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• Click **F5**

![Refresh icon and F5 key](image)

Location of Buttons

![Location of buttons](image)

F5 Key
Top row of Keyboard

5/9/2016
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• Echo is caused by multiple browsers/tabs open to a single event – multiple audio feeds.
• Close all but one browser/tab and the echo will clear up.

Example of Two Browsers Tabs open in Same Event
Submitting Questions

Type questions in the “Chat with Presenter” section, located in the bottom-left corner of your screen.

Welcome to Today’s Event

Thank you for joining us today! Our event will start shortly.
FY 2017 Inpatient Prospective Payment System (IPPS) Proposed Rule

Short-Term Acute Care Hospital Quality Reporting Programs Overview

Grace H. Im, JD, MPH
Program Lead, Hospital Inpatient Quality Reporting Program and Hospital Value-Based Purchasing Program
Quality Measurement and Value-Based Incentives Group, Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services

Delia L. Houseal, PhD, MPH
Program Lead, Hospital-Acquired Condition Reduction Program and Hospital Readmissions Reduction Program
Quality Measurement and Value-Based Incentives Group, Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services

May, 9, 2016
Purpose

This presentation will provide participants with the Fiscal Year (FY) 2017 Inpatient Prospective Payment System (IPPS) hospital quality program proposals, as well as an overview of how to log comments to become a matter of record and receive response in the Final Rule. It will also address the Proposed Rule’s impact on the following programs:

- Hospital Inpatient Quality Reporting Program
- Hospital Value-Based Purchasing Program
- Hospital-Acquired Condition Reduction Program
- Hospital Readmissions Reduction Program

Please Note: The Centers for Medicare & Medicaid Services (CMS) cannot respond to comments or answer questions related to the Proposed Rule during this webcast.
Objectives

Participants will be able to:

• Locate the FY 2017 IPPS Proposed Rule text
• Identify proposed changes within the FY 2017 IPPS Proposed Rule
• Learn the time period for comments on the FY 2017 IPPS Proposed Rule
• Submit formal comments to CMS, in a public forum, regarding the FY 2017 IPPS Proposed Rule
HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

GRACE H. IM, JD, MPH
Proposed Removal of Measures in the Hospital IQR Program

CMS is proposing to remove 15 measures for the FY 2019 payment determination and subsequent years.
Proposed Removal of Chart-Abstracted Measures in the Hospital IQR Program

<table>
<thead>
<tr>
<th>Measure</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>STK-4: Thrombolytic Therapy</td>
<td>Topped-Out</td>
</tr>
<tr>
<td>VTE-5: VTE Discharge Instructions</td>
<td>Topped-Out</td>
</tr>
</tbody>
</table>
Proposed Removal of Structural Measures for the Hospital IQR Program

<table>
<thead>
<tr>
<th>Measure</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care</td>
<td>Performance does not result in better patient outcomes</td>
</tr>
<tr>
<td>Participation in a Systematic Clinical Database Registry for General Surgery</td>
<td>Performance does not result in better patient outcomes</td>
</tr>
</tbody>
</table>
## Proposed Removal of eCQM Measures for the Hospital IQR Program

<table>
<thead>
<tr>
<th>Measure</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI-2: Aspirin Prescribed at Discharge for AMI</td>
<td>Topped-out</td>
</tr>
<tr>
<td>AMI-7a: Fibrinolytic Therapy Received Within 30 minutes of Hospital Arrival</td>
<td>Performance or improvement does not result in better patient outcomes</td>
</tr>
<tr>
<td>AMI-10: Statin Prescribed at Discharge</td>
<td>Topped-out</td>
</tr>
<tr>
<td>HTN: Healthy Term Newborn</td>
<td>No longer feasible to implement the measure specifications</td>
</tr>
<tr>
<td>PN-6: Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients</td>
<td>No longer feasible to implement the measure specifications</td>
</tr>
<tr>
<td>SCIP-Inf-1a: Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision</td>
<td>Topped-out</td>
</tr>
<tr>
<td>SCIP-Inf-2a: Prophylactic Antibiotic Selection for Surgical Patients</td>
<td>Topped-out</td>
</tr>
</tbody>
</table>
Proposed Removal of eCQM Measures for the Hospital IQR Program

