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Audio from computer speakers breaking up?  
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Click Refresh icon  
– or –  
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Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor (SC)

Today’s Presentation
Navigating QualityNet Pages and Reports: Inpatient Programs

Hosted by
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor (SC)

January 31, 2019
Speakers

Candace Jackson, ADN
Project Lead, Hospital Inpatient Quality Reporting (IQR) Program
Hospital Inpatient VIQR Outreach and Education SC

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Outreach and Education Lead
Hospital Inpatient VIQR Outreach and Education SC

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Program Lead, Hospital Acquired-Condition (HAC) Reduction Program
Hospital Quality Reporting Program Support Contractor (HQRPSC)

Laura Blum, MPH
Program Lead, Hospital Readmissions Reduction Program (HRRP)
HQRPSC

Moderator
Bethany Wheeler-Bunch, MSHA
Hospital Value-Based Purchasing (VBP) Program Support Contract Lead
Hospital Inpatient VIQR Outreach and Education SC
Purpose

This event will provide an overview of the resources available for the Centers for Medicare & Medicaid Services (CMS) inpatient quality programs on QualityNet. In addition, this event will provide an overview of how to retrieve reports through the QualityNet Secure Portal.
Objectives

By the end of this presentation, participants will be able to:

• Find inpatient quality program \textit{QualityNet} pages and other available resources.
• Run reports in the \textit{QualityNet Secure Portal}.
• Retrieve reports from the Auto Route Inbox.
Audience Question

Where can I find up-to-date information on CMS inpatient programs?

1. QualityNet
2. Quality Reporting Center
3. Unsure
Hospital IQR Program Overview

The Hospital Inpatient Quality Reporting (IQR) Program was developed as a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Section 5001(a) of Public Law 109-171 of the Deficit Reduction Act of 2005 provided new requirements for the Hospital IQR Program, which built on the voluntary Hospital Quality Initiative.

The Hospital IQR Program is intended to equip consumers with quality of care information to make more informed decisions about healthcare options. It is also intended to encourage hospitals and clinicians to improve the quality of inpatient care provided to all patients. The hospital quality of care information gathered through the program is available to consumers on the Hospital Compare website.

Hospital IQR Program Resources

Hospital Contact Change Form
- Contact Change Form, PDF Fillable Form-122 KB (Updated 04/27/18) - Use to report any changes regarding key contacts at the hospital (e.g., CEO/administrator, IQR contact, medical records contact, National Healthcare Safety Network contact, and QualityNet Security Administrators) to help ensure the facility receives all necessary correspondence regarding the Hospital IQR Program.

Hospital IQR Important Dates and Deadlines - Third Quarter 2017 through Fourth Quarter
### Hospital IQR Program Important Dates and Deadlines

<table>
<thead>
<tr>
<th>Discharge Quarters</th>
<th>HCAHPS Submission</th>
<th>Population &amp; Sampling Submission</th>
<th>Clinical and HAI Submission</th>
<th>PC-01 Web-Based Submission</th>
<th>HAI Validation Templates**</th>
<th>Estimated CDAC Record Request**</th>
<th>Estimated Date Records Due to CDAC**</th>
</tr>
</thead>
</table>

**FY 2020 APU (CY 2017 eCQM Validation)**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Estimated CDAC Record Request</th>
<th>Estimated Date Records Due to CDAC**</th>
</tr>
</thead>
<tbody>
<tr>
<td>eCQMs (Hospital IQR Program alignment with Promoting Interoperability Program***)</td>
<td>Random: 08-14-2018</td>
<td>Random: 09-13-2018</td>
</tr>
</tbody>
</table>

** FY 2020 APU Measures/Requirement

<table>
<thead>
<tr>
<th>Measure</th>
<th>Quarters/Dates Included</th>
<th>Submission Deadline/Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>eCQMs (Hospital IQR Program alignment with Promoting Interoperability Program***)</td>
<td>One self-selected quarter of data (1Q 2017, 2Q 2017, 3Q 2017, or 4Q 2017)</td>
<td>Feb 28, 2019</td>
</tr>
<tr>
<td>DACA</td>
<td>January 1, 2018–December 31, 2018</td>
<td>April 1, 2019–May 15, 2019</td>
</tr>
<tr>
<td>Influenza Vaccination Coverage Among HCP</td>
<td>October 1, 2017–March 31, 2018</td>
<td>May 15, 2018</td>
</tr>
</tbody>
</table>

* Required for chart abstracted measures only.
** Validation for FY 2020 includes 3Q 2017, 4Q 2017, 1Q 2018, and 2Q 2018.
*** For the Hospital IQR Program in FY 2020, hospitals must report at least four eCQMs from the same quarter.

**NOTES:** All dates are subject to change. Generally, data must be submitted no later than 11:59 p.m. Pacific Time on the submission deadline with the exception of HCAHPS, which must be submitted by 11:59 p.m. Central Time; validation medical records must be received by CDAC no later than 4:30 p.m. Eastern Time. Data for clinical and electronic measures, population and sampling, structural measures, DACA, and web-based measures are transmitted within the QualityNet Secure Portal. Data for HAI Validation Templates are transmitted within the QualityNet Secure Portal via Secure File Transfer. Data for HAI and HCP measures are submitted to the CDC through the NHSN. Medical records are submitted to the CDAC according to convened instructions.
Notice of Participation

Notice of Participation
Hospital Inpatient Quality Reporting (IQR) Program

To participate in the Hospital Inpatient Quality Reporting (IQR) Program, each hospital must complete a Notice of Participation using an online tool on the QualityNet Secure Portal.

New hospitals and existing hospitals that wish to participate in the Hospital IQR Program for the first time must complete a Notice of Participation pledge that includes the name and address of each hospital campus that shares the same Centers for Medicare & Medicaid Services (CMS) Certification Number (CCN).

Hospitals that wish to participate in the Hospital IQR Program need to submit a Notice of Participation no later than 180 days from their Medicare Accept Date. These hospitals need to begin submitting program data starting with the first day of the quarter following the date when the hospital signed its Notice of Participation.

Hospitals that would like to participate in the program for the first time or that previously withdrew from the program and would like to participate again must complete a Notice of Participation by December 31 of the calendar year preceding the first quarter of the calendar year in which the Hospital IQR Program data submission is required for any given fiscal year.

