MINUTES – DRAFT
QUALITY IMPROVEMENT AND PATIENT SAFETY COMMITTEE
May 10, 2017

Quality Improvement & Patient Safety Committee
John Ostuni, Chair, MD, Chair, *Westbury*
Evelyn Dooley Seidman, MD, Vice-Chair, *Westbury*
Clare Bradley, *Westbury*
Mustafa Kaakour, MD, *via telephone*
Roy Korn, MD, *via telephone*
Greg Pinto, MD, *via Web*
Barry Rabin, MD, *via telephone*
Gregory Threatte, MD, *via telephone*
Willie Underwood, MD, *via telephone*

MSSNY Staff:
Moe Auster, Esq., MSSNY Staff, Division of Governmental Affairs
Pat Clancy, MSSNY Staff, Division of Governmental Affairs
Anna Cioffi, MSSNY Staff, Division of Government Affairs

Welcome and Approval of Minutes:
The meeting was convened. The minutes of May 10, 2017, were unanimously approved without modification. The new committee members were welcomed by Dr. Ostuni, MD.

Medicare Review Policy presentation:
Kevin Krawiecki, Vice-President for Fiscal Policy and Melanie Graham, Director, Federal Fiscal Policy presented on behalf of HANYS. Moe said that we asked Kevin and Melanie to participate because they had been helpful to us previously. In 2016, we had a resolution that went to the MSSNY House of Delegates dealing with Medicare observation policy and the two-midnight rule. Recognizing that the hospitals have a substantial interest in this, Kevin and Melanie came up with some suggestions about how the resolution could be drafted so that we could have a shared goal. Ultimately, the resolution went to the AMA and became policy.

Melanie Graham Presented on the Two-Midnight Rule:
There is a new policy that was effective as of October 1, 2013 or federal fiscal year 2014. The main reason behind the implementation of the two-midnight rule was HANYS and the industry were suggesting to CMS and Congress that clear guidance was needed due to the fact that the Recovery Audit Contractors (RAC) had been hammering folks with the RAC denials for patient status reviews or short inpatient stays. Because New York was one of the first states for the demonstration of the RACôs, NewYork hospitals have been hit hard with this for many years. This two-midnight policy is based on a physicianôs expectation that if a patient required an inpatient hospital admission that was at least two-midnights, it would be deemed that would be deemed appropriate for a payment under the inpatient PPS. There were also some exceptions to that rule, such as unforeseen circumstances such as death, discharge of medical advice, transfers to another hospital and some other issues.

There was still a need for more clarity and one of the problems was that CMS didnôt address the issue of those short stays that were less than two-midnight that were also appropriate inpatient admission. We continued our advocacy over the years and in 2016 CMS made some modifications to the two-midnight rule and will also allow less than two-midnights would be payable under IPPS, but they would be payable on a case-by-case basis based on a physician judgment that considers severity of signs and symptoms, risk of adverse events and some other things. While the two-night benchmark ï the expectation that a physician expects that patient to require two-midnights or more for inpatient payment ï CMS will include outpatient time toward the two-midnight benchmark, however, that time does not count as inpatient care for skilled nursing facilities (SNF) eligibility. Under the new modification for less than two-midnights, those cases would not count towards a three day stay requirement for SNF eligibility. It is important to note that, while outpatient time can count toward the two-midnight benchmark, it does not go towards the three day SNF rule.

The RACôs were doing all of these patient status reviews and there was tons of denials. It had caused a backlog at the ALJ level for years that they still canôt seem to resolve. They were the front line reviewers for these patient status reviews for many years. In 2015 CMS changed the rules and put the QIOôs (Quality Improvement Organization) as the front line reviewers, and Livanta is our QIO in New York State. RACôs are paid incentives and the QIOôs are not. They have no incentives to deny claims and there is a huge reduction in the number of claims they would be reviewing. RACôs were reviewing for some hospitals up to 200 to 400 medical records in 45 days. The QIOôs will only look at 25 claims for large hospitals and 10 for anything less. It is significantly less that what folks have been used to in the past and they are only reviewing less than two-midnight post payment claims and they determine that based on the admission date to the discharge date if itôs less than two days and that is how they pick their samples and send information out. They will only do this two times in a year, so itôs every six months they will perform a round of these reviews and they will provide education

