FFY 2020 IPPS OVERVIEW

CHA Hospital Finance & Reimbursement Seminar
Sacramento | July 23, 2019
Glendale | July 25, 2019

Katrina A. Pagonis
Co-Chair Regulatory Department
Hooper, Lundy & Bookman
(415) 875-8515
kpagonis@health-law.com

FFY 2019 Proposed and FFY 2018 Final IPPS Rules

- Highlights covered today:
  - Inpatient payment update
  - Disproportionate Share Hospital (DSH) and UC-DSH
  - Area Wage Index
  - New Technology Add-On Payment and CAR T-Cell Therapy
  - Payment Consequences of Quality Metrics
  - Promoting Interoperability Program

Inpatient Payment Update
Basic IPPS Rates for FFY 2019 (Final) and FFY 2020 (Proposed)

<table>
<thead>
<tr>
<th></th>
<th>FY 2019 Final IPPS Rule</th>
<th>FY 2020 Proposed IPPS Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Basket</td>
<td>2.9%</td>
<td>3.2%</td>
</tr>
<tr>
<td>ACA Reductions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Market Basket</td>
<td>-0.75%</td>
<td>—</td>
</tr>
<tr>
<td>Productivity</td>
<td>-0.8%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Subtotal (Applicable Percentage Increase)</td>
<td>1.35%</td>
<td>2.7%</td>
</tr>
<tr>
<td>MACRA Restoration of ATRA Recoupment</td>
<td>0.5%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Total General Adjustment Before Sequester</td>
<td>1.85%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

Note: This update does not include hospital-specific payment changes due to readmissions, value-based purchasing, hospital acquired conditions, meaningful use, etc. It also does not include budget neutrality factors applied to the standardized amount.

ACA Multifactor Productivity Cuts

- Applies beginning in FY 2012
- 10-year moving average of changes in annual non-farm productivity, as determined by the Secretary
- Can result in a market basket increase of less than zero
- Payments in a current year may be less than the prior year
- Applies to other provider types

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Cut</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>- 1.0%</td>
</tr>
<tr>
<td>2013</td>
<td>- 0.7%</td>
</tr>
<tr>
<td>2014</td>
<td>- 0.5%</td>
</tr>
<tr>
<td>2015</td>
<td>- 0.5%</td>
</tr>
<tr>
<td>2016</td>
<td>- 0.5%</td>
</tr>
<tr>
<td>2017</td>
<td>- 0.3%</td>
</tr>
<tr>
<td>2018</td>
<td>- 0.8%</td>
</tr>
<tr>
<td>2019</td>
<td>- 0.8%</td>
</tr>
<tr>
<td>2020 proposed</td>
<td>- 0.5%</td>
</tr>
</tbody>
</table>

ATRA 3.9% IPPS Coding Adjustment

- FFY 2020: +0.5% (+$497 M)
Hospital Dependent Adjustments Proposed for FY 2020

<table>
<thead>
<tr>
<th>Proposed FY 2020</th>
<th>Hospital submitted quality data and is a meaningful EHR user</th>
<th>Hospital submitted quality data and is not a meaningful EHR user</th>
<th>Hospital did not submit quality data and is a meaningful EHR user</th>
<th>Hospital did not submit quality data and is not a meaningful EHR user</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Basket Increase</td>
<td>3.2</td>
<td>3.2</td>
<td>3.2</td>
<td>3.2</td>
</tr>
<tr>
<td>Adjustment for Failure to Submit Quality Data</td>
<td>—</td>
<td>—</td>
<td>—0.8</td>
<td>—0.8</td>
</tr>
<tr>
<td>Adjustment for Failure to be a Meaningful EHR User</td>
<td>—</td>
<td>—1.4</td>
<td>—</td>
<td>—2.4</td>
</tr>
<tr>
<td>MFP Adjustment</td>
<td>—0.5</td>
<td>—0.5</td>
<td>—0.5</td>
<td>—0.5</td>
</tr>
<tr>
<td>Applicable % Increase Applied to Standardized Amounts</td>
<td>2.7</td>
<td>1.9</td>
<td>0.3</td>
<td>—0.5</td>
</tr>
</tbody>
</table>

