Short Cost Reports:** If a hospital's cost report data does not equal 12 months data will be annualized utilizing the following calculation:

$$\left(\frac{\text{Length of a Full Year (365 or 366 calendar days)}}{\text{Number of Days in Cost Reporting Year}}\right) \times \text{Total uncompensated Care Costs for Cost Report Year}$$

- **Scaling Factor:** To ensure total uncompensated care payments do not exceed the DSH estimate a scaling factor will be applied to Factor 3 values of all DSH eligible hospitals to reduce the effects of averaging 3 separate fiscal years.
- **Definition of Uncompensated Care:** Beginning FY 2018 "uncompensated care" will be defined as the cost of charity care and non-Medicare bad debt (amount on line 30 of Worksheet S-10).
    - Medicaid shortfalls reported on Worksheet S-10 are excluded from the definition.

$$\text{Cost of Charity Care (S-10 line 23)} + \text{Cost of non-Medicare bad debt expense (S-10 line 29)} = \text{Cost of non-Medicare uncompensated care (S-10 line 30)}$$

Additional Final Changes to Factor 3 continued..

Trims to apply to CCRs on Line 1 of Worksheet S-10: for all hospitals with a CCR greater than 3 standard deviations above the national corresponding national geometric mean a statewide average will be assigned.

Methodology for Trimming CCRs:

Step 1	Remove all Maryland hospitals, all-inclusive rate providers and providers that did not report a CCR on Worksheet S-10, Line 1.
Step 2	CCR recalculated for hospitals with multiple cost reports included in the 2014 HCRIS data.
Step 3	CCR "ceiling" calculated using the CCRs reported on Worksheet S-10, Line 1, from all IPPS hospitals that were not removed in Step 1 (including non-DSH eligible hospitals), or the recalculated CCR described in Step 2. All hospitals that exceed ceiling are removed.
Step 4	Urban and rural statewide average CCRs are determined using Line 1 of Worksheet S-10 for hospitals within each State (including non-DSH eligible hospitals) for remaining hospitals from Step 3.
Step 5	Appropriate statewide average CCR (urban or rural) calculated in Step 4 is assigned to all hospitals with a CCR greater than 3 standard deviations above the CCR Ceiling, all-inclusive rate providers and providers that did not report a CCR on Worksheet S-10, Line 1.

FY 2018 Status of Existing New Technology Add-On Payment - Denied Extensions

- **CardioMEMS™ HF System** is an implantable pulmonary artery hemodynamic monitoring system for the management of heart failure; (02HR30Z, 02HQ30Z)

- **LUTONIX® and IN.PACT™ Admiral™** Both of these technologies are drug coated balloon percutaneous transluminal angioplasty catheters for patients with peripheral artery disease;

- **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)

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

FY 2018 Status of Existing New Technology Add-On Payment - Continuation

- ✓ **Defitelio®** a treatment for patients with hepatic veno-occlusive disease with evidence of multi-organ dysfunction
  - The maximum new technology add-on payment amount for a case involving the use of Defitelio® will remain $75,900 for FY 2018.
  - CMS estimates FY2018 add-on payment at approximately $5.2 million
- ✓ **GORE EXCLUDER ® Iliac Branch Endoprosthesis** for the repair of common iliac or aortoiliac aneurysms.
  - The maximum new technology add-on payment for a case involving the use of the GORE IBE device will remain $5,250 for FY 2018.
  - CMS estimates FY2018 add-on payment at approximately $5.7 million
- ✓ **Idarucizumab** is a humanized fragment antigen-binding molecule, which specifically binds to PRADAXA® (an oral direct thrombin inhibitor) to deactivate the anticoagulant effect.
  - The maximum new technology add-on payment amount for a case involving the use of Idarucizumab will remain $1,750 for FY 2018.
  - CMS estimates FY2018 add-on payment at approximately $14.8 million
- ✓ **Vistoguard™** is an antidote to Fluorouracil toxicity in patients treated with the chemotherapeutic agent 5-fluorouracil for solid tumors.
  - The maximum new technology add-on payment for a case involving the use of the Vistogard™ device will remain $ 40,130 for FY 2018
  - CMS estimates FY2018 add-on payment at approximately $3.0 million

