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# Federal Quality Policy Update

Alabama Hospital Association Fall Quality Forum

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October 16, 2018

# The Context

- **Congress**
  - Nominations
  - Appropriations
  - Opioids Package
  - *Site-Neutral Payment*
  - *Interest in 340B program*
- **The Administration**
  - Focus on Regulatory Relief
  - *Proposed Site-Neutral Cuts*
  - *Proposed Payment Cuts to 340B hospitals*
- **2018 Mid-Term Elections**

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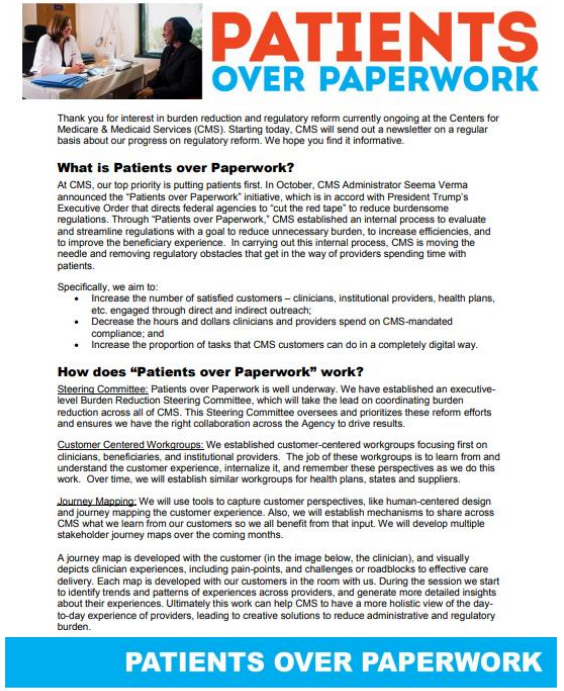
# CMS Patients Over Paperwork

- Launched in Oct. 2017
- Agency-wide effort to evaluate and streamline regulations to reduce unnecessary burden
- Stated Goals
  - Increase stakeholder engagement
  - Decrease hours/dollars on CMS-mandated compliance
  - Increase proportion of tasks that can be completed electronically
- How they're doing it
  - RFIs, listening sessions, framework development, rulemaking



PATIENTS OVER PAPERWORK

Thank you for interest in burden reduction and regulatory reform currently ongoing at the Centers for Medicare & Medicaid Services (CMS). Starting today, CMS will send out a newsletter on a regular basis about our progress on regulatory reform. We hope you find it informative.

**What is Patients over Paperwork?**

At CMS, our top priority is putting patients first. In October, CMS Administrator Seema Verma announced the "Patients over Paperwork" initiative, which is in accord with President Trump's Executive Order that directs federal agencies to "cut the red tape" to reduce burdensome regulations. Through "Patients over Paperwork," CMS established an internal process to evaluate and streamline regulations with a goal to reduce unnecessary burden, to increase efficiencies, and to improve the beneficiary experience. In carrying out this internal process, CMS is moving the needle and removing regulatory obstacles that get in the way of providers spending time with patients.

Specifically, we aim to:

- Increase the number of satisfied customers – clinicians, institutional providers, health plans, etc. engaged through direct and indirect outreach;
- Decrease the hours and dollars clinicians and providers spend on CMS-mandated compliance; and
- Increase the proportion of tasks that CMS customers can do in a completely digital way.

**How does "Patients over Paperwork" work?**

Steering Committee: Patients over Paperwork is well underway. We have established an executive-level Burden Reduction Steering Committee, which will take the lead on coordinating burden reduction across all of CMS. This Steering Committee oversees and prioritizes these reform efforts and ensures we have the right collaboration across the Agency to drive results.

Customer Centered Workgroups: We established customer-centered workgroups focusing first on clinicians, beneficiaries, and institutional providers. The job of these workgroups is to learn from and understand the customer experience, internalize it, and remember these perspectives as we do this work. Over time, we will establish similar workgroups for health plans, states and suppliers.

Journey Mapping: We will use tools to capture customer perspectives, like human-centered design and journey mapping the customer experience. Also, we will establish mechanisms to share across CMS what we learn from our customers so we all benefit from that input. We will develop multiple stakeholder journey maps over the coming months.

A journey map is developed with the customer (in the image below, the clinician), and visually depicts clinician experiences, including pain-points, and challenges or roadblocks to effective care delivery. Each map is developed with our customers in the room with us. During the session we start to identify trends and patterns of experiences across providers, and generate more detailed insights about their experiences. Ultimately this work can help CMS to have a more holistic view of the day-to-day experience of providers, leading to creative solutions to reduce administrative and regulatory burden.

