Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

FY 2021 IPPS/LTCH PPS Final Rule Overview for Hospital Quality Programs

Questions and Answers

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This document answers provider questions submitted to WebinarQuestions@hsag.com. Subject-matter experts developed the responses.

COVID-19

Question 1: **Slide 15. Will submitted data for quarter (Q)1 and Q2 2020 be used to calculate payments for value-based purchasing (VBP) or other pay for performance programs?**

No, Q1 and Q2 2020 data will not be used in program measure or score calculations for the Hospital Acquired Condition (HAC) Reduction Program, Hospital Readmissions Reduction Program (HRRP), and Hospital Value-Based Purchasing (VBP) Programs. Refer to the Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency Interim Final Rule that was released on September 2, 2020.

Question 2: **What accommodations will be made for smaller facilities when the removal of Q1 and Q2 data leaves them with not enough data for [Hospital VBP Program] performance measurement?**

CMS has not modified the minimum requirements in order to have scores calculated in each measure, each domain, or the Total Performance Score. Hospitals that do not have a minimum of three of the four domains scored will be excluded from the Hospital VBP Program. Excluded hospitals will not have their base-operating Diagnosis Related Group (DRG) payment amounts reduced by two percent, and they will not be eligible to receive incentive payments.

Question 3: **Was the Data Accuracy and Completeness Acknowledgement (DACA) for calendar year (CY) 2019 data required this year? Ours was completed, but it appears online as incomplete.**

In the March 27, 2020, Guidance Memo - Quality Reporting and Value-based Purchasing Programs COVID-19 guidance memo, CMS noted that providers are excepted from submitting the DACA during the April 1 through May 15 submission deadline for the reporting period of January 1, 2019 through December 31, 2019. For CY 2020, the submission period for signing the DACA will be from April 1, 2021 through May 17, 2021. If you experience technical issues signing the DACA, please contact the *QualityNet* Help Desk at qnetsupport@hcqis.org or (866) 288-8912.

Question 4: **When will CMS know if impacts on CY 2020 data warrant an extraordinary circumstance exception (ECE) for the entire year?**

CMS will continue to monitor the situation for potential adjustments and will update exception lists, excepted reporting periods, and submission deadlines accordingly as events occur.

Question 5: **How will the exceptions granted for Healthcare-Associated Infection (HAI) reporting for Q1 and Q2 2020, due to COVID-19, impact the HAC Reduction Program?**

On September 2, 2020, CMS published an Interim Final Rule (CMS-3401-IFC) that specifies CMS will exclude the HAI data hospitals submitted from scoring calculations for the HAC Reduction Program in future program years. The HAC Reduction Program scoring methodology will remain the same for all hospitals. Hospitals that meet the minimum case threshold counts will be scored for the program but effectively have abbreviated performance periods for future program years (for example, FY 2022: January 1, 2019–December 31, 2019 and July 1, 2020–December 31, 2020). We encourage hospitals to continue to submit HAI data to the National Healthcare Safety Network (NHSN) if possible, in the interest of data continuity, as well as for surveillance and monitoring purposes.

Question 6: **How is the publicly reported data going to look for Sepsis (SEP)-1 and Perinatal Care (PC)-01 for Q1 and Q2 2020 since that data are excluded? Are they skipped, and Q4 2019 data will show until Q3 2020 data are available? Additionally, will Q1 and Q2 HAI and Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) data be posted to *Hospital Compare*?**

In response to the 2019 Coronavirus (COVID-19) pandemic, CMS extended many flexibilities for the Hospital Quality Reporting and VBP Programs. An unprecedented level of flexibilities was given for data collection and reporting for Q4 2019 and the first two quarters (Q1 and Q2) of 2020. These efforts were meant to reduce provider burden and ensure clinicians could focus on caring for their patients in the face of a never-before-seen global pandemic.

In addition to policy exceptions and extensions granted for quality measure reporting and data submission deadlines, CMS will not publicly report data collected during the 1st and 2nd quarters of 2020.

As a result, measures that are normally refreshed quarterly will not be refreshed for the first and second refresh after the affected quarters are

introduced. This prevents updating of measures when the omission of 1st and/or 2nd quarter data would not provide any additional value. CMS wants to ensure that measures are refreshed at every point where the public display of hospital quality reporting data provides value to the end consumers, so quarterly refreshed measures will resume their quarterly updates once 3rd quarter 2020 data is due to be publicly reported.

