Nassau-Suffolk Hospital Council, Inc.

Quality News

December, 2015 Vol. 5 No. 3

A Publication of the Nassau-Suffolk Hospital Council

CMS Releases OPPS Final Rule for CY 2016

On October 30, 2015 CMS released the Outpatient Prospective Payment System final rule for CY 2016. The final rule included some very minor changes to the Outpatient Quality Reporting Program (OQR) and modifications to the Two-Midnight Rule.

Changes to the OQR program were minimal and will not have a profound effect on hospital quality improvement staff. Under the final rule, CMS adds one new measure to the program: OP 33 – External Beam Radiotherapy. The measure will begin effecting payment in CY 2018 and will be used to determine the percent of patients with "painful bone metastases and no history of radiation who receive EBRT on an appropriate schedule". CMS will also remove one measure from the program for CY 2016: OP 15 - Use of Computed Tomography.

Final modifications to the Two-Midnight Rule very closely resemble those proposed. In the final rule, CMS recognizes that there are some cases for which inpatient admission and payment may be appropriate for a stay that spans less than two midnights. In such cases, the admitting provider will be required to document in the medical record that an inpatient level of care is reasonable and necessary. Other information in the record should support the decision to admit.

Factors that will determine appropriateness of such an admission include:

- Severity of the patient's signs and symptoms
- Medical probability of something adverse happening
- The need for diagnostic studies that are appropriately outpatient services

CMS reiterates in the final rule that surgeries requiring a hospital stay of less than 24 hours are still considered outpatient and should be billed as such.

Any inpatient stay that does not span at least one midnight will be prioritized for review. As proposed, the Quality Improvement Organizations (Livanta for hospitals in NYS), will be responsible for a majority of patient status reviews effective October 1, 2015.

This issue includes information about:

Going forward, the RACs will only work with hospitals that have experienced a high rate of denials or those who have consistently "ignored" the tenants of the Two-Midnight Rule.

Despite the advocacy efforts of the allied associations, CMS is maintaining the 0.2% payment reduction that was initially imposed to account for an expected increase in inpatient stays and related costs as a result of the Two-Midnight Rule. Continued advocacy efforts will be focused on eliminating this payment reduction.

In the rule, CMS also finalizes payment policies for advanced care planning including patient education and assistance with advanced directives.

This rule will become effective on January 1, 2016.

Final Rule for Meaningful Use Stage 3 Released

On October 16, 2015, CMS released the final rules for the Electronic Health Record Incentive Program and Stage 3 Meaningful Use in partnership with a final rule from the ONC outlining requirements for EHR Technology for 2017. There were several significant changes to the EHR Incentive Program all of which were designed to transition hospitals and eligible professionals to the final stage of the Meaningful Use program (Stage 3) by calendar year 2018.

EHR Incentive Program Changes

FY 2016 is the last year that hospitals can qualify for EHR incentive program payments from Medicare.

Those that have not attested to some stage of Meaningful Use will be continue to be penalized for every fiscal year that they do not attest, a policy that began in FY 2015. Penalties are assessed through Inpatient Prospective Payment System adjustments every fiscal year, and will be based on the calendar year two years prior. For example, a penalty in FY 2018 will be based on performance in CY 2016.

CMS finalized its proposal to realign reporting periods for eligible providers and hospitals starting in 2017 (hospitals will participate on CY instead of FY). As such, all hospitals and eligible providers, regardless of the Stage to which they are attesting, will only be required to report on a 90-day period for 2015. Per the final rule, providers can choose any 90-day period between 10/1/2014 and 12/31/2015 on which to report.

CMS is offering new participants some flexibility in reporting requirements in an effort to get them caught up quickly. Participants that are new to the Medicare Meaningful Use program in years 2016 and 2017 will only be required to report on a 90-day period during those program years. However, all providers, regardless of their history with the program, must meet some version of the Stage 2 requirements for attestation in 2015.

