# Hospital Inpatient Quality Reporting (IQR) Program

## Support Contractor

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

## Presentation Transcript


### Speakers

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**Candace Jackson:** I would like to welcome everyone to today's IQR presentation titled, *FY 2020 IPPS/LTCH PPS Proposed Rule Overview for Hospital Quality Programs*. I am Candace Jackson, the Hospital IQR Program Project Lead at the CMS Hospital Inpatient VIQR Outreach And Education Support Contractor. I will be the moderator for today's event. Before we begin, I'd like to make our first few regular announcements. This program is being recorded. A transcript of the presentation, along with the answers to the questions asked today, will be posted to the inpatient website, *www.QualityReportingCenter.com,* at a later date. If you registered for this event, a reminder email and a copy of today's slides were sent to your email about a few hours ago. If you did not receive that email, you can download the slides at our inpatient website, and again, that is *www.QualityReportingCenter.com.* If you have a question as we move through the webinar, please type your question into the chat window and we will answer questions as time allows at the end of the webinar. For the presenters to best answer your questions we request, at the beginning of your question, please type the slide number associated in the chat window.

Our speakers for today's event will be Grace Snyder, the CMS Program Lead for the Hospital IQR Program and Hospital Value-Based Purchasing Program; Michael Brea, the CMS Program Lead for the Hospital-Acquired Condition Reduction Program; and Erin Patton, the CMS Program Lead for the Hospital Readmissions Reduction Program.

Today's presentation will provide participants with an overview of the fiscal year 2020 proposed changes for the Hospital Inpatient Quality Reporting Program, the Hospital Value-Based Purchasing Program, the Hospital-Acquired Condition Reduction Program, and the Hospital Readmissions Reduction Program, as addressed in the recently released Inpatient Prospective Payment System proposed rule.

At the end of today's presentation, participants will be able to locate the fiscal year 2020 IPPS proposed rule, identify the proposed program changes, and identify the time period and how to submit public comments to CMS. Please note that, during this presentation, CMS will not be able to provide additional information, clarification, or guidance related to the

proposed rule. CMS strongly encourages stakeholders to submit their comments or questions through the formal comment submission process, which will be discussed later in the presentation.

Here is just a list of the acronyms that we will use throughout the presentation.

I would now like to turn the presentation over to Grace Snyder, who will address the proposed changes related to the Hospital Inpatient Quality Reporting Program. Grace, the floor is yours.

**Grace Snyder:** Thank you, Candace. I'd like to welcome everyone on our webinar today and thank you for taking the time out of your day to join us. I appreciate this opportunity to share with you several proposals for the Hospital Inpatient Quality Reporting Program, or IQR program. Our proposals this year focus on two priority goals of advancing the use of EHR-based data for quality measurement and using quality measures in support of addressing the opioid epidemic. Next slide, please.

I'll start with a high-level summary of the proposals for the IQR program and then go into more detail in the upcoming slides. Our proposal this year for the IQR program include proposals to adopt two new electronic clinical quality measures, or eCQMs, to the eCQM measure set for hospitals; proposals for eCQM reporting requirements for the 2020 through 2022 reporting periods; a proposal to adopt the hybrid hospitalized readmission measure in a stepwise manner that's going to start with voluntary reporting before moving to mandatory reporting of the measure; and, in connection with proposing to adopt the hybrid measure, a proposal to remove the claims-based version of the hospital-wide readmission measure, which we're currently using in the IQR program. Next slide, please.

In this IPPS proposed rule this year, we're proposing two new electronic clinical quality measures, or eCQMs, to add to the eCQM measures at the hospital, and we're proposing to add them to the program and make them available for reporting beginning with the 2021 reporting period, which would give hospitals and their EHR vendors approximately two years to

implement them to be ready to report 2021 data. I'd also like to note that these same new eCQMs are also proposed for use in the Promoting Interoperability Program for hospitals. Next slide, please.

Both of these new eCQMs are related to the use of opioids in the inpatient care setting. The first eCQM that I will discuss is the Safe Use of Opioids - Concurrent Prescribing eCQM. This measure 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. The concept for this measure is based on the 2016 CDC guidelines for prescribing opioids for chronic pain and based on recommended clinical guidelines on concurrent prescribing. The measure is endorsed by the National Quality Forum, and we believe this measure really has the potential to help reduce preventable mortality and the cause of adverse events. Next slide, please.