Inpatient Quality Reporting (IQR)/electronic Clinical Quality Measures (eCQMs)

Question 7: **Slide 19. Does the Electronic Health Record (EHR) Submitter Identification (EHR Submitter ID) need to be in the Quality Reporting Document Architecture (QRDA) file?**

Yes, that is one of the five required pieces of information in the QRDA file to support the succession management process. The succession management process allows the most recently submitted and accepted production QRDA Category I file to overwrite the original file based on the exact match of the following five key elements within the file: CMS Certification Number (CCN), CMS Program Name, EHR Patient ID, EHR Submitter ID, and the reporting period specified in the Reporting Parameters Section. Please review page 5 of the 2020 CMS Implementation Guide for QRDA Category I data posted on the eCQI Resource Center.

Question 8: **Slide 22. Can the four eCQMs selected be the same for each quarter for CY 2021?**

Yes, the four self-selected eCQMs can be the same for the two self-selected quarters for CY 2021. For CY 2022 and forward, it is required to report on three self-selected eCQMs in addition to the Safe Use of Opioids - Concurrent Prescribing measure.

Question 9: **Slide 22. Can the four eCQMs selected be different for each quarter? Additionally, do the eCQMs selected have to be the same ones The Joint Commission requires?**

No, for CY 2021 submitters must submit on the same four self-selected eCQMs for both self-selected quarters that are reported. In CY 2022 and subsequent years, submitters must submit on the same three self-selected eCQMs and the Safe Use of Opioids eCQM for each of the self-selected reporting quarters in a given a reporting year. There is no requirement for

the eCQMs reported to CMS to be the same as the eCQMs selected for reporting to The Joint Commission.

Question 10: **Slide 22. How will we be expected to submit the two self-selected quarters worth of data? Can all data be in one QRDA Category I file, or must it be two separate file submissions?**

Submitters can report multiple quarters of QRDA Category I files within one batch file submission to the Hospital Quality Reporting (HQR) System. Submitters are expected to report one QRDA I file, per patient, per quarter. Submitters are not required to submit multiple quarter data in two separate batch file submissions. The maximum batch file size is 14,999 QRDA Category I files. Hospitals who find they need to report a larger number of QRDA Category I files are encouraged to submit multiple batches to fully represent their patient population. Submission of data for eCQMs is still once annually, in the spring following the calendar year of data to be reported. For example, the deadline for reporting CY 2020 is March 1st 2021.

Question 11: **Slide 22. Given that changes occur to the measures, ICD-10 coding, and so on in the fourth quarter of each calendar year, requiring significant updates by EHR vendors, what suggestions does CMS have for organizations preparing to be successful at reporting Q4 data by February of the following year?**

Annual updates are released at least six months before the next reporting period begins. The annual update includes the eCQM specifications, logic and guidance documentation, technical release notes, and reference to the Value Set Authority Center (VSAC) for eCQM Value Sets and direct reference codes. This information is provided during this timeframe to allow adequate time and assist stakeholders to understand and implement eCQMs. CMS previously released a Q4 addendum to update ICD-10 codes, however received feedback on the burden and inability for stakeholders to consume these updates in a timely fashion prior to reporting. The most recent published eCQM specifications for the given reporting period should be used. Visit the eCQI Resource Center to locate the relevant information based on the reporting period: https://ecqi.healthit.gov/eh-cah?globalyearfilter=2020.

CMS previously released a Q4 addendum to update ICD-10 codes, however received feedback on the burden and inability for stakeholders to consume these updates in a timely fashion prior to reporting. The most recent published eCQM specifications for the given reporting period should be used. Visit the eCQI Resource Center to locate the relevant

information based on the reporting period: https://ecqi.healthit.gov/eh-cah?globalyearfilter=2020

Question 12: **When the four quarters of eCQM data are required in CY 2023 and subsequent years, will it be acceptable to submit a quarter at a time, like the chart-abstracted measures, or must all four quarters be submitted at once by the February 28 submission deadline?**

In the FY 2017 IPPS/LTCH PPS final rule (81 FR 57172), we finalized the alignment of the Hospital IQR Program eCQM submission deadline with that of the Medicare Promoting Interoperability Program—the end of two months following the close of the calendar year—for the CY 2017 reporting period/FY 2019 payment determination and subsequent years. We note the submission deadline may be moved to the next business day if it falls on a weekend or federal holiday. In the FY 2021 IPPS/LTCH PPS proposed rule, we did not propose any changes to the eCQM submission deadlines. Even though hospitals will be required to gradually increase the number of quarters of eCQM data submitted, the submission deadline does not change and will remain annual. Hospitals must still submit eCQM data by the end of the data submission time period regardless of how many quarters of data are required to be reported for a given calendar year. That time period will continue to be the two months following the close of the respective calendar year.

