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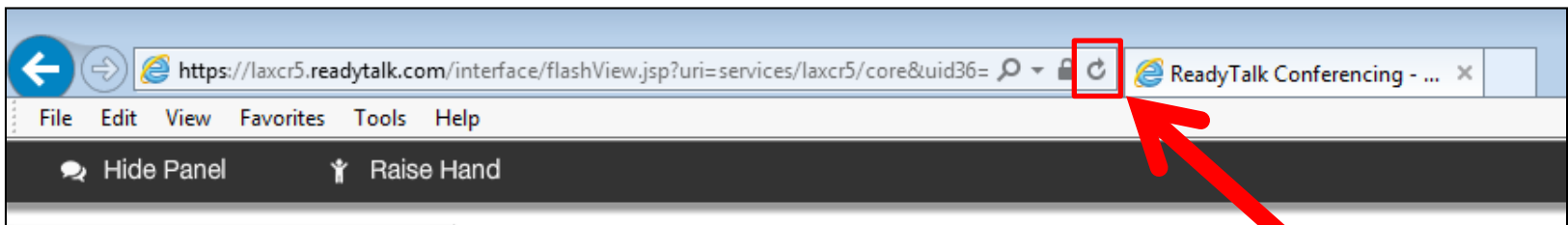


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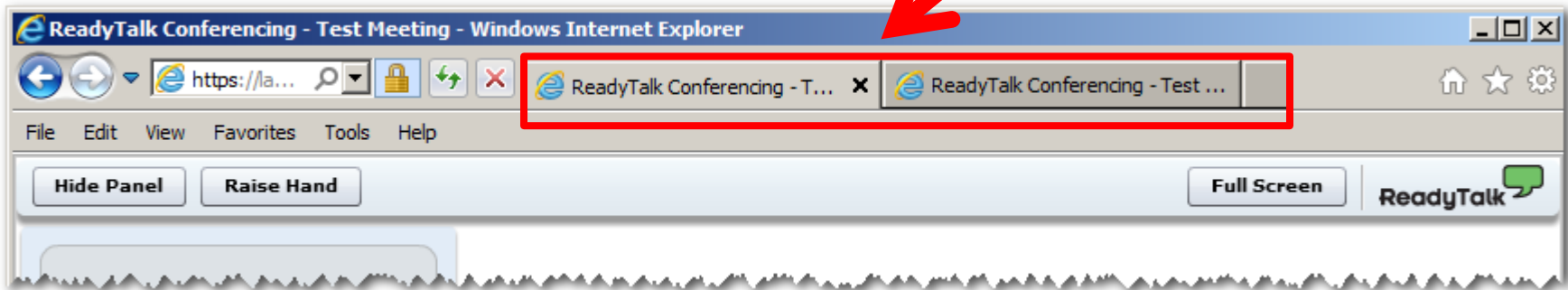


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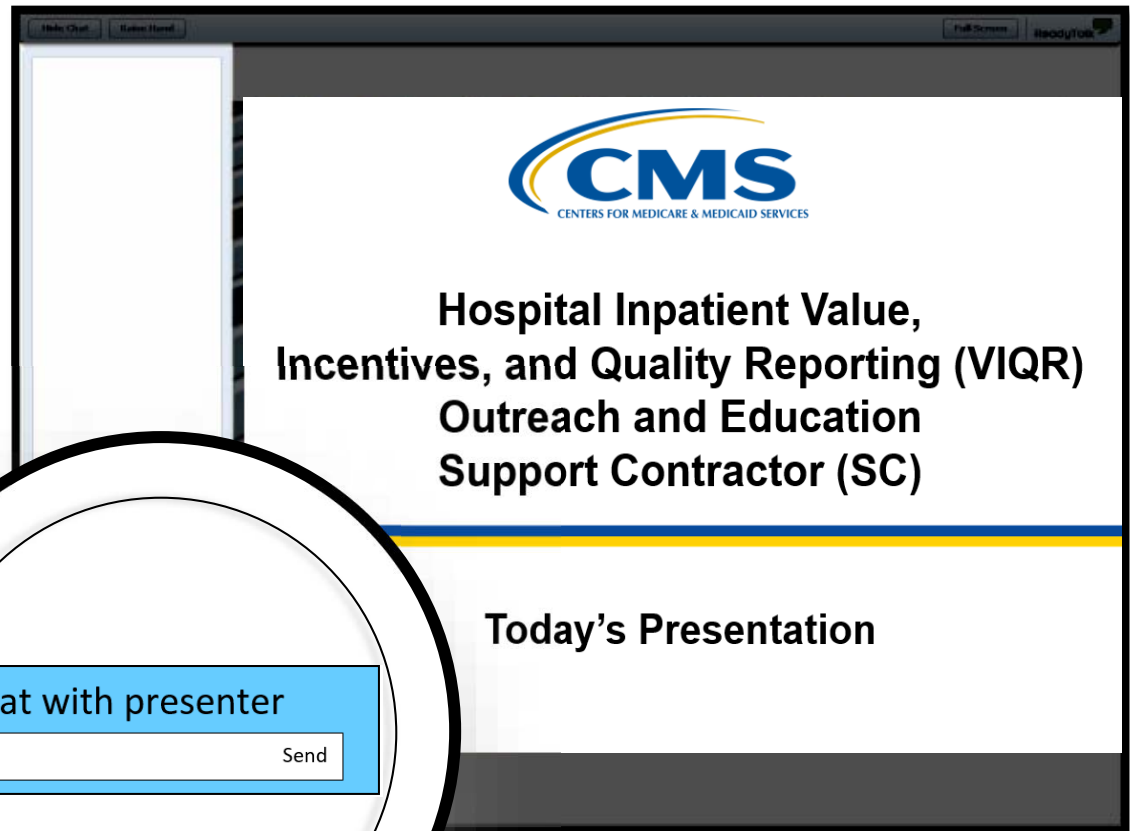
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# **FY 2020 IPPS/LTCH PPS Proposed Rule Overview for Hospital Quality Programs**

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**May 21, 2019**

# Speakers

## **Grace H. Snyder, JD, MPH**

Program Lead

Hospital Inpatient Quality Reporting (IQR) Program and Hospital Value-Based Purchasing (VBP) Program, Quality Measurement and Value-Based Incentives Group (QMVIG), Center for Clinical Standards and Quality (CCSQ), CMS

## **Michael Brea, MBA**

Program Lead, Hospital-Acquired Condition (HAC) Reduction Program  
QMVIG, CCSQ, CMS

## **Erin Patton, MPH, CHES**

Program Lead, Hospital Readmissions Reduction Program (HRRP)  
QMVIG, CCSQ, CMS

## **Moderator**

## **Candace Jackson, RN**

Project Lead, Hospital IQR Program  
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)  
Outreach and Education Support Contractor

# Purpose

This presentation will provide an overview of the Fiscal Year (FY) 2020 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Proposed Rule as it relates to the following:

- Hospital IQR Program
- Hospital VBP Program
- HAC Reduction Program
- Hospital Readmissions Reduction Program (HRRP)

# Objectives

Participants will be able to:

- Locate the FY 2020 IPPS/LTCH PPS Proposed Rule text.
- Identify proposed program changes within the FY 2020 IPPS/LTCH PPS Proposed Rule.
- Identify the time period for submitting public comments to CMS on the FY 2020 IPPS/LTCH Proposed Rule.
- Describe how to submit formal comments to CMS regarding the FY 2020 IPPS/LTCH PPS Proposed Rule.



