

Centers for Medicare & Medicaid Services
Open Door Forum: Hospital/Quality Initiative

Moderator: Jill Darling
Tuesday, August 30, 2022
2:00 pm ET

Coordinator: Welcome and thank you all for standing by at this time. At this time all participant lines are in a listen-only mode. After today's presentation you will have the opportunity to ask questions, and you may do so over the phone by pressing Star 1 at that time.

Today's call is being recorded. If you have any objections you may disconnect at this time. It is my pleasure to turn the call over to your host for today, Miss Jill Darling. Thank you ma'am. You may begin.

Jill Darling: Thank you (Holly), and thank you everyone for your patience in waiting for us to begin our Hospital Quality Initiative Open Door Forum. I'm Jill Darling in the CMS Office of Communications, and welcome today.

Before we get into today's agenda I have one brief announcement. This open door forum is open to everyone, but if you are a member of the press you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you do have any inquiries please contact CMS at press@cms.hhs.gov. And I will hand the call off to Emily Forrest.

Emily Forrest: Thanks Jill, and good afternoon everyone. This is Emily Forrest. Thanks for joining us today. We'll be providing an overview of the final policies in the

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Fiscal Year 2023 IPPS and LTCH final rule, which was issued on August 1. Hopefully we've had a chance to take a look at that.

I also wanted to note that the comment period for the Calendar Year 2023 OPSS and ASC proposed rule, which we talked about at our last forum, has a comment period that closes on September 13. And also, the CY 2023 Physician Fee Schedule proposed rule, which we also discussed on a previous open door forum, does include dental payment policies that impact services occurring in both the hospital inpatient and hospital outpatient settings. The comment period for the CY 2023 PFS proposed rule closes on September 6. So just wanted to remind folks of those two things.

We encourage folks to get their comments in to us as early as possible to aid in our review of those comments, which also helps us get the responses and the final rule out as timely as we're able. I also wanted to mention that we will be also reserving some time at the end for some questions on issues presented today. So that further ado I will turn it over to Jim to begin with our update.

Jim Mildenerger: Good afternoon. My name is Jim Mildenerger. And I will be presenting on a few different topics today from the final rule.

The first of which is the payment updates for IPPS and long-term care hospitals. For IPPS we are increasing operating payment rates by 4.3% for IPPS hospitals that participate in the Inpatient Quality Reporting Program successfully, and are meaningful electronic health record users.

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This reflects the hospital market update of 4.1% reduced by 0.3% productivity adjustment and increased by 0.5% adjustment required by legislation. This update reflects the most recent data available including the revised outlook regarding the US economy and as a result is 1.1 percentage point higher than the proposed update for Fiscal Year 2023.

We are also increasing the capital payment rate by 2.4% for IPPS hospitals. We estimate these increases in the IPPS operating and capital payment rates will increase IPPS hospital payments by about \$2.6 billion in Fiscal Year 2023.

We estimate that the total amount available to make uncompensated care payments in Fiscal Year 2023 to IPPS hospitals will be \$6.8 billion. This is approximately \$318 million less than last year. This total uncompensated care payment amount reflects CMS Office of the Actuaries projections that incorporate the estimated impact of the COVID-19 pandemic.

In the rule we also bring to light that under current law additional payments for Medicare dependent hospitals and the temporary change in payments for low volume hospitals are set to expire in Fiscal Year 2023. In the past these payments have been extended by legislation, but if they were to expire CMS estimates that payment to these hospitals would decrease by \$0.6 billion.

For the LTCH PPS we are applying a 3.8% annual update to the LTCH PPS standard federal payment rate based on our current estimate of the LTCH market basket increase of 4.1% and a 0.3% adjustment for productivity. For Fiscal Year 2023 CMS expects LTCH PPS payments to increase by

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approximately \$71 million. This estimated change in payments reflects an estimated increase in payments to standard federal payment rate cases of \$61 million and a projected increase of \$9 million in payments to site neutral payment rate cases.

I'll next be discussing a few changes in our wage index policy. The first of which is a permanent cap on wage index decreases.

So, in the past we have implemented temporary transition policies to mitigate significant fluctuations in payments due to changes in the wage index. For example, in the Fiscal Year 2021 rule we finalized a 5% cap on wage index decreases in conjunction with our adoption to revise OMB CBSA delineations.

In taking the temporary approach in the past we have sought to mitigate short term instability and fluctuations that can negatively impact hospitals as a result of policy changes. However, we recognize that even without specific changes in wage index policy significant year to year fluctuations in an areas wage index, can also occur due to other external factors beyond the hospital's control such as the COVID-19 PHE.