Outlier Payment Adjustment

<table>
<thead>
<tr>
<th></th>
<th>Proposed Fixed Loss Threshold</th>
<th>Finalized Fixed Loss Threshold</th>
<th>Actual Outlier Payments as a Percentage of Total MS–DRG Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFY 2018</td>
<td>$26,713</td>
<td>$26,601</td>
<td>Estimated: 4.94% (Target: 5.1%)</td>
</tr>
<tr>
<td>FFY 2019</td>
<td>$27,545</td>
<td>$25,769</td>
<td>(Target: 5.1%)</td>
</tr>
<tr>
<td>FFY 2020</td>
<td>$26,994</td>
<td>TBD</td>
<td>(Target: 5.1%)</td>
</tr>
</tbody>
</table>

Medicare DSH
DSH and UC-DSH Payment Policy

- Total DSH Payment Projections under Traditional Formula: $16.857 Billion
- 25% paid under Traditional Method
- 75% Dedicated to New Pool (Factor 1)
- Factor 2: Program reductions based on % uninsured compared to 2013 baseline
- Factor 3: Distribution based on uncompensated care

Medicare DSH: FY 2019 vs. Proposed FY 2020

<table>
<thead>
<tr>
<th>Factor 1</th>
<th>FY 2019</th>
<th>Proposed FY 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>(75% DSH Payment Projections Under Old Formula)</td>
<td>$12.254 billion</td>
<td>$12.643 billion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factor 2</th>
<th>FY 2019</th>
<th>Proposed FY 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Reductions based on uncompensated care)</td>
<td>32.49% cut ($8.273 billion remaining)</td>
<td>32.86% cut ($8.489 billion remaining)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factor 3</th>
<th>FY 2019</th>
<th>Proposed FY 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Distribution)</td>
<td>Average of Factor 3 values from three data years:</td>
<td>Single year of data:</td>
</tr>
<tr>
<td></td>
<td>• Low Income Patient Days (FY 2013 Medicaid Days + FY 2014 SSI Ratios)</td>
<td>• FFY 2016 Trimmed S-10 Line 30</td>
</tr>
<tr>
<td></td>
<td>• FFY 2014 Trimmed S-10 Line 30</td>
<td>• Alternative Considered: FFY 2017 Trimmed S-10 Line 30</td>
</tr>
</tbody>
</table>

FFY 2020 Proposed S-10 Transition

- Phase-in of Worksheet S-10, Line 30 (Charity Care and Non-Medicare Bad Debt Expense), again proposed for FFY 2020 with solely audited FFY 2015 data
- Unaudited FFY 2015 used in FFY 2019
- Seeking comment on using unaudited FFY 2017 data instead
- Would depart from the three-year Factor 3 averaging currently in place

<table>
<thead>
<tr>
<th>Proxy Data</th>
<th>S-10 Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFY 2015</td>
<td>FFY 2012 Medicaid Days + FFY 2014 Medicare SSI Days</td>
</tr>
<tr>
<td>FFY 2016</td>
<td>FFY 2013 Medicaid Days + FFY 2015 Medicare SSI Days</td>
</tr>
<tr>
<td>FFY 2019</td>
<td>FFY 2016 Medicaid Days + FFY 2016 Medicare SSI Days</td>
</tr>
<tr>
<td>FFY 2020 (proposed)</td>
<td>Phased-out</td>
</tr>
<tr>
<td>FFY 2014 S-10, Line 30</td>
<td>FFY 2014 S-10, Line 30</td>
</tr>
<tr>
<td>FFY 2015 S-10, Line 30</td>
<td>FFY 2015 S-10, Line 30</td>
</tr>
<tr>
<td>FFY 2015 S-10, Line 30</td>
<td>FFY 2015 S-10, Line 30</td>
</tr>
</tbody>
</table>
Factor 3: Other Considerations

- All-Inclusive Rate Hospitals
  - Proposed to remain excluded from trimming methodology due to how different their CCRs tend to be.
  - CMS proposing to use S-10 data, with trimming applied, for these hospitals instead of the prior Medicaid/Medicare SSI days, as the trimming will mitigate any aberrant CCRs.

- New Hospitals
  - For CCNs created on or after October 1, 2015, hospitals will not receive interim UCC payments, but instead paid at CR settlement.
  - Factor 3 to be determined based on their individual FFY 2020 S-10 in numerator with national FFY 2015 value as denominator.