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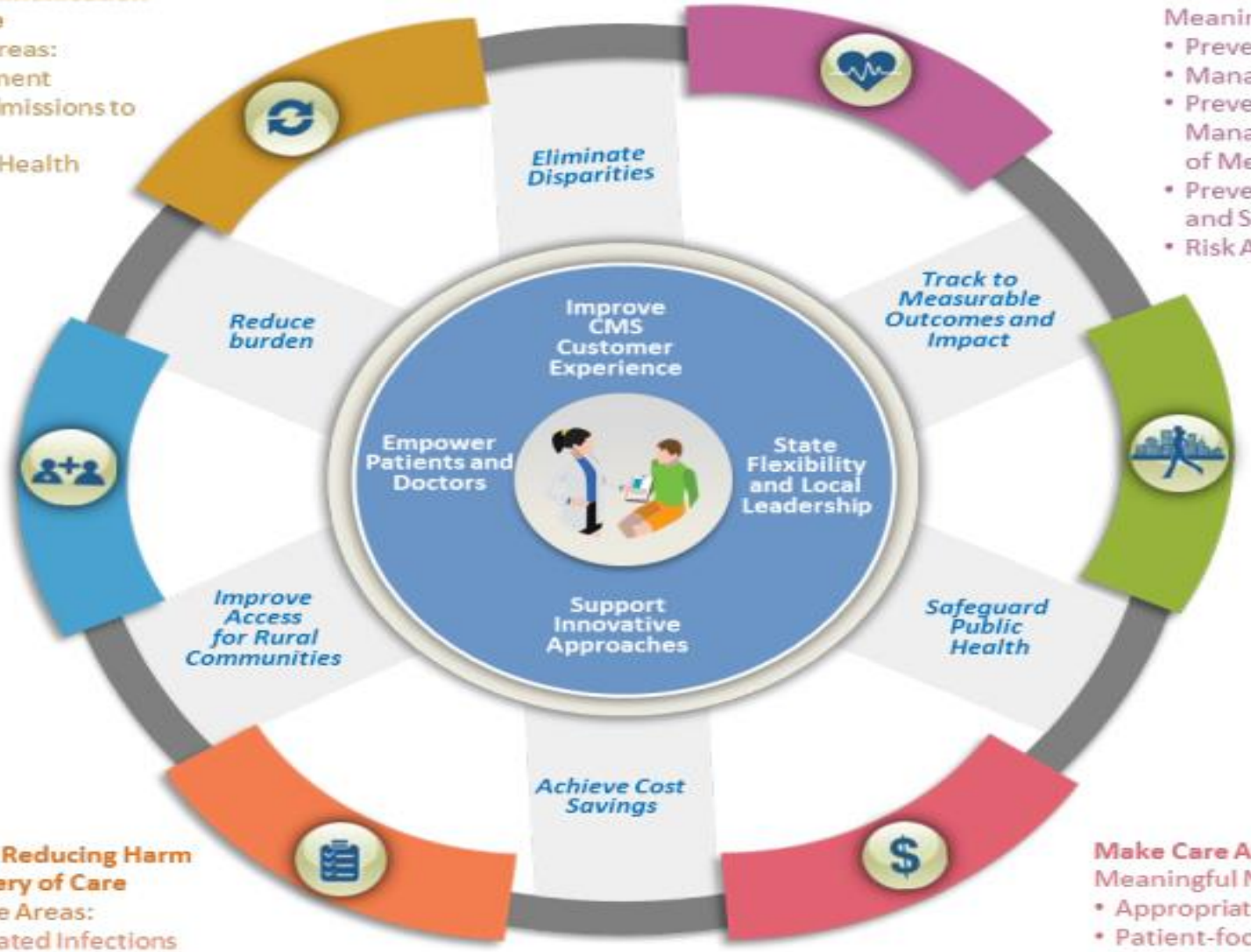
# CMS's "Meaningful Measures" Initiative




**Promote Effective Communication & Coordination of Care**
Meaningful Measure Areas:
- Medication Management
- Admissions and Readmissions to Hospitals
- Seamless Transfer of Health Information

**Promote Effective Prevention & Treatment of Chronic Disease**
Meaningful Measure Areas:
- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality

**Strengthen Person & Family Engagement as Partners in their Care**
Meaningful Measure Areas:
- Care is Personalized and Aligned with Patient's Goals
- End of Life Care according to Preferences
- Patient's Experience and Functional Outcomes

**Work with Communities to Promote Best Practices of Healthy Living**
Meaningful Measure Areas:
- Equity of Care
- Community Engagement

**Make Care Safer by Reducing Harm Caused in the Delivery of Care**
Meaningful Measure Areas:
- Healthcare-Associated Infections
- Preventable Healthcare Harm

**Make Care Affordable**
Meaningful Measure Areas:
- Appropriate Use of Healthcare
- Patient-focused Episode of Care
- Risk Adjusted Total Cost of Care

# Updates to Measure Removal Factors

- Factor 1: Measure performance among providers is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made (measure is “topped out”).
- Factor 2: Performance or improvement on a measure does not result in better patient outcomes.
- Factor 3: The measure does not align with current clinical guidelines or practice.
- Factor 4: A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.
- Factor 5: A measure that is more proximal in time to desired patient outcomes for the particular topic is available.
- Factor 6: A measure that is more strongly associated with desired patient outcomes for the particular topic is available.
- Factor 7: Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.
- **NEW! Factor 8: the costs associated with a measure outweigh the benefit of its continued use in the program.**

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# Significant Progress on Measures that Matter

- AHA influenced CMS's "Meaningful Measures"
  - **16** out of **19** CMS meaningful measure areas align with AHA measure priority list (other 3 reflect AHA cross-org priorities)