The second eCQM that we are proposing is the Hospital Harm - Opioid-Related Adverse Events eCQM. This measure is designed to reduce adverse events associated with the administration of opioids in the hospital setting, adverse events such as respiratory depression that could lead to brain damage and death. This measure tracks the number of patients who receive naloxone outside of the operating room either for a situation after 24 hours from hospital arrival or with evidence of hospital opioid administration prior to naloxone administration during the first 24 hours after hospital arrival. We believe this measure can help lead to safer patient care by incentivizing hospitals to track and improve monitoring of patients who receive opioids during hospitalization. Last month, this measure was submitted to National Quality Forum, or NQF, for endorsement. Next slide, please.

For this Hospital Harm - Opioid-Related Adverse Events eCQM we are also seeking comment on potential unintended consequences specifically because some stakeholders have expressed concern that some providers could withhold the use of naloxone for patients who are in respiratory depression, believing that it may help them do better on this measure. We are also really interested in receiving any public comments on the potential for this measure to disincentivize the appropriate use of naloxone

in the hospital setting or the potential of withholding opioids when they are medically necessary in patients requiring palliative care or who are at the end of life. For both of these new proposed eCQMs, I'd like to note that they were developed from the get-go as eCQMs. They're not, for example, chart-abstracted measures that were electronically specified. This means that the availability of the data elements in the EHR and the workflow were taken into consideration from the beginning of the measure development process. We believe implementation should be easier than it was for the eCQMs that we're already using in the IQR program. Next slide, please.

I'd also like to describe and discuss proposals that we have more specifically related to upcoming eCQM reporting requirements. Right now, many of you are working on the 2019 eCQM reporting requirements, which is to report one self-selected calendar quarter of 2019 data or four self-selected eCQMs using the 2015 edition of certified EHR technology. For the 2020 and 2021 reporting requirements, we're proposing to continue the same requirement. We understand that hospitals working with their vendors are still really focused on implementing the infrastructure and getting comfortable with the current set of eCQMs and the current reporting requirements. So, as we've mentioned in previous rulemaking, we want to take an incremental approach to increasing EHR-based quality reporting. Now, I would like to note, for the 2021 reporting period, as I mentioned previously, that's when we're proposing to add the two new opioid related eCQMs and they would become part of the eCQM measure sets for hospitals to choose from. Next slide, please.

Then, for 2022 eCQM reporting, we're proposing that all hospitals must report the Safe Use of Opioids - Concurrent Prescribing eCQM, along with three other self-selected eCQMs. That would be still a total of four eCQMs, but one of which would need to be the Safe Use of Opioids - Concurrent Prescribing measure, and we proposed that we would require the reporting of one self-selected calendar quarter of 2022 data. I'd also like to note again that we are proposing the same eCQM reporting requirements for the Promoting Interoperability Program for hospitals. So,

like today, you would report once to CMS to get credit for both the IQR program and the clinical quality measure requirement of the Promoting Interoperability Program. Next slide, please.

On this slide, it summarizes for you some other previously finalized requirements related to eCQM reporting, including the availability of zero denominator and case threshold exemptions for hospitals with EHRs capable of reporting the measures but without enough patients to report one or more of the eCQMs. In this proposed rule, we are not proposing any changes to the technical requirements related to eCQM reporting. So, eCQMs should be reported using the 2015 edition of certified EHR technology, and we refer you to the eCQI Resource Center for the applicable annual update for the electronic specifications and QRDA implementation guide. We do have a proposal in this year's proposed rule to also continue the requirement that EHRs be certified to all of the eCQMs in the measure set. Next slide, please.

This slide just summarizes and lists the current set of eCQMs that we have previously finalized. This is beginning with calendar year 2020 reporting. It's right now eight eCQMs, and, starting with 2021 reporting, we're proposing to add two new eCQMs to this set for a total of 10, and, just to clarify, for right now 2019 reporting, eCQM reporting that you're working on, there is still available 15 eCQMs to choose from for the IQR program. But, in last year's final rule, we finalized the removal of seven of those measures. So, beginning with 2020 reporting, we have these eight eCQMs in the program, and again, in this year's proposed rule, we're adding to add two more to choose from. Next slide, please.