<table>
<thead>
<tr>
<th>Measure</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCIP-Inf-9: Urinary Catheter Removed on Postoperative Day 1 or Postoperative Day 2 with Day of Surgery Being Day Zero</td>
<td>No longer feasible to implement the measure specifications</td>
</tr>
<tr>
<td>*STK-4: Thrombolytic Therapy</td>
<td>Topped-out</td>
</tr>
<tr>
<td>VTE-3: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy</td>
<td>No longer feasible to implement the measure specifications</td>
</tr>
<tr>
<td>VTE-4: Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol (or Nomogram)</td>
<td>No longer feasible to implement the measure specifications</td>
</tr>
<tr>
<td>*VTE-5: Venous Thromboembolism Discharge Instructions</td>
<td>No longer feasible to implement the measure specifications</td>
</tr>
<tr>
<td>VTE-6: Incidence of Potentially Preventable Venous Thromboembolism</td>
<td>No longer feasible to implement the measure specifications</td>
</tr>
</tbody>
</table>

*Chart-abstracted version of the measure also proposed for removal.*
Proposed Refinements to Existing Measures

Refinements are proposed for the following measures:

- PN Payment: Hospital-Level, Risk-Standardized 30-Day Episode-of-Care Payment Measure for Pneumonia
- PSI 90: Patient Safety and Adverse Events Composite
PN Payment Measure

PN Payment Measure refinements would:

• Include expansion to include hospitalization for patients with a principal diagnosis of:
  ▪ Aspiration pneumonia
  ▪ Sepsis or respiratory failure who also have a secondary diagnosis of pneumonia present on admission

• Be effective for FY 2018 payment determination and subsequent years

• Aligns with the measure cohorts for PN Mortality and PN Readmission measures finalized in last year’s rule.
PSI 90 Measure

• Name changed to “Patient Safety and Adverse Events Composite”
• Addition of three indicators:
  - PSI 09 Perioperative Hemorrhage or Hematoma Rate
  - PSI 10 Physiologic and Metabolic Derangement Rate
  - PSI 11 Postoperative Respiratory Failure Rate
• Re-specification of two indicators:
  - PSI 12, Perioperative Pulmonary Edema or Deep Vein Thrombosis Rate
  - PSI 15, Accidental Puncture or Laceration Rate, have been re-specified
• Removal of PSI 07 Central Venous Catheter-Related Blood Stream Infection Rate
• Re-weighting of component indicators in the modified PSI 90 measure is based not only on the volume of each of the patient safety and adverse events, but also the harms associated with the events.
CMS is proposing to modify the reporting periods for FYs 2018 and 2019 payment determinations and subsequent years.

- **FY 2018**
  - Would only use ICD-9 data

- **FY 2019**
  - 21-month reporting period spanning October 1, 2015–June 30, 2017
  - Would only use ICD-10 data
New Hospital IQR Program Measures for FY 2019

CMS is proposing to add four new claims-based measures to the Hospital IQR Program for the FY 2019 payment determination and subsequent years, including:

• Three clinical episode-based payment measures
  ▪ Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure
  ▪ Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure
  ▪ Spinal Fusion Clinical Episode-Based Payment Measure

• One outcome measure
  ▪ Excess Days in Acute Care after Hospitalization for Pneumonia
Proposals for IQR Program

eCQM Reporting

• Hospitals would be required to report on all 15 available eCQMs (if proposal to remove 13 eCQMs is finalized), beginning with CY 2017 reporting for the FY 2019 payment determination and subsequent years.

• All QRDA–I files would need to be electronically submitted through the QualityNet Secure Portal.

• QRDA-I files would need to be submitted on an annual basis for one full calendar year of data.

• The submission deadline would be end of two months following close of the reporting calendar year (e.g., CY 2017 eCQM submission deadline is February 28, 2018).
Proposed eCQM Certification Policies for the IQR Program

• For the CY 2017 reporting period/FY 2019 payment determination only:
  ▪ Hospitals must report using either the 2014 or 2015 Edition of CEHRT.

• For the CY 2017 reporting period/FY 2019 payment determination and subsequent years:
  ▪ Hospitals must submit eCQM data via QRDA I files.
  ▪ Hospitals may continue to use a third party to submit QRDA I files on their behalf.
  ▪ Hospitals may continue to either use abstraction or pull the data from non-certified sources in order to then input these data into CEHRT for capture and reporting QRDA I files.