A hospital that has previously indicated its intent to participate is considered an active participant until
Measures

Hospital Inpatient Quality Reporting Program

Measures

Hospital Inpatient Quality Reporting (IQR) Program Measures by Fiscal Year (FY) Payment Determination/Calendar Year (CY) Reporting Period

The annual Hospital IQR Measures reference guide, for use specifically by participants in the Hospital IQR Program, indicates whether a measure is eligible for inclusion in the Hospital Value-Based Purchasing (VBP) Program and whether the measure is eligible for submission as an electronic Clinical Quality Measure (eCQM). Additionally, the guide indicates the measure data source and whether it will display on Hospital Compare.

- Hospital IQR FY 2019 Measures, PDF-123 KB (Updated 10/31/17) – for CY 2017 reporting period
- Hospital IQR FY 2020 Measures, PDF-121 KB (12/08/17) – for CY 2018 reporting period

Acute Care Hospital Quality Improvement Program Measures by FY Payment Determination

The annual Acute Care Hospital Quality Improvement Program Measures reference guide provides a comparison of measures for five Centers for Medicare & Medicaid Services (CMS) acute care hospital quality improvement programs, including the:

- Hospital IQR Program
- Hospital VBP Program
# CMS Hospital Inpatient Quality Reporting Program Measures Fiscal Year 2020 Payment Update

## Measures Required to Meet Hospital IQR Program APU Requirements

### Healthcare-Associated Infection

<table>
<thead>
<tr>
<th>Short Name</th>
<th>Measure Name</th>
<th>Data Source</th>
<th>Reported on Hospital Compare?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAUTI</td>
<td>National Healthcare Safety Network Catheter-Associated Urinary Tract Infection Outcome Measure</td>
<td>NHSN</td>
<td>Yes</td>
</tr>
<tr>
<td>CDI</td>
<td>National Healthcare Safety Network Facility-wide Inpatient Hospital-onset <em>Clostridium difficile</em> Infection Outcome Measure</td>
<td>NHSN</td>
<td>Yes</td>
</tr>
<tr>
<td>CLABSI</td>
<td>National Healthcare Safety Network Central Line-Associated Bloodstream Infection Outcome Measure</td>
<td>NHSN</td>
<td>Yes</td>
</tr>
<tr>
<td>Colon and Abdominal Hysterectomy SSI</td>
<td>American College of Surgeons – Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection Outcome Measure</td>
<td>NHSN</td>
<td>Yes</td>
</tr>
<tr>
<td>HCP</td>
<td>Influenza Vaccination Coverage Among Healthcare Personnel</td>
<td>NHSN</td>
<td>Yes</td>
</tr>
<tr>
<td>MRSA Bacteremia</td>
<td>National Healthcare Safety Network Facility-wide Inpatient Hospital-onset Methicillin-resistant <em>Staphylococcus aureus</em> Bacteremia Outcome Measure</td>
<td>NHSN</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Chart-Abstracted Clinical Process of Care

<table>
<thead>
<tr>
<th>Reported on Hospital Compare?</th>
</tr>
</thead>
</table>
Annual Payment Update (APU) Recipients

Hospitals eligible for the Hospital Inpatient Quality Reporting (IQR) Program are included annually in one of three lists:

- Hospitals receiving full Annual Payment Update (APU) – hospitals that satisfactorily met the requirements for the Hospital IQR Program. These hospitals will receive the full annual market basket update.
- Hospitals not receiving full APU – hospitals that did not satisfactorily meet the criteria for the Hospital IQR Program. These hospitals will receive their annual market basket update with a reduction by one-fourth of the applicable market basket update.
- Hospitals choosing not to participate – hospitals that actively chose not to participate. These hospitals will receive their annual market basket update with a reduction by one-fourth of the applicable market basket update.

Fiscal Year (FY) 2019 (Updated 08/30/18)
- Hospitals receiving full APU – PDF or XLS
Extraordinary Circumstances Form

Hospital Inpatient Quality Reporting Program

How to Participate
Notice of Participation
Measures
APU Recipients
APU Reconsideration
QIN-QIO Contacts
Web-Based Data Collection
Extraordinary Circumstances Form
Support Contact

Extraordinary Circumstances Exceptions (ECE) Policy

Hospital Inpatient Quality Reporting Program

The Centers for Medicare & Medicaid Services (CMS) offers a process for hospitals to request and for CMS to grant extensions or exceptions with respect to the reporting of required quality data—including electronic Clinical Quality Measure (eCQM) data—when there are extraordinary circumstances beyond the control of the hospital.

Non-eCQM Related ECEs

Hospitals may request an extension of or exception from various quality reporting requirements due to extraordinary circumstances beyond the control of the facility. Such circumstances may include, but are not limited to, natural disasters (such as a severe hurricane or flood) or systemic problems with CMS data collection systems that directly affected the ability of facilities to submit data.

For non-eCQM related ECEs, hospitals must submit an Extraordinary Circumstances Exceptions (ECE) Request Form (PDF-71 KB), with all required sections completed within 90 calendar days of the extraordinary circumstance. The hospital may request consideration for an extension or exception of the requirement to submit quality data for one or more quarters. If the hospital requests an exception for validation, the hospital will only have the requested quarter included in validation if all requested medical records are submitted for the quarter.

eCQM Related ECEs
Maria Gugliuzza, MBA
Outreach and Education Lead, Hospital Inpatient
VIQR Outreach and Education SC

Hospital Value-Based Purchasing (VBP) Program
Hospital Value-Based Purchasing (HVBP)

Background
Section 1886(o) of the Social Security Act sets forth the statutory requirements for the Hospital Value-Based Purchasing (HVBP) Program. The program uses the hospital quality data reporting infrastructure developed for the Hospital Inpatient Quality Reporting (IQR) Program, which was authorized by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

The Hospital VBP Program is part of the Centers for Medicare & Medicaid Services' (CMS') long-standing effort to link Medicare's payment system to improve healthcare quality, including the quality of care provided in the inpatient hospital setting.

The program implements value-based purchasing to the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in approximately 3,000 hospitals across the country.

Hospitals are paid for inpatient acute care services based on the quality of care, not just quantity of the services they provide.