Also in this year's proposed rule, we're proposing the adoption of the Hybrid Hospital-Wide Readmission Measure that uses both claims data and clinical data from hospitals' EHRs. We refer to it as a hybrid measure because it uses two different data sources to calculate the measure. The measure focuses on unplanned readmissions that arise from acute clinical events requiring rehospitalization within 30 days of discharge. Planned readmissions are not considered readmissions in this measure outcome. However, all unplanned readmissions are considered an outcome,

regardless of the cause. The hybrid measure and other hybrid measures we are working on are being developed in response to stakeholder feedback encouraging the use of patient clinical data in outcome measures and to increase the use of EHR data in quality measurement. The methodology of this measure aligns with the claims-based hospital-wide readmission measure that's currently used in the IQR program The difference is that the hybrid measure uses clinical data from the EHR as part of the risk adjustment. Next slide, please.

As I mentioned, as a hybrid measure, it uses both claims data and EHR data to calculate the measure. At CMS, we already have the claims data. However, the EHR data will need to be reported by hospitals, and specifically, the EHR data are a set of 13 core clinical data elements that include six vital signs (the patient heart rate, respiratory rate, temperature, systolic blood pressure, oxygen saturation, and weight) and also seven laboratory test results (hematocrit, white blood cell count, sodium, potassium, bicarbonate, creatinine, and glucose). It would also require the reporting of six linking variables to be able to match the EHR data to the CMS claims data for the same patient, and these linking variables are the hospital's CMS Certification Number, the patient's health insurance claim number (or Medicare Beneficiary Identifier), and also patient's date of birth, sex, admission date, and discharge date. After hospitals report the EHR data elements using the QRDA Category I files, we here at CMS would then merge the EHR data with the claims data to be able to calculate the readmission rate. Next slide, please.

In proposing the adoption of the Hybrid Hospital-Wide Readmission Measure, we want to be able to, in a stepwise manner, be able to give hospitals and their vendors enough time to be able to successfully implement and report the measure. So, we are proposing to start with two voluntary reporting periods. The first reporting period, or measurement period, would be July 1, 2021 through June 30, 2022. We're proposing that the EHR data be submitted to CMS within three months following the end of the reporting period. In 2022, that would be September 30, 2022, the submission deadline for the EHR data. The second voluntary reporting

period would run from July 1, 2022 through June 30, 2023. I would like to note this is one year or four quarters of data and it aligns with the reporting period for the claims-based version of the hospital-wide readmission measure that we're currently using. Then, if you think of it as the third year of reporting, that's when the measure will become mandatory, starting with the July 1, 2023 through June 30, 2024, measurement period. This would impact the hospital's annual payment updates beginning with fiscal year 2026 if the EHR data is not successfully submitted to CMS. This would also mean that we would begin public reporting of the hybrid measure data on our *Hospital Compare* website. Next slide, please.

More specifically related to public reporting, first, I definitely want to state that we will not be publicly reporting data from the voluntary reporting periods. However, it's a great opportunity to begin reporting of the data and we would share confidential feedback reports so that hospitals can see how they're doing on the hybrid measure before we begin to publicly report the data. And, as I mentioned previously, we would begin to publicly report the data with the July 2023 through June 2024 reporting period data, and that corresponds to the data for the measure being publicly reported on *Hospital Compare* website which is anticipated for the July 2025 *Hospital Compare* refresh. Next slide, please.

As we're proposing to adopt the Hybrid Hospital-Wide Readmission measure, we're also proposing to remove the claims-based version of the Hospital-Wide Readmission measure when the hybrid measure becomes a mandatory measure, and, in terms of the reporting periods for both the hybrid and the claims based measures, the reporting period are aligned to go from July through June of the next year for a 12-month or four-quarter reporting period. So, there would be no interruption in terms of data for this measure being publicly reported on the *Hospital Compare* website. As noted in the previous slide, starting with the July 2025 refresh of the *Hospital Compare* website, that's when we would begin reporting performance on hybrid measure, rather than the claims-based version of the measure. Next slide, please.

