Medicare Rural Hospital Flexibility (FLEX) Program Update

Federal Office Of Rural Health Policy

April 12th 2016
Agenda

• Flex Overview
• FORHP Overview
• Flex Technical Assistance and Evaluation Partners
• MBQIP Updates: OP-4, 18, IMM-2
• MBQIP Resources
• Questions
Flex Overview

• In 1997 the Medicare Rural Hospital Flexibility Program (Flex) was authorized by Congress under Section 1820 of the Social Security Act (42 U.S.C. 1395i–4).
  – In response to the rapid increase of rural hospital closures
  – Established Critical Access Hospitals (CAHs) designation/criteria;
  – Established the Flex grant program

• Created the Flex program to engage state designated entities in activities relating to:
  – planning and implementing rural health care plans and networks;
  – designating facilities as Critical Access Hospitals (CAHs);
  – providing support for CAHs for quality improvement, quality reporting, performance improvements, and benchmarking; and integrating rural emergency medical services (EMS).
Flex Overview

• Today, Flex is composed of five (5) Program Areas:
  – Quality Improvement
    • Medicare Beneficiary Quality Improvement Program MBQIP (MBQIP)
  – Financial and Operational Improvement
  – Population Health Management and EMS Integration (optional)
  – CAH Designation (optional)
  – Integration of Innovative Models (optional)
The Home of the Hospital State Division

Federal Office Rural Health Policy (FORHP)

Hospital State Division (HSD)

Policy Research Division (PRD)

Community Based Division (CBD)

Office for the Advancement of Telehealth (OAT)
The Home of Flex, SHIP and SORH!
HSD Grants by the Numbers

State Offices of Rural Health
- 50 States
- $170K federal - 3:1 match

Small Hospital Improvement Program
- 47 States
- ~1600 small rural hospitals/$9000 per hospital
- $~15million

Flex Program
- 45 states
- ~1334 CAHs,
- $22 million

Other resources, grants
- RQITA; TASC; FMT
- NOSORH
- CBD Grants
- OAT Grants
The Big Picture of Flex

Flex Grants
- 45 States
- ~1332 CAHs
- $22 Million
- Four FORHP Project Officers

Flex Partners
- Technical Assistance and Services Center
- Rural Quality Improvement Technical Assistance
- Flex Monitoring Team

Evaluation & Data
- Work Plan Data
- Financial Data
- Quality Data
- PIMS Data

Location of Critical Access Hospitals
Information Gathered Through December 16, 2015
The Flex Team!

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To Be Determined
Flex TA and Evaluation Partners

- FMT
- Flex
- RQITA
- TASC
Flex Technical Assistance (TA) Partners

• Technical Assistance and Services Center (TASC)
  – Develop webinars, workshops, resource guides, subject matter experts to support Flex grantees and CAHs improvement efforts across the 5 Flex grant program areas.

• Rural Quality Improvement TA (RQITA)
  – Assist Flex grantees with CAH challenges around data reporting and improvement through newsletters, toolkits, one-one consultations, and other resources.
Flex Evaluation and Research

• Flex Monitoring Team (FMT)
  – is a consortium of the Rural Health Research Centers at the Universities of Minnesota, North Carolina-Chapel Hill, and Southern Maine, funded by the Federal Office of Rural Health Policy to evaluate the impact of the Medicare Rural Hospital Flexibility Grant Program (the Flex Program).
  – FMT synthesizes work plan, CAH quality and financial data
  – FMT creates policy briefs and other reports as informed by data elements
  – CAHMPAS
Flex Supporting Partners

- NOSORH
- FMT
- NRHA
- RQITA
- Flex
- TASC
- RHI-hub
Pulling it All Together
Flex participation: MBQIP Criteria Overview

• MBQIP Goal: 100% CAH reporting on ALL MBQIP core measures

• Current Status:
  – 98% of CAHs have signed MOUs with FORHP
  – 96% of CAHs are reporting data for at least one quarter in at least one domain between 2nd Quarter 2014 – 2nd Quarter 2015 (props to you all!)
MBQIP Criteria Overview (cont.)

- Phased approach to give flexibility to CAHs to report on all MBQIP core measures
- Criteria for Eligibility for Flex funds and participation in Flex-funded activities
  - FY 2015 (September 2015 – August 2016): Capacity building
  - FY 2016 (September 2016 – August 2017):
    - (1) a signed Memorandum of Understanding with FORHP
    - (2) submitted data on MBQIP measures for at least one quarter for at least one measure in at least one of the four quality domains within a certain reporting period
  - FY 2017 (September 2017 – August 2018): more details will be provided in September 2016
Criteria: Reporting Period

- Patient Engagement (HCAHPS): 2Q14 - 2Q15
- Care Transitions (EDTC): 2Q14 – 4Q15
- Outpatient (OP-1, 2, 3, and 5): 2Q14 – 2Q15
  - OP- 4, 18, 20, 21, and 22 - these measures do not apply for this year’s eligibility requirements
- Patient Safety
  - Inpatient (HF-1, 2, 3 and PN-3b, 6): 2Q14 – 2Q15. These measures are included in this year’s eligibility requirements (Sept 2016 – Aug 2017), but will be excluded in next year’s eligibility requirements since CMS retired these inpatient measures
  - OP-27 and Imm-2 – these two measures do not apply for this year’s eligibility requirements
Criteria: Exceptions to waive penalty for CAHs not eligible for Flex funds