For an individual hospital these fluctuations can be difficult to predict. And we recognize that predictability in Medicare payments is important to enable hospitals to budget and plan their operations.

In previous rules we have received comments recommending a permanent cap policy as a means to reduce overall volatility for hospitals. We have

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considered these comments and are finalizing our proposal beginning in Fiscal Year 2023 to apply a 5% cap on any decreases to a hospital's wage index from its wage index in the prior year regardless of the circumstances causing the decline. That is under this policy, a hospital's wage index will not be less than 95% of its final wage index for the prior Fiscal Year.

Similar to the temporary transition policies of the past we are applying this permanent wage index cap policy in a budget neutral manner. And we also note that this policy is being adopted for both the IPPS wage index and the LTCH wage index.

The next wage index topic I was going to discuss is changes to the wage index rural floor calculation. So, based on the Citrix court decision, and comments received, CMS is not finalizing the rural floor wage index policy as proposed which would've excluded hospitals that have reclassified from urban to rural from the calculation of the rural floor and the wage index for rural areas in the state in which the county is located.

Rather CMS is finalizing a policy that calculates the rural floor as it was calculated before Fiscal Year 2020. For Fiscal Year 2023, and subsequent years, CMS is finalizing a policy to include the wage data of hospitals that have reclassified from urban to rural in the calculation of the rural floor, and the wage index for rural areas in the State in which the county is located.

That concludes my topics. And I'll turn it over next to Julia Venanzi to discuss the hospital quality updates.

Julia Venanzi: Thank you, Jim. Good afternoon. My name is Julia Venanzi. And I will be providing highlights of the finalized proposals for the Statutory Hospital Quality Program.

So, in this year's IPPS final rule we finalized several new measures for the Hospital Inpatient Quality Reporting Program or the Hospital IQR Program, which is a pay for reporting quality measurement program for the inpatient hospital setting. Under this program acute care hospitals must report quality measure data or incur a one quarter reduction to their annual payment update.

In this year's final rule, for the first time, we have adopted quality measures that are focused on addressing healthcare disparities. The first measure, the hospital commitment to health equity structural measure, is an attestation measure that will ask hospitals a set of yes or no questions regarding their commitment to health equity, specifically if they have a strategic plan, if they collect and analyze data, if they participate in quality improvement activities and if hospital leadership are engaged in these activities.

Hospitals will respond either yes or no to these questions. And data collection for this measure begins with the calendar year 2023 reporting period.

We've also finalized two complementary measures that are focused on screening patients for certain health related social needs. The first of these measures, the screening for social drivers of health measure, assesses the proportion of patients screened for the following five health related social needs food insecurity, housing instability, transportation needs, difficult with

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utilities and then interpersonal safety. Hospitals will report the total number of patients screened for this information.

And then the second measure, which is related, is the screen positive rate for social drivers of health. This measure will require hospitals to report on the total number of screened patients who indicate that they have one of these health related social needs.

We have also focused on maternal health in this year's final rule with the finalization of two new measures. The first of which the cesarean birth rate eCQM which assesses the rate of deliveries at the hospital by C-section. And then the second measure the severe obstetric complications eCQM which assesses the proportion of severe obstetric complications that occur during the delivery hospitalization. Complications include cardiac arrest, hemorrhage, renal or respiratory failure, sepsis, as well as the number of others that are listed in the final rule.

Related to maternal health we have also finalized a new publicly reported birthing friendly hospital designation that will focus on maternity care so that consumers will be able to more easily identify hospitals that provide high quality maternity care. The designation will be rolled out for the first time in the fall 2023 using data from the program's maternal morbidity structural measure which hospitals are already reporting on. They reported data for the first time in May 2022 for this measure.

That measure requires hospitals to attest whether they are participating in a state or national perinatal quality improvement collaborative and if they are

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implementing the patient safety practices as part of those quality improvement initiatives.

In the proposed rule, we also solicited comments from the public on other ways that we could address maternal health in that designation such as potentially including new conditions of participation or including new quality measures. In the final rule, we have summarized the comments that we received, and we'll take that feedback into consideration for potential future rule making.

Additional new quality measures that we finalized for the Hospital IQR Program include a measure that assesses opioid related adverse events during hospitalization, a measure that assesses malnutrition risk diagnosis and development of a nutrition care plan for patients who are 65 and older. And then a measure that assesses improvement in patients reported functional status by comparing patients responses both before and then after they have had an elective hip or knee replacement surgery in the hospital.