Through this proposed rule, we'd also like to seek the public's comments on three potential future measures for the IQR and Promoting Interoperability Programs, and all three of these measures are eCQMs. One is a Hospital Harm - Severe Hypoglycemia measure. Second is a Hospital Harm - Pressure Injury measure. The third is a Caesarian Birth measure, referred to as PC-02. It's stewarded by the Joint Commission and looks at the rates of nulliparous women with a normal-term, singleton fetus in the vertex position undergoing C-section. As I mentioned, we would love to hear stakeholders' feedback on one or more of these measures as potential future measures to add to the eCQM measure set for hospitals. Next slide, please.

Then, lastly for the IQR program, I also wanted to note we have in the proposed rule some more discussion on our expanding efforts to provide hospitals with confidential disparity results for outcome measures, and, in terms of referring to disparity results, we started for each hospital last fall with the pneumonia readmission measure. And we calculated the measure looking at hospital patients who are duly eligible for Medicare and Medicaid, in comparison to hospital patients who are Medicare patients but not also on Medicaid, to look at two different patient groups. And, in this proposed rule, we discuss how we're going to expand on that effort. So, we'd start with the pneumonia readmission measure, and we'll be doing those disparity method calculations for five additional readmission measures for AMI, CABG, COPD, heart failure, and the hip replacement/knee replacement readmission measure. Next slide, please.

Okay, I will next move on to the Hospital VBP Program and proposals we have in this year's IPPS proposed rule. Next slide, please.

First of all, to just start off with a little bit of background on the statutory requirements of the Hospital VBP Program. So, for fiscal year 2020 hospital payments, the Social Security Act requires us to withhold 2 percent and then redistribute that 2 percent as value-based incentive payments to hospitals based on how they perform in the Hospital Value-Based Purchasing Program, and, for fiscal year 2020, we estimate that the total amount that will be available will be approximately $1.9 billion. Next slide, please.

This slide provides a summary of the different versions of Table 16 that are available, and I just wanted to take a quick moment to explain what Table 16 is and how Table 16a and Table 16b differ. So, as part of the proposed rule, we have available on the *CMS.gov* website, Table 16, which is an estimate of each hospital's payment adjustment, where we estimate it would be under the Hospital Value-Based Purchasing Program. However, this is based on last year's total performance scores because that's the most recent data we have available. So, I just want to note that caveat. So, we're estimating the payment adjustments for fiscal year 2020, but we're having to use fiscal year 2019 Total Performance Scores because that's the data we currently have. So, it's not going to reflect the actual payment adjustments for fiscal year 2020. Table 16a will be published as part of the final rule this year, which will come out on August 1, and that table will continue to use fiscal year 2019 Total Performance Scores because hospitals will, at that point in time, be in the middle of the review and corrections period for fiscal year 2020 results from the Hospital VBP Program. So, for Table 16a, we'll still have to use the previous year's Total Performance Scores, but it will be updated to reflect more recent MedPAR data. And then, I think really, it's Table 16b which will come out in the fall, and we'll post it in the same location on the *CMS.gov* website that will have the actual payment adjustment factors for each hospital for fiscal year 2020, and it will be based on the fiscal year 2020 Total Performance Scores. Next slide, please.

So, in this year's proposed rule, we really only have one main proposal for the Hospital VBP Program and it's an administrative proposal. So, there's no changes to the measures that are used in the Hospital VBP Program. However, in last year's rule, we finalized the collection of Hospital-Acquired Infection measure data that come to us through the CDC's National Healthcare Safety Network to be collected through the Hospital-Acquired Condition Reduction Program because those measures will be formally removed from the IQR program. So, to reflect that change in the program under which the HAI data will be coming into CMS, the Hospital VBP Program, which uses the same HAI measures, is proposing to use that same HAI data that will now be coming into CMS through the HAC

Reduction Program, and this proposed policy would begin with January 1, 2020 for 2020 data collection. And 2020 data will be used to calculate the performance period data for reflecting fiscal year 2022 of the Hospital VBP Program. Next slide, please.