- Hospitals that have been building capacity/assessing readiness for MBQIP for the past year and are preparing to start submitting data in September 2016

- Hospitals that signed the Memorandum of Understanding between September 2015 thru August 2016 and is building capacity

- Hospitals who just received CAH designation

- Hospitals with extenuating circumstances

Questions on any exceptions not outlined above should be directed to your FORHP Project Officer
Two Additional MBQIP Required Outpatient Measures

• Due to CART technical issues, OP-4 and OP-18 will be required MBQIP measures

• Flex programs/CAHs will not be penalized from participating in Flex if data for these two metrics is not reported between September 2016 – August 2017

• September 2016 – August 2017: Capacity building for these two outpatient measures

• September 2017: CAHs will be required to report on these two measures
Situation

• Some hospitals have had their cases for the AMI (OP 1-5) and ED Throughput (OP-18, 20, 22*) rejected from the data warehouse because OP-4 and OP-18 data elements were not part of the submission process

• Occurs when CAHs change their measure preferences in CART to only collect certain measures in a measure set
Assessment

• FORHP is not certain how many CAHs have changed their measure preferences in CART
• Requiring submission of OP-4 and OP-18 will have a limited impact on CAH data collection burden
  – Additional data elements needed to submit OP-4 and OP-18
    • OP-4: Aspirin on Arrival and Reason for no aspirin on arrival
    • OP-18: ED departure date and ED departure time
  – No additional cases need to be abstracted
• Cases for measures OP-1, 2, 3, 5, and 20 will be rejected from the data warehouse if OP-4 and OP-18 are not included. Hospitals not submitting on required MBQIP core measures will be on the non-submission list and possibly deemed not eligible to receive Flex funds or participate in Flex-funded activities.
FORHP Recommendations

• Flex Coordinators:
  – Add these two measures to non-competing continuation application workplan
  – Update documentation and any lists of required MBQIP measures to include OP-4 and OP-18
  – Inform CAHs of the inclusion of these two additional measures in the required MBQIP measure set

• CAHs are highly encouraged to NOT adjust the measure setting preferences on CART after downloading the updated version of the tool prior to abstracting any cases
  – Updated CART version for Q4 2015 is anticipated in April 2016
  – Next CMS Outpatient data submission deadline (Q4 2015 discharges) is June 1, 2016

• CAHs using vendor tools: We are not aware of instances where CAHs using a vendor tool have had cases rejected from QualityNet warehouse for this reason

• TASC and RQITA are updating all documents relevant to these changes
Situation: Immunization 2 Update

• For CAHs choosing to report IMM-2 for Q4 2015: some CAHs are at risk of having their IMM-2 cases rejected from QualityNet
• Due to QualityNet requirements to submit complete measure sets (IMM-1 and IMM-2)
• In Q1 of 2015, CMS changed the status of IMM-1 measure to make it optional. It will no longer be available for data collection starting in Q1 2016
Assessment: Two Options

• If CAHs do NOT change CART measure preferences, CAHs must collect the IMM-1 data element for Q4 2015, in order for their cases to be accepted (one additional data element)
  – For CAHs that have already unselected this measure in their CART measure preferences, they would need to go in and select that they want to collect on the IMM-1 measure.
  – Additional data element = IMM-2 = pneumococcal vaccination status

• If a CAH changes CART measure preferences to exclude IMM-1, CAHs only need to collect data elements on IMM-2 to get their cases accepted.
  – PRIOR to ANY DATA SUBMISSION, they must go into the QualityNet Secure Portal and ‘unselect’ the IMM-1 measure in their measure designation. This MUST be done prior to any data submission to QualityNet. Once data has been submitted this cannot be changed.
MBQIP Questions

• If you have questions/comments related to the measure submission process, please reach out to TASC@ruralcenter.org

• If you have questions/comments related to this policy change, please reach out to MBQIP@hrsa.gov
Flex Must Have Resources

- MBQIP Measures Matrix: [https://www.ruralcenter.org/tasc/resources/mbqip-measures-matrix](https://www.ruralcenter.org/tasc/resources/mbqip-measures-matrix)
  - MBQIP, MU, P4P/HEN and QIN-QIO priorities
- MBQIP Fact Sheets: [https://www.ruralcenter.org/tasc/resources/mbqip-measures-fact-sheets](https://www.ruralcenter.org/tasc/resources/mbqip-measures-fact-sheets)
- Flex Related Data Reports and Portals
  - TASC Population Health Portal
  - FMT CAHMPAS – just released
- [https://www.ruralhealthinfo.org/](https://www.ruralhealthinfo.org/)
The FORHP Flex Team extends a big Thanks!

Questions?