# Administrative Procedures Act

- Because CMS must comply with the Administrative Procedures Act, we are not able to provide additional information, clarification, or guidance related to the proposed rule.
- We encourage stakeholders to submit comments or questions through the formal comment submission process, as described in this webinar.

# Acronyms and Abbreviations

AA	aortic aneurysm	FY	Fiscal Year	ORAE	opioid related adverse event
ACS	American College of Surgeons	HAC	hospital-acquired condition	PC	Perinatal Care
AMI	Acute myocardial infarction	HAI	healthcare-associated infection	PCHQR	PPS-Exempt Cancer Hospital Quality Reporting
CABG	coronary artery bypass graft	HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems	PN	pneumonia
CAC	Children's Asthma Care	HCP	healthcare personnel	PPS	prospective payment system
CAUTI	Catheter-associated Urinary Tract Infection	HF	heart failure	PSI	Patient Safety Indicator
CCSQ	Center for Clinical Standards and Quality	HRR	Hospital Readmission Reduction	Q	quarter
CDC	Centers for Disease Control and Prevention	HRRP	Hospital Readmissions Reduction Program	QRDA	Quality Reporting Document Architecture
CDI	<i>Clostridium difficile</i> Infection	HSAG	Health Services Advisory Group	QRP	Quality Reporting Program
CE	continuing education	HSR	hospital-specific report	READM	readmission
CFR	Code of Federal Regulations	HWR	Hospital-Wide Readmission	RSCR	Risk-Standardized Complication Rate
Chole	cholecystectomy	IMM	immunization	RSMR	Risk-Standardized Mortality Rate
CLABSI	Central Line-associated Bloodstream Infection	IPPS	inpatient prospective payment system	RSRR	Risk-Standardized Readmission Rate
CMS	Centers for Medicare & Medicaid Services	IQR	Inpatient Quality Reporting	SFusion	spinal fusion
COPD	chronic obstructive pulmonary disease	LTCH	Long-Term Care Hospital	STK	stroke
CY	Calendar Year	MDH	Medicare Dependent Hospitals	THA	Total Hip Arthroplasty
DRG	diagnosis-related group	MedPAR	Medicare Provider and Analysis Review	TKA	Total Knee Arthroplasty
eCQM	electronic clinical quality measure	MMA	Medicare Modernization Act	TPS	Total Performance Score
ED	emergency department	MORT	mortality	UTI	urinary tract infection
EHDI	Early Hearing Detection and Intervention	MRSA	Methicillin-resistant <i>Staphylococcus aureus</i>	VBP	Value-Based Purchasing
EHR	electronic health record	MSPB	Medicare Spending per Beneficiary	VIQR	Value, Incentives, and Quality Reporting
ERR	Excess Readmission Ratio	NHSN	National Healthcare Safety Network	VTE	venous thromboembolism
FFS	fee-for-service	NQF	National Quality Forum		

**Grace H. Snyder, JD, MPH**

Program Lead, Hospital IQR Program and Hospital VBP Program  
QMVIG, CCSQ, CMS

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## **Hospital IQR Program**

# Overview of Hospital IQR Program Proposals

- Proposals to adopt two new electronic clinical quality measures (eCQMs) to the eCQM measure set
- Proposals for eCQM reporting requirements for the CY 2020 through CY 2022 reporting periods
- Proposal to adopt the Hybrid Hospital-Wide Readmission (HWR) measure in a stepwise manner with two years of voluntary reporting, followed by mandatory reporting of the measure
- Proposal to remove the claims-based version of the HWR measure when the hybrid version of the measure becomes mandatory

# Proposed Adoption of Two Opioid-Related eCQMs

Proposals to add the following two opioid-related eCQMs to the eCQM measure set, beginning with the CY 2021 reporting period/FY 2023 payment determination:

- Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e)
- Hospital Harm – Opioid-Related Adverse Events eCQM

\*Similar proposals have been made to adopt these measures for the Promoting Interoperability Programs for Eligible Hospitals and Critical Access Hospitals.

# Proposed Adoption of Two Opioid-Related eCQMs

## Safe Use of Opioids – Concurrent Prescribing eCQM

- Focuses on the proportion of patients aged 18 and older who are prescribed two or more opioids or an opioid and benzodiazepine concurrently at discharge
- Measure concept based on the *2016 CDC Guideline for Prescribing Opioids for Chronic Pain* and recommended clinical guidelines on concurrent prescribing
- Endorsed by the National Quality Forum (NQF) in May 2018
- Has the potential to reduce preventable mortality and costs of adverse events

# Proposed Adoption of Two Opioid-Related eCQMs

## Hospital Harm – Opioid-Related Adverse Events eCQM

- Designed to reduce adverse events associated with the administration of opioids in the hospital setting, such as respiratory depression that can lead to brain damage and death
- Tracks the number of patients who receive naloxone outside of the operating room either: (1) *after* 24 hours from hospital arrival; or (2) with evidence of hospital opioid administration *prior to* naloxone administration *during* the first 24 hours after hospital arrival
- Can lead to safer patient care by incentivizing hospitals to track and improve monitoring of patients who receive opioids during hospitalization
- Submitted for endorsement by NQF's Patient Safety Standing Committee in April 2019

# Proposed Adoption of Two Opioid-Related eCQMs

## Hospital Harm – Opioid-Related Adverse Events eCQM (cont.)

- Because some stakeholders have expressed concern that some providers could withhold the use of naloxone for patients who are in respiratory depression, believing that may help those providers avoid poor performance on this measure, CMS is also soliciting public comment on the potential for this measure to disincentivize the appropriate use of naloxone in the hospital setting or withholding opioids when they are medically necessary in patients requiring palliative care or who are at end of life.



# Form, Manner, and Timing of eCQM Data Submission

CMS proposes to establish the following eCQM reporting and submission requirements:

- For CY 2020 reporting period/FY 2022 payment determination, extend current requirements (i.e., report one, self-selected calendar quarter of data (i.e., 1Q, 2Q, 3Q, or 4Q) on four of the available eCQMs in the eCQM measure set)
- For CY 2021 reporting period/FY 2023 payment determination, extend current requirements as described above

# Form, Manner, and Timing of eCQM Data Submission

- For CY 2022 reporting period/FY 2024 payment determination, extend current requirements with the following modification:
  - Report one, self-selected calendar quarter of data for:
    - Three, self-selected eCQMs
    - AND
    - Proposed Safe Use of Opioids – Concurrent Prescribing eCQM

**Note:** Meeting the Hospital IQR Program eCQM requirement also satisfies the CQM electronic reporting requirement for the Medicare Promoting Interoperability Program (previously known as the Medicare EHR Incentive Program).