Purpose
The Hospital VBP Program is designed to promote better clinical outcomes for hospital patients, as well as improve their experience of care during hospital stays. Specifically, Hospital VBP seeks to...
Immediate Jeopardy
Hospital VBP Program Quick Reference Guide

Eligibility for Participation in the Hospital VBP Program and Immediate Jeopardy Origination

The Centers for Medicare & Medicaid Services (CMS) Hospital Value-Based Purchasing (VBP) Program applies to subsection (d) hospitals, but excludes hospitals from participating for a fiscal year in which the following conditions apply:

1. A hospital that is subject to the payment reduction under section 1886(b)(3)(B)(viii)(I) of the Social Security Act (the Hospital Inpatient Quality Reporting Program)

2. A hospital for which, during the performance period for the fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients

3. A hospital for which there are not a minimum number of measures that apply to the hospital for the performance period for

Immediate Jeopardy Definition: Violation of a Condition of Participation (CoP)

CMS uses the Medicare State Survey and Certification process for citing deficiencies that pose immediate jeopardy to patients. Hospitals cited for deficiencies by this process during the performance period will be excluded from the Hospital VBP Program for the fiscal year. Hospitals excluded from the Hospital VBP Program would not incur the applicable withhold and would not be eligible to receive incentive payments for the fiscal year.

Immediate Jeopardy Definition: Emergency Medical Treatment and Labor Act (EMTALA) Violations

The CMS Regional Office determines whether there was an EMTALA violation after reviewing the State Survey Agency’s report and an expert physician reviews the findings. Then it determines whether the violation constitutes an

Performance Periods for Purposes of Immediate Jeopardy (FY 2019- FY 2022)

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2019</td>
<td>07/01/2014 – 12/31/2017</td>
</tr>
<tr>
<td>FY 2020</td>
<td>07/01/2015 – 12/31/2018</td>
</tr>
<tr>
<td>FY 2021</td>
<td>04/01/2016-12/31/2019</td>
</tr>
<tr>
<td>FY 2022</td>
<td>04/01/2017-12/31/2020</td>
</tr>
</tbody>
</table>

CoP vs. EMTALA Citation Dates

- **CoP**: The survey end date generated in the Automated Survey Processing Environment (ASPen) is used as the date for assignment of the immediate jeopardy citation to a particular performance period.
- **EMTALA**: The date of CMS’ final issuance of Form CMS-2567 to the hospital is used as the date for assignment of the immediate
Baseline and Performance Periods

Hospital Value-Based Purchasing (HVBP)

Baseline and Performance Periods

- Baseline and Performance Periods - Previous Years

Eligibility
Measures
Scoring
Reports
Performance Standards
Review and Corrections/Appeals
Payments
Extraordinary Circumstances Form

Baseline and Performance Periods
Hospital Value-Based Purchasing

In developing Hospital Value-Based Purchasing (VBP), the Centers for Medicare & Medicaid Services (CMS) conducted extensive research and stakeholder outreach. Information outlining Hospital VBP was published in the CMS Final Rules.

Among other topics, these final rules include details on:
- program structure, including quality and cost measure categories ("domains")
- quality and cost measures selected for the program
- criteria for participating and non-participating hospitals
- periods of performance for quality measurement
- performance standards for all quality measures
- scoring methodology

Fiscal Year (FY) 2020 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: 30-Day Mortality Measures</td>
<td>July 1, 2010 – June 30, 2013</td>
<td>July 1, 2015 – June 30, 2018</td>
</tr>
<tr>
<td>Clinical Care: THA/TKA</td>
<td>July 1, 2010 – June 30, 2013</td>
<td>July 1, 2015 – June 30, 2018</td>
</tr>
</tbody>
</table>
Eligibility

Hospital Value-Based Purchasing (HVBP)

Minimum Cases and Measures

CMS established the following minimum reporting requirements for number of cases, measures, and surveys:

FY 2018 Minimum Reporting Requirements
- Clinical Care: 25 cases in at least 2 of the 3 measures.
- Patient-and-Caregiver Centered Experience of Care/Care Coordination: 100 completed surveys.
- Safety: Hospitals must report the applicable case minimum for at least 3 of the 7 measures for the Safety domain.
  - AHRQ (PSL-90): 3 cases for any one of the underlying indicators.
  - CAUTI: 1 predicted infection.
  - CLABSI: 1 predicted infection.
  - CDI: 1 predicted infection.
  - MRSA: 1 predicted infection.
  - SSI: A minimum of 1 predicted infection must be calculated in at least 1 of the 2 SSI strata in order to receive a SSI measure score.
    - SSI – Colon: 1 predicted infection.
    - SSI – Abdominal Hysterectomy: 1 predicted infection.
  - PC-01: 10 cases.
- Efficiency and Cost Reduction: 25 episodes of care for the Medicare Spending per Beneficiary.
Measures

- Fiscal Years 2018 - 2023 Measures
  - Hospital Value-Based Purchasing (VBP)

Clinical Care Domain

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure Description</th>
<th>FY 2018</th>
<th>FY 2019</th>
<th>FY 2020</th>
<th>FY 2021</th>
<th>FY 2022</th>
<th>FY 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORT-30-AMI</td>
<td>Acute Myocardial Infarction (AMI) 30-Day Mortality Rate</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>MORT-30-HF</td>
<td>Heart Failure (HF) 30-Day Mortality Rate</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>MORT-30 PN</td>
<td>Pneumonia (PN) 30-Day Mortality Rate</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
Scoring

Hospital Value-Based Purchasing (VBP)

A hospital’s performance in Hospital Value-Based Purchasing (VBP) is based on measures/dimensions for the domains per fiscal year (FY). The hospital’s Total Performance Score (TPS) is composed of the following:

FY 2018 Scoring

<table>
<thead>
<tr>
<th>Domain</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Care</td>
<td>25%</td>
</tr>
<tr>
<td>Patient- and Caregiver-Centered Experience</td>
<td>25%</td>
</tr>
<tr>
<td>of Care/Care Coordination</td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>25%</td>
</tr>
<tr>
<td>Efficiency and Cost Reduction</td>
<td>25%</td>
</tr>
</tbody>
</table>

FY 2019 & FY 2020 Scoring

<table>
<thead>
<tr>
<th>Domain</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Achievement and Improvement Scoring

Hospital Value-Based Purchasing (HVBP)

Baseline and Performance Periods
Eligibility
Measures
Scoring

- Achievement and Improvement

- Scoring - Previous Years

Reports
Performance Standards
Review and Corre"
Reports

Hospital Value-Based Purchasing (HVBP)

Baseline and Performance Periods
Eligibility
Measures
Scoring
Reports
- Previous Years' Reports
Performance Standards
Review and Corrections/Appeals
Payments

Reports
Hospital Value-Based Purchasing

The Centers for Medicare & Medicaid Services (CMS) provides hospitals with reports reflecting the Hospital Value-Based Purchasing (VBP) program's impact for each fiscal year (FY).