So, I will move now to cover the measure suppression policies in the hospital pay for performance programs. So, for the hospital pay for performance quality programs we have finalized the suppression of certain quality measures for the purposes of scoring and payment due to the impact of the COVID-19 pandemic, particularly the Delta variant on measured data from calendar year 2021.

As well is our ability to make fair national comparisons of hospitals when COVID-19 impacted hospitals differently in different locations at different

times of the year. However, I will note that we will continue to collect all quality measure data, and we'll continue to publicly report all of that data for transparency.

So, moving specifically to the Hospital Value-Based Purchasing Program and the Hospital-Acquired Condition Reduction Program. Due to the impact of COVID-19 in 2021 we are finalizing the suppression of several measures used in these two programs. So again, by suppression we mean to not use a measure for the purpose of scoring or payment, but that we are continuing to use those measures for public reporting.

In addition, because of the extent of the measures being suppressed we have also finalized a special scoring methodology for Fiscal Year 2023 that would result in each hospital receiving a neutral payment adjustment for the Hospital VPB Program and then no penalty under the Hospital-Acquired Condition Reduction Program.

This approach to addressing the impact of COVID-19 on the pay for performance program is similar to the measure suppression that we finalized in the Fiscal Year 2022 final rule last year. We also note in this year's final rule that our intention is to use Calendar Year 2022 measure data which is tied to the Fiscal Year 2024 payment barring any significant unforeseen circumstances with the COVID-19 pandemic.

For the Hospital Readmissions Reduction Program, we are able to resume use of all six readmission measures by making some refinements to the measure

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specifications in order to account for patients with COVID-19 or with a history of COVID-19.

So, I will move now to the request for information that were included in the Fiscal Year 23 IPPS proposed rule. So, this year in the proposed rule we asked for input from the public on several cost-cutting topic areas.

On the topic of measuring disparities in healthcare quality we requested information on using quality measures that could potentially be stratified to look at particular subgroups of patients as well as seeking feedback on our overarching principles to guide such activities. We also requested input from the public on how hospitals and other healthcare organizations could better prepare for the harmful impacts of climate change on beneficiaries and consumers and how CMS and HHS can support them in doing so including how we might support the development of plans to better prepare for continuous operations in the event of a climate related emergency.

And then lastly, we also requested input from the public on our ongoing efforts to modernize the quality measurement enterprise by leveraging EHRs and other digital sources of quality data that are standardized to improve the accuracy and to reduce the burden of exchanging data across systems. For example, using the Fast Healthcare Interoperability Resources data standard, or the FHIR data standard.

So, for each of these three RFIs the comments that we received are summarized in the final rule. And just wanted to note that we appreciate all

the feedback that we received, and we will take it into consider for future potential rule making. So, I will now turn things over to Jessica Warren.

Jessica Warren: Thanks so much Julia. My name is Jessica Warren. And I'm with the Medicare Promoting Interoperability Program for eligible hospitals and cause. For this presentation I'll highlight several of our finalized policies for Fiscal Year 2023 IPPS final rule, and then a few reminders at the end for a timeline to keep in consideration.

So, beginning with the Calendar Year 2023 EHR reporting period, we finalized requiring the query of prescription drug monitoring program measures query of PDMP. This will now be required worth 10 ten points.

And we did modify our original proposal to include two exclusions. Now we are adopting three exclusions. We've also expanded to include not only Schedule II opioids, but Schedule III and IV drugs as well. And you can reference the final rule for a fairly extensive list of what would be considered.

We finalized adding an additional option for fulfilling the health information exchange objective. And that is the enabling exchange under the Trusted Exchange Framework and Common Agreement, TEFCA, measure. And this would be the third option for completing the objective. We have sending and receiving and also bidirectional.

Under the Public Health and Clinical Data Exchange Objective we have included a new measure. And that is called the Antimicrobial Use and

Antimicrobial Resistance Surveillance Measure. And this is going to begin with the 2024 EHR reporting period.

Additionally, under Public Health and Clinical Data Exchange Objectives we have consolidated the existing three levels of active engagement into two. So previously we had Level 1, Level 2 and Level 3.

Now we have combined Level 1 and Level 2 into Option 1. And that is called Pre-Production and Validation. And then Level 3 is now called Finalized Option 2 Testing and Validation.

We have finalized modification to our scoring methodology. We have reduced the number of points associated with the Health Information Exchange objective measure. And that would go from 40 to 30 points.