FY 2018 Approved Applications for New Technology Add-On Payment

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

- ✓ **EDWARDS INTUITY Elite™ Valve System (INTUITY) and LivaNova Perceval Valve (Perceval)** both of these terchnologies are prosthetic aortic valves inserted during surgical aortic valve replacement (AVR)

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

New Technology Add-On Payments— Denied New Applications

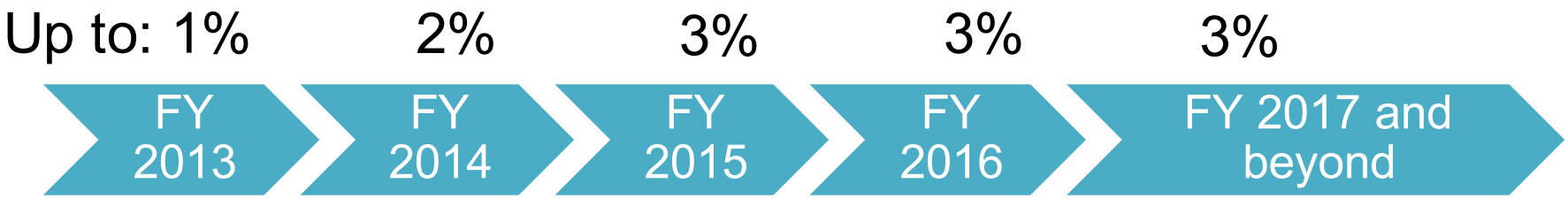
- **KTE-C19** is an engineered autologous T-cell immunotherapy used for the treatment of adult patients with relapsed/refractory aggressive B-cell non-Hodgkin lymphoma (NHL) who are ineligible for autologous stem cell transplant (ASCT).
  - Withdrew application before Final Rule was issued.
- **VYXEOS™** is a nano-scale liposomal formulation containing a fixed combination of cytarabine and daunorubicin used to treat adult patients with acute myeloid leukemia (AML).
  - Did not received FDA approval for its technology by July 1, 2017 and is not eligible for consideration for new technology add-on payments for FY2018.
- **GammaTile™** is a brachytherapy technology for use in the treatment of patients diagnosed with brain tumors using cesium-131 radioactive sources embedded in a collagen matrix.
  - Withdrew application before Final Rule was issued.

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, 2013 - June 30, 2016) for FY 2018 payment.

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

HRRP: FY18 Changes

- Performance period crosses ICD-10-CM implementation, measure codes are now posted on Quality Net in the FY 2017 Specifications Report Appendix D
- Extraordinary Circumstances Exception- changes to align with other hospital programs:
  - Requests can be signed by an organizations designated contact other than the CEO
  - CMS aims to complete reviews within 90 days
  - If a systematic issue is identified, CMS will alert all facilities affected and grant an ECE
- 2,577 hospitals will be penalized under the HRRP in FY 2018; with reductions totaling $566 million, $24 million more than the estimated savings for FY 2017

HRRP: FY 2019 Changes

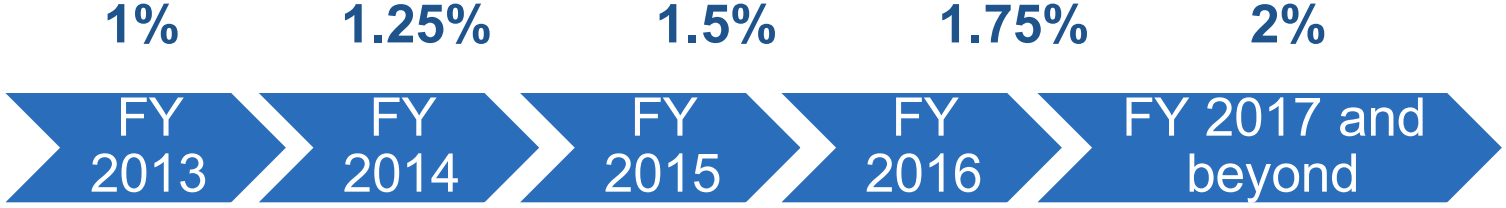
21st Century Cures Act requires modifying payment adjustment by assigning hospitals to peer groups based on proportion of dual-eligible inpatients