CMS provides the Baseline Measures Report and Percentage Payment Summary Report to hospitals each year. CMS anticipates the upcoming fiscal year Percentage Payment Summary Report to be available by August 1, prior to the start of the same fiscal year.

Reports are only available on the QualityNet Secure Portal to hospital users who are active, registered QualityNet users and assigned the following roles:
- Hospital Reporting Feedback – Inpatient role (required to receive the report)
- File Exchange & Search role (required to download the report from the secure portal)

Report releases
CMS previously provided or anticipates providing the following reports to hospitals:

FY 2020 Hospital VBP Program Reports
- CMS anticipates the release of the Hospital VBP Program FY 2020 Baseline Measures Report in 2018. The Baseline Measures Report allows hospitals to monitor their baseline period data and set targets for their VBP Improvement.
Performance Standards

CMS assesses each hospital's total performance by comparing its Achievement and Improvement scores for each applicable Hospital VBPM measure. CMS uses a threshold (50th percentile) and benchmark (mean of the top decile) to determine how many points to award for the Achievement and Improvement scores. CMS compares the Achievement and Improvement scores and uses whichever is greater to determine the measure score.

Achievement points are awarded by comparing an individual hospital's rates during the performance period to all hospitals' rates from the baseline period:

- Hospital rates at or better than the benchmark = 10 Achievement points
- Hospital rates worse than the achievement threshold = 0 Achievement points
- Hospital's rate is equal to or better than the achievement threshold and worse than the benchmark = 1-9 Achievement points

Improvement points are awarded by comparing an individual hospital's rates during the performance period to that same individual hospital's rates from the baseline period:

- Hospital rates at or better than the benchmark = 9 Improvement points
- Hospital rates at or worse than the baseline period rate = 0 Improvement points
- Hospital's rate is between the baseline period rate and the benchmark = 0-9 Improvement points

Note: Hospitals with rates at or better than the benchmark, but not better than their baseline period rate (that is, they have a performance period rate below the baseline period rate), will receive 0 improvement points, as no improvement was actually observed.

The Patient Experience of Care (FY 2013-FY 2016), Patient and Caregiver Centered Experience of Care/Care Coordination (FY 2017-2018), and Person and Community Engagement (FY 2019 and subsequent fiscal years) domain score is the sum of a hospital’s Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) base score and that hospital’s HCAHPS Consistency...
Payments

Hospital Value-Based Purchasing (VBP)

Hospital Value-Based Purchasing (VBP) is funded through a reduction from participating hospitals’ Diagnosis-Related Group (DRG) payments for the applicable fiscal year. The money that is withheld will be redistributed to hospitals based on their Total Performance Scores (TPS), as required by statute, and the actual amount earned by hospitals will depend on the actual range and distribution of all eligible/participating hospitals’ TPSs. A hospital may earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that program year.

Value-Based Incentive Payment Percentage by Program Fiscal Year

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Percent Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>1.0</td>
</tr>
<tr>
<td>2014</td>
<td>1.25</td>
</tr>
<tr>
<td>2015</td>
<td>1.5</td>
</tr>
</tbody>
</table>
Resources

Hospital Value-Based Purchasing (HVBP)

Baseline and Performance Periods
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Measures
Scoring
Reports
Performance Standards
Review and Corrections/Appeals
Payments
Extraordinary Circumstances Form

Resources
- Resources - Previous Years
Webinars/Calls

Resources
Hospital Value-Based Purchasing

Hospital Value-Based Purchasing (CMS.gov) – the Centers for Medicare & Medicaid Services’ (CMS) primary source of information about the Hospital Value-Based Purchasing (VBP) for hospitals, clinicians, and other stakeholders. Information includes:

- National Provider Call Presentations
- Fact Sheets
- Open Door Forums

How to Read Your Reports

The How to Read Your Fiscal Year Baseline Measures Report helps hospitals understand how to use the Baseline Measures Report to monitor their baseline performance for all domains and measures.

How to Read Your Fiscal Year Hospital Value-Based Purchasing (VBP) Payment Summary Report provides participating hospitals with information on how to interpret the Percentage Payment Summary Report, which outlines a hospital’s value-based incentive payment percentage for each Medicare discharge.

- Fiscal Year (FY) 2020
  - How to Read Your FY 2020 Baseline Measures Report, PDF-700 KB
  - FY 2019
    - How to Read Your FY 2019 Baseline Measures Report, PDF-957 KB
    - How to Read Your FY 2019 Hospital Value-Based Purchasing (VBP) Program Percentage Payment Summary Report (PPSR), PDF-6 MB
- FY 2018
Resources: Help Guides and Quick Reference Guides

All on QualityNet

- Step-by-Step Calculations for Value-Based Purchasing
- How to Read Your FY 2019 Hospital VBP Program Percentage Payment Summary Report (PPSR)
- Program Summary
- FY 2019 Value-Based Purchasing Domain Weighting

https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772237202
Hospital-Acquired Condition (HAC) Reduction Program
Overview
Hospital-Acquired Condition (HAC) Reduction Program

Section 1886(p) of the Social Security Act established the Hospital-Acquired Condition (HAC) Reduction Program to encourage hospitals to reduce HACs. Beginning with Federal Fiscal Year (FY) 2015 discharges (i.e., beginning on October 1, 2014), the HAC Reduction Program requires the Secretary of Health and Human Services (HHS) to adjust payments to hospitals that rank in the worst-performing 25 percent of all subsection (d) hospitals with respect to HAC quality measures. As set forth in the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) may reduce these hospitals’ payments by one percent.