All hospitals attesting to Stage 2 Meaningful Use in the years 2015 through 2017 will be required to report on the same nine objectives and measures. The new Stage 2 measures are a combination of the previous Stage 1 and Stage 2 requirements. All other objectives and measures included in previous years have been removed or incorporated in some way into the nine required. Required objectives include:

- Protect Patient Health Information
- Clinical Decision Support
- Computerized Provider Order Entry
- Electronic Prescribing * (was a menu objective in previous years, now required)
- Health Information Exchange
- Patient Specific Education
- Medication Reconciliation
- Patient Electronic Access (VTD)
- Public Health and Clinical Data Registry Reporting (only measure that includes flexibility)

For 2015 only, hospitals meant to be at Stage 1 can attest to the "Stage 1 version" or an alternate version of the newly required measures and objectives. For measures that didn't exist in Stage 1, new hospitals and EPs will have the opportunity to take advantage of exclusions. In 2016, CMS will be much stricter with eligibility requirements for exclusion.

Changes of note to some of the "trouble measures" include:

Summary of Care: This measure has been simplified and now only requires that a summary of care document be sent electronically for 10% of transitions and referrals. However, CMS has been more specific about the data that must be included in a summary of care document. Required data includes: a current problem list, current medication list and current medication allergy list or an indication that the patient has no allergies. It must also include all of the following information, if it is available to the hospital: patient name, procedures, encounter diagnosis, immunizations, and laboratory test results, vital signs, smoking status, functional status, demographic information, care plan field, care team members and discharge instructions if the hospital has it.

E-prescribing: All hospitals will be required to query 10 percent of all hospital discharge medication orders for permissible prescriptions against a drug formulary and transmit the script electronically using a certified EHR. Some exclusion criteria exists for providers meant to be in Stage 1, but these exclusions will expire in 2017. *View, Transmit, Download:* For 2015 and 2016, CMS will only require that at least one patient in 2015 and one patient in 2016 uses the patient portal (in contrast to 5% requirement previously in place). In 2017, the requirement will increase back up to 5% of patients.

Finally, 2014 cEHRT can be used for attestation for 2015 and 2016. For attestation in 2017, hospitals will have the option to use 2015 cEHRT, which will be required by 2018.

Stage 3 Meaningful Use

Hospitals will first be able to attest to Stage 3 voluntarily in CY 2017 before it is required for all hospitals and providers in CY 2018. Providers who attest in 2017 will only be required

to report on a 90-day period. To successfully attest to Stage 3 requirements, hospitals will have to have 2015 cEHRT. There will be no further stages of Meaningful Use after Stage 3.

Under Stage 3, all providers will report on the objectives similar to those as listed above. There will be 21 measures in total across the 8 objectives. However, the Medication Reconciliation and Patient Specific Education objectives will be removed and a Coordination of Care through Patient Engagement objective will be added. Measures from the removed objectives will be folded into others as appropriate.

Stage 3 measures will require heightened functionality and additional requirements, most notably a requirement for application program interface (API) that would provide patients access to their information through an app.

Changes to the measures are complex and members are encouraged to use the tools provided by the allied associations to prepare for 2015 attestation by the deadline of February 29, 2016.

IPPS Final Rule for FY 2016 Released

CMS finalized major changes to the Hospital Inpatient Quality Reporting Program. The organization removed the chart-abstracted versions of nine measures while retaining the eCQM version of five of the measures that have "topped out". Measures that were removed are as follows:

- STK-06 discharged on a statin (topped out)
- STK-08 stroke education (topped out)
- VTE-1: VTE prophylaxis (topped out)
- VTE-2: Intensive care unit VTE (topped out)
- VTE-3: VTE patients with anticoagulation overlap therapy (topped out)
- AMI-7a Fibrinolytic therapy received within 30 minutes (removed completely)
- STK-1: VTE prophylaxis (removed completely)
- IMM-1 Pneumonia Vaccination (removed completely)
- SCIP-INF-4 Cardiac surgery patients with controlled postoperative blood glucose (removed completely)

CMS will require hospitals to report electronically (using their EHRs) on 4 of 28 eCQMs as part of the continued effort to foster alignment with MU and to encourage the transition towards full electronic reporting.

The rule requires hospitals to begin submitting data electronically in CY 2016 (affecting payment in FY 2018).

CMS finalized its proposal to add 7 new measures. Those affecting payment in FY 2018 include:

- Hospital Survey on Patient Safety Culture
- Elective tha/tka 90-day episode of care
- Excess acute care days after AMI and HF Hospitalization

New measures effecting FY 2019 payment include:

- Kidney/UTI episode of care payment
- Cellulitis episode of care
- Gastrointestinal hemorrhage episode of care

CMS finalized changes as proposed to domain scoring and weights for the Hospital Acquired Condition Reduction (HACR) Program.