- FY / CY 2019 CMS policies by the numbers:
  - **29 percent reduction** in inpatient hospital measures
  - **28 percent reduction** in inpatient psychiatric measures
  - **55 percent reduction** in outpatient hospital measures (proposed)
  - **34 measures removed** from MIPS (proposed)
  - **10 measures removed** from various post-acute care programs (final)

- AHA-facilitated collaborative effort for public / private measure alignment underway

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# IPPS: Impact of CMS Meaningful Measure Policies

| | IQR | VBP | HAC | HRRP |
|---|---|---|---|---|
| Number of measures in FY 2019 Program | 62 | 18 | 6 | 6 |
| Number of Measures Removed, FYs 2019 -2023 | 39 | 4 | 0 | 0 |
| **Number of Measures in FY 2023** | **23** | **14** | **6** | **6** |

- IQR:
  - 18 measures removed from ALL CMS hospital quality reporting and value programs
  - 21 measures “de-duplicated” (removed from IQR, but retained for only one CMS hospital program)
- VBP
  - 4 measures removed to “de-duplicate” with IQR
  - CMS did NOT finalize proposal to remove 6 safety measures from VBP
    - Concerns remain about inconsistent/duplicative penalties between HAC and VBP

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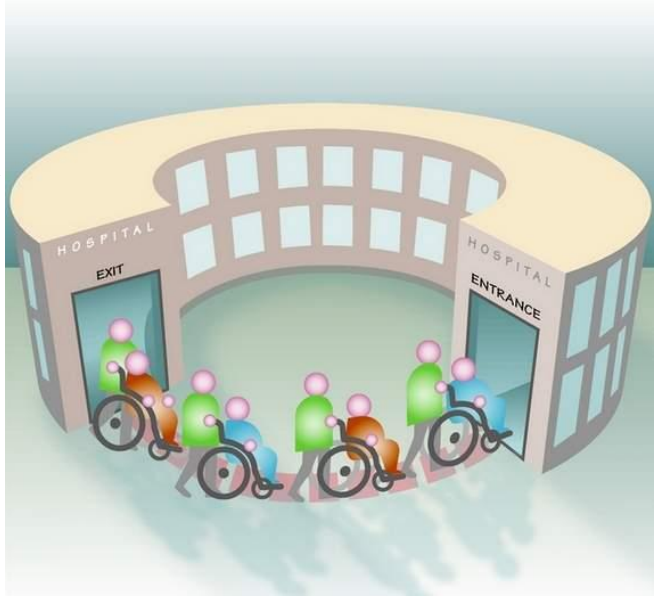
# Hospital Readmissions Reduction Program (HRRP)

- Hospitals with “excess” readmissions have their base inpatient Medicare payments reduced by:
  - 1 percent in FY 2013, 2 percent in FY 2014, 3 percent in FY 2015 and beyond
- Uses 30-day readmissions measures for a total of six conditions:
  - FY 2013: AMI, HF, PN
  - FY 2015: Elective hip/knee, COPD
  - FY 2017: CABG
- Socioeconomic adjustment will start with FY 2019 penalties
  - Mandated by 21st Century Cures Act of 2016
  - Budget neutral (that is, aggregate penalties must be same as non-SES adjusted approach)