- **Determine hospital dual eligible population**
  - Identify duals eligible using MMA file
  - Define proportion of dual-eligible inpatient stays as Dual Eligible Stays/ (MA and Medicare FFS stays)
  - Define data period to be the same as 3-year performance period
- **Assign Hospitals to Peer Groups in Quintiles**
- **Adjust the payment formula:** Use peer group specific threshold excess readmission ratio (median ERR) in place of current threshold (1.00)
  - 50th percentile is a consistent ranking standard whereas the mean would fluctuate between years and peer groups

* CMS preferred methodology

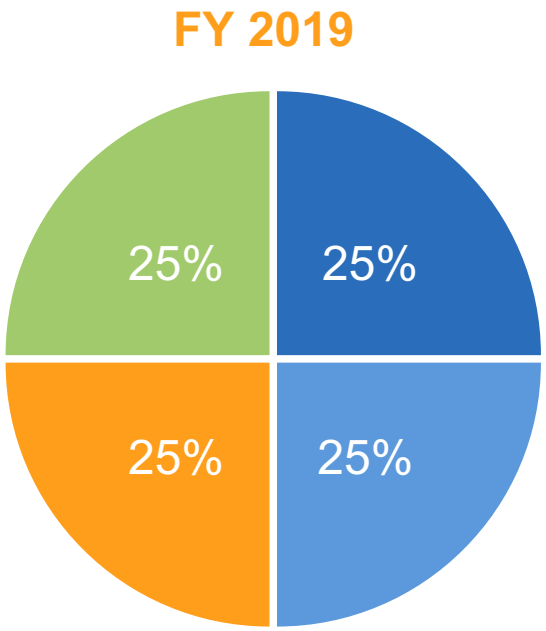
Inpatient Value-Based Purchasing (VBP)

- 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
- Quality measures from Hospital Compare measure set
  - FY 19: Adds 1 clinical care measures and expands CAUTI and CLABSI (previously finalized); removes 1 safety (finalized in FY18 rule)
  - FY 21: Adds 1 clinical care measure, 2 efficiency measures and expands pneumonia mortality (previously finalized)
  - FY 22: Adds 1 clinical care measure (previously finalized) and 1 efficiency measure (finalized FY 18 Rule)
  - FY 23: Add I safety measure (finalized FY18 rule)
- Inpatient Quality Reporting measures are “on deck” for VBP.

Inpatient VBP FY 2019



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

Measure ID	NQS-Based Domain
MORT-30-AMI	Clinical Care
MORT-30-HF	Clinical Care
MORT-30-PN	Clinical Care
THA/TKA	Clinical Care
HCAHPS	Patient and Community Engagement
CTM-3	
CAUTI	Safety
CLABSI	Safety
MRSA	Safety
C. Diff	Safety
~~*PSI-90*~~	~~*Safety Proposed to Remove*~~
SSI	Safety
PC-01	Safety
MSPB-1	Efficiency and Cost Reduction

Inpatient VBP: Changes

- FY 2019
  - Remove PSI-90
  - Changes to domain scoring policies
    - Safety- Reduced the number of measures a hospital must have to receive a score from 3 to 2 measures
    - Efficiency
      - Must have a score for any measure in the domain; currently must have an MSPB score
      - MSPB is 50%, AMI and HF is 50%
- FY 2022
  - Add Hospital-Level, Risk-Standardized Payment Associated With a 30-Day Episode-of-Care for Pneumonia (NQF #2579)
    - Will be posted on Hospital Compare in July
    - Use same scoring methodology as MSPB
    - Baseline: July 1, 2013 – June 30, 2016
    - Performance: August 1, 2018 – June 30, 2020
- FY 2023
  - Modified PSI-90
    - Will be posted on Hospital Compare in Fall 2017
    - Baseline: October 1, 2015 – June 30, 2017
    - Performance: June 1, 2019 – June 30, 2021

(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 2018 reports anticipated 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]