We've increased the number of points allocated to Public Health and Clinical Data Exchange Objective. And that went from ten to 25 points.

We've reduced the number of points associated with provide patients electronic access to their health information measure. And that would go from 40 points to 25 points.

With regards to the TEFCA RFI, Trusted Exchange Framework and Common Agreement, we received quite a bit of feedback. We are reviewing everything internally for potential consideration in future rule making. We did not address any of the feedback that we received in the final rule, but rest assured we are reviewing everything.

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And then last for our program reminders the 2021 hardship exemption application closes this Thursday, September 1 at 11:59 pm. That's Eastern Standard Time.

Our reconsideration period will open for 30 days between the mid-end of September and early October. So, keep an eye on our program page.

And finally, the last possible start date for collecting 2022 data for the EHR reporting period would be on October 3. So, October 3 starts the last 90 days of the calendar year.

And that's it for hospital promoting interoperability. Next up we have Dawn Linn. And she will speak to conditions of participation. Thank you.

Dawn Linn: Thank you, Jessica. Hello. I hope everyone is doing well today. My name is Dawn Linn. I'm happy to have the opportunity to be on the call today and provide a brief overview of the hospital and critical access hospital requirements for COVID-19-related data reporting after the PHE declaration ends.

Under the current regulations, hospitals and critical access hospitals, otherwise known as CAHs, are required to report COVID-19-related data. However, these requirements are tied to the existing PHE declaration. Therefore, the current COVID-19-related data reporting requirements will end at the end of the PHE declaration.

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These data reported by hospitals and CAHs have been and continue to be important in supporting their surveillance and response to COVID-19, which is caused by a novel and unpredictable virus, SARS-CoV-2. Thus, in this rule we proposed to revise those Conditions of Participation for hospitals and CAHs to require these facilities to continue to report COVID-19 related data after the PHE ends.

And in this rule, we are finalizing that proposal rule. Specifically, hospitals and CAHs will be required to continue to report COVID-19-related data after the end of the PHE until the sunset date of April 30, 2024, unless the Secretary determines an earlier end date. However, in the final rule we decreased the data categories that hospitals and CAHs would be required to report based on feedback from stakeholders and a re-evaluation of the data categories by CMS in collaboration with CDC and ASPR to discern those data categories that would be most informative for assuring patient health and safety in a post-PHE state.

These finalized requirements will allow the specific format for reporting, the data elements to report, and the reporting frequency to be adjusted by the Secretary in response to evolving epidemiological circumstances. So, for example, if case counts are low, and have been for some time, it may be reasonable to reduce reporting frequency, potentially even to zero which would effectively turn off reporting for a given data element. At the same time, if case counts are increasing, it may be necessary to increase the scope and frequency of data reporting.

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We also proposed in the rule to establish data reporting requirements for future local, state, and national PHE declarations related to an infectious disease. CMS is not finalizing this proposal. We believe that additional consideration is necessary to establish a longer-term solution for data collection and reporting that ensures the ongoing preparedness of the entire health care system in the event of another PHE involving an infectious disease or a PHE resulting from natural or human made factors.

We also believe that continued collaboration among government and interested parties would be beneficial to standardize and streamline data reporting to the extent possible, thereby reducing burden on facilities, particularly during emergencies when resources are stretched and patient care related work demands are elevated. While CMS considers a longer-term solution for data collection and reporting by facilities in the event of future emergencies, it is our expectation that hospitals and CAHs will continue assessing and improving the readiness report data in the event of a future declared PHE consistent with their existing their requirements for emergency preparedness.

Thank you for your time. Let's turn it over to our next speaker, Michele Hudson.

Michelle Hudson: Hi. Thank you, Dawn. Even though FY 2023 hasn't started yet I have some timeline reminders for the hospital wage index for FY 2024. This Thursday, September 1, is the deadline to submit an application for the FY 2024 Medicare Geographic Classification Review Board, or MGCRB, wage index

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classification, and to submit a request for cancellation of a withdrawal or termination.

The following day, Friday, September 2, is the deadline for hospitals to request revisions to their FY '20 worksheet S-3 wage data and CY 2019 Occupational Mix data as included in the FY 2024 Wage Preliminary Public Use File that was posted this past May. And to provide documentation to support the request.

Maximus must receive the request and supporting documentation by September at 11:59 pm Eastern Time. I'll now turn it over to (Wil Gehne), who will talk about modernizing the CMS payment software.

Wil Gehne: Thanks Michele. My name is Wil Gehne and I work in the Provider Billing Group. Around this time last year, I joined this forum to call everyone's attention to a fact sheet describing our efforts to modernize Medicare's claims process and software.