UCC Proposals and Alternatives

<table>
<thead>
<tr>
<th>CMS Proposal for FFY 2020</th>
<th>CMS Seeks Comment on FFY 2020 Alternative</th>
<th>Alternative #1 – A Blend Use of FFY 2015 Cost Report Data (1 Year Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFY 2020: 2/3 of 2019 UCC payment + 1/3 of calculated payment based on the 2017 S-10 report (inclusive of revised trim methodology)</td>
<td>FFY 2021: 1/3 of S-10 payment + 2/3 of average calculated payment from the 2017 and 2018 S-10 reports</td>
<td></td>
</tr>
<tr>
<td>FFY 2021: 1/3 2019 UCC payment + 2/3 of average calculated payment from the 2017 and 2018 S-10 reports</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pros**
- Hospitals that believe their 2015 data is accurate may see a benefit over 2017 data.
- Approximately 400 hospitals were audited, however the "expected vs actual" adjustment that was reversed is not reflective in CMS provided data. Therefore any analysis of impact is a challenge and is likely to change in the final rule.

**Cons**
- The same risks of relying on just one year of data apply.
Background: Area Wage Index – What Is It?

The "adjusted" area wage index is currently used in:
- Medicare inpatient prospective payment system
- Medicare outpatient prospective payment system
- Medi-Cal FFS (APR-DRG) system

The "unadjusted" area wage index is used in:
- Medicare skilled-nursing facility PPS (70.5% labor share)
- Medicare inpatient rehabilitation facility PPS (70.5% labor share)
- Medicare inpatient psychiatric facility PPS (74.8% labor share)

Many hospitals factor the "adjusted" AWI into Medicare Advantage (MA) and Medi-Cal Managed Care contracts. Also the AHW is used in setting MA rates.

* The "adjusted" AWI accounts for reclassification and rural floor budget neutrality.
** Any change in Medi-Cal FFS in one year will be adjusted the following year to make the change budget neutral.
*** CMS proposes to reduce the AHW for FY 2020 as opposed to a one year delay.

Background: Current Use of Medicare’s Area Wage Index

CMS FFY 2020 Area Wage Index Proposals

- **Data** — Exclusion of verifiable but "aberrant" data from seven hospitals
- **Rural Floor** — Exclusion of urban hospitals that have been reclassified as rural from the rural floor
- **Wage Compression** — Increasing wage index values for lowest quartile hospitals, paid for by a reduction in wage index values for hospitals in the highest quartile
- **Temporary Stop Loss** — Proposed 5% cap on any decrease in a hospital’s wage index in FFY 2020 as compared to FFY 2019 (funded by budget neutral reduction to the standardized amount)
Exclusion of Accurate and Verifiable Data

- CMS excluded verifiable and accurate wage data for seven California hospitals and indicated an intent to exclude the entire health system (98 hospitals) in future years.
- Rationale?
  - CMS does “not believe that the average hourly wages” of these hospitals “accurately reflect the economic conditions in their respective labor market areas during the FY 2016 cost reporting period”
  - The average hourly wages of these hospitals differ most from their respective CBSAs.
  - The inclusion of these data would distort the wage index.

Exclusion of Accurate and Verifiable Data (cont.)

- Criteria for Exclusion?
  - The health system negotiates labor contracts in California on a regional basis (northern and southern) and therefore wages “do not reflect competitive local labor market salaries.”
  - The health system “is part of a managed care organization and an integrated delivery system wherein the hospitals rely on the system’s health care plans for funding.”
  - The identified hospitals’ average hourly wages differ most from their respective CBSA hourly wages.

Exclusion of Accurate and Verifiable Data (cont.)

- Preparing for a Legal Challenge:
  - 1395ww(d)(3)(E) does not permit exclusion of accurate data (wage index is updated based on a “survey,” not CMS’s view of what wages should be in a market).
  - Arbitrary and capricious to exclude the hospitals without a standard.
  - If there is a standard, CMS failed to disclose it in the proposed rule, such that it has not been subject to notice-and-comment rulemaking.
  - Interferes with federal labor laws.
  - Interferes with wage competition.
Rural Floor

- BBA of 1997: For discharges on or after 10/1/97, the area wage index applicable to any urban hospital in a state may not be less than the area wage index applicable to rural hospitals in that state.
- OIG, Nov. 2018: “[MedPAC] is not aware of any empirical support for [the rural floor] policy, and that the policy is built on the false assumption that hospital wage rates in all urban labor markets in a State are always higher than the average hospital wage rate in rural areas of that State.”

Rural Floor (cont.)