# Form, Manner, and Timing of eCQM Data Submission

- Submission deadline is end of two months following the close of the calendar year (or next business day if deadline falls on a weekend or federal holiday)
- Zero denominator declaration and/or case threshold exemption available for hospitals with electronic health records (EHRs) capable of reporting eCQMs, but without enough patients who meet the denominator criteria
- Technical requirements:
  - EHR technology certified to the 2015 Edition (Office of the National Coordinator for Health Information Technology [ONC] certification standards)
  - eCQM specifications published in CMS' eCQM Annual Update and related addenda for the applicable reporting year, available on the eCQI Resource Center website at <https://ecqi.healthit.gov/eh>
  - Quality Reporting Document Architecture (QRDA) Category I file format, using the CMS QRDA I Implementation Guide for the applicable reporting year, available at <https://ecqi.healthit.gov/qrda>
- **Proposal to continue the requirement that EHRs be certified to all available eCQMs used in the Hospital IQR Program**

# eCQM Measure Set: CY 2020 Reporting Period (FY 2022 Payment Determination)

<b>ED-2</b> Median Admit Decision Time to ED Departure Time for Admitted Patients	<b>PC-05</b> Exclusive Breast Milk Feeding	<b>STK-02</b> Discharged on Antithrombotic Therapy	<b>STK-03</b> Anticoagulation Therapy for Atrial Fibrillation/Flutter
<b>STK-05</b> Antithrombotic Therapy By End of Hospital Day 2	<b>STK-06</b> Discharged on Statin Medication	<b>VTE-1</b> Venous Thromboembolism Prophylaxis	<b>VTE-2</b> Intensive Care Unit Venous Thromboembolism Prophylaxis

# Proposed Adoption of Hybrid HWR Measure

## Hybrid Hospital-Wide Readmission (HWR) Measure with Claims and Electronic Health Record Data (NQF #2879)

- Focuses on unplanned readmissions that arise from acute clinical events requiring rehospitalization within 30 days of discharge
- Planned readmissions, which are generally not signals of care quality, are not considered readmissions in the measure outcome
- All unplanned readmissions are considered an outcome, regardless of cause
- Hybrid measures are being developed in response to stakeholder feedback encouraging the use of clinical data in outcome measures and to increase the use of EHR data in quality measurement
- Measure methodology of the Hybrid HWR measure aligns with the claims-based HWR measure currently used in the Hospital IQR Program, with the difference that the hybrid measure uses clinical data from EHRs as part of the risk adjustment

# Proposed Adoption of Hybrid HWR Measure

## Hybrid Hospital-Wide Readmission (HWR) Measure with Claims and Electronic Health Record Data (NQF #2879)

- CMS has access to the claims-based data
- Hospitals would submit the following data from their certified EHRs for at least 90 percent of their Medicare fee-for-service (FFS) patients aged 65 and older, using QRDA Category I files for reporting to CMS:
  - **13** core clinical data elements:
    - **Six** vital signs (heart rate, respiratory rate, temperature, systolic blood pressure, oxygen saturation, weight)
    - **Seven** laboratory test results (hematocrit, white blood cell count, sodium, potassium, bicarbonate, creatinine, glucose)
  - **Six** linking variables to match the EHR data to the CMS claims data (CMS Certification Number, Health Insurance Claim Number or Medicare Beneficiary Identifier, date of birth, sex, admission date, discharge date)
- CMS merges the EHR data elements with the claims data and calculates the 30-day risk-standardized readmission rate.

# Proposed Adoption of Hybrid HWR Measure

## Proposed Implementation Steps:

### 1. Two voluntary reporting periods

- July 1, 2021 through June 30, 2022
  - Proposed submission deadline is the first business day three months following the end of the applicable reporting period (e.g., submit data by September 30, 2022)
- July 1, 2022 through June 30, 2023
  - Submit data by October 2, 2023
- Reporting periods include four quarters of data

### 2. Mandatory reporting

- Starting with the July 1, 2023 through June 30, 2024 reporting period
  - Impacting FY 2026 payment determination, and for subsequent years

# Public Reporting of the Hybrid HWR Measure

- Data not publicly reported during the two voluntary reporting periods.
- CMS proposes to begin public reporting of the Hybrid HWR measure results, beginning with data collected from the July 1, 2023 through June 30, 2024 reporting period.
- CMS anticipates data to be included in the July 2025 refresh of the *Hospital Compare* website.



# Proposed Measure Removal

## Claims-Based Hospital-Wide All-Cause Unplanned Readmission Measure (NQF #1789)

- In connection with the proposal to adopt the Hybrid HWR measure, CMS proposes to remove the claims-based HWR measure.
- Claims-based HWR measure would be replaced beginning when the Hybrid HWR measure becomes mandatory, with the July 1, 2023 through June 30, 2024 reporting period, impacting the FY 2026 payment determination and for subsequent years.
- Hybrid HWR measure provides substantive improvement over the claims-based version by including clinical variables in the risk adjustment, which come from the very start of the inpatient stay and improve face validity of the measure.

# Potential Future Quality Measures

CMS invites public comment on the possible future inclusion of the following three eCQMs:

- Hospital Harm – Severe Hypoglycemia
  - Rate at which severe hypoglycemic events caused by hospital administration of medications occur in the acute care setting
- Hospital Harm – Pressure Injury
  - Rate at which new hospital-acquired pressure injuries occur during an acute care hospitalization
- Cesarean Birth (PC-02) (NQF #0471e)
  - Rate of nulliparous women with a normal-term, singleton fetus in the vertex position undergoing C-section

\*All three measures are also being considered for potential future inclusion in the Promoting Interoperability Programs.

# Accounting for Social Risk Factors: Confidential Reporting of Stratified Data

- Update provided on expanding efforts to provide confidential disparity results to hospitals for additional outcome measures
- In the spring of 2020, CMS plans to include in hospital-specific reports (HSRs) disparity results by patients' dual eligible status for five additional claims-based readmission measures for:
  - Acute myocardial infarction (AMI)
  - Coronary artery bypass graft (CABG)
  - Chronic obstructive pulmonary disease (COPD)
  - Heart failure (HF)
  - Total Hip Arthroplasty/Total Knee Arthroplasty (THA/TKA)

**Grace H. Snyder, JD, MPH**

Program Lead, Hospital IQR Program and Hospital VBP Program  
QMVIG, CCSQ, CMS

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## **Hospital VBP Program**

# FY 2020 Estimated Funds for Hospital VBP

- Under section 1886(o)(7)(C)(v) of the Social Security Act, the applicable percent withhold for FY 2020 is **2.00** percent.
- The estimated total amount available for value-based incentive payments to hospitals paid under the IPPS for FY 2020 is approximately **\$1.9 billion**.