CMS finalized measures and scoring methodology (vol 78, FR 50717) for this program in the FY 2014 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System (IPPS/LTCH PPS) Final Rule. CMS uses the Total HAC Score to determine the worst-performing quartile of all subsection (d) hospitals. CMS finalized and adopted the new Winsorized z-score methodology for the FY 2018 HAC Reduction Program in the FY 2017 IPPS/LTCH PPS Final Rule. For FY 2019, the Total HAC Score is based on data for six quality measures in two domains:

- Domain 1 – CMS Recalibrated Patient Safety Indicator (PSI) 90 (CMS PSI 90)
- Domain 2 – National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI)
Measures

Hospital-Acquired Condition (HAC) Reduction Program

In the FY 2017 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System (IPPS/LTCPPS) Final Rule, CMS adopted the following measures.

FY 2019 Measures

1. Domain 1 — CMS Recalibrated Patient Safety Indicator (PSI) 90
CMS calculates the CMS PSI 90 using Medicare Fee-for-service claims for discharges from October 1, 2015 through June 30, 2017*. The CMS PSI 90 measure includes:

- PSI 03 — Pressure Ulcer Rate
- PSI 06 — Iatrogenic Pneumothorax Rate
- PSI 08 — In-Hospital Fall with Hip Fracture Rate
- PSI 09 — Perioperative Hemorrhage or Hematoma Rate**
- PSI 10 — Postoperative Acute Kidney Injury Requiring Dialysis Rate**
- PSI 11 — Postoperative Respiratory Failure Rate**
- PSI 12 — Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
- PSI 13 — Postoperative Sepsis Rate
- PSI 14 — Postoperative Wound Dehiscence Rate
- PSI 15 — Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate
Eligibility

Program Eligibility
Hospital-Acquired Condition (HAC) Reduction Program

As defined under the Social Security Act, all subsection (d) hospitals are subject to the HAC Reduction Program. CMS exempts certain hospitals and hospital units from the HAC Reduction Program. Exempted hospitals and units include:

- Critical access hospitals (CAH)
- Rehabilitation hospitals and units
- Long-term care hospitals (LTCH)
- Psychiatric hospitals and units
- Children’s hospitals
- Prospective Payment System (PPS)-exempt cancer hospitals
- Short-term acute care hospitals located in Guam, the U.S. Virgin Islands, the Northern Mariana Islands, and American Samoa
- Religious nonmedical health care institutions (RNHCI)

For a full description of subsection (d) hospitals, refer to the Social Security Act on the Social Security.
Scoring Methodology

**Hospital-Acquired Condition (HAC) Reduction Program**

The HAC Reduction Program encourages hospitals to reduce HACs, as stated in the Fiscal Year (FY) 2014 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System (IPPS/LTC PPS) Final Rule. Beginning in FY 2018, the Centers for Medicare & Medicaid Services (CMS) implemented a new scoring methodology.

**FY 2018 and 2019 Scoring Methodology**

CMS calculates a Total HAC Score composed of two domains to identify the worst-performing quartile of hospitals.

**Domain 1 – CMS Recalibrated Patient Safety Indicators (PSI) 90: Patient Safety and Adverse Events Composite**

**Domain 2 – Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) healthcare-associated infection (HAI) measures:**

- Central Line-Associated Bloodstream Infection (CLABSI)
- Catheter-Associated Urinary Tract Infection (CAUTI)
- Surgical Site Infection (SSI)
Payment Adjustment

Hospital-Acquired Condition (HAC) Reduction Program

Subsection (d) hospitals with a Total HAC Score greater than the 75th percentile of all Total HAC Scores (i.e., the worst-performing quartile) will be subject to a 1 percent payment reduction. This payment reduction applies to all Medicare discharges between October 1, 2018 and September 30, 2019 (i.e., fiscal year 2019). The payment reduction occurs when CMS pays hospital claims. Hospitals that do not rank in the worst-performing quartile will not be subject to a payment reduction. In fiscal year (FY) 2019, CMS notified hospitals whether they will receive a payment reduction in the Hospital-Acquired Condition (HAC) Reduction Program Hospital-Specific Report (HSR). CMS delivered HSRS to hospitals via the QualityNet Secure Portal in July 2018.

CMS applies payment adjustments in the following order:

1. Hospital Value-Based Purchasing (VBP) Program payment adjustment
2. Hospital Readmissions Reduction Program (HRRP) payment adjustment
3. Disproportionate share hospital (DSH) and indirect medical education (IME) payment adjustment
4. HAC Reduction Program payment adjustment

For example, if both the Hospital VBP and HRRP payment adjustments are based on a $1,000,000 base operating diagnosis-related group (DRG) payment amount and the hospital loses 2 percent for
Hospital-Specific Reports

Hospital-Specific Reports
Hospital-Acquired Condition (HAC) Reduction Program

The Centers for Medicare and Medicaid Services (CMS) will generate a Fiscal Year (FY) 2019 Hospital-Specific Report (HSR) for each hospital eligible for the HAC Reduction Program. The HSR is a Microsoft Excel file that presents the following information:

- Total HAC Score
- Domain 1 and Domain 2 scores
- Measure result and Winsorized z-score for the CMS Recalibrated Patient Safety Indicator (PSI) 90 (CMS PSI 90)
- Discharge-level data used to calculate CMS PSI 90 measure results
- Measure results and Winsorized z-scores for the following Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) measures:
  - Central Line-Associated Bloodstream Infection (CLABSI)
  - Catheter-Associated Urinary Tract Infection (CAUTI)
  - Surgical Site Infection (SSI) – colon and hysterectomy
  - Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia
Resources

Hospital-Acquired Condition (HAC) Reduction Program

Fiscal Year (FY) 2019 HAC Reduction Program

- **HAC Reduction Program Scoring Methodology Infographic**, PDF-387 KB (03/22/17) – Overview of the HAC Reduction Program Scoring Methodology using Winsorized z-scores
- **FY 2019 Timeline**, PDF-188 KB (07/25/18) – Timeline for the implementation of the FY 2018 HAC Reduction Program
- **FY 2019 HAC Reduction Program Fact Sheet**, PDF-365 KB (07/25/18) – Overview of the HAC Reduction Program
- **HAC Reduction Program Matrix of Key Dates**, PDF-81 KB (07/25/18) – Key information and dates for the measures in the FY 2019 HAC Reduction Program