• Beginning with the CY 2018 reporting period/FY 2020 payment determination and subsequent years:
  ▪ Hospitals must report using the 2015 Edition of CEHRT.
### Proposed CQM Measures for Electronic Reporting to the Hospital IQR and EHR Incentive Programs

<table>
<thead>
<tr>
<th></th>
<th>ED-1</th>
<th>STK-2</th>
<th>STK-6</th>
<th>AMI – 8a</th>
<th>PC-01</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED-2</td>
<td></td>
<td>STK-3</td>
<td>STK-8</td>
<td>VTE-1</td>
<td>PC-05</td>
</tr>
<tr>
<td>ED- 3*</td>
<td></td>
<td>STK-5</td>
<td>STK-10</td>
<td>VTE-2</td>
<td>CAC-3</td>
</tr>
<tr>
<td>EHDI-1a</td>
<td></td>
<td>*ED- 3 is an Outpatient Measure and not applicable for IQR.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Proposed Modifications For Validation of Hospital IQR Program Data

Modifications proposed for FY 2020 payment determination:

• Continue to include up to 600 hospitals for chart-abstracted validation

• Include up to 200 additional hospitals for eCQM validation

• Require submission of timely and complete medical record information from the Electronic Health Record (EHR) for at least 75 percent of sampled records
  ▪ Would not be scored on the basis of measure accuracy
eCQM Validation: 
Number and Selection of Hospitals

• eCQM validation would begin Spring 2018 for FY 2020 payment determinations

• Up to 200 hospitals would be selected for eCQM validation via random sample. The following hospitals would be excluded:
  ▪ Any hospital selected for chart-abstracted measure validation
  ▪ Any hospital that has been granted a Hospital IQR Program “Extraordinary Circumstances Exemption” for the applicable eCQM reporting period
CMS is proposing that:

- 32 cases (individual patient-level reports) be randomly selected from the Quality Reporting Data Architecture (QRDA) I file submitted per hospital selected for validation.
- Each selected hospital would submit the randomly selected cases to the Clinical Data Warehouse within 30 days of the medical records request date.
eCQM Validation: Submission Requirements

• CMS is proposing to require sufficient patient level information necessary to match the requested medical record to the original submitted eCQM measure data

• Sufficient patient level information is defined as the entire medical record that sufficiently documents the eCQM measure data elements, including but not limited to:
  - Arrival date and time
  - Inpatient admission date
  - Discharge date from inpatient episode of care
The accuracy of eCQM data (the extent to which data abstracted for validation matches the data submitted in the QRDA I files) submitted for validation would not affect a hospital’s validation score for the FY 2020 payment determination.

**Note:** This is would be for FY 2020 payment determination only.

Selected hospitals must submit at least 75 percent of sampled eCQM measure medical records within 30 days of the date listed on the CDAC medical records request, or would be subject to payment reduction.
Extraordinary Circumstances Extensions or Exemptions (ECE) Policy

CMS is proposing to update the ECE policy by:

• Extending the request deadline for non-eCQM circumstances from 30 to 90 calendar days following an extraordinary circumstance
  ▪ Deadline for ECE requests would apply for extraordinary circumstance events that occur on or after October 1, 2016

• Establishing a separate submission deadline for ECE requests related to eCQM reporting circumstances to be April 1 following the end of the reporting calendar year
  ▪ Deadline for ECE requests would first apply with an April 1, 2017 deadline for the CY 2016 reporting period (through December 31, 2016) and apply for subsequent eCQM reporting years
Possible New Quality Measures and Measure Topics

CMS is seeking public comment on possible new quality measures and measure topics:

• Update of Stroke Mortality Measure by inclusion of NIH Stroke Scale data for risk adjustment
• New NHSN Antimicrobial Use Measure
• Potential measures of behavioral health
• Potential public reporting of quality measures data stratified by race, ethnicity, sex, and disability and future hospital quality measures that incorporate health equity
HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM
GRACE H. IM, JD, MPH

FY 2017 Inpatient Prospective Payment System (IPPS) Proposed Rule
Short-Term Acute Care Hospital Quality Reporting Programs Overview
FY 2017 Estimated Funds

• Under section 1886(o)(7)(C)(iv) of the Social Security Act, the applicable percent for the FY 2017 program year is 2.00 percent.

• CMS estimates that the total amount available for value-based incentive payments for FY 2017 is approximately $1.7 billion.