The proposal to include data on CAUTIs and CLABSIs outside of the ICU (including medical, surgical and med-surg wards) in penalty calculations was also finalized and will affect the HACR program in FY 2018 and the HVBP in FY 2019.

CMS finalized its proposal to modify the pneumonia measure in a way that would expand the patient population to include patients with a principal discharge diagnosis of aspiration pneumonia and patients with a principal discharge diagnosis of sepsis (excluding severe sepsis) who also have a secondary diagnosis of pneumonia that is coded as present on admission. This change will affect the HAC, Inpatient Quality Reporting and Readmissions Reduction programs for FY 2017 payment calculations.

CMS will remove two measures from the HVBP program for fiscal year 2018: IMM-2 flu vaccination and AMI-7a Fibrinolytic Therapy within 30 minutes of arrival. CMS added two new measures for future years: a three-item care transition measure that will be based on patient responses to HCAHPS questions and will effect payment in FFY 2018 and a COPD mortality measure effecting payment in 2021.

CMS also finalized the changes to the HVBP scoring methodology and domain weights as proposed.

The rule will become effective October 1, 2015.

CMS Releases data on Hospital Value Based Purchasing and Readmissions Reduction Program Performance

In August, CMS released data on the Hospital Value Based Purchasing (HVBP) and Hospital Readmission Reduction Programs that included adjustment factors for participating hospitals under each of the programs.

Under the HRRP, hospitals are subject to a penalty of up to 3% of their base operating DRG payments for readmission rates that are higher than expected. The Readmissions Reduction factor determining the penalty is calculated using performance data from July 1, 2011-June 30, 2014 and effects payment for fiscal year 2016.

In fiscal year 2016, about 77% of hospitals nationwide received a penalty under the HRRP. Only 1% received the maximum penalty of 3%, and the average penalty was around 0.6%.

Under the HVBP, hospitals receive either a positive or negative adjustment based on their performance on a series of quality measures. The adjustment factors effecting fiscal year 2016 payments are mostly based on performance data from calendar year 2014, though the performance periods do vary by measure.

For fiscal year 2016, roughly 60% of hospitals received positive adjustments under the HVBP program but only 2% of hospitals nationwide received the maximum positive adjustment of 1.75%. The average positive adjustment for hospitals was around 0.6% and the average penalty was around 0.3%

The Government Accountability Office released an analysis of data from FY 2013-2015 in early October. Major findings of this report include:

- Safety net hospitals tended to perform more poorly with either smaller bonuses or greater penalties than others
- There doesn't seem to be a significant difference between rural hospital performance and the national average
- Small urban hospitals performed slightly better than those overall

*The data is from tables included in the FY 2016 IPPS Final Rule and Correction Notice.

CMS Proposes Rule for Discharge Planning

On October 29th CMS issued a proposed rule that would revise discharge planning requirements for all hospital inpatients, observation patients, same-day surgery patients that have received anesthesia and some ED patients for which a plan is deemed necessary by the treating physician. The rule would require that hospitals develop policies around discharge planning for patients that would be included in the above listed categories as well as those receiving outpatient services for which a discharge plan has been deemed necessary by the medical staff. These policies must also be approved by members of the hospital's Board.

If the rule is finalized as proposed, CMS will require that the discharge planning process be patient-centered and patient-driven and that the agreed upon plan focuses on the patient's goals and preferences as developed through interactions with their provider. Caregivers should be active partners in the discharge planning process as well.

Provisions in the proposed rule require that the patient's post-discharge needs are identified within 24 hours of admission and regularly reevaluated and modified as appropriate.

The rule would require that practitioners are an active part of the discharge planning process with specific emphasis on the role they will need to play in establishing patient goals and treatment preferences. In every discharge plan the patient's diagnosis, co-morbidities, ongoing care needs and readmission risk must be considered and accounted for.

Tenants of the IMPACT Act that could be included as part of this rule would require that providers assist families in selecting where or from whom they would like to receive their post-acute care by sharing relevant quality-related data such as that found on Nursing Home Compare. For patients discharged to home, plans will need to include care instructions for the caregiver, warning-signs that indicate medical attention is required and medication reconciliation.