**FY 2018 HAC Reduction Program**

- **HAC Reduction Program Scoring Methodology Infographic**, PDF-387 KB (03/22/17) – Overview of the HAC Reduction Program Scoring Methodology using Winsorized z-scores
- **FY 2018 Timeline**, PDF-264 KB (03/13/17) – Timeline for the implementation of the FY 2018 HAC Reduction Program
- **FY 2018 HAC Reduction Program Fact Sheet**, PDF-365 KB (03/13/17) – Overview of the HAC Reduction Program
Resources: Scoring Methodology, Infographic, Timeline, and Key Dates

HAC Reduction Program Scoring Methodology Using Winsorized z-scores

**Winsorization:**
Truncating the measure distributions at the 5th and 95th percentiles to reduce the impact of outliers

**Hospital A Winsorized SSI measure result = 1.351**

**Hospital A Winsorized CDI measure result = 0.919**

Hypothetical calculations for Hospital A using Winsorized z-score approach*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percentile</th>
<th>Winsorized Measure Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSI 90</td>
<td>0.0485</td>
<td>0.6537</td>
</tr>
<tr>
<td>CLABSI</td>
<td>0.972</td>
<td>0.972</td>
</tr>
<tr>
<td>CAUTI</td>
<td>0.912</td>
<td>0.912</td>
</tr>
<tr>
<td>SSIs</td>
<td>2.795</td>
<td>2.795</td>
</tr>
<tr>
<td>MSAs</td>
<td>1.356</td>
<td>1.356</td>
</tr>
<tr>
<td>CDDs</td>
<td>0.919</td>
<td>0.919</td>
</tr>
</tbody>
</table>

*Hypothetical values for illustration purposes that are not based on real data
**Calculated assuming eligible subsection of Hospital A with a measure result for the given measure

Matrix of Key Dates

<table>
<thead>
<tr>
<th>Fiscal Year (FY)</th>
<th>Measures Included</th>
<th>Performance Period</th>
<th>Scoring Calculation Review and Corrected Period</th>
<th>Payment Adjustment Applying to</th>
<th>Public Reporting on Hospital Compare FY</th>
<th>Comment</th>
</tr>
</thead>
</table>

01/31/2019
Resources: CMS Patient Safety Indicators

<table>
<thead>
<tr>
<th>Program/Software Specific Information</th>
<th>Fiscal Year (FY) 2019 Hospital IQR</th>
<th>FY 2019 HAC Reduction Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS PSI Software Version</td>
<td>Recalibrated Version 8.0</td>
<td>Recalibrated Version 8.0</td>
</tr>
<tr>
<td>Discharge Period</td>
<td>10/01/15 to 06/30/17**</td>
<td>10/01/15 to 06/30/17**</td>
</tr>
<tr>
<td>Number of Diagnosis Codes</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Number of Procedure Codes</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Program-Specific Hospital-Specific Reports</td>
<td>FY 2019 Hospital IQR</td>
<td>FY 2019 HAC Reduction Program</td>
</tr>
<tr>
<td>Patient Safety Indicators Technical Specifications</td>
<td>Version 7.0 Technical Specifications, September 2017 (applies to ICD-10 recalibrated version 8.0)</td>
<td>Version 7.0 Technical Specifications, September 2017 (applies to ICD-10 recalibrated version 8.0)</td>
</tr>
</tbody>
</table>
Hospital Readmissions Reduction Program (HRRP)
HRRP Landing Page

Overview
Hospital Readmissions Reduction Program

Section 3025 of the 2010 Affordable Care Act (Public Law 111-148) requires the Secretary of the Department of Health and Human Services (HHS) to establish the Hospital Readmissions Reduction Program and reduce payments to Inpatient Prospective Payment System (IPPS) hospitals for excess readmissions beginning October 1, 2012 (i.e., Federal Fiscal Year [FY] 2013).

The Hospital Readmissions Reduction Program supports CMS’ national goal of improving healthcare for Americans by linking payment to the quality of hospital care. CMS measures conditions and procedures that significantly affect the lives of large numbers of patients. Research shows that hospital readmission rates for these patients vary across the nation, which highlights an opportunity to improve the quality of care and save taxpayer dollars by incentivizing providers to reduce excess readmissions.

The 21st Century Cures Act requires CMS assess payment reductions based on a hospital’s performance relative to other hospitals with a similar proportion of patients that are dually eligible for Medicare and full-benefit Medicaid. The legislation requires estimated payments under the new stratified methodology equal payments under the non-stratified methodology to maintain budget neutrality.

Table:

<table>
<thead>
<tr>
<th>Hospital Readmissions Reduction Program (HRRP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
</tr>
<tr>
<td>Measures</td>
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<tr>
<td>Payment Adjustment Factor</td>
</tr>
<tr>
<td>Review and Corrections Process</td>
</tr>
<tr>
<td>Hospital-Specific Reports</td>
</tr>
<tr>
<td>Resources</td>
</tr>
<tr>
<td>Extraordinary Circumstance Exception</td>
</tr>
</tbody>
</table>

About Hospital Readmission Reductions Program
- Frequently Asked Questions, PDF
- Fact Sheet, PDF
Eligibility

Hospital Readmissions Reduction Program

As defined under the Social Security Act, all subsection (d) hospitals are subject to the Hospital Readmissions Reduction Program. CMS exempts certain hospitals and hospital units from HRRP. Exempted hospitals and units include:

- Critical access hospitals (CAH)
- Rehabilitation hospitals and units
- Long-term care hospitals (LTCH)
- Psychiatric hospitals and units
- Children’s hospitals
- Prospective Payment System (PPS)-exempt cancer hospitals
- Short-term acute care hospitals located in Guam, the U.S. Virgin Islands, the Northern Mariana Islands, and American Samoa
- Religious nonmedical health care institutions (RNHCI)

Maryland hospitals are exempt from payment reductions under HRRP. These hospitals currently include those designated as CHCF and those of Maryland.
Measures

Hospital Readmissions Reduction Program

The FY 2019 Hospital Readmissions Reduction Program (HRRP) includes the following 30-day risk-standardized readmission measures:

<table>
<thead>
<tr>
<th>Effective Program Year</th>
<th>30-day Risk Standardized Readmission Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2013</td>
<td>• Acute myocardial infarction (AMI)</td>
</tr>
<tr>
<td></td>
<td>• Heart failure (HF)</td>
</tr>
<tr>
<td></td>
<td>• Pneumonia</td>
</tr>
<tr>
<td>FY 2015</td>
<td>• Chronic obstructive pulmonary disease (COPD)</td>
</tr>
<tr>
<td></td>
<td>• Elective primary total hip and/or total knee arthroplasty (THA/TKA)</td>
</tr>
<tr>
<td>FY 2017</td>
<td>• Coronary Artery Bypass Graft (CABG) Surgery</td>
</tr>
</tbody>
</table>
Excess Readmission Ratio

The Centers for Medicare & Medicaid Services (CMS) calculates an excess readmission ratio (ERR) for each of the measures in the FY 2019 Hospital Readmissions Reduction Program (HRRP) to measure hospital performance. CMS uses the ERRs to determine hospitals’ payment adjustment factors. ERRs are the ratio of predicted-to-expected readmissions for each measure in HRRP:

- **Predicted readmissions** are the number of unplanned readmissions CMS predicted based on a hospital’s performance with its case mix and the estimated effect on readmissions (i.e., the hospital-specific effect). Section 3025 of the Affordable Care Act refers to predicted readmissions as “Adjusted Actual Readmissions”.
- **Expected readmissions** are the number of unplanned readmissions CMS expected based on a hospital’s average performance with its case mix and the average hospital effect.

The ERR is the ratio of a hospital’s predicted-to-expected readmission rates for a given measure. The Affordable Care Act refers to the ERR as the Standardized Readmission Ratio. If a hospital performs better than an average hospital that admitted similar patients (i.e., patients with similar risk factors for readmission, like age and comorbidities), the ERR will be less than 1.0000. If a hospital performs worse than average, the ERR will be greater than 1.0000.
Payment Adjustment Factor

Payment Adjustment Factor
Hospital Readmissions Reduction Program

The Centers for Medicare & Medicaid Services (CMS) calculates an excess readmission ratio (ERR) for each of the measures in the FY 2019 Hospital Readmissions Reduction Program. CMS uses the ERRs to determine the payment adjustment factor. CMS calculates the payment adjustment factor from historical data for Medicare fee-for-service (FFS) patients discharged with one or more conditions specified under the program.

CMS assesses performance relative to the performance of hospitals within the same peer group. Hospitals are stratified into five peer groups, or quintiles, based on the proportion of dual-eligible stays. A hospital’s dual proportion is the proportion of Medicare FFS and managed care stays where the patient was dually eligible for Medicare and full-benefit Medicaid. The median ERR within the peer group is the threshold that assesses hospital performance on each measure. Measures with 25 or more eligible discharges and an ERR above the peer group median ERR enter the payment adjustment factor formula. A budget neutrality modifier is applied to scale payment adjustments to retain a similar amount of Medicare saving under the stratified and non-stratified methodologies. The payment adjustment factor formula determines the size of the payment reduction. CMS capped the payment reduction at 3% (i.e. a minimum payment adjustment factor of 0.97).

Please refer to the FY 2019 HRRP Payment Adjustment Determination Infographic on the Resources.
Hospital-Specific Reports

Hospital Readmissions Reduction Program (HRRP)

Hospital-Specific Reports

Hospital Readmissions Reduction Program

Hospitals can preview their data prior to public reporting. Hospitals receive a Hospital-Specific Report (HSR) with detailed information about their Payment Adjustment Factor and component results. The Centers for Medicare and Medicaid Services (CMS) produces HSRs for all hospitals participating in the Hospital Readmissions Reduction Program.

HSRs are available to hospital staff who register as QualityNet users and serve in one of two QualityNet roles:

- Hospital Reporting Feedback - Inpatient role — required to receive the report
- File Exchange & Search role — required to download the report from the QualityNet Secure Portal

For assistance downloading the HSR from the QualityNet Secure Portal, contact the QualityNet Help Desk at qnetsupport@hcis.org, include your hospital's name and CMS Certification Number (CCN) in the request.

Fiscal Year (FY) 2019 Hospital-Specific Report (HSR)

- FY 2019 Hospital Readmissions Reduction Program Mock HSR. XLS-113 KB (08/15/18) - This file provides an example HSR using mock data. The mock HSR shows how CMS presents measure
Resources

Hospital Readmissions Reduction Program (HRRP)

Eligibility
Measures
Payment Adjustment Factor
Review and Corrections Process
Hospital-Specific Reports

Resources
- Archived Resources
- Extraordinary

Fiscal Year (FY) 2019 Hospital Readmissions Reduction Program

- FY 2019 Hospital Readmissions Reduction Program Frequently Asked Questions (FAQs), PDF-156 KB (08/13/18) - A list of questions and answers (FAQs) regarding the calculation and public reporting of the Center for Medicare and Medicaid Services (CMS) 30-day Risk-Standardized Readmission measures for the FY 2018 Hospital Readmissions Reduction Program (HRRP).
- FY 2019 Hospital Readmissions Reduction Program Fact Sheet, PDF-61 KB (08/13/18) - Overview of the Hospital Readmissions Reduction Program measures, as well as their development and purpose. This document is a helpful introduction to the project for hospital staff and executives.
- Hospital Readmissions Reduction Program Matrix of Key Dates, PDF-47 KB (08/13/18) - This document covers important information regarding the program measures and key dates.
- FY 2019 Hospital Readmissions Reduction Program Payment Adjustment Determination Infographic, PDF-94 KB (08/13/18) - Illustration of how CMS determines payment adjustment under the program.
Resources: FY 2019 HRRP Payment Adjustment Methodology and Matrix of Key Dates

FY 2019 Hospital Readmissions Reduction Program Payment Adjustment Methodology

Use hospital claims to generate ERRs and peer groups

1. Medicare FFS
   - Calculate ERRs for each measure
   \[ \text{ERR} = \frac{\text{Predicted readmission rate}}{\text{Expected readmission rate}} \]
   - Medicaid FFS + Managed Care
   - Calculate dual proportion for each hospital and stratify hospitals into 5 peer groups

2. Key Dates for Fiscal Years 2016 – 2019

<table>
<thead>
<tr>
<th>Fiscal Year (FY)</th>
<th>Measures Included</th>
<th>Performance Period</th>
<th>Claims Data “Snapshot”</th>
<th>Review and Corrections Period</th>
<th>Payment Adjustment Dates</th>
<th>Public Reporting on Hospital Compare</th>
</tr>
</thead>
</table>
Retrieving Reports
Audience Question

Where in the QualityNet Secure Portal can you retrieve reports?