• CMS intends to update this estimate for the FY 2017 IPPS Final Rule, using more recent MedPAR data.
FY 2017 Tables 16, 16A, 16B

• Table 16 (Proxy Adjustment Factors)
  ▪ Based on the Total Performance Scores (TPSs) from FY 2016
  ▪ Available on CMS.gov at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Proposed-Rule-Home-Page-Items/FY2017-IPPS-Proposed-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

• Table 16A (Updated Proxy Adjustment Factors)
  ▪ CMS intends to update Table 16 as Table 16A in the IPPS Final Rule to reflect changes based on more updated MedPAR data

• Table 16B (Actual Adjustment Factors)
  ▪ After hospitals have been given an opportunity to review and correct their actual TPSs for FY 2017, CMS intends to display in October:
    o Actual value-based incentive payment adjustment factors
    o Exchange function slope
    o Estimated amount available for the FY 2017 program year
AHRQ PSI-90 FY 2018 Performance Period

- CMS is proposing to use a shortened 15-month performance period from July 1, 2014 through September 30, 2015 for the FY 2018 program year.
- ICD-10-CM/PCS implementation began on October 1, 2015.
  - The performance period as currently finalized for the FY 2018 program year would necessitate using both ICD-9 and ICD-10 claims data to calculate performance standards for the PSI 90 measure.
- CMS’ system requires an ICD-10 risk-adjusted version of the AHRQ QI PSI software by December 2016 for use in the FY 2018 payment year.
  - At this time, a risk adjusted ICD-10 version of the PSI 90 software is not expected to be available until late CY 2017.

<table>
<thead>
<tr>
<th>Proposed Policy</th>
<th>Baseline Period (No Change)</th>
<th>Performance Period</th>
</tr>
</thead>
</table>
Domains and CMS Quality Strategy

Domain Name Modification
CMS is proposing to change the Patient- and Caregiver-Centered Experience of Care/Care Coordination domain name to Person and Community Engagement, beginning with the FY 2019 program year.

Linking Hospital VBP Program Domains to CMS Quality Strategy Goals

<table>
<thead>
<tr>
<th>Hospital VBP Program Domain</th>
<th>CMS Quality Strategy Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>• Make Care Safer by Reducing Harm Caused in the Delivery of Care</td>
</tr>
<tr>
<td>Efficiency and Cost Reduction</td>
<td>• Make Care Affordable</td>
</tr>
<tr>
<td>Clinical Care</td>
<td>• Promote Effective Prevention and Treatment of Chronic Disease</td>
</tr>
<tr>
<td>Person and Community Engagement</td>
<td>• Promote Effective Communication and Coordination of Care</td>
</tr>
<tr>
<td></td>
<td>• Strengthen Persons and Their Families as Partners in Their Care</td>
</tr>
</tbody>
</table>
FY 2019 Domains and Measures

SAFETY
1. AHRQ PSI-90: Complication/patient safety for selected indicators (composite)
2. CDI: Clostridium difficile Infection
3. CAUTI: Catheter-Associated Urinary Tract Infection
4. CLABSI: Central Line-Associated Blood Stream Infection
5. MRSA: Methicillin-Resistant Staphylococcus aureus Bacteremia
6. SSI: Surgical Site Infection Colon Surgery & Abdominal Hysterectomy
7. PC-01: Elective Delivery Prior to 39 Completed Weeks Gestation

EFFICIENCY AND COST REDUCTION
1. MSPB-1: Medicare Spending per Beneficiary (MSPB)

CLINICAL CARE
1. MORT-30-AMI: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
2. MORT-30-HF: Heart Failure (HF) 30-Day Mortality Rate
3. MORT-30-PN: Pneumonia (PN) 30-Day Mortality Rate
4. THA/TKA: Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate*

Person and Community Engagement

Domain Weights
- Safety: 25%
- Clinical Care: 25%
- Efficiency and Cost Reduction: 25%
- Person and Community Engagement: 25%

An asterisk (*) indicates a newly adopted measure for the Hospital VBP Program.
## FY 2019 Baseline and Performance Periods

<table>
<thead>
<tr>
<th>Domain</th>
<th>Baseline Period</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Person and Community Engagement</strong></td>
<td>January 1–December 31, 2015</td>
<td>January 1–December 31, 2017</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• PC-01</td>
<td>January 1–December 31, 2015</td>
<td>January 1–December 31, 2017</td>
</tr>
<tr>
<td>• HAI Measures</td>
<td>January 1–December 31, 2015</td>
<td>January 1–December 31, 2017</td>
</tr>
</tbody>
</table>
## FY 2019 Minimum Data Requirements