HAC Reduction Program

- FY 2018 Changes Recap
  - Adopted modified PSI-90
  - Replaced decile-based scoring with “Winsorized Z-Score Method”
- FY 2018 Change
  - Align ECE with IQR
- FY 2020 Change
  - Extend performance period from one year to two years
  - Original program policy was a two year performance period but it was shortened to accommodate ICD-10-CM transition
  - PSI-90: July 1, 2016 – June 30, 2018
  - NHSN: January 1, 2017- December 31, 2018

Hospital Inpatient Quality Reporting (IQR) Changes

Hospital Inpatient Quality Reporting Program Data Collection

Measure Category	FY 2019 PD Count	Changes	FY 2020 PD Count
Chart-Abstracted	6	No Change	6
eCQMs	15 8 Required **4**	**Require 4 for FY 17 and 18**	**4**
HAI / NHSN	6	No change	6
30 day Mortality	6	No change	6
30 day Readmission	8	No change; V**oluntary reporting of one additional measure**	8
Excess Days	3	No change	3
AHRQ	2	No change	2
Hip/Knee Complications	1	No change	1
Efficiency	11	No Change	11
Structural	2	No Change	2
HCAHPS	1	No change	1
Totals	46		46

IQR: Changes

- HCAHPS: Revise Pain Management Questions beginning January 1, 2018 (FY 2020 payment determination)
  - During this hospital stay, did you have any pain?
  - During this hospital stay, how often did hospital staff talk with you about how much pain you had?
  - During this hospital stay, how often did hospital staff talk with you about how to treat your pain?
- Stroke Mortality Measure (FY 2023 payment determination)
  - Include NIH Stoke Scale in measure risk adjustment
- Voluntary Reporting of Hybrid Readmission Measure
  - Combines claims and EHR data
  - Voluntary data submission January 1- June 30, 2018
  - CMS is considering proposing as a required measure for FY 2023 payment determination and will require data submission to support a dry run as early as 2020

Data Submission and Validation

Require 4 of 15 eCQMs for 2017 and 2018

Discharge Reporting Period	Submission Deadline
One self-selected quarter in 2017	February 28, 2018
One self-selected quarter in 2018	February 28, 2019

CEHRT Editions

- EHR technology must be certified to all eCQMs available
- Can use 2014 edition or 2015 edition of CEHRT for CY2018 reporting/FY2020 payment

eCQM Validation (CY 2018 reporting/FY 2020 payment)

- 200 hospitals selected for validation of eCQMs, 32 cases randomly selected (previously finalized)
  - » Submit eight cases per quarter from QRDA I (new change)
  - » Exclude hospitals granted ECE exception for eCQMs or chosen for chart abstraction validation
  - » Exclude hospitals if they did not have at least five discharges for at least one eCQM (new change)
  - » eCQM validation does not impact validation score
- Hospitals can request an educational review for chart-abstracted measures from CMS

EHR Incentive Program (Meaningful Use) Proposed Changes

- eCQM Requirements
  - Report 4 of 16 available eCQMs in 2017 and 2018
    - 15 overlap with IQR plus one that overlaps with OQR
  - Attestation no longer an option in 2018
  - Can use 2014 or 2015 CEHRT for 2018 reporting
- Other changes
  - Report objectives/measures for any continuous 90 day reporting period in 2018, previously one year
  - Establishes exception for when CEHRT is decertified
- EP changes
  - Excludes EPs who furnish most (75%) care in ASC (POS code 24), in accordance with 21st Century Cures

Changes to Survey and Certification Requirements

- Facilities can demonstrate compliance with Medicare conditions of participation through a national accrediting organization that is approved (deemed) by CMS
- CMS, state agencies and two private entities make survey results and correction plans available publicly
- CMS proposed that each accreditation organization deemed by CMS make all provider survey results and correction plans available publicly for the past 3 years
- CMS proposed a parallel proposal for diagnostic imaging accreditation organizations
- CMS is not finalizing this proposal noting the law prohibits CMS from disclosing survey reports or compelling the AOs to disclose their reports themselves