# FY 2020 Tables 16, 16A, and 16B

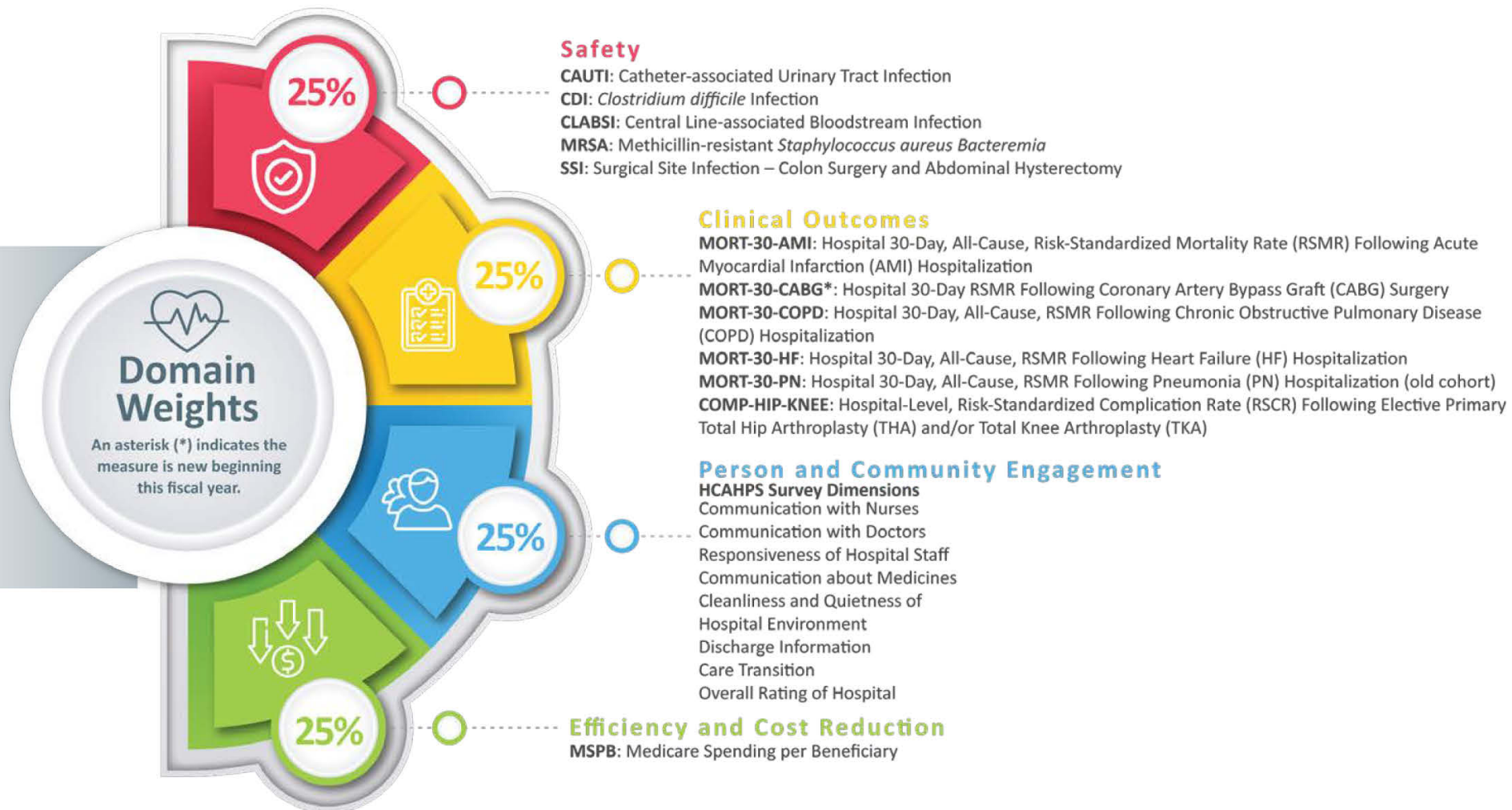
- Table 16 (Proxy Adjustment Factors)
  - Based on Total Performance Scores (TPSs) from FY 2019
  - Available on CMS.gov at:  
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Proposed-Rule-Home-Page-Items/FY2020-IPPS-Proposed-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending>
- 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 Incentive Payment Adjustment Factors)
  - After hospitals have been given an opportunity to review and correct their actual TPSs for FY 2020, CMS intends to display Table 16B in the fall of 2019.

# Proposed Administrative Policies for NHSN HAI Measure Data

- CMS is proposing that the Hospital VBP Program would use the same data to calculate the NHSN HAI measures that the HAC Reduction Program will collect and use for purposes of calculating the HAI measures under that program.
- This proposed policy would begin January 1, 2020 for CY 2020 data collection, which would apply to the Hospital VBP Program starting with data for the FY 2022 program year performance period.
- If this proposal is finalized, hospitals would continue to submit HAI data to the CDC's NHSN for use of the HAI data in both the HAC Reduction and Hospital VBP Programs.