<table>
<thead>
<tr>
<th>Domain/Measure/TPS</th>
<th>Minimum Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Person and Community Engagement Domain Score</strong></td>
<td>100 HCAHPS Surveys</td>
</tr>
<tr>
<td><strong>Efficiency and Cost Reduction Domain Score</strong></td>
<td>25 Episodes of Care in the MSPB Measure</td>
</tr>
<tr>
<td><strong>Clinical Care Domain</strong></td>
<td>Two measure scores with a minimum of 25 cases in each of the three 30-Day Morality measures and THA/TKA measure</td>
</tr>
<tr>
<td><strong>Safety Domain</strong></td>
<td>Minimum of three measure scores</td>
</tr>
<tr>
<td></td>
<td>• AHRQ PSI-90: three cases for any one underlying indicator</td>
</tr>
<tr>
<td></td>
<td>• HAI Measures: one predicted infection</td>
</tr>
<tr>
<td></td>
<td>• PC-01: 10 cases</td>
</tr>
<tr>
<td><strong>Total Performance Score</strong></td>
<td>A minimum of three of the four domains receiving domain scores</td>
</tr>
</tbody>
</table>
Central Line-Associated Bloodstream Infection (CLABS) and Catheter-Associated Urinary Tract Infection (CAUTI) Inclusion of Select Ward (non-ICU) Locations

- Proposing to include selected ward (non-ICU) locations in the CLABSI and CAUTI measures beginning with the FY 2019 program year.
- No proposed changes to the baseline or performance periods.

<table>
<thead>
<tr>
<th>Data Period</th>
<th>FY 2017 Program Year</th>
<th>FY 2018 Program Year</th>
<th>FY 2019 Program Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline Periods</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult, Pediatric,</td>
<td>Adult, Pediatric, and Neonatal ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards</td>
<td>Adult, Pediatric, and Neonatal ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards</td>
<td></td>
</tr>
<tr>
<td>Neonatal ICU locations</td>
<td>Adult and Pediatric ICU locations</td>
<td>Adult and Pediatric ICU locations</td>
<td>Adult and Pediatric ICU locations</td>
</tr>
<tr>
<td>CAUTI:</td>
<td>Adult and Pediatric ICU locations</td>
<td>Adult and Pediatric ICU locations</td>
<td>Adult and Pediatric ICU locations</td>
</tr>
<tr>
<td><strong>Performance Periods</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult, Pediatric,</td>
<td>Adult, Pediatric, and Neonatal ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards</td>
<td>Adult, Pediatric, and Neonatal ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards</td>
<td></td>
</tr>
<tr>
<td>Neonatal ICU locations</td>
<td>Adult and Pediatric ICU locations</td>
<td>Adult and Pediatric ICU locations</td>
<td>Adult and Pediatric ICU locations</td>
</tr>
<tr>
<td>CAUTI:</td>
<td>Adult and Pediatric ICU locations</td>
<td>Adult and Pediatric ICU locations</td>
<td>Adult and Pediatric ICU locations</td>
</tr>
</tbody>
</table>
FY 2021 Acute Myocardial Infarction (AMI) Payment Measure

Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for AMI

(AMI Payment) is an NQF-endorsed measure assessing hospital risk-standardized payment associated with a 30-day episode-of-care for AMI.

- **Baseline Period**: Beginning with the FY 2021 program year
- **Domain**: Would be added to the *Efficiency and Cost Reduction* domain
  - Aligns with the CMS Quality Strategy Goal of Making Care Affordable
- **Performance Standards**: Calculated based on data from the performance period not the baseline period
Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for HF (HF Payment) is an NQF-endorsed measure assessing hospital risk-standardized Medicare payment associated with a 30-day episode-of-care for heart failure.

- **Baseline Period**: Beginning with the FY 2021 program year
- **Domain**: Would be added to the *Efficiency and Cost Reduction* domain
  - Aligns with the CMS Quality Strategy Goal of Making Care Affordable
- **Performance Standards**: Calculated based on data from the performance period *not* the baseline period
FY 2021 Update to Pneumonia Mortality Measure

Hospital 30-Day, All-Cause, RSMR Following Pneumonia Hospitalization (NQF #0468) (MORT-30-PN [updated cohort])

This measure is a risk-adjusted, NQF-endorsed mortality measure monitoring mortality rates following PN hospitalizations.