PPS-Exempt Cancer Hospital Quality Reporting (PHCQR) Measures for FY 2020

Measure	Public Display/ Changes
Adjuvant chemotherapy is considered or administered within 4 months of surgery for certain colon cancer patients (NQF #0223)	2014 **Remove- topped out**
Combination chemotherapy is considered or administered within 4 mos. of diagnosis to certain breast cancer patients (NQF #0559)	2014 **Remove- topped out**
Adjuvant hormonal therapy for certain breast cancer patients (NQF #0220)	2015 **Remove- topped out**
The Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOLChemo) (NQF #0210)	**Add**
The Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (NQF #0215)	**Add**
The Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (NQF #0216)	**Add**
The Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (EOL-ICU) (NQF #0213)	**Add**

** Considering six patient-reported outcome measures for future

PCHQR Measures for FY 2020

Measure	Public Display
NHSN CLABSI (NQF #0139)	Deferred
NSHN CAUTI (NQF #0138)	Deferred
NHSN SSI (NQF #0753)	
NHSN CDI (NQF #1717)	
NSHN MRSA bacteremia (NQF #1716)	
NHSN Influenza vaccination coverage among health care personnel (NQF #0431)	
Oncology: Radiation Dose Limits to Normal Tissues (NQF #0382)	2016
Oncology: Pain Intensity Quantified (NQF #0384)	2016
Oncology: Plan of Care for Pain (NQF #0383)	2016
Prostate Cancer-Adjuvant Hormonal Therapy for High-Risk Patients (NQF #0390)	2016
Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients (NQF #0389)	2016
HCAHPS	2016
External Beam Radiotherapy for Bone Metastases (NQF#1822)	2017
Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	

LTCH Quality Reporting Measures and Proposed Changes for FY 2020

Measure Title	FY 2020	Public Reporting
Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)	**Replace**	X
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	**Add**	
All-Cause Unplanned Readmissions for 30 Days Post Discharge from LTCHs (NQF #2512)	**Remove**	
Mechanical Ventilation Process Measure: Compliance with Spontaneous Breathing Test by Day 2 of the LTCH Stay	**Add**	
Mechanical Ventilation Outcome Measure: Ventilator Liberation Rate	**Add**	
NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)	X	X
NHSN Central line-associated Blood Stream Infection (CLABSI) Outcome Measure (NQF #0139)	X	X
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)	X	X
Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)	X	X
NHSN Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)	X	X
NHSN Facility-Wide Inpatient Hospital-onset Clostridium Difficile Infection (CDI) Outcome Measure (NQF #1717)	X	X

LTCHQR Measures for FY 2020

Measure Title	FY 2020	Public Reporting
Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (Application of NQF #0674)	X	Add
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	Add
Change in Mobility among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632)	X	Add
NHSN Ventilator Associated Event Outcome Measure	X	Add
Medicare spending per beneficiary MSPB-PAC LTCH	X	Add
Discharge to Community PAC LTCH	X	Add
Preventable Readmissions 30 Days Post LTCH Discharge	X	Add
Drug Regimen Review Conducted with Follow-up	X	

- Patient Assessment Data
  - Required under IMPACT Act
  - Standardizes patient assessment data across LTCH, SNF, HH, IRF
  - Did not finalize proposed addition of elements to LCDS

IPFQR Measures for FY 2020

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)
SUB-3 and SUB-3a	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge
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)
N/A	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility

Important Links

Premier detailed summary

Proposed Rule

CMS press release

CMS fact sheet

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Transforming Healthcare TOGETHER

Appendix

New Technology Add-on Payments: Three criterion

- **Three criteria** for a new medical service or technology to receive the additional payment:
  - (1) ***Newness Criterion*** - the medical service or technology must be new
  - (2) ***Cost Criterion*** - the medical service or technology must be costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate;
  - (3) ***Substantial Clinical Improvement Criterion*** - the service or technology must demonstrate a substantial clinical improvement over existing services or technologies. Created new component within ICD-10 PCS codes, labeled Section "X" (analogous to outpatient C codes).