# FY 2022

## Domains and Measures





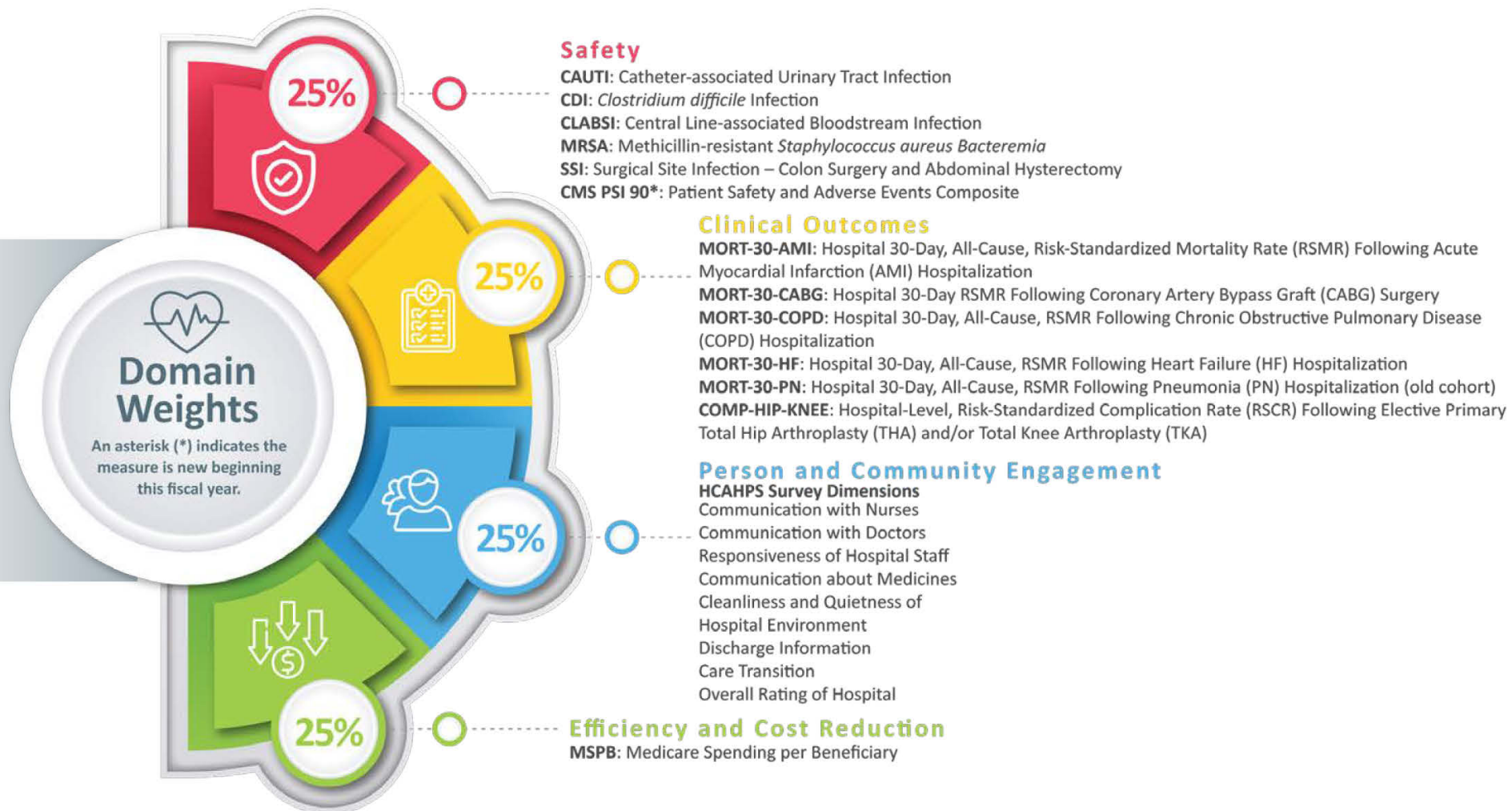
# FY 2022

## Measurement Periods

Domain	Baseline Period	Performance Period
Clinical Outcomes <ul style="list-style-type: none"> <li>MORT-30-AMI, MORT-30-CABG, MORT-30-COPD, MORT-30-HF</li> <li>MORT-30-PN (Updated Cohort)</li> <li>COMP-HIP-KNEE</li> </ul>	July 1, 2012–June 30, 2015	July 1, 2017–June 30, 2020
	July 1, 2012–June 30, 2015	September 1, 2017–June 30, 2020
	April 1, 2012–March 31, 2015	April 1, 2017–March 31, 2020
Person and Community Engagement	January 1–December 31, 2018	January 1–December 31, 2020
Safety (HAI Measures)	January 1–December 31, 2018	January 1–December 31, 2020
Efficiency and Cost Reduction	January 1–December 31, 2018	January 1–December 31, 2020

# FY 2023–2025

## Domains and Measures



# FY 2023

## Measurement Periods

Domain	Baseline Period	Performance Period
Clinical Outcomes <ul style="list-style-type: none"> <li>MORT-30-AMI, MORT-30-CABG, MORT-30-COPD, MORT-30-HF, MORT-30-PN (Updated Cohort)</li> <li>COMP-HIP-KNEE</li> </ul>	July 1, 2013–June 30, 2016  April 1, 2013–March 31, 2016	July 1, 2018–June 30, 2021  April 1, 2018–March 31, 2021
Person and Community Engagement	January 1–December 31, 2019	January 1–December 31, 2021
Safety <ul style="list-style-type: none"> <li>HAI Measures</li> <li>CMS PSI 90</li> </ul>	January 1–December 31, 2019 October 1, 2015–June 30, 2017	January 1–December 31, 2021 July 1, 2019–June 30, 2021
Efficiency and Cost Reduction	January 1–December 31, 2019	January 1–December 31, 2021

# FY 2024

## Measurement Periods

Domain	Baseline Period	Performance Period
Clinical Outcomes <ul style="list-style-type: none"> <li>MORT-30-AMI, MORT-30-CABG, MORT-30-COPD, MORT-30-HF, MORT-30-PN (Updated Cohort)</li> <li>COMP-HIP-KNEE</li> </ul>	July 1, 2014–June 30, 2017  April 1, 2014–March 31, 2017	July 1, 2019–June 30, 2022  April 1, 2019–March 31, 2022
Person and Community Engagement	January 1–December 31, 2020	January 1–December 31, 2022
Safety <ul style="list-style-type: none"> <li>HAI Measures</li> <li>CMS PSI 90</li> </ul>	January 1–December 31, 2020 July 1, 2016–June 30, 2018	January 1–December 31, 2022 July 1, 2020–June 30, 2022
Efficiency and Cost Reduction	January 1–December 31, 2020	January 1–December 31, 2022

# FY 2025

## Measurement Periods

Domain	Baseline Period	Performance Period
Clinical Outcomes <ul style="list-style-type: none"> <li>MORT-30-AMI, MORT-30-CABG, MORT-30-COPD, MORT-30-HF, MORT-30-PN (Updated Cohort)</li> <li>COMP-HIP-KNEE</li> </ul>	July 1, 2015–June 30, 2018  April 1, 2015–March 31, 2018	July 1, 2020–June 30, 2023  April 1, 2020–March 31, 2023
Person and Community Engagement	January 1–December 31, 2021	January 1–December 31, 2023
Safety <ul style="list-style-type: none"> <li>HAI Measures</li> <li>CMS PSI 90</li> </ul>	January 1–December 31, 2021 July 1, 2017–June 30, 2019	January 1–December 31, 2023 July 1, 2021–June 30, 2023
Efficiency and Cost Reduction	January 1–December 31, 2021	January 1–December 31, 2023

**Michael Brea, MBA**

Program Lead, HAC Reduction Program, QMVIG, CCSQ, CMS

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## **HAC Reduction Program**

# Summary of FY 2020 Proposals

In the FY 2020 IPPS/LTCH PPS Proposed Rule, CMS proposes to:

1. Adopt a measure removal policy that aligns with the removal factor policies previously adopted in other quality reporting and quality payment programs.
2. Clarify policies for validation of the Centers for Disease Control and Prevention (CDC) NHSN HAI measures.
3. Adopt the data collection periods for the FY 2022 program year.

# Proposed Measure Removal Policy for HAC Reduction Program

Factor Number	Removal Factor Description
1	Measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made. (topped-out measures)
2	Measure does not align with current clinical guidelines or practice.
3	Measure can be replaced by a more broadly applicable measure (across settings or populations) or a measure that is more proximal in time to desired patient outcomes for the particular topic.
4	Measure performance or improvement does not result in better patient outcomes.
5	Measure can be replaced by a measure that is more strongly associated with desired patient outcomes for the particular topic.
6	Measure collection or public reporting leads to negative unintended consequences other than patient harm.
7	Measure is not feasible to be implemented as specified.
8	The costs associated with a measure outweigh the benefit of its continued use in the program.