- CMS is proposing to add the measure to the Clinical Care domain beginning with the FY 2021 program year
- The MORT-30-PN measure underwent a substantive revision, which expanded the measure cohort to include:
  - Patients with a principal discharge diagnosis of pneumonia (the current reported cohort)
  - Patients with a principal discharge diagnosis of aspiration pneumonia
  - Patients with a principal discharge diagnosis of sepsis (excluding severe sepsis) with a secondary diagnosis of pneumonia coded as present on admission
- The non-updated cohort version of the measure will remain in the Hospital VBP Program in fiscal years prior to FY 2021
<table>
<thead>
<tr>
<th>Domain</th>
<th>Baseline Period</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• THA/TKA</td>
<td>April 1, 2011–March 31, 2014</td>
<td>April 1, 2016–March 31, 2019</td>
</tr>
<tr>
<td>• MORT-30-PN (updated cohort)</td>
<td>July 1, 2012–June 30, 2015</td>
<td>August 1, 2017–June 30, 2019</td>
</tr>
<tr>
<td>Efficiency and Cost Reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Payment (AMI Payment and HF Payment)</td>
<td>July 1, 2012–June 30, 2015</td>
<td>July 1, 2017–June 30, 2019</td>
</tr>
<tr>
<td>• MSPB</td>
<td>January 1–December 31, 2017</td>
<td>January 1–December 31, 2019</td>
</tr>
</tbody>
</table>
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following CABG Surgery (MORT-30-CABG) measure is a risk-adjusted, NQF-endorsed mortality measure monitoring mortality rates following Coronary Artery Bypass Graft (CABG) hospitalizations.

- **Baseline Period:** Beginning with the FY 2022 program year
- **Domain:** Would be added to the *Clinical Care* domain
  - Aligns with the CMS Quality Strategy Goal of Effective Prevention and Treatment of Chronic Disease
## FY 2022 Previously Adopted and Newly Proposed Baseline and Performance Periods

<table>
<thead>
<tr>
<th>Domain</th>
<th>Baseline Period</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• THA/TKA</td>
<td>April 1, 2012–March 31, 2015</td>
<td>April 1, 2017–March 31, 2020</td>
</tr>
</tbody>
</table>
CMS is considering adopting a scoring methodology for a future program year that would assess quality measures and efficiency measures in tandem to produce a composite score reflective of value. They are seeking public comments on two general approaches to the assessment:

- Specific measures of value could be developed by measure developers and incorporated into the Hospital IQR Program and then the Hospital VBP Program through the measure development process.
- The Program’s scoring methodology could be used to incorporate value based on the performance of hospitals by either: (a) comparing scores on specific quality and cost measures; or (b) comparing quality and efficiency domain scores.
Updates to Immediate Jeopardy Exclusion

- **Volume of Citations Required for Exclusion**
  - CMS is proposing to amend regulations to change the definition of the term “Cited for deficiencies that pose immediate jeopardy” to increase the number of surveys on which a hospital must be cited for immediate jeopardy before being excluded from the Hospital VBP Program from **two to three**.
  - Because we expect that the effective date of this change will be October 1, 2016 (the first day of the FY 2017 Hospital VBP program year), only hospitals that were cited three times during the performance period that applies to the FY 2017 program year would be excluded from the Hospital VBP Program.

- **EMTALA-related Immediate Jeopardy Citations**
  - In the case of EMTALA-related immediate jeopardy citations only, CMS is proposing to change the policy regarding the date of the immediate jeopardy citation for possible exclusion from the Hospital VBP Program from the survey end date generated in ASPEN to the date of CMS’ final issuance of Form CMS-2567 to the hospital.
HOSPITAL-ACQUIRED CONDITION REDUCTION PROGRAM (HACRP)

DELIA L. HOUSEAL, PHD, MPH
Summary of Proposals

- Establish National Healthcare Safety Network (NHSN) Centers for Disease Control and Prevention (CDC) Healthcare-Associated Infection (HAI) data submission requirements for newly opened hospitals
- Clarify data requirements for Domain 1 scoring
- Adopt the modified PSI-90: Patient Safety and Adverse Events Composite measure
- Establish Domain 1 performance periods for the FY 2018 and FY 2019 Hospital-Acquired Condition (HAC) Reduction Programs
- Change the program scoring methodology from the current decile-based scoring to a continuous scoring methodology
CMS proposed the following NHSN HAI data submission requirements for newly opened hospitals:

• If a hospital files a notice of participation (NOP) with the Hospital IQR Program within six months of opening, the hospital must begin submitting data for the NHSN HAI measures no later than the first day of the quarter following the NOP.