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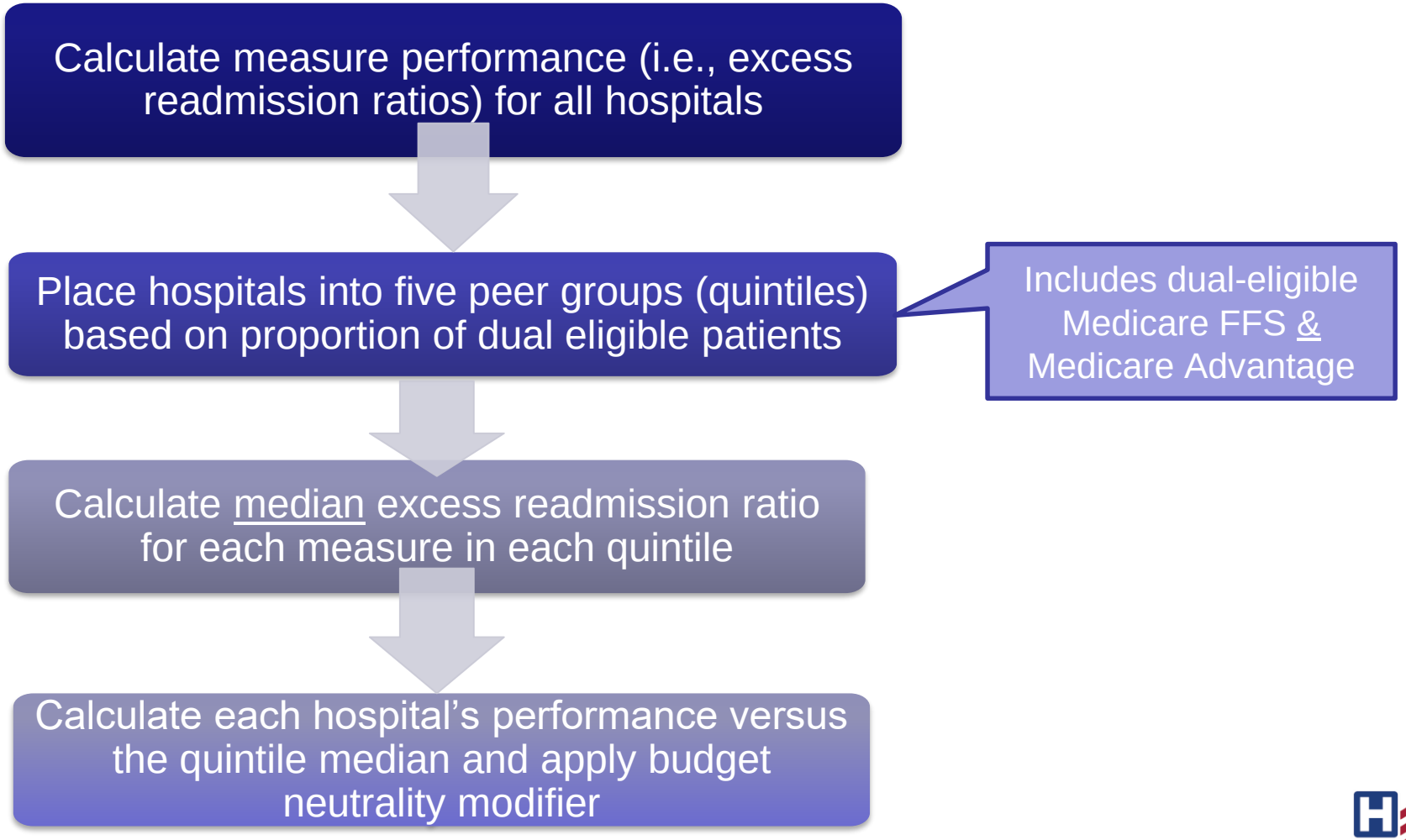
# Hospital Readmissions Penalties: Readmissions Socioeconomic Adjustment Starts Oct. 1

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# HACs: Current v. New (FY 2020) Scoring Approach

***A hospital's Total HAC Score determines its performance…***

**Current Scoring Methodology**

1. Score each individual HAC measure (Winsorized z-score)
2. Calculate domain scores (85% HAI measures, 15% PSI)
3. Calculate the Total HAC Score

**New Scoring Methodology**

1. **Score each individual HAC measure (Winsorized z-score)**
2. **Sum individual measure scores (all weighted equally) to create Total HAC Score**

***…hospitals with Total HAC Scores in highest (i.e., worst performing) quartile receive penalty***

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# HACcidental Penalties?