CMS recommends that submitters should submit their QRDA I files shortly after the opening of the HQR System for test and production eCQM data. Submitting QRDA I data ahead of the deadline allows submitters to receive more real-time feedback relative to measure performance. In addition, earlier QRDA I submissions allows additional time to review and revise any rejected QRDA I files prior the deadline.

Question 13: **When will the Hospital Quality Reporting (HQR) System open to accept submission of eCQM data for CY 2020 from hospitals?**

On Friday, October 30, 2020, a Listserve communication was distributed to the submitter community stating the HQR System opened for test and production eCQM submissions. The submission deadline is Monday, March 1, 2021, at 11:59 p.m. Pacific Time (PT).

Question 14: **Are the specifications available for the Safe Use of Opioids - Concurrent Prescribing measure?**

The specifications for the Safe Use of Opioids–Concurrent Prescribing measure are posted on the 2021 EH/CAH eCQMs tab of the eCQI Resource Center.

Question 15: **Are the benchmarks for the eCQM measures published?**

Benchmarks are not available for the Eligible Hospital (EH)/Critical Access Hospital (CAH) eCQM reporting. Benchmark information exists for the Eligible Professional/Eligible Clinician eCQMs on the eCQI Resource Center.

Question 16: **Is the PC-01 measure still collected?**

PC-01 aggregate measure data are still being collected for the Hospital IQR Program.

Question 17: **Recently, there was an e-mail regarding the process for submission of population and sampling data. The e-mail is a bit unclear. Is the process for sending population and sampling XML files changing? Can they still be submitted along with clinical files for the Hospital IQR Program?**

CMS released an announcement Wednesday, August 5, 2020, stating the Population and Sampling XML files can no longer be submitted via the *QualityNet* Secure File Transfer (SFT). As of Tuesday, August 18, 2020, submitters can upload the population and sampling XML files to the CMS Clinical Data Warehouse via the HQR System using the File Upload tool.

Question 18: **What are the Hospital IQR Program chart-abstracted measure submission deadlines for CY 2021?**

Currently, the Hospital IQR Program population and sampling and chart-abstracted submission deadlines for CY 2021 data will be:

Quarter	Population and Sampling	Chart-Abstracted Measures
Q1 2021	August 2, 2021	August 16, 2021
Q2 2021	November 1, 2021	November 15, 2021

Q3 2021	February 1, 2022	February 15, 2022
Q4 2021	May 2, 2022	May 16, 2022

Validation

Question 19: **Are critical access hospitals included in the validation process?**

No. Critical access hospitals are not subject to CMS validation requirements.

Question 20: **Are the HAI measures removed from validation?**

The HAI measures were removed from the Hospital IQR Program beginning with the CY 2020 reporting period/FY 2022 payment determination in the FY 2019 IPPS/LTCH PPS Final Rule (83 FR 41608). Subsequently, validation of the HAI measures will occur only under the HAC Reduction Program beginning with the Q3 2020 discharges for the FY 2023 program year, FY 2019 IPPS/LTCH PPS (83 FR 41478–41484) Final Rule and FY 2020 IPPS/LTCH PPS Final Rule (84 FR 41483).

Although validation of the HAI measures is now under the HAC Reduction Program, the underlying validation processes will continue to occur in the same manner as before under the Hospital IQR Program.

Question 21: **Will validation be 100 percent passed or failed by having at least a 75 percent score for the chart-abstracted measures? How is the submission of eCQMs factored into the validation pass or fail?**

Under the final rule, CMS established a scoring method that would combine the validation scores of chart-abstracted measures and eCQMs into one validation score, affecting FY 2024 payment determination. However, the eCQM portion of the combined agreement rate will initially be weighted at 0 percent in FY 2024, and chart abstracted measure agreement rate will be weighted at 100 percent.