• If a hospital does not file an NOP with the Hospital IQR Program within six months of opening, the hospital would be required to begin submitting data for the CDC NHSN HAI measures on the first day of the quarter following the end of the six-month period to file the NOP.
Requirements for Domain 1 Scoring

Hospitals with less than 12 months of PSI-90 data would not receive a Domain 1 score, regardless of the number of eligible discharges at the hospital.
Adopting the Modified PSI-90: Patient Safety and Adverse Events Composite

CMS is proposing adoption of the revised PSI-90 Composite in the FY 2017 IPPS/LTCH PPS proposed rule for the FY 2018 HACRP. The proposal includes:

• Adding the following component indicators to the composite:
  ▪ PSI-09 Perioperative hemorrhage rate
  ▪ PSI-10 Perioperative physiologic metabolic derangement rate
  ▪ PSI-11 Post-operative respiratory failure rate

• Removing the following component indicator from the composite:
  ▪ PSI-07 Central venous catheter-related blood stream infection rate
FYs 2018 and 2019 Domain 1 Performance Periods

Domain 1 Performance Period

- FY 2018: Use 15-month performance period from July 1, 2014 through September 30, 2015 for FY 2018
Revised HACRP Scoring Methodology: Decile-Based

Concerns with the current decile-based scoring methodology include:

- Ties at the penalty threshold
- Difficulty distinguishing performance among hospitals with a limited amount of data
- Situations in which hospitals with no adverse events and no Domain 2 score are eligible for penalty
Scoring Methodology: Winsorizing Z-Score

• The proposed Winsorized z-score method (z-score) uses a continuous measure score rather than grouping measure results into deciles.

\[
Z\text{-Score} = \frac{\text{(Hospital’s Measure Performance} - \text{Mean Performance for All Hospitals)}}{\text{Standard Deviation for All Hospitals}}
\]

• Poor performing hospitals earn a positive z-score, reflecting measure values above the national mean.
• Better performing hospitals earn a negative z-score, reflecting measure values below the national mean.
Scoring Methodology: Winzorizing

The Winsorized z-score method:

- Eliminates the situation in which hospitals with no adverse events and no Domain 2 score are eligible for a penalty
- Makes it easier to distinguish performance across hospitals
- Substantially reduces ties of total HAC scores
- Creates a more level playing field for hospitals with data in only one Domain
HACRP Resources

• HAC Reduction Program Methodology and General Information
  ▪ QualityNet HAC Reduction Program:
    [Link]
• HAC Reduction Program Results
  ▪ Medicare.gov Hospital Compare HAC Reduction Program:
    [Link]
  ▪ CMS.gov HAC Reduction Program: [Link]
• PSI 90 Composite
  ▪ QualityNet AHRQ Indicators:
    [Link]
• CLABSI, CAUTI, SSI, MRSA and CDI
  ▪ HAIs: [Link]
• HAC Scoring Methodology Reevaluation
  ▪ [Link]
FY 2017 Inpatient Prospective Payment System (IPPS) Proposed Rule
Short-Term Acute Care Hospital Quality Reporting Programs Overview

HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP)
DELIA L. HOUSEAL, PHD, MPH
Summary of Proposals

- Clarify public reporting timeline of the excess readmission ratios on *Hospital Compare*
  - Annual reporting following the review period
  - Alignment with other quality reporting and performance programs
- No changes to the HRRP measures
## Program Measures

<table>
<thead>
<tr>
<th>Claims-Based Readmission Measures</th>
<th>NQF Measure Number</th>
<th>FY 2018 Reporting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute myocardial infarction</td>
<td>NQF #0505</td>
<td>July 1, 2013 - June 30, 2016</td>
</tr>
<tr>
<td>Heart failure</td>
<td>NQF #0330</td>
<td>July 1, 2013 - June 30, 2016</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>NQF #0506</td>
<td>July 1, 2013 - June 30, 2016</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>NQF #1891</td>
<td>July 1, 2013 - June 30, 2016</td>
</tr>
<tr>
<td>Elective primary total hip arthroplasty and/or total knee arthroplasty</td>
<td>NQF #1551</td>
<td>July 1, 2013 - June 30, 2016</td>
</tr>
<tr>
<td>Coronary artery bypass graft surgery</td>
<td>NQF #2515</td>
<td>July 1, 2013 - June 30, 2016</td>
</tr>
</tbody>
</table>
Resources for Reducing Hospital Readmissions