Livanta has been working on this since October 1, 2015, however, there were some delays in the process because of CMS. They are only in their second round of the reviews. RACôs are not doing any of these patient status reviews anymore unless they are referred to by the QIO. When the QIOôs have done education and determine that there are still high denial rates, then they can refer these cases to the RACôs. At this time CMS has not provided any instructions to the RAC and the QIO in exactly what those criteria will consist of.

Melanie referred to the three-day SNF rule and it did not basically apply to that. While at this time the industry has asked for changes to this policy for years and there is currently no change to the three-day SNF rule. As the current Medicare rules state, a beneficiary is eligible for inpatient SNF care only when a patient has been admitted to a hospital as inpatient for three consecutive days and that does not include observation or care in the emergency department.

Melanie then discussed some of the Medicare bundled payment models. There is a voluntarily bundled payment model called the Bundled Payment for Care Improvement (BPCI) and thatôs a voluntary model. They also implemented two mandatory bundled payment models that would hold hospitals in certain geographic areas financially responsible for 90-day episodes of care. The first one is the Comprehensive Joint Replacement (CJR) and thatôs will test bundled payments for hip and knee replacements while the Episode Payment Model (EPM) thatós the most recent one and will test episodes of care for AMI, CABG and it also extends the CJR hip and femur fracture treatment.

There is a piece of legislation that was introduced in March called ñImproving Access in Medicare Coverage for 2017.ò The House and the Senate both introduced identical bills that would allow patients under observation to be deemed as inpatient for purposes of meeting that three-day inpatient stay for SNF eligibility under Medicare. This does not repeal the three-day inpatient stay requirement but it expands the definition of inpatient for this purpose. The language says that this act simply restores the original objective of the three-day rule which was to insure Medicare coverage of SNF stays following hospital care for a three-day stay. What is noted in this bill is that research has concluded that outpatient observation status has increased substantially over patient admissions. That is very reasonable because we have seen similar trends especially with the implementation of two-midnight policy and all the RAC reviews in New York because folks that were submitting everything as an inpatient admission have changed their practices due to education and denials they received from the RACôs and MACôs and the two-midnight policy.

Melanie also wanted to make the committee aware of the Medicare Outpatient Observation Notice (MOON). This is a requirement under the notice act that all hospitals and COGôs have to provide in an oral notification to beneficiaries within 36 hours after receiving observation services which was effective on March 8, 2017. Hospitals are required to use the MOON for all Medicare beneficiaries that receive outpatient observation services for more than 24 hours. In New York State we have an observation law as well. HANYS has some issues with the MOON because it basically is inconsistent with the language in the notice act. HANYS and the AHA will continue to push CMS toward toward some sort of pre-populated text boxes. Kevin, sharing physicians concerns, that HANYS is very optimistic to see the three-day SNF waiver in the various bundling programs to the extent that they continue under the current administration.

Report on the Long Term Care Subcommittee:
The following items were discussed at the earlier Subcommittee meeting:

1. A resolution was adopted by the HOD concerning the face-to-face requirement for the provision of home care services. The resolution specifies that it should be simplified and is going on to the AMA for consideration and hopefully we will have a national platform on that.

2. VA-MSSNY collaboration which started about two to three years ago and it has been effective thanks to MSSNY staff. We have a great educational program. Three webinars have been presented ï Post Traumatic Stress Disorder and Traumatic Brain Injury (PTSD), Suicide and Substance Use. Another interesting program as part of the collaboration operation is the Dwyer Peer-to-Peer Program ï it is a vet to vet connection program and one of the key leaders in this program is Dr. Frank Dowling and we will have a presentation at our next meeting.
3. Quality and Safety in Nursing Homes.