So, these next set of slides, there are no new proposals. The next set of slides summarize what we have previously finalized for the Hospital VBP Program and we want to be able to share that information in a more easily digestible manner in these slides. So, this slide reflects the four domains: Safety, Clinical Outcomes, Person and Community Engagement, and Efficiency and Cost Reduction for fiscal year 2022. And it also lists each of the individual measures that are within those domains and used to calculate hospitals Total Performance Scores. Next slide, please.

Then, this slide shows the measurement periods, both the baseline period and the performance period for each of the measures that will be used for the fiscal year 2022 program year. Just as a reminder, we use hospitals performance during the baseline period to establish the performance standards, the benchmark and achievement thresholds that we use for scoring on the Hospital VBP Program. For each measure, we use the higher of the hospital's improvement score for the measure, how well they did during the performance period, compared to their own performance during the baseline, or we take, if higher, we use the achievement score, which is based on how a hospital does during the performance period relative to other hospitals on the same measure during the performance period. Next slide, please.

Okay. This slide shows the domains and the measures for the fiscal year 2023 through 2025 program years. Next slide, please.

Then, these next set of slides also reflect the specific measurement periods for each program year. So, I won't spend too much time on it, but here's fiscal year 2023. Next slide, please.

And then for 2024. Next slide, please.

And fiscal year 2025. So, I'll leave you at your leisure to look at these slides again in more detail. Next slide, please.

Okay. That wraps up my presentation of our proposals for the Hospital IQR Program and the Hospital VBP Program. Again, I'd like to thank everyone for joining us today, and now I'm going to turn this over to my colleague Michael Brea. Thank you.

**Michael Brea:** Thank you, Grace, and thank you everyone for joining us today. I'm excited to have this opportunity to talk with you about the recently published proposed rule as it relates to the Hospital-Acquired Condition or the HAC Reduction Program as it's frequently called. Again, my name is Michael Brea, and I'm the program lead for the HAC Reduction Program. I'm only going to provide a very high-level overview during this webinar because of time constraints. I expect that you'll have questions and want to know more details that I'm not able to provide today. So, I encourage you to read the rule and submit questions as necessary.

On this slide, you'll see a summary of our modest proposals for this year. The first is to adopt a measure removal policy that aligns with the removal factor policies previously adopted for the other quality reporting, quality payment programs. We also clarified policies for validation for the CDC NHSN HAI measures and we also propose data collection periods for FY 2022 program year.

So, this slide shows the proposed measure removal policy for the HAC Reduction Program. While CMS is not proposing to remove any measures in this proposed rule, we are proposing to adopt a removal factor policy as part of our ongoing efforts to ensure that the HAC Reduction Program measure set continues to promote improved health outcomes for beneficiaries, while minimizing the overall burden and cost associated with the program. In addition, the adoption of measure removal factors align the HAC Reduction Program with our other quality reporting quality programs and help ensure consistency in our measure evaluation methodology across programs. The eight factors are listed there on your screen, the first of which is measure performance among hospitals is so

high and unvarying that meaningful distinctions and improvements in performance can no longer be made (i.e., topped-out measures). The second is that a measure does not align with current clinical guidance or practice. Third, the measure can be replaced by 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. Measure removal factor four: measure performance improvement does not result in better patient outcome. Number five: the measure can be replaced by a measure that is more strongly associated with desired patient outcomes for the particular topic. Six: measure collection or public reporting leads to negative unintended consequences other than patient harm. Factor seven: the measure is not feasible to implement as specified. Last but not least, factor eight, the cost associated with the measure outweigh the benefit of its continued use in the program. Just a reminder, CMS proposes to remove measures on a case by case basis. Measures meeting these criteria do not necessarily deem them removable from the program.