General Program Information:
https://www.qualitynet.org/dcs/ContentServer?c=Page&papgename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458

HRRP General Inquiries:
qnetsupport@hcqis.org

HRRP Measure Methodology Inquiries:
cmsreadmissionmeasures@yale.edu

More Program and Payment Adjustment Information:

Readmission Measures:
https://www.qualitynet.org/dcs/ContentServer?c=Page&papgename=QnetPublic%2FPage%2FQnetTier3&cid=1219069855273

Initiatives to Reduce Readmissions:
https://www.qualitynet.org/dcs/ContentServer?c=Page&papgename=QnetPublic%2FPage%2FQnetTier4&cid=1228766331358

Details regarding various quality reporting programs can be found on the pages listed below:

- Hospital Readmissions Reduction Program pp. 25094-25098
- Hospital Value-Based Purchasing (VBP) Program pp. 25099-25117
- Hospital-Acquired Condition (HAC) Reduction Program pp. 25117-25124
- Hospital Inpatient Quality Reporting (IQR) Program pp. 25174-25205
- PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program pp. 25205-25213
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP) pp. 25213-25238
- Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program pp. 25238-25244
- Clinical Quality Measurement for Eligible Hospitals and Critical Access Hospitals (CAHs) Participating in the EHR Incentive Programs in 2017 pp. 25244-25247
Commenting on the FY 2017 IPPS/LTCH Proposed Rule

• CMS is accepting comments on the Proposed Rule until 5 p.m. ET on June 17, 2016.

• Comments can be submitted via four methods*:
  ▪ Electronically
  ▪ By regular mail
  ▪ By express or overnight mail
  ▪ By hand or courier

• CMS will respond to comments in the Final Rule scheduled to be issued by August 1, 2016.

* Note: Please review the Proposed Rule for specific instructions for each method and submit by ONLY one method.
Continuing Education Approval

This program has been approved for 1.0 continuing education (CE) unit for the following professional boards:

- Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling
- Florida Board of Nursing Home Administrators
- Florida Council of Dietetics
- Florida Board of Pharmacy
- Board of Registered Nursing (Provider #16578)
  - It is your responsibility to submit this form to your accrediting body for credit.
CE Credit Process

• Complete the ReadyTalk® survey that will pop up after the webinar, or wait for the survey that will be sent to all registrants within the next 48 hours.

• After completion of the survey, click “Done” at the bottom of the screen.

• Another page will open that asks you to register in HSAG’s Learning Management Center.
  ▪ This is a separate registration from ReadyTalk®.
  ▪ Please use your PERSONAL email so you can receive your certificate.
  ▪ Healthcare facilities have firewalls up that block our certificates.
CE Certificate Problems?

- If you do not immediately receive a response to the email that you signed up with in the Learning Management Center, you have a firewall up that is blocking the link that is sent out.

- Please go back to the **New User** link and register your personal email account.
  - Personal emails do not have firewalls.
CE Credit Process: Survey

10. What is your overall level of satisfaction with this presentation?
- [ ] Very satisfied
- [ ] Somewhat satisfied
- [ ] Neutral
- [ ] Somewhat dissatisfied
- [ ] Very dissatisfied

If you answered "very dissatisfied", please explain

11. What topics would be of interest to you for future presentations?

12. If you have questions or concerns, please feel free to leave your name and phone number or email address and we will contact you.

Done
CE Credit Process

Thank you for completing our survey!
Please click on one of the links below to obtain your certificate for your state licensure.
You must be registered with the learning management site.

New User Link:
https://mchshapps.com/register/default.aspx?ID=da0a12bc-db39-408f-b429-d6f6b9cc1ae

Existing User Link:
https://mchshapps.com/test/adduser.aspx?ID=da0a12bc-db39-408f-b429-d6f6b9cc1ae

Note: If you click the 'Done' button below, you will not have the opportunity to receive your certificate without participating in a longer survey.

Done
CE Credit Process: New User
CE Credit Process: Existing User
QUESTIONS?