# Proposed Changes to Validation Selection Methodology

- In the FY 2019 IPPS/LTCH PPS Final Rule, CMS finalized the adoption of the Hospital IQR Program CDC NHSN HAI measure validation process to begin with Q3 2020 discharges for FY 2023.
- We are proposing to change the number of hospitals targeted from exactly 200 hospitals to “up to 200 hospitals” to allow us to only select hospitals that meet the targeting criteria.

# Proposed Changes to Validation Selection Methodology

- We also are clarifying our selection process for both the random and targeted sample of hospitals subject to HAC Reduction Program validation.
- The pool of 400 hospitals will be selected randomly and validated for both the CDC NHSN HAI measures for the HAC Reduction Program and the Hospital IQR Program's chart-abstracted measures.
- The HAC Reduction Program will include all hospitals. The Hospital IQR Program will remove any hospital without an active notice of participation in the Hospital IQR Program.

# Proposed Validation Filtering Method

- To better target true events for CLABSI and CAUTI, consistent with CDC guidance, we propose implementing a filtering method to eliminate any cases from the validation pool for which all positive blood or urine cultures were collected during the first or second day following admission.
- We estimate that implementing the proposed filtering method will help us better understand the overreporting and underreporting of such events.

# FY 2022 Proposed Applicable Period

<b>Measures</b>	<b>Performance Period</b>
CMS PSI 90	July 1, 2018 – June 30, 2020
CDC NHSN HAI <ul data-bbox="144 821 415 1149" style="list-style-type: none"><li>• CLABSI</li><li>• CAUTI</li><li>• SSI</li><li>• MRSA</li><li>• CDI</li></ul>	January 1, 2019 – December 31, 2020

# HAC Reduction Program Resources

- **HAC Reduction Program General Information on *QualityNet***  
[www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166](http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166)
- **HAC Reduction Program Scoring Methodology on *QualityNet***  
<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228774298601>
- **Stakeholder Questions**
  - Email: [hacrp@lantanagroup.com](mailto:hacrp@lantanagroup.com)
  - Email the Hospital Inpatient Q&A Tool: <https://cms-ip.custhelp.com/>

**Erin Patton, MPH, CHES**

Program Lead, HRRP, QMVG, CCSQ, CMS

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## **Hospital Readmissions Reduction Program (HRRP)**

# Summary of FY 2020 Proposal

- Applicable period for FY 2022
- Adoption of measure removal factors policy
- Update to previously finalized definition of “dual-eligible” beginning in FY 2021
- Implementation of subregulatory process
- Revision of regulatory text in Code of Federal Regulations (CFR) (42 CFR 412.152 and 412.154)

# Proposed Applicable Period for FY 2022

<b>Claims-Based Readmissions Measures</b>	<b>NQF Measure Number</b>	<b>Performance Period*</b>
AMI	NQF #0505	July 1, 2017 – June 30, 2020
HF	NQF #0330	July 1, 2017 – June 30, 2020
PN	NQF #0506	July 1, 2017 – June 30, 2020
COPD	NQF #1891	July 1, 2017 – June 30, 2020
THA/TKA	NQF #1551	July 1, 2017 – June 30, 2020
CABG	NQF #2515	July 1, 2017 – June 30, 2020

\*The applicable period also applies to dual proportion and payment calculations.



# Proposed Measure Removal Factor Policy

Adopting the measure removal factor policy ensures that the HRRP measure set continues to promote improved health outcomes for patients while reducing burden and costs associated with the program.

# Measure Removal Factors

Factor Number	Removal Factor Description
1	Measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made. (topped-out measures)
2	Measure does not align with current clinical guidelines or practice.
3	Measure can be replaced by a more broadly applicable measure (across settings or populations) or a measure that is more proximal in time to desired patient outcomes for the particular topic.
4	Measure performance or improvement does not result in better patient outcomes.
5	Measure can be replaced by a measure that is more strongly associated with desired patient outcomes for the particular topic.
6	Measure collection or public reporting leads to negative unintended consequences other than patient harm.
7	Measure is not feasible to be implemented as specified.
8	The costs associated with a measure outweigh the benefit of its continued use in the program.

# Proposed Update to Previously Finalized Definition of “Dual-Eligible”

## **CMS proposes to update the definition to:**

Dual-eligible is identified as having full-benefit status in both the Medicare and Medicaid programs (i.e., Medicare Fee for Service (FFS) and Medicare Advantage patients) in data sourced from the State Medicare Modernization Act (MMA) files for the month the beneficiary was discharged from the hospital, except for those patient beneficiaries who die in the month of discharge, **who will be identified using the previous month’s data sourced from the State MMA files.**

# Proposed Subregulatory Process

- CMS proposes making nonsubstantive updates to data sourcing and technical aspects of the payment adjustment factor components through a subregulatory process.
  - This allows for faster implementation of updates to improve the accuracy of the calculations outside of rulemaking.
  - Substantive changes still proposed/finalized through rulemaking.
- Updates to the technical aspects of the payment adjustment factor components will be provided in the HSR user guide (including but not limited to):
  - Dual Proportion
  - Peer Group Assignment
  - Peer Group Median Excess Readmission Ratio (ERR)
  - Neutrality Modifier
  - Ratio of Diagnosis Related Group (DRG) Payments to Total Payments

# Proposed Revisions of Regulatory Text

CMS proposes to revise 42 CFR 412.152, 412.154 definitions and codify previously finalized policies.

- **Aggregate payments for excess readmissions** – Specify the sum of the product for each applicable condition, among others, of “the excess readmission ratio for the hospital for the applicable period minus the peer group median ERR” (instead of minus 1) (proposed paragraph 3(3) of the definition) and include the neutrality modifier.
- **Applicable condition** – Include other conditions/procedures as deemed appropriate by the Secretary.
- **Base operating DRG payment amount** – Specify this amount also *includes* the difference between the hospital-specific payment rate and the Federal payment rate (under Medicare Dependent Hospitals [MDH] only).

# HRRP Resources

- **HRRP Program Information**

<https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html>

- **HRRP General Inquiries**

- Email: [HRRP@lantanagroup.com](mailto:HRRP@lantanagroup.com)

- Email the Q&A tool: <https://cms-ip.custhelp.com/app/homehrrp/p/843>

- **Program and Payment Adjustment Factor Overview**

<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPa ge%2FQnetTier2&cid=1228772412458>

- **Measure Methodology Inquiries** [cmsreadmissionmeasures@yale.edu](mailto:cmsreadmissionmeasures@yale.edu)

- **Overview of Readmission Measures**

<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPa ge%2FQnetTier3&cid=1219069855273>

- **Initiatives to Reduce Readmissions**

<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPa ge%2FQnetTier4&cid=1228766331358>

**Candace Jackson, ADN**

Project Lead, Hospital IQR Program

Hospital Inpatient VIQR Outreach and Education Support Contractor

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## **FY 2020 IPPS/LTCH PPS Proposed Rule Page Directory and Submission of Comments**

# FY 2019 IPPS/LTCH PPS Proposed Rule Page Directory

- Download the FY 2020 IPPS/LTCH PPS Proposed Rule from the *Federal Register* at <https://www.govinfo.gov/content/pkg/FR-2019-05-03/pdf/2019-08330.pdf>.
- Details regarding various quality programs can be found on the pages listed below:
  - HRRP pp. 19423 - 19428
  - Hospital VBP Program pp. 19428 - 19440
  - HAC Reduction Program pp. 19440 - 19446
  - Hospital IQR Program pp. 19473 - 19500
  - PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program pp. 19500 - 19510
  - Long-Term Care Hospital Quality Reporting Program (LTCH QRP) pp. 19510 - 19554
  - Promoting Interoperability pp. 19554 - 19569



# Commenting on the FY 2020 IPPS/LTCH PPS Proposed Rule

- CMS is accepting comments on the FY 2020 IPPS/LTCH PPS Proposed Rule until **June 24, 2019**.
- Comments can be submitted via four methods\*:
  - Electronically
  - Regular mail
  - Express or overnight mail
  - Hand courier
- CMS will respond to comments in the final rule scheduled to be issued by August 1, 2019.