Although the validation of reported eCQM data will not affect the validation scoring in FY 2024, hospitals selected for validation will be required to submit timely and complete medical records for at least 75 percent of the eCQM records that CMS requests. For example, if eight medical records are requested, at least six complete medical records must

be submitted to meet the 75 percent medical record submission requirement for eCQMs.

Thus, for FY 2024 payment determination, hospitals will be held accountable for the validation scoring of their chart-abstracted clinical process of care measures and for their requirement to submit at least 75 percent of the requested medical records for eCQM cases.

Question 22: **Slide 25. If you submitted eCQM data for Q1 or Q2 in 2020 and were selected for validation, how will this impact your validation score if only using Q3 and Q4 2020 data?**

Validation for FY 2023 payment determination will be based on chart-abstracted measure data submitted for Q3 and Q4 2020, as well as eCQM data submitted for the 2020 calendar year (1Q 2020–4Q 2020); hence, the validation of eCQM data will be applicable to all four quarters (1Q 2020–4Q 2020). We note that FY 2023 payment determination associated with CY 2020 eCQM data is based on submitting timely and complete medical records requested by CMS.

Question 23: **Slide 30. Will CMS provide SFT process criteria for our information systems to be able to send the files electronically?**

Hospitals will not need any special criteria or changes to their systems for submission of medical records for validation.

The *QualityNet Secure Portal* **SFT** application will no longer be available for use; users will now use CMS' new **Managed File Transfer (MFT)** application. Users can only log into the new MFT application with their Health Care Quality Information Systems (HCQIS) Access Roles and Profile (HARP) credentials. The MFT application functions almost identically to the old SFT application, so users who have submitted HAI Validation Templates and/or medical records electronically to the Validation Support Contractor and/or the Clinical Data Abstraction Center (CDAC) will find the new process very easy and smooth.

Here is a short description of the process: Hospitals will receive a medical records request packet indicating the cases that have been selected for validation. Hospitals will gather each selected medical record in a separate PDF file format. A user at the hospital will log into the MFT application and submit the medical record PDF files.

CMS will release user guides and submission instruction documentation before the electronic submission requirement officially takes effect.

Question 24: **How will an eCQM chart be validated? Can you explain what will be expected?**

eCQMs will be validated in the same manner as they have been over the last three years of eCQM validation. After the eCQM data reporting submission deadline, CMS will randomly select eCQM cases submitted for validation among hospitals selected for validation. The CDAC will then send a medical records request to each selected hospital. The CDAC will abstract the medical record using the guidance, definitions, and logic in the eCQM specifications.

When validating cases, the CDAC reviews data found in both discrete and non-discrete fields of the records provided, and both the QRDA data and the medical record data are compared to the guidance and definitions in the eCQM specifications.

Question 25: **For HAC and IQR validation, will the random and targeted selected facility lists be the same starting Q3 2020?**

The HAI measures were removed from the Hospital IQR Program beginning with CY 2020 reporting period/FY 2022 payment determination in the FY 2019 IPPS/LTCH PPS Final Rule (83 FR 41608). Therefore, validation of the HAI measures will occur only under the HAC Reduction Program beginning with Q3 2020 discharges for the FY 2023 program year, FY 2019 IPPS/LTCH PPS Final Rule (83 FR 41478–41484) and FY 2020 IPPS/LTCH PPS Final Rule (84 FR 41483).

Although validation of the HAI measures is now under the HAC Reduction Program, the underlying validation processes will continue to occur in the same manner as they have previously under the Hospital IQR Program:

CMS will select one pool of subsection (d) hospitals for validation of chart-abstracted measures in both the Hospital IQR Program and HAC Reduction Program. The pool of hospitals will be selected and validated for both the HAI measures for the HAC Reduction Program and the Hospital IQR Program's chart-abstracted measures. The HAC Reduction Program will include all subsection (d) hospitals in the sample; whereas, the Hospital IQR Program will remove from the sample any subsection (d) hospital without an active notice of participation in the Hospital IQR Program (83 FR 41479).

Question 26: **When will hospitals be selected for FY 2023 validation?**

CMS anticipates notifying providers of their random selection for FY 2023 inpatient data validation between December 2020–January 2021.

Question 27: **Are the same validation contractors doing the HAC validation?**

It is CMS's intention to maintain a seamless transition of the validation of the HAI measures from the hospital community's perspective. Although the HAI measures have been transitioned out