We also have some proposed changes to the validation selection methodology. We propose a change to the previously finalized validation selection methodology in the FY ‘19 IPPS/LTCH PPS Final Rule. We finalized our policy to select 200 additional hospitals for targeted validation and five targeting criteria. While we are retaining the same targeting criteria that we finalized last year, we’re proposing to change the number of hospitals targeted from exactly 200 to up to 200, and we believe this change is necessary to provide flexibility in the selection process for the HAC Reduction Program so that we can implement a targeting process for validation of chart-abstracted measures in both the Hospital IQR Program and the HAC Reduction Program in a manner that does not unnecessarily subject hospitals to selection just to meet that 200 number. So, this policy would allow us to only select hospitals that meet the targeting criteria and allow us to remove hospitals that do not have the requisite number of NHSN HAI events from the targeted validation pool. Then, we’re also clarifying our selection process for both the random and targeted sample sub-section (d) hospitals subject to the HAC Reduction Program validation. We’re clarifying that the HAC Reduction Program, in conjunction with the Hospital IQR Program, will use an aggregated random

sample selection methodology through which the validation team would select one poll of 400 sub-section (d) hospitals for validation of the chart-abstracted measures in both Hospital IQR and HAC Reduction [Programs]. The pool of 400 hospitals will be selected randomly and validated for both the NHSN HAI measures for the HAC Reduction Program and the [Hospital] IQR Program chart-abstracted measures. The HAC Reduction Program will include all sub-section (d) hospitals, whereas the Hospital IQR Program will remove any sub-section (d) hospital without an active Notice of Participation in the [Hospital] IQR Program.

To better target true events for NHSN HAI validation, we proposed this year to clarify our approach for selecting CLABSI and CAUTI cases for those chart-abstracted validation processes when the NHSN HAI validation, that is currently performed under IQR, moves over to the HAC Reduction Program, beginning with the reporting of quarter three calendar year 2020 infection events. To date, our experience has shown us that many candidate cases selected for validation have all their positive cultures collected during the first or second day following admission and, as such, would be considered community onset events for CLABSI and CAUTI. Therefore, we're proposing to clarify that we will eliminate these candidate CLABSI and CAUTI cases from the NHSN HAI selection process prior to random case selection via filtering method. The filtering method would 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. And we estimate that, by implementing this proposed filtering method, the number of true events validated for CLABSI and CAUTI will increase without increasing the overall sample size, which will help us better understand the over-reporting and under-reporting of such events.

Then, we're proposing to adopt the applicable period for the FY '22 HAC Reduction Program for the CMS PSI 90 as the 24-month period from July 1, 2018 through June 30, 2020, and applicable period for the NHSN HAI measures as the 24-month period from January 1, 2019 through December 31, 2020.

On the screen, you'll find resources for the HAC Reduction Program. For any questions, you may email the HAC Reduction Program support contractor at hacrp@lantanagroup.com and, with that, I will turn it over to my colleague, Erin Patton, to discuss the Hospital Readmissions Reduction Program. Thank you.

**Erin Patton:** Good afternoon. My name is Erin Patton, and I'm the Program Lead for the Hospital Readmissions Reduction Program. Today, I'll be discussing the fiscal year 2020 proposals for the Hospital Readmissions Reduction Program. Next slide.

This slide provides a summary of the Hospital Readmissions Reduction Program, or HRRP, proposed rule. I encourage you to reference the rule for additional details. Proposals for the FY 2020 rule include establishing the applicable period for fiscal year 2022, adoption of measure removal factors, an update to the previously finalized definition of "dual-eligible" starting in fiscal year 2021, a sub-regulatory process, and revisions to regulatory text. Next slide.

HRRP includes six claims-based readmission measures that are listed here. These include acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, elective primary total hip and total knee arthroplasty, and coronary artery bypass graft surgery. All six measures will remain for fiscal year 2022. The applicable period for HRRP used three years of claims data, which is also the same time period applied to dual proportion and payment calculation. Next slide.

While we are not proposing to remove any measures from the HRRP in this proposed rule, we are proposing to adopt a measure removal practice policy as part of our efforts to ensure that the HRRP measure set continues to promote improved health outcomes for beneficiaries, while minimizing the overall burden and costs associated with the program. The adoption of measure removal factors would align the Hospital Readmissions Reduction Program with our other quality reporting and quality payment programs and help ensure consistency in our measure evaluation methodology across the program. Next slide.

We believe that alignment between CMS quality programs is important to provide stakeholders with a clear, consistent, and transparent process. To align with our other quality reporting and quality payment programs, we're proposing to adopt the following removal factors listed on this slide for the Hospital Readmissions Reduction Program. These factors are the same as those described earlier during the HAC RP presentation. As a reminder, these factors are considerations taken into account when deciding whether or not to remove measures, not firm requirements. We will propose to remove measures based on these factors on a case by case basis. Next slide.