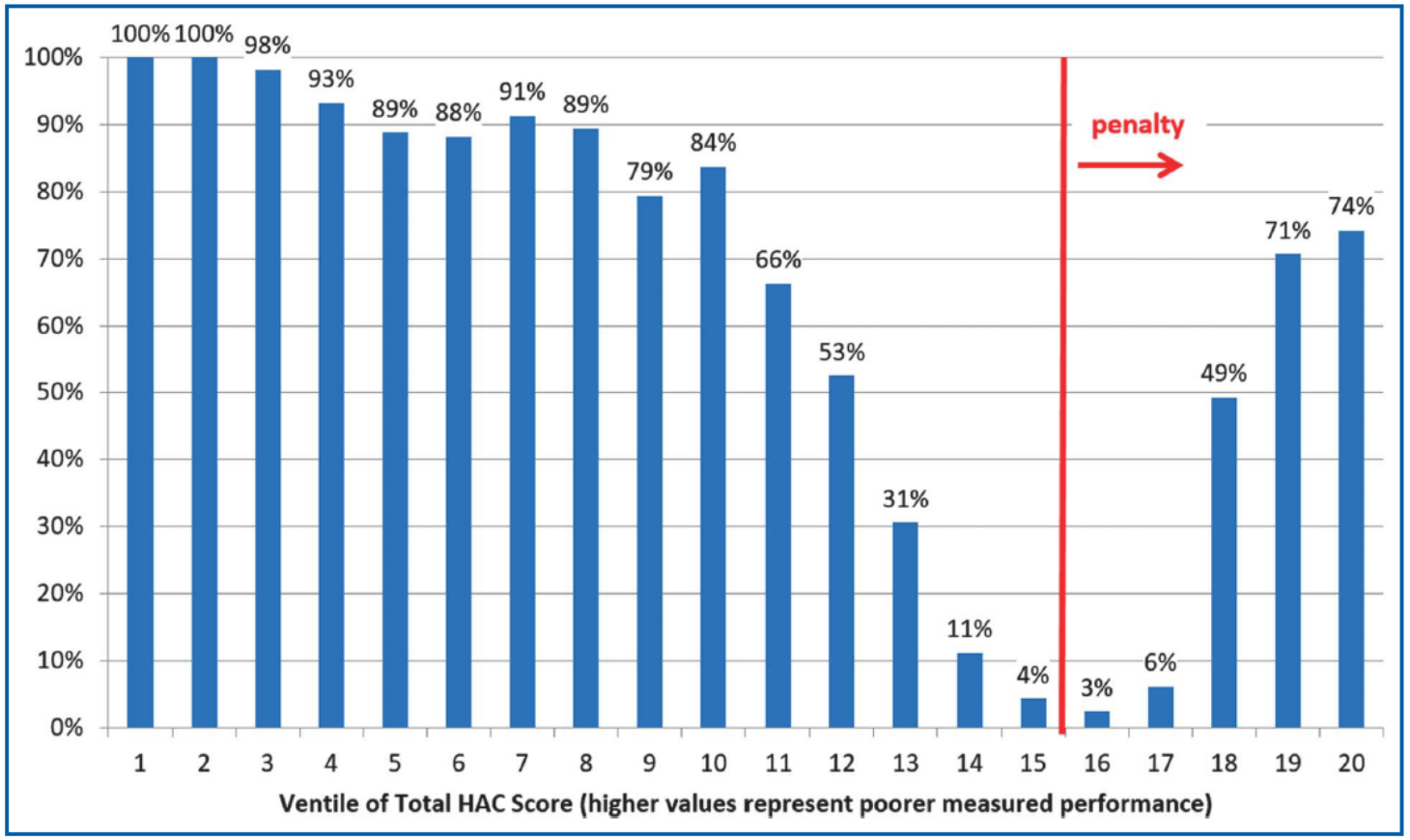


**Figure 1.** Percent of hospitals ($n = 3,198$) statistically significantly different from threshold, 95% significance level. Source: Authors' analysis of data from Hospital Compare.

Source: Soltoff S, Koenig L, Demehin A, Foster N, Vaz C. Identifying Poor-Performing Hospitals in the Medicare Hospital-Acquired Condition Reduction Program: An Assessment of Reliability. *Journal of Health Care Quality.* March 2018

- **HAC Program has right goal but wrong approach**
  - Does not recognize improvement
  - Disproportionately penalizes hospitals treating complex patients
  - Flawed PSI measure
- Penalties not based on statistically significant differences in performance

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# IQR HCAHPS Pain Questions

- HCAHPS pain composite already removed from VBP
- CMS previously replaced pain management questions in HCAHPS with “Communication about Pain” questions
- Stakeholders continue to voice concerns regarding inadvertent pressure to prescribe opioids for pain
- CMS proposes to remove questions beginning with **Jan. 2022** discharges
  - Can’t do it earlier: agency needs time to make “necessary updates”
  - Still wants to collect data on impact of questions to inform future program changes

cahps® Surveys and Tools to Advance Patient-Centered Care

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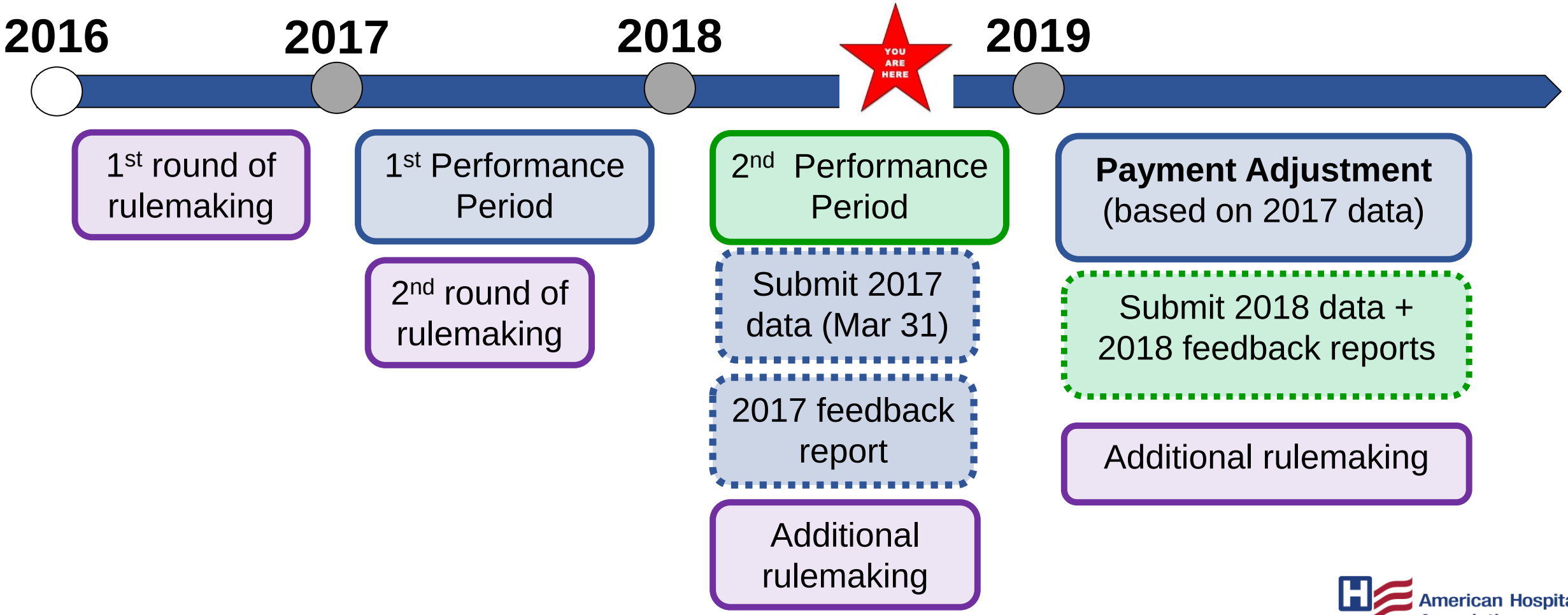
# OQR: Measures Proposed for Removal