\***NOTE:** Please review the proposed rule for specific instructions for each method and submit by **only** one method.

**Candace Jackson, ADN**

Project Lead, Hospital IQR Program

Hospital Inpatient VIQR Outreach and Education Support Contractor

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## **Summary of Measures by Quality Program**

# Claims-Based Coordination of Care Measures (Excess Days in Acute Care)

Measure ID	Measure Name	Hospital IQR Program				
		Fiscal Year				
		20	21	22	23	24
AMI Excess Days	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	✓	✓	✓	✓	✓
HF Excess Days	Excess Days in Acute Care after Hospitalization for Heart Failure	✓	✓	✓	✓	✓
PN Excess Days	Excess Days in Acute Care after Hospitalization for Pneumonia	✓	✓	✓	✓	✓

# Claims-Based Coordination of Care Measures (Readmission)

Measure ID	Measure Name	Hospital IQR Program					HRR Program				
		Fiscal Year					Fiscal Year				
		20	21	22	23	24	20	21	22	23	24
READM-30-AMI	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization						✓	✓	✓	✓	✓
READM-30-PN	Hospital 30-Day, All-Cause, RSRR Following Pneumonia Hospitalization						✓	✓	✓	✓	✓
READM-30-THA/TKA	Hospital-Level 30-Day, All-Cause RSRR Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)						✓	✓	✓	✓	✓
READM-30-HWR	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	✓	✓	✓	✓	✓					
READM-30-COPD	Hospital 30-Day, All-Cause, RSRR Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization						✓	✓	✓	✓	✓
READM-30-CABG	Hospital 30-Day, All-Cause, RSRR Following Coronary Artery Bypass Graft (CABG) Surgery						✓	✓	✓	✓	✓
READM-30-HF	Hospital 30-Day, All-Cause, RSRR Following Heart Failure (HF) Hospitalization						✓	✓	✓	✓	✓

# Claims-Based Mortality Outcome Measures

Measure ID	Measure Name	Hospital IQR Program					Hospital VBP Program				
		Fiscal Year					Fiscal Year				
		20	21	22	23	24	20	21	22	23	24
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization						✓	✓	✓	✓	✓
MORT-30-HF	Hospital 30-Day, All-Cause, RSMR Following Heart Failure (HF) Hospitalization						✓	✓	✓	✓	✓
MORT-30-PN	Hospital 30-Day, All-Cause, RSMR Following Pneumonia Hospitalization (New Cohort)	✓						✓	✓	✓	✓
	Hospital 30-Day, All-Cause, RSMR Following Pneumonia Hospitalization (Old Cohort)						✓				
MORT-30-COPD	Hospital 30-Day, All-Cause, RSMR Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	✓						✓	✓	✓	✓
MORT-30-STK	Hospital 30-Day, All-Cause, RSMR Following Acute Ischemic Stroke	✓	✓	✓	✓	✓					
MORT-30-CABG	Hospital 30-Day, All-Cause, RSMR Following Coronary Artery Bypass Graft (CABG) Surgery	✓	✓						✓	✓	✓

# Claims-Based Patient Safety Measures

Measure ID	Measure Name	Hospital IQR Program					Hospital VBP Program					HAC Reduction Program				
		Fiscal Year					Fiscal Year					Fiscal Year				
		20	21	22	23	24	20	21	22	23	24	20	21	22	23	24
COMP-HIP-KNEE	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	✓	✓	✓			✓	✓	✓	✓	✓					
PSI 04	CMS Recalibrated Death Rate among Surgical inpatients with Serious Treatable Complications	✓	✓	✓	✓	✓										
PSI 90	Patient Safety and Adverse Events Composite									✓	✓	✓	✓	✓	✓	

# Claims-Based Payment Measures

Measure ID	Measure Name	Hospital IQR Program					Hospital VBP Program				
		Fiscal Year					Fiscal Year				
		20	21	22	23	24	20	21	22	23	24
MSPB	Medicare Spending Per Beneficiary - Hospital						✓	✓	✓	✓	✓
AMI Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI)	✓	✓	✓	✓	✓					
HF Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care For Heart Failure (HF)	✓	✓	✓	✓	✓					
PN Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia	✓	✓	✓	✓	✓					
THA/TKA Payment	Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty	✓	✓	✓	✓	✓					

# Clinical Process of Care Measures (via Chart Abstraction)

Measure ID	Measure Name	Hospital IQR Program					Hospital VBP Program							
		Fiscal Year					Fiscal Year							
		20	21	22	23	24	20	21	22	23	24			
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients	✓												
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients	✓	✓											
IMM-2	Influenza Immunization	✓												
PC-01	Elective Delivery	✓	✓	✓	✓	✓	✓							
Sepsis	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	✓	✓	✓	✓	✓								
VTE-6	Incidence of Potentially Preventable Venous Thromboembolism	✓												



# EHR-Based Clinical Process of Care Measures (eCQMs)

Measure ID	Measure Name	Hospital IQR Program					Promoting Interoperability Program				
		Fiscal Year					Fiscal Year				
		20	21	22	23	24	20	21	22	23	24
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	✓	✓				✓	✓			
CAC-3	Home Management Plan of Care Document Given to Patient/Caregiver	✓	✓				✓	✓			
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients	✓	✓				✓	✓			
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients	✓	✓	✓	✓	✓	✓	✓	✓	✓	
ED-3	Median Time from ED Arrival to ED Departure for Discharged ED Patients						✓	✓			
EHDI-1a	Hearing Screening Prior to Hospital Discharge	✓	✓				✓	✓			
Harm-ORAE	Hospital Harm – Opioid-Related Adverse Events				✓	✓			✓	✓	
PC-01	Elective Delivery	✓	✓				✓	✓			
PC-05	Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother's Choice	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Safe Use of Opioids	Safe Use of Opioids – Concurrent Prescribing				✓	✓			✓	✓	
STK-02	Discharged on Antithrombotic Therapy	✓	✓	✓	✓	✓	✓	✓	✓	✓	
STK-03	Anticoagulation Therapy for Atrial Fibrillation/Flutter	✓	✓	✓	✓	✓	✓	✓	✓	✓	
STK-05	Antithrombotic Therapy by the End of Hospital Day Two	✓	✓	✓	✓	✓	✓	✓	✓	✓	
STK-06	Discharged on Statin Medication	✓	✓	✓	✓	✓	✓	✓	✓	✓	
STK-08	Stroke Education	✓	✓				✓	✓			
STK-10	Assessed for Rehabilitation	✓	✓				✓	✓			
VTE-1	Venous Thromboembolism Prophylaxis	✓	✓	✓	✓	✓	✓	✓	✓	✓	
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	✓	✓	✓	✓	✓	✓	✓	✓	✓	