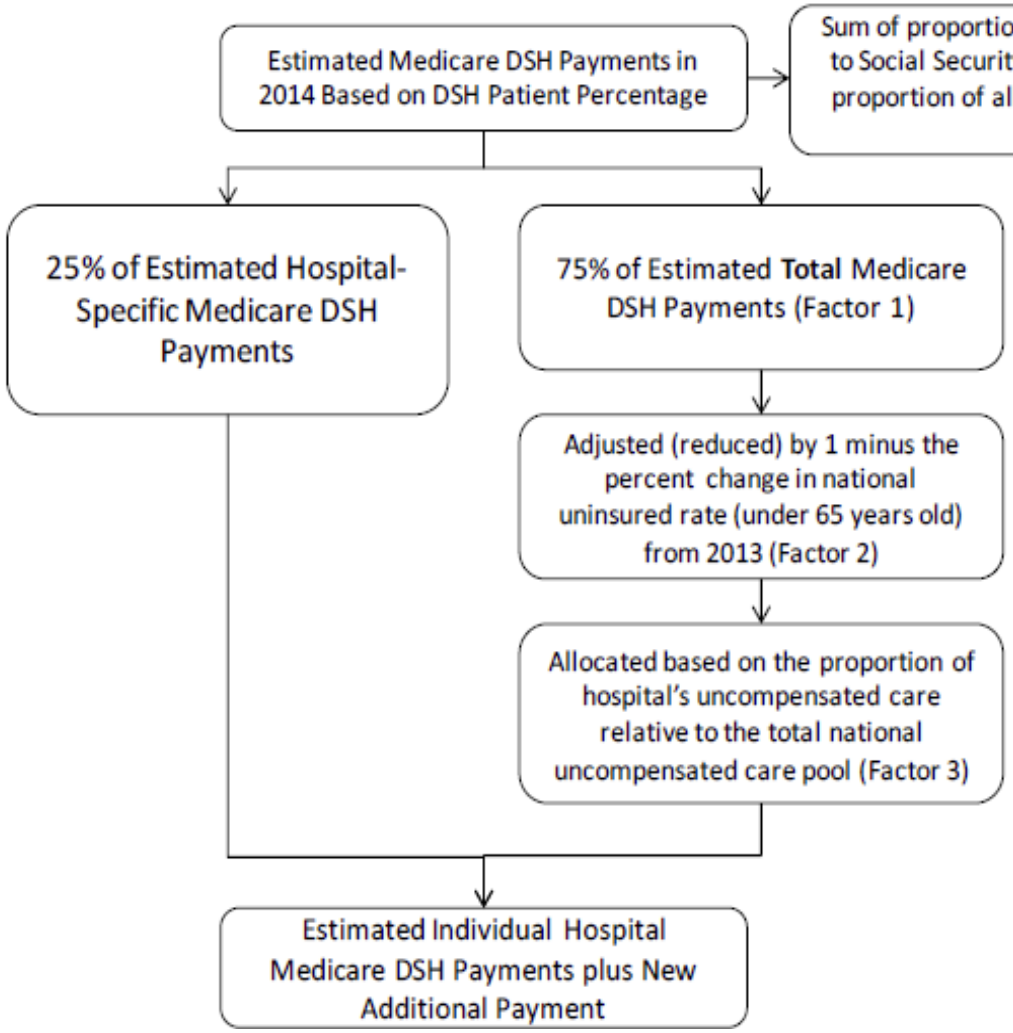
Medicare DSH: "Empirically Justified" DSH Payment Adjustment

- 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

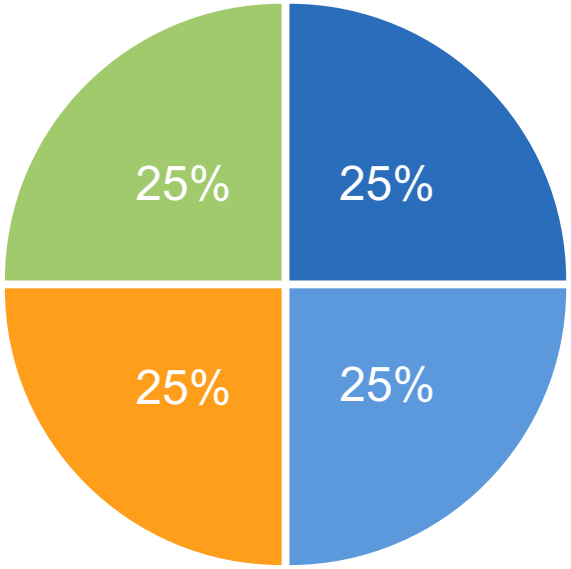
HRRP: Adjustment Calculation for FY 2018