| Measure Number | Measure Title | Rationale for Removal |
|---|---|---|
| OP-27 | Influenza Vaccination Coverage among Healthcare Personnel | Costs to use NHSN outweigh benefits of measure |
| OP-5 | Median Time to ECG | Costs outweigh benefits; little variation; NQF endorsement removed |
| OP-9 | Mammography Follow-up Rates | Not in line with recently updated clinical practices |
| OP-11 | Thorax Computed Tomography (CT) Use of Contrast Material | Topped out |
| OP-12 | The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into Their Qualified/Certified EHR System as Discrete Searchable Data | Does not directly assess quality or patient outcomes; not NQF-endorsed |

# Measures Proposed for Removal, cont.

| Measure Number | Measure Title | Rationale for Removal |
|---|---|---|
| OP-14 | Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT | Topped out |
| OP-17 | Tracking Clinical Results between Visits | Does not directly assess quality or patient outcomes; NQF endorsement removed |
| OP-29 | Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients | Costs outweigh benefits; measure available in MIPS |
| OP-30 | Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use | Costs outweigh benefits; measure available in MIPS |
| OP-31 | Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery | Costs outweigh benefits; low reporting rates |

# Where are we on MACRA Quality Payment Program?

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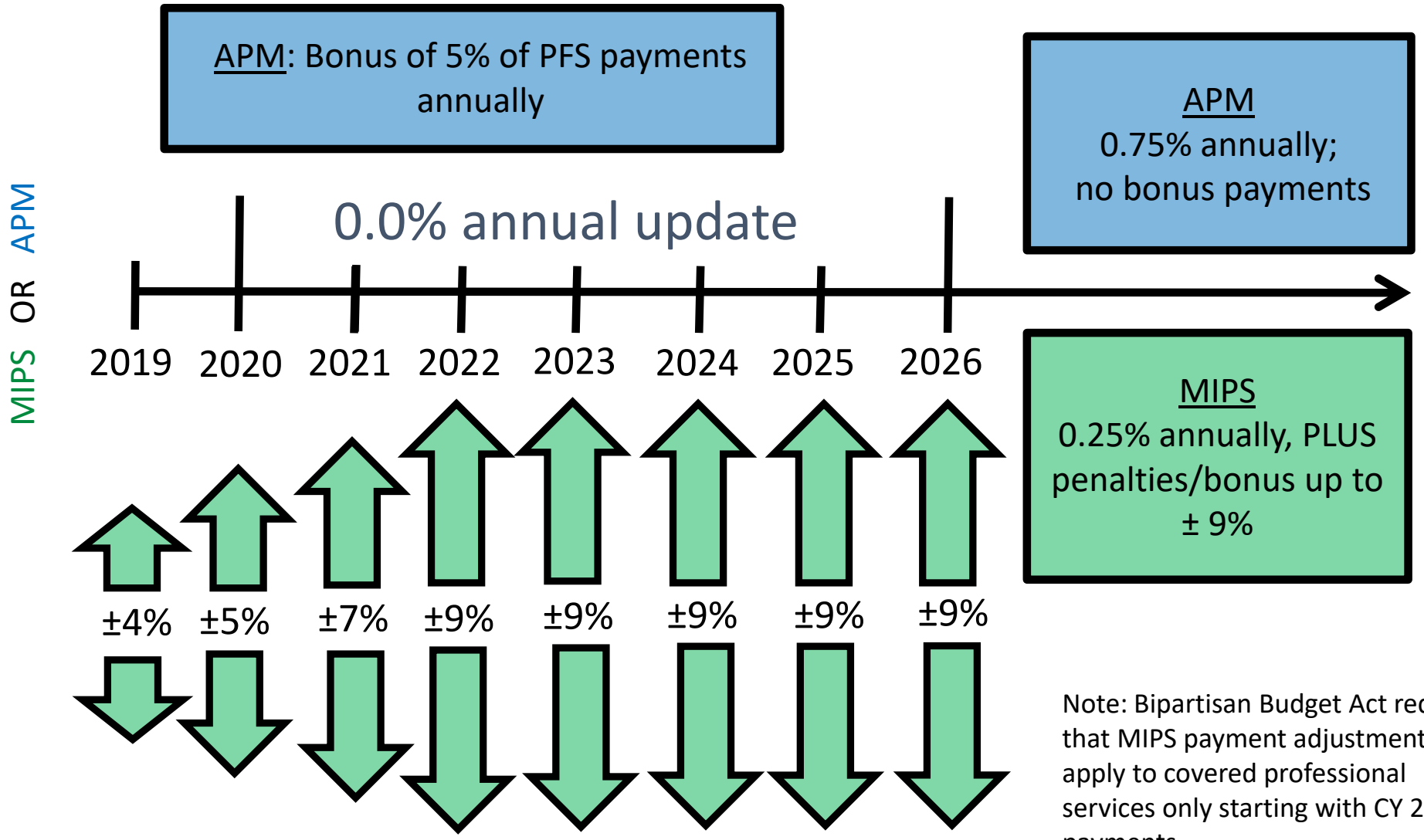
# Payment Impact Under MACRA QPP