# HAI Measures

Measure ID	Measure Name NHSN: National Healthcare Safety Network	Hospital IQR Program					Hospital VBP Program					HAC Reduction Program				
		Fiscal Year					Fiscal Year					Fiscal Year				
		20	21	22	23	24	20	21	22	23	24	20	21	22	23	24
CLABSI	NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CAUTI	NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Colon and Abdominal Hysterectomy SSI	ACS-CDC Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure • Colon Procedures • Hysterectomy Procedures	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MRSA Bacteremia	NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) Bacteremia Outcome Measure	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDI	NHSN Facility-wide Inpatient Hospital-onset <i>Clostridium difficile</i> Infection (CDI) Outcome Measure	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCP	NHSN Influenza Vaccination Coverage Among Healthcare Personnel	✓	✓	✓	✓	✓										

# Hybrid Measure

Measure ID	Measure Name	Hospital IQR Program				
		Fiscal Year				
		20	21	22	23	24
Hybrid HWR	Hybrid Hospital-Wide All-Cause Readmission <b>Note: Measure is voluntary until FY 2026</b>	✓				✓

# Patient Experience of Care Survey Measures

Measure ID	Measure Name	Hospital IQR Program					Hospital VBP Program				
		Fiscal Year					Fiscal Year				
		20	21	22	23	24	20	21	22	23	24
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

## FY 2020 IPPS/LTCH PPS Proposed Rule Overview for Hospital Quality Programs

### Questions

FY 2020 IPPS/LTCH PPS Proposed Rule Overview for Hospital Quality Programs

## **Continuing Education**

# Continuing Education (CE) Approval

This program has been approved for CE credit for the following boards:

- **National credit**
  - Board of Registered Nursing (Provider #16578)
- **Florida-only credit**
  - Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling
  - Board of Registered Nursing
  - Board of Nursing Home Administrators
  - Board of Dietetics and Nutrition Practice Council
  - Board of Pharmacy

**NOTE:** To verify CE approval for any other state, license, or certification, please check with your licensing or certification board.

# CE Credit Process: Three Steps

1. Complete the ReadyTalk<sup>®</sup> survey that will pop up after the webinar.
2. Register on the HSAG Learning Management Center for the certificate.
3. Print out your certificate.



**NOTE:** An additional survey will be sent to all registrants within the next 48 hours.



# CE Credit Process: Survey

No

Please provide any additional comments

**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

Powered by [SurveyMonkey](#)  
Check out our [sample surveys](#) and create your own now!

# CE Credit Process: Certificate

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://lmc.hshapps.com/register/default.aspx?ID=da0a12bc-db39-408f-b429-d6f6b9ccb1ae>

**Existing User Link:**

<https://lmc.hshapps.com/test/adduser.aspx?ID=da0a12bc-db39-408f-b429-d6f6b9ccb1ae>

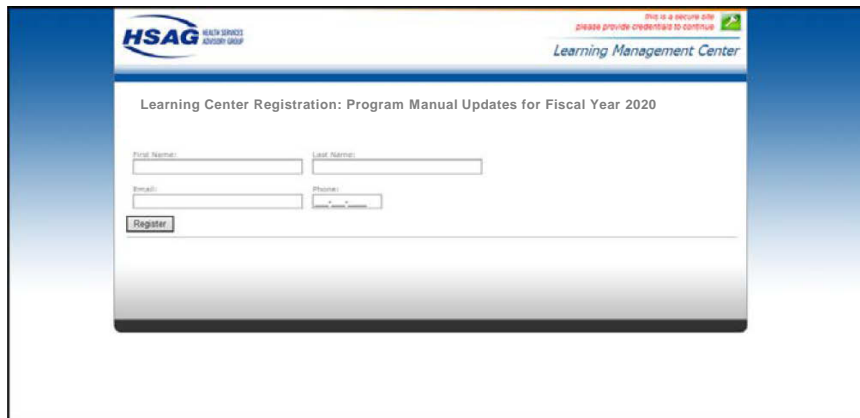
**Note:** If you click the 'Done' button below, you will not have the opportunity to receive your certificate without participating in a longer survey.

Done

# Register for Credit

## New User

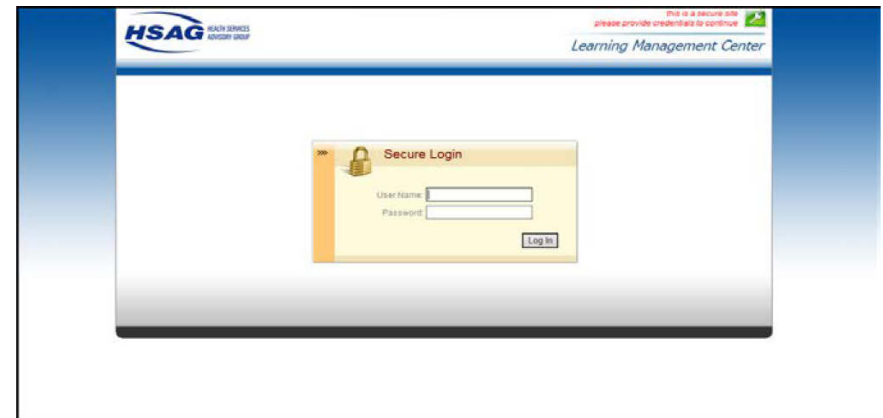
Use personal email and phone.  
Go to email address  
and finish process.



The screenshot shows the 'Learning Management Center' registration page. At the top, there is a blue header with the HSAG logo and the text 'HEALTH SERVICES DIVISION GROUP'. Below the header, the page title is 'Learning Center Registration: Program Manual Updates for Fiscal Year 2020'. The registration form includes fields for 'First Name', 'Last Name', 'Email', and 'Phone', along with a 'Register' button. A security warning at the top right states 'This is a secure site please provide credentials to continue'.

## Existing User

Entire email is your user name.  
You can reset your password.



The screenshot shows the 'Secure Login' page. At the top, there is a blue header with the HSAG logo and the text 'HEALTH SERVICES DIVISION GROUP'. Below the header, the page title is 'Learning Management Center'. The login form includes fields for 'User Name' and 'Password', along with a 'Log In' button. A security warning at the top right states 'This is a secure site please provide credentials to continue'.

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**Thank You**