1. Run Report Interface
2. Auto Route Inbox
3. Unsure
Retrieval Methods

- Run Reports
- QualityNet Secure File Transfer
  Auto Route Inbox
QualityNet User Roles

• Hospital Reporting Feedback – Inpatient role  
  (Required to receive the report)

• File Exchange & Search role  
  (Required to download the report from the QualityNet Secure Portal)
ListServe Notification

The Centers for Medicare & Medicaid Services (CMS) has made available the Percentage Payment Summary Reports (PPSRs) for the Fiscal Year (FY) 2019 Hospital Value-Based Purchasing (VBP) Program to participating hospitals. The FY 2019 PPSRs provide Performance Score (PS) and value-based incentive payment adjustment factors for the seventh year of the program.

A PPSR helps guide, How to Reduce Your Fiscal Year (FY) 2019 Hospital Value-Based Purchasing (VBP) Program Percentage Payment Summary Report (PPSR), is available on the Resources - Hospital Value-Based Program web page on QualityNet.

To access the PPSR, users must have an active QualityNet account and access to the QualityNet Secure Portal. Users must also have been assigned two necessary QualityNet roles:

- The Hospital Reporting Federation – Inpatient role (to receive the report)
- The File Exchange and Search role (to download the report from the Secure Portal)

To run the report, log in to your QualityNet Secure Portal account, and then perform the following steps:

2. Select Run Report(s) from the “All Future Tri...” option.
4. Select the View Reports button.
5. Then, select the Hospital Value-Based Purchasing – Percentage Payment Summary Report.
6. Next, select the desired report parameters and run the report.

Review and Corrections and Appeals

Hospitals may review and request recalculations of the performance scores on each condition, domain, and VBP within 30 calendar days of the posting date of the PPSR on QualityNet. The review and corrections period begins July 27 and ends at 11:59 p.m. Pacific Time.

Neither the review and corrections process nor the appeals process allows hospitals to submit additional corrections related to the underlying data or claim or add new data or claims to the data extracted to calculate the scores.

Note: Hospitals can only request an appeal after first requesting a review and corrections of their performance scores and receiving a decision from CMS denying their review and corrections recalculaton request. Hospitals that do not submit this formal request will not be eligible to submit a CMS Hospital VBP Program appeal request for the applicable fiscal year.

Additional information on the review and corrections and appeals process is available on QualityNet. From the [Hospitals – Inpatient] tab drop-down list, select the Hospital Value-Based Purchasing (VBP) link. Then, select the Review and Corrections/Appellate Type navigation pane. Direct link: https://www.qualitynet.org/docs/CenterServer%252Fpages%252FPrograms%252FQualityNet%252FVBP%252FAppealTypes%252FHospitals.pdf

For further assistance regarding the information contained in this message, contact the Hospital Inpatient Value, Incentives, and Quality Reporting (VQIR) Outreach and Education Support Contractor (ESC) team through the Hospital Inpatient Questions and Answers (HIAQ) Team or by calling toll free, 844 472-4877 or (661) 809-8763, weekdays from 8 a.m. to 5 p.m. ET.
ListServe Confirmation
QualityNet News

Providers selected for Hospital OQR Program CY 2020 validation
The Centers for Medicare & Medicaid Services (CMS) Hospital Outpatient Quality Reporting (OQR) Program has selected up to 500 hospitals for validation of chart-abstracted measures for the calendar year (CY) 2020 Annual Payment Update (APU) determination.

Full Article »

Headlines
- CMS releases HSRs for FY 2019 Readmissions Reduction Program; Review and Corrections period begins
- CY 2019 OPPS/ASC Proposed Rule published, open for comment
- Hospital VBP Program FY 2019 Percentage Payment Summary Report now available
- CMS releases October 2018 Hospital Compare preview reports
Running a Report: My Reports
Running a Report: Run Reports
Running a Report: Run Report(s)
Running a Report: Report Program
Running a Report: Report Category
Running a Report: View Reports

The available reports are grouped by program and category combination. If you have access to a single program, your program is pre-selected, and if the category related to the selected program will be pre-selected. Choose a program, then category, and then click on VIEW REPORTS to view your report choices. Select the report you wish to run from the table below by clicking on the report name.
Running a Report: Percentage Payment Summary Report
Running a Report: Baseline Measures Report
Running a Report: Run Report
Locating Reports
Locating Reports: Search Report(s)
Locating Reports: Download Report
Locating the Reports: Open/Save
Auto Route E-mail Notification

From: noreply@hqgis.org
Sent: Tuesday, August 14, 2018 2:52 PM
To: 
Subject: Auto Route: You have received a new file

Dear QualityNet User:
You have been sent a file (Example_HSR.zip) that is ready for your review. Please login to https://www.qualitynet.org/ with your QualityNet User ID and click on Secure File Transfer to retrieve your file from “AutoRoute_inbox” folder. If you have questions or concerns, please contact QualityNet help desk at qnetsupport@hqgis.org or (866) 288-8912.
Secure File Transfer
Auto Route Inbox
Resources

• Technical questions or issues related to accessing reports
  o Email the QualityNet Help Desk at qnetsupport@HCQIS.org
  o Call the QualityNet Help Desk at (866) 288-8912
• Questions related to the Hospital IQR and VBP Programs
  o Submit questions via the Hospital Inpatient Questions and Answers (Q&A) tool at https://cms-ip.custhelp.com
  o Call the Hospital Inpatient VIQR Outreach and Education Support Contract Team at (844) 472-4477
• Questions related to the HAC Reduction Program
  o Email hacrp@lantanagroup.com
• Questions related to the HRRP
  o Email hrrp@lantanagroup.com
• Hospital Compare website
  o Direct Link: https://www.medicare.gov/hospitalcompare/
  o For general questions regarding Hospital Compare and the data, email HospitalCompare@lantanagroup.com
Questions
Continuing Education Approval

This program has been approved for continuing education (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® 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

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.
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-d6f6b9cc1ae

**Existing User Link:**
https://lmc.hshapps.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
Register for Credit

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

Existing User
Entire email is your user name.
You can reset your password.
Thank You for Attending
Disclaimer

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