Note: Bipartisan Budget Act requires that MIPS payment adjustments apply to covered professional services only starting with CY 2020 payments

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# 2019 QPP Proposals – Key Takeaways


- **Gradual implementation of MIPS continues**
  - Low-volume threshold still excludes large number of clinicians (590,000)
  - MIPS opt-in available
  - Carry over of most 2018 quality reporting requirements
  - Expansion to new clinician types (PT, OT, social work, psychologists)
- **Impact of MIPS cost measurement grows**
  - Increased category weight to 15 percent, and new episode-based measures
- **MIPS Advancing Care Information (ACI) category renamed and revamped**
  - Now “Promoting Interoperability”, with greater alignment with hospital program
- **CMS staying the course on MIPS facility-based measurement**
  - Available in 2019, with minor proposed expansions
- **Changes to advanced APM track are quite minor**
- ***Excluded clinicians have more time to prepare…but stakes are rising!***

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# MIPS: Performance Categories

| Category | CY 2019 Final | CY 2020 Final | CY 2021 Proposed |
|---|---|---|---|
| Quality | 60% | 50% | **45%*** |
| Cost / Resource Use | N/A | 10% | **15%*** |
| Improvement Activities | 15% | 15% | **15%** |
| Promoting Interoperability | 25% | 25% | **25%** |

- Bipartisan Budget Act gives CMS flexibility to gradually raise cost category weight and lower quality category weight until they are both 30% in 2024
- CMS proposes to raise cost category weight by 5 percent each year until CY 2024

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# MIPS: Low-Volume Threshold

## CY 2018 Reporting Final (CY 2020 Payment)

***Clinicians excluded from MIPS if they bill:***

- $90,000 or less of allowed charges for part B covered professional services

*OR*

- 200 or fewer Medicare part B patients

## CY 2019 Reporting Proposed (CY 2021 Payment)

***Clinicians excluded from MIPS if they bill:***

- $90,000 or less of allowed charges for part B covered professional services

*OR*

- 200 or fewer Medicare part B patients

*OR*

– 200 or fewer covered professional services

MIPS "Opt-In" available for clinicians that surpass 1 or 2 of the low-volume threshold criteria

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# MIPS: Applicability to Rural Providers

- **CAHs:**
  - MIPS adjustments may apply to CAHs billing under Method II whose clinicians have reassigned their billing rights to the CAH
    - Professional services portion only
  - Clinicians in Method I CAHs may be subject to MIPS adjustments (but the **CAH's** payments not affected)
- **FQHCs/RHCs:**
  - MIPS does not apply to clinicians billing under the payment systems for FQHCs/RHCs
  - However, MIPS may apply if FQHC/RHC clinicians bill services under the PFS (such as in moonlighting arrangements)

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# MIPS Facility-based Measurement


- MACRA permits CMS to use measures / data from CMS facility-level quality measurement programs in the MIPS
- CMS will allow hospital-based clinicians to have MIPS quality and cost category linked to their hospital's VBP performance
- Will be available for CY 2019 MIPS performance period (affecting CY 2021 payment)
- No separate data reporting required

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# MIPS Facility-Based Measurement

| | |
|---|---|
| Eligibility | • **Clinicians** with 75% of covered professional services in inpatient, ED, or on-campus outpatient hospital* settings<br>• **Groups** with 75 percent of clinicians meeting individual clinician threshold<br>• Uses **place of service** codes (POS 21, 22*, 23) – must have at least one service billed in inpatient or ED setting* |
| Attribution | • Clinicians and groups attributed to **hospital where they provide services to the most** Medicare beneficiaries |
| Scoring | • **Covert** hospital VBP TPS into MIPS quality and cost category scores<br>• MIPS scores correspond to **same percentile of performance** as hospital VBP |
| Election* | • CMS would **automatically apply facility-based scoring to those clinicians and groups that meet eligibility criteria** unless their combined cost and quality performance is better under MIPS data they choose to submit. |

*New proposal for CY 2019 reporting

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# The Tangled Web of Standards Oversight

**CMS**

Conditions of Participation (CoPs) & Conditions for Coverage (CfCs)

Interpretive Guidance

Contracts for Complaint Surveys

Deemed Status Requirements & Other AO Requirements

Validation Surveys

CoP Compliance Surveys

Contracts for Complaint Surveys

Contracts for Validation Surveys

**Accrediting Organizations**

(e.g., Joint Commission)

- Accreditation standards & surveys
- Disease certification standards & surveys
- CMS complaint surveys

**State Agencies**

- State licensure
- CMS CoP compliance surveys
- CMS complaint & validation surveys

# Survey & Certification: Key Issues

- Alignment of standards, methodology between accrediting organizations (AOs) and CMS
  - Concurrent survey pilot
- Clarity and consistency in how to interpret standards, especially immediate jeopardy (IJ) citations
- Survey burdens
  - Validation surveys
  - Individual surveyors