- **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)] + [Sum of DRG payments for CABG* (Excess Readmission Ratio for CABG– 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 2018)

The most DRG base operating payment can be reduced on a claim due to the Readmission Adjustment Factor in FY 2018 is 3 percent

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
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 2019

Domain	Baseline Period	Performance Period
Safety (PC-01, CAUTI, CLABSI, SSI, C. diff, MRSA)	January 1, 2015 - December 31, 2015	January 1, 2017 - December 31, 2017
Clinical Care • Mortality measures • THA/TKA	July 1, 2009 - June 30, 2012 July 1, 2010 – June 30, 2013	July 1, 2014 – June 30, 2017 January 1, 2015 – June 30, 2017
Efficiency and Cost Reduction (MSPB)	January 1, 2015 – December 31, 2015	January 1, 2017 – December 31, 2017
Person and Community Engagement (HCAHPS, CTM-3)	January 1, 2015 – December 31, 2015	January 1, 2017 – December 31, 2017

Inpatient VBP

Measure	Baseline Period	Performance Period
FY 2020 Hospital VBP Program		
Clinical Care • Mortality • THA/TKA	 July 1, 2010 – June 30, 2013 July 1, 2010 – June 30, 2013	 July 1, 2015 – June 30, 2018 July 1, 2015 – June 30, 2018
Safety	January 1, 2016 – December 31, 2016	January 1, 2018 – December 31, 2018
Efficiency	January 1, 2016 – December 31, 2016	January 1, 2018 – December 31, 2018
HCAHPS	January 1, 2016 – December 31, 2016	January 1, 2018 – December 31, 2018
FY 2021 Hospital VBP Program		
Clinical Care • Mortality • Mortality-PN • THA/TKA	 July 1, 2011 – June 30, 2014 July 1, 2012 – June 30, 2015 April 1, 2011 – March 31, 2014	 July 1, 2016 – June 30, 2019 September 1, 2017 – June 30, 2019 April 1, 2016 – March 31, 2019
Safety	January 1, 2017 – December 31, 2017	January 1, 2019 – December 31, 2019
Efficiency • MSPB • AMI, HF	 January 1, 2017 – December 31, 2017 July 1, 2012 – June 30, 2015	 January 1, 2019 – December 31, 2019 July 1, 2017- June 30, 2019
HCAHPS	January 1, 2017 – December 31, 2017	January 1, 2019 – December 31, 2019

*Previously adopted measurement periods

IQR: Measures for Future Consideration

- Quality of Informed Consent Documents for Hospital-Performed Elective Procedures
- End of Life Measure for Cancer Patients
  - The Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOLChemo) (NQF #0210)
  - The Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (NQF #0215)
  - The Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (NQF #0216)
  - The Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (EOL-ICU) (NQF #0213)
- Nurse Staffing Measures
  - Skill Mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], Unlicensed Assistive Personnel [UAP], and Contract) (Nursing Skill Mix) Measure (NQF #0204)
  - Nursing Hours per Patient Day Measure (NQF #0205)
- Additional eCQMs for IQR and EHR Incentive Program
  - Safe Use of Opioids – Concurrent Prescribing
  - Malnutrition Meaures (4)
  - Tobacco Use Measuress (3)
  - Substance Use Measures (3)

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. Finalized adoption of revised PSI-90 would remove this indicator from HACRP for FY 2018 and beyond *** Hip Fracture in PSI-90

HAC Reduction Program

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 *Removal for FY 2018*
FY 2015 and onward	PSI-8 Postoperative Hip Fracture Rate
Final FY 2018	PSI 09 Postoperative Hemorrhage Or Hematoma Rate
Final FY 2018	PSI 10 Physiologic And Metabolic Derangement Rate
Final 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*

HAC Reduction Program

FY 2018 – 2020 Performance Periods

Payment Determination	Domain 1 (PSI-90)	Domain 2 (NHSN)
FY 2018	July 1, 2014 – September 30, 2015	January 1, 2015 – December 31, 2016
FY 2019	October 1, 2015 – June 30, 2017	January 1, 2016 – December 31, 2017
FY 2020	July 1, 2016- June 30, 2018	January 1, 2017 – December 31, 2018