- Proposal: “[B]eginning in FY 2020, the rural floor would be calculated without including the wage data of urban hospitals that have reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103).”
- Asserted Authority: CMS contends that it has discretion to exclude the wage data of reclassified hospitals from the calculation of the rural floor because the statute does not require the inclusion of this data.
- Rationale:
  - “Urban to rural reclassifications have stretched the rural floor provision beyond a policy designed to address such anomalies.”
  - “We believe this proposed policy is necessary and appropriate to address the unanticipated effects of rural reclassifications on the rural floor and the resulting wage index disparities, including the effects of the manipulation of the rural floor by certain hospitals.”

CMS Proposals: CMS Administrator Seema Verma

“[O]ne in five Americans are living in rural areas and the hospitals that serve them are the backbone of our nation’s healthcare system,” said CMS Administrator Seema Verma. “Rural Americans face many obstacles as the result of our fragmented healthcare system, including living in communities with disproportionately higher poverty rates, more chronic conditions, and more uninsured or underserved individuals. The Trump administration is committed to addressing inequities in health care, which is why we are proposing historic Medicare payment changes that will help bring stability to rural hospitals and improve patients’ access to quality healthcare.”
Wage Compression

- **Purported Issue:**
The current system "allows hospitals in States with significantly higher wage indexes to maintain and improve their favorable position in the current system by setting higher than market value wages for their employees . . . Low wage index States . . . Cannot afford to pay wages that would allow their hospitals to climb back toward the median wage index. Over time this condition of circularity has increased the gap between the wage indexes of the high and low wage States to a much larger degree than what the wage index was initially designed to address."

- **Proposal:**
For four years, increase wage index values for low-wage hospitals and pay for it by reducing wage index values for high-wage hospitals

Wage Compression (cont.)

- **Amount of increase for hospitals in the bottom quartile:**
  - Half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals

- **Amount of reduction for hospitals in the top quartile:**
  - Multiply the difference between the otherwise applicable final wage index value for a year for that hospital and the 75th percentile wage index value for that year across hospitals by a uniform multiplicative budget neutrality factor (proposed at 4.3%)

  - E.g., Hospital A Wage Index Value = 1.7351, 75th percentile = 1.0351, apply a wage index of 1.7351-((1.7351-1.0351)*0.043) = 1.705

Wage Index Alternatives Considered

- **Alternative #1:**
  - Application of a budget neutrality factor to the federal rate rather than to the wage index of high wage index hospitals to offset increases to hospitals below the 25th percentile wage index value

- **Alternative #2:**
  - Obtaining budget neutrality by reducing high wage index values by an amount equal to half the difference between the hospital's baseline wage index value and the 75th percentile wage index value. This would then be followed by an adjustment to the federal rate to ensure budget neutrality

- **Alternative #3**
  - Creation of a national rural wage index (estimated at 0.8569) to replace the current state-specific rural/floor wage index values
California Is Affected Disproportionately

- The effect of the compression policy is that hospitals in certain states will, in the aggregate, lose revenue while other states will gain revenue.
- The revenue losses are highly concentrated to certain areas.
- Of the projected $187 million in losses, 98% will come from hospitals in just seven states.
- California will lose the most - $107 million (57%).

California Rural Communities Are Hurt By This Policy

- Rural hospitals: Medicare patients treated and projected gains/losses.
- California rural hospitals treat more Medicare patients than rural hospitals in most other states but will lose the most revenue.

Area Wage Index Proposal Puts CA Hospitals in the Crosshairs

- A new proposal from CMS could reduce resources to care for patients at California hospitals.
Other Proposals

Critical Access Hospitals: Resident Training & Ambulance

- **CAHs as Nonprovider Sites for Resident FTE Slots**
  - Hospitals may include residents training in a nonprovider setting if they incur the cost of residents’ salaries and benefits, etc.
  - Statute does not define “nonprovider”. At present, CAHs are not treated as nonprovider sites, so instead they are paid at 101% of costs for training.
  - Proposal: Beginning October 1, 2019, permit a CAH to be a nonprovider site for resident FTE slots if the hospitals that pay for the residents’ salaries and benefits, etc., at a CAH may include those residents.

- **Payment for CAH Ambulance Services**
  - Current policy: 101% of costs if CAH is the ONLY supplier of ambulance services located within a 35-mile drive of the CAH; otherwise, Ambulance Fee Schedule is applied.
  - Proposal: 101% of costs if CAH is the ONLY supplier of ambulance services located within a 35-mile drive of the CAH, excluding suppliers not legally authorized to transport individuals to or from the CAH.