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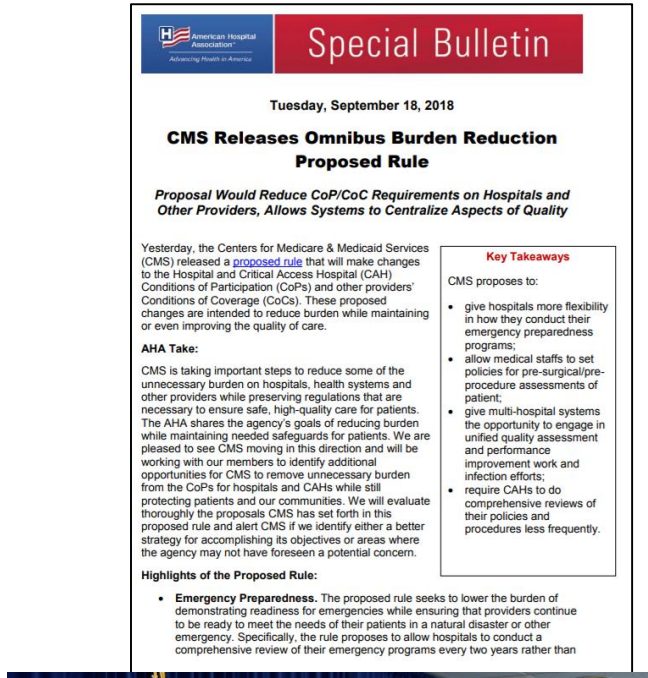
# Omnibus Burden Reduction Rule (Medicare CoPs)

- Proposed rule released Sep. 17

- Major Proposed Changes
  - Transplant center requirements
  - Multi-hospital system approaches to quality and infection control permitted
  - Flexibility on emergency preparedness training & CAH review of policies
  - Greater flexibility on pre-operative assessments
  - Eliminate ASC requirements to have agreements with hospitals in case something goes wrong

- Comments due Nov. 19



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Special Bulletin

Tuesday, September 18, 2018

**CMS Releases Omnibus Burden Reduction Proposed Rule**

***Proposal Would Reduce CoP/CoC Requirements on Hospitals and Other Providers, Allows Systems to Centralize Aspects of Quality***

Yesterday, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule that will make changes to the Hospital and Critical Access Hospital (CAH) Conditions of Participation (CoPs) and other providers' Conditions of Coverage (CoCs). These proposed changes are intended to reduce burden while maintaining or even improving the quality of care.

**AHA Take:**

CMS is taking important steps to reduce some of the unnecessary burden on hospitals, health systems and other providers while preserving regulations that are necessary to ensure safe, high-quality care for patients. The AHA shares the agency's goals of reducing burden while maintaining needed safeguards for patients. We are pleased to see CMS moving in this direction and will be working with our members to identify additional opportunities for CMS to remove unnecessary burden from the CoPs for hospitals and CAHs while still protecting patients and our communities. We will evaluate thoroughly the proposals CMS has set forth in this proposed rule and alert CMS if we identify either a better strategy for accomplishing its objectives or areas where the agency may not have foreseen a potential concern.

**Key Takeaways**

CMS proposes to:

- give hospitals more flexibility in how they conduct their emergency preparedness programs;
- allow medical staffs to set policies for pre-surgical/pre-procedure assessments of patient;
- give multi-hospital systems the opportunity to engage in unified quality assessment and performance improvement work and infection efforts;
- require CAHs to do comprehensive reviews of their policies and procedures less frequently.

**Highlights of the Proposed Rule:**

- **Emergency Preparedness.** The proposed rule seeks to lower the burden of demonstrating readiness for emergencies while ensuring that providers continue to be ready to meet the needs of their patients in a natural disaster or other emergency. Specifically, the rule proposes to allow hospitals to conduct a comprehensive review of their emergency programs every two years rather than

# Other Medicare CoP Updates

- No final rules yet on:
  - Discharge planning
  - Antibiotic stewardship
- Awaiting CMS guidance on
  - Co-location
  - Ligature Risk
- Concurrent validation and accreditation survey pilot

# TJC Study on Patient Suicide

- First data-driven estimate of number of suicides in US hospitals
  - Based on CDC National Violent Death Reporting System (NCDRS) and TJC Sentinel Event Database
- Major Findings:
  - **49-65** hospital inpatient suicides per year (less than often cited 1,500)
  - **75-80%** among psychiatric inpatients
    - **3.2 per 100,000** psychiatric inpatient admissions (0.03 per 100,000 non-psychiatric inpatients)
  - Method, location, fixture use
    - 70% by hanging
    - ~50% in bathroom (~33% in bedroom)
    - 54% used door, door handle, or door hinge

The Joint Commission

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# Quality Issues to Watch in 2019

- Progress of “Meaningful Measures”
- Hospital Pay-for-Performance programs
  - MedPAC’s HVIP
  - Including rural hospitals in quality reporting programs
- More work on CoPs; right-sizing regulation
- 20th Anniversary of *To Err is Human*: Telling the story of quality improvement
- Revisions to star ratings?
- Quality in new payment models?


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# Federal Quality Policy Update

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