The subcommittee talked about settling priorities for the coming year. The VA-MSSNY collaboration will be continued. The second is the continuation of our Home Care Task Force dealing with home care issues. A number were issues were identified during the multiple meetings of the task force that were not addressed. Only the face-to-face issue went into a resolution.

Report on the Pain Management Palliative Care and Addiction Course at the HOD
Pat said that she has sent out the evaluation from the HOD. We had 132 attendees, 129 of them were physicians, 3 non-physicians. Pat referred to the chart entitled ñBased on your participation today, have you identified any barriers to implementation of the strategies and skills taught?ò Twenty-eight percent of those responding are unlikely to prescribe controlled substances; 16% said it takes too much time; 10% financial burden to their practice, 9% inadequate training and 13% said there was other health issues and there were those who chose not to answer the question and everybody knows that there is a statutory requirement for three hours of pain management, palliative care and addiction and we brought this program under the Quality Committee to the HOD.

Dr. Underwood asked if there was any way we could take this data from the evaluation and use it in a short article. Pat responded that could be done but said that at this point in time there are a lot of different components of our program that have been evaluated and this is one segment of our program on pain management and palliative care and addiction. We have had over 3,000 physicians and other health care providers who have taken our webinar series in March. Weôve completed evaluations of that. Since we launched our online program, as of April 4th we have over 4,000 health care providers, the majority of which are physicians who have taken the online course. We are more focused in getting physicians up to speed and in compliance with this state requirement and during the summer months we will go back and compile from all the webinars and seminars and the online program we have done and put out information on this comprehensive program weôve done. This is a possibility because we do have to compile cumulative report for CME credits but at this point in time we are very focused on making sure that everyone is in compliance and attesting to the DOH by July 1, 2017. Pat said that the planning committee is guiding our educational program. This has been under discussion with them but they have indicated that we have to wait until July 1 before all the data is collected.

Priorities Set:
Dr. Ostuni said that Dr. Rothberg mandated setting up three priorities for our committee going forward. One of our priorities is to look into the Medicaid program and to see what the changes in the health care system are going to mean to the population it serves, the medical education which it pays a big price for and for our safety in that hospital. Practice transformation itôs going to deal with value-based payments, and we are going to deal with MIPS, we are going is related to what weôve discussed and is something we should keep as one of our priorities. Dr. Ostuni said that it will be practice transformation and itôs going to deal with value-based payments, DSRIP, Medicare and MACRA.

Dr. Dooley said that the Medicare changes in the Medicare program are also rather large and although it is true the Affordable Care Act (ACA) may be repealed or changed, the MACRA program with MIPS and APMôs likely will not change. Another title they use is the Quality Payment Program which started in January of 2017. CMS has a

new way of evaluating clinicians who provide care to Medicare beneficiaries, itôs not that you are going to see a patient and get reimbursed.

Our second priority should be the MOC program. This could possibly be a topic for our course in 2018. We have to keep up-to-date on that because it is changing. They are trying to make it more functional and they are doing that.

Our third priority should be long term care insurance. There was a task force under President Obama that gave its initial report in November 2016 but did not come to a conclusion. There was an addendum about three months later where they actually came to the same conclusion that we did two years ago recommending a new task force. We have to continue to discuss long term care issues. The reason he is bringing this up because nobody is talking about long term health care. Dr. Ostuni recommended that we get the materials out to our members.

New Business:
Dr. Ostuni would like to have a presentation on the antibiotic stewardship program. There are only two things since these changes have been made as far as seeing inappropriate admissions. The two forms that helped is the MOLST form and the antibiotic stewardship program. It has been effective and how doctors have accepted with less turmoil.

Dr.Ostuni said that a Subcommittee of Telemedicine is going to be formed and it will be under the HIT Committee. What he would like is that if anyone wants to be on the Telemedicine Committee, please let us know.

Old Business: None

Next Meeting and Adjournment: The Committee will meet again on September 27, 2017 from 1:00 PM to 3:00 PM for the next meeting. Meeting was adjourned.