New Technology Add-On Payments

- **Statute**: Add-On payment must be set at “an amount that adequately reflects the estimated average cost of such service or technology.”
- **Current Rule**: New Technology Add-on Payment is the lesser of:
  - 50% of the costs of the new medical service or technology
  - 50% of the amount by which the costs of the case exceed the standard DRG payment
- **Proposal**: Increase from 50% to 65%
Chimeric Antigen Receptor T-Cell Therapy

- Proposed to continue new technology add-on payments for FFY 2020 (FFY 2020 is the final year under current law)
- Requested additional comments on alternative approaches
  - Establishing a new MS–DRG for CAR T-Cell Therapy
  - Use a Cost-to-Charge Ratio of 1.0
- Data Issues in Weighting of MS–DRG 016
  - Inclusion of clinical trial cases with low or no charges for the drug product
  - Trimming of high-cost cases (nearly half of non-clinical trial cases)

Comprehensive CC/MCC Analysis

- Comprehensive review of the CC/MCC lists to better recognize severity of illness.
- Similar methodology used in FFY 2008 to conduct analysis of CC/MCC lists that ultimately resulted in the implementation of MS-DRGs.
- According to CMS, proposals are based on review of the data as well as consideration of the clinical nature of each of the secondary diagnoses and the severity level of clinically similar diagnoses.

Comprehensive CC/MCC Analysis (cont.)

- Change in the severity level designation for 1,492 diagnosis codes after reviewing 71,932 codes
  - Shown in Table 6P.1c. available via the Internet on the CMS website at: http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html
- Net result:
  - MCCs – decrease of 145 codes (-4.5%)
  - CCs – decrease of 837 codes (-5.8%)
  - Non-CCs – increase of 982 codes (1.8%)
Comprehensive CC/MCC Analysis (cont.)

- Results of Impact Analysis – Summary of Number of Codes Proposed for Conversion

<table>
<thead>
<tr>
<th>Current Version 36 Severity Level</th>
<th>Proposed Version 37 Severity Level</th>
<th>Number of Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-CC</td>
<td>CC</td>
<td>163</td>
</tr>
<tr>
<td>CC</td>
<td>Non-CC</td>
<td>1,148</td>
</tr>
<tr>
<td>CC</td>
<td>MCC</td>
<td>17</td>
</tr>
<tr>
<td>MCC</td>
<td>CC</td>
<td>136</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>1,492</td>
</tr>
</tbody>
</table>

Inpatient Quality Reporting (IQR) Program

- CMS proposes to add two opioid-related eCQMs beginning with the CY 2021 reporting year:
  - Safe Use of Opioids - Concurrent Prescribing (NQF #3316e)
    - Assesses proportion of adult inpatient discharges with prescriptions for either two or more opioids, or an opioid and a benzodiazepine
  - Hospital Harm - Opioid-Related Adverse Events
    - Assesses proportion of patients discharged from inpatient admission receiving naloxone either at least 24 hours after hospital arrival; or within the 24 hours of hospital arrival with evidence opioid administered in hospital
IQR eCQM Data Submission Requirements

- CY 2020 and CY 2021 reporting periods:
  - CMS proposes to extend current requirements (report four self-selected measures from eCQM measure set for one, self-selected calendar quarter of data)
- CY 2022 reporting period: CMS proposes to require hospitals report one, self-selected calendar quarter of data for:
  - Three, self-selected eCQMs
  - Proposed Safe Use of Opioids – Concurrent Prescribing eCQM

Proposed Mandatory Reporting of Hybrid Hospital-Wide Readmission (HWR) Measure

CMS proposes to require reporting of currently voluntary Hybrid HWR measure beginning with the FFY 2026 payment determination

- CMS proposes two new voluntary reporting periods:
  - July 1, 2021 through June 30, 2022
  - July 1, 2022 through June 30, 2023
- CMS proposes mandatory reporting beginning:
  - July 1, 2023 through June 30, 2024
- In connection with the proposal to adopt the Hybrid HWR measure, CMS proposes to remove the current claims-based HWR measure (NQF #1789) beginning with the FFY 2026 payment determination
- CMS anticipates public reporting would begin in 2025

Hybrid HWR Measure with Claims and Electronic Health Record Data (NQF #2879)