CMS is also proposing to adopt a definition for "dual-eligible." This updated definition is necessary to account for misidentification of the dual eligible status of patient beneficiaries who die in the month of discharge, which can occur under the current definition. We were not aware at the time we finalized our current definition of "dual-eligible" that there are times when the data source from the State MMA files may under-report the number of beneficiaries with dual eligibility status for the month in which the beneficiary dies and, therefore, these data are not a fully accurate reflection of dual-eligible status for the month in which the beneficiary dies. We have identified two situations that lead to the under-reporting of dual-eligible patients. One: The dual-eligible status is not recorded in the month of death. Two: The dual-eligible status changes from dual in the month prior to death to non-dual in the month of death. While the number of misidentified beneficiaries is very small and did not have a substantive impact, we believe that the most accurate information available is the most appropriate policy for the program and consistent with our initial rationale of using the State MMA files as the source to identify dual eligible. Next slide.

In the fiscal year 2020 rule, we are proposing a sub-regulatory process. There are times when data sourcing and other technical aspects of the payment adjustment factor component change and require updating, even when those changes do not alter the intent of our previously finalized policies. HRRP relies on these payments adjustment factor components

including, but not limited to, dual proportion, peer group assignment, peer group meeting ERR, neutrality modifier, and ratio of DRG payments to total payments to determine hospital payments in each fiscal year. CMS identified another reason for a sub-regulatory process when we identified the issues with data accuracy for determining dual-eligible status from data source from the State MMA files for beneficiaries who die in the same month as discharge. With this proposed sub-regulatory process, we will be able to more quickly implement updates to improve the accuracy of the calculation outside of rulemaking. Substantive changes will still be proposed and finalized through rulemaking. Any updates to the technical aspects of the payment adjustment factor components will be provided in the HSR guide. Next slide.

Finally, we are proposing to update previously finalized definitions, including "aggregate payments for excess readmissions," "applicable condition," and "base operating DRG payment amount." Note that the "base operating DRG payment amount" is being updated to align with Section 1886 of the act because the regulatory text was not updated following the expiration of the fiscal year 2013 changes. Next slide.

CMS welcomes public comments on the fiscal year 2020 proposals for HRRP. This slide also contains more detailed resources on HRRP and resources on reducing hospital readmissions. I thank you for your time and attention today, and I'll hand it back over to Candace Jackson. Thank you.

**Candace Jackson**: Thank you, Erin. This slide provides you with a direct link to the fiscal year 2020 IPPS proposed rule and the pages for each of the specific programs, and then, lastly, CMS is accepting comments on the fiscal year 2020 IPPS proposed rule until June 24, 2019. Comments can be submitted either electronically, by regular mail, by express or overnight mail, or by hand carrier. Please note that you should review proposed rule for specific instructions for each method and submit by only one method. CMS will respond to comments in the final rule, which is scheduled to be issued August of 2019.

This next section identifies the measures that are included in each program through fiscal year 2024.

This slide shows the Excess Days in Acute Care measures.

This slide shows the applicable Readmission measures.

The Mortality measures are listed on this slide.

This slide shows the claims-based patient Safety measures.

The applicable payment measures are listed on this slide.

The chart-abstracted clinical process of care measures are listed on this slide.

On this slide is the applicable electronic clinical process of care measures.

This slide shows the applicable HAI measures.

This slide is for the Hybrid Hospital-Wide All-Cause Readmission measure.

And lastly, this slide is for the HCAHPS measure.

I'd like to thank Grace, Mike, and Erin for providing the information today. As there was so much valuable information to cover, we unfortunately will not have time for a live Q&A session. As mentioned earlier, we would strongly encourage you to submit your comments or questions through the formal comments submission process.

Additionally, all questions again will be responded to and posted to the *Quality Reporting Center* website at a later date. For the CEU process, please review the slides related to the process that follow in this webinar. And if you have any questions, please contact Debra Price at DPrice@HSAG.com. And again, we thank you for joining us today, and we hope you have a great remainder of your day. Thank you.