On your agenda is a link to an update of that fact sheet. It summarizes our process over the last year and describes upcoming releases of Java versions of various programs.

Hospitals should be aware that we converted the hospital inpatient claims software, that is the Medicare Code Editor, or MCE, and the MSCRG grouper back in October of 2021 Version 39. To allow for - to allow time for transition we made Cobol assembler versions of Version 39 available to the public

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throughout 2022 along with the Java version even though the Java version was used by Medicare systems this year.

Today, I wanted to make sure that all hospitals and software vendors are aware that for Fiscal Year 2023, beginning of Version 40 in October 2022, we have posted only the Java version of the programs to the CMS Web site. If you've not already done so please take prompt action to ensure your billing systems are ready to accommodate this change on October 1.

We're also now in a transition period for the Integrated Outpatient Code Editor, or IOCE. We released a test version of the Java software for IOCE based on Version 23.1 on the CMS Web site on July 22. All hospitals, and their software vendors, are encouraged to experiment with this test version and to send any questions to our mailbox, which is Grouper Beta Testing, all one word, GrouperBetaTesting@cms.hhs.gov.

We've received very few inquiries over the last month that it's been posted. And we think this may be due to hospitals and vendors waiting for a standalone version of the program versus the mainframe Java version that's currently available. We're working to produce the standalone version by the end of September so look for it on the Web site then.

If you go to the regular IOCE Quarterly Release page a link to test versions is now active on the left-hand menu. This year's January IOCE release, Version 24.0, will include both the current mainframe Cobol assembly version and the Java version.

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This will provide hospitals and vendors a parallel testing period. But please note that the April 2023 IOCE release, Version 24.1, will be Java only. So, it's important to take advantage of the transition period that's currently in progress so that you're prepared for April 1, 2023. With that I'll hand it back to Jill.

Jill Darling: Thank you Wil. And thank you to all of our speakers today. (Holly), will you please open the lines for Q&A?

Coordinator: Thank you. If you would like to ask a question please unmute your phone, press Star 1 and record your first and last name fully and clearly so I may introduce you. Again, that is Star 1 to ask a question.

If you would like to withdraw your request press Star 2. It may take a few moments for questions to come in. Please stand by. And I have no questions at this time. But again, if you would like to ask a question please press Star 1.

Jill Darling: Hi everyone. It's Jill Darling. So, if we are waiting for some questions that's fine. Just to let you know if you do have any questions or comments after today's call you are more than welcome to email the hospital_odf@cms.hhs.gov mailbox. So please we encourage you to utilize that. And (Holly), do we have any questions in the queue?

Coordinator: Yes. Our first question comes from (Sandra Bruton). You may go ahead.

(Sandra Bruton): Hi. I have a question about today's call. Will there be a transcript available to review after made available after this call?

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Jill Darling: Hi, this is Jill. There will be a transcript and audio recording. It won't be directly after this call because we do have to review and edit...

(Sandra Bruton): Sure.

Jill Darling: ...to make sure that the transcript matches the audio recording. So - but it will get posted through our podcast and transcript Web page on CMS so give us a couple of weeks.

(Sandra Bruton): Thank you.

Jill Darling: You're welcome.

Coordinator: And our next question comes from (Teresa Riles). You may go ahead.

(Teresa Riles): Yes, I have a question regarding the health care equity measure. How often will that be reported? Will it be quarterly, annually? I don't recall reading it in the final rule.

Julia Venanzi: Hi, this is Julia Venanzi. Just want to confirm, are you talking about the commitment to health equity structural measure? I think you are...

(Teresa Riles): Yes, that's what I...

Julia Venanzi: ...but I just wanted to know. Okay.

(Teresa Riles): Yes. I just wrote...

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((Crosstalk))

Julia Venanzi: No, that's okay. Yes, that will be reported annually.

(Teresa Riles): Okay, thank you. Goodbye.

Julia Venanzi: Yes.

Coordinator: And I have no more questions at this time, but again to ask a question please press Star 1.

Jill Darling: And (Holly) we'll check me one more time for questions.

Coordinator: And I have no questions at this time.

Jill Darling: Okay, great. Thank you, (Holly). And thank you everyone for joining us. Again, hospital_odf@cms.hhs.gov for further questions. This will conclude today's call. Have a wonderful day.

Coordinator: And this concludes today's conference. Thank you for participating. You may disconnect at this time. Speakers, please stand by.

END

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