- Hospitals would submit the following data from their certified EHRs for at least 90 percent of their Medicare fee-for-service (FFS) patients aged 65 and older, using QRDA Category I files for reporting to CMS:
  - 13 core clinical data elements:
    - 6 vital signs (heart rate, respiratory rate, temperature, systolic blood pressure, oxygen saturation, weight)
    - 7 laboratory test results (hematocrit, white blood cell count, sodium, potassium, bicarbonate, creatinine, glucose)
    - 6 linking variables to match the EHR data to the CMS claims data (CMS Certification Number, Health Insurance Claim Number or Medicare Beneficiary Identifier, date of birth, sex, admission date, discharge date)
- CMS merges the EHR data elements with the claims data and calculates the 30-day risk-standardized readmission rate.
Accounting for Social Risk Factors: Confidential Reporting of Stratified Data

- In the spring of 2020, CMS plans to include in confidential hospital-specific reports (HSRs) disparity results by patients’ dual eligible status for five additional claims-based readmission measures for:
  - Acute myocardial infarction (AMI)
  - Coronary artery bypass graft (CABG)
  - Chronic obstructive pulmonary disease (COPD)
  - Heart failure (HF)
  - Total hip arthroplasty/Total knee arthroplasty (THA/TKA)

Hospital Value Based Purchasing (VBP) Program

- CMS proposes to use data submitted to the CDC’s NHSN for HAI measures in both the Hospital VBP and HAC Reduction Programs beginning with Jan. 1, 2020
- Previously, the Hospital VBP used data submitted to the IQR program; HAI measures were removed from the IQR program beginning with the FFY 2022 VBP performance period
- This proposed policy would apply to the Hospital VBP Program starting with data for the FFY 2022 program year performance period

Proposed Administrative Policies for NHSN HAI Measure Data
Previously Adopted VBP Domains and Measures

Hospital Acquired Condition (HAC) Reduction Program

HAC Reduction Program

- CMS proposes to:
  - Adopt a measure removal policy that aligns with the removal factor policies previously adopted in other quality reporting and quality payment programs.
  - Clarify policies for validation of the Centers for Disease Control and Prevention (CDC) NHSN HAIs measures:
    - Change the number of hospitals targeted for validation from exactly 200 hospitals to "up to 200 hospitals" to avoid selecting hospitals simply to meet the 200 number
    - Implement filtering method to remove positive blood or urine cultures collected during the first or second day following admission from validation pool
Hospital Readmissions Reduction Program (HRRP)

CMS proposes to:

- Adopt a measure removal policy that aligns with the removal factor policies previously adopted in other quality reporting and quality payment programs.
- Establish a 1-month look back period – beginning with FFY 2021 – in the State Medicare Modernization Act data files to determine dual-eligible status for beneficiaries who die in the month of discharge.
- Adopt a subregulatory process to address potential future nonsubstantive changes outside of rulemaking.
Proposed Applicable Period for FFY 2022

<table>
<thead>
<tr>
<th>Measure</th>
<th>NQF Measure Number</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI</td>
<td>NQF #0303</td>
<td>July 1, 2017 – June 30, 2020</td>
</tr>
<tr>
<td>HF</td>
<td>NQF #0330</td>
<td>July 1, 2017 – June 30, 2020</td>
</tr>
<tr>
<td>PN</td>
<td>NQF #0506</td>
<td>July 1, 2017 – June 30, 2020</td>
</tr>
<tr>
<td>COPD</td>
<td>NQF #1891</td>
<td>July 1, 2017 – June 30, 2020</td>
</tr>
<tr>
<td>THA/TKA</td>
<td>NQF #1551</td>
<td>July 1, 2017 – June 30, 2020</td>
</tr>
<tr>
<td>CABG</td>
<td>NQF #0615</td>
<td>July 1, 2017 – June 30, 2020</td>
</tr>
</tbody>
</table>

Medicare and Medicaid Promoting Interoperability Program

- CMS proposes to:
  - Adopt a reporting period of a minimum of any continuous 90-day period in CY 2021
  - Update requirements for opioid-related measures under ePrescribing objective:
    - Query of PDMP measure would remain optional for 2020 and beyond; starting with 2019, would be reported as a yes/no measure rather than numerator/denominator
    - Verify Opioid Treatment measure would remain optional in 2019 and be removed beginning with 2020 reporting
  - Adopt the same eCQM reporting requirements as proposed for the IQR program
Questions?

Raise your hand or submit a question at www.menti.com and enter code 29 15 36

Thank You

Katrina Pagonis
Co-Chair, Regulatory Department
Hooper, Lundy & Bookman, PC
(415) 875-8515
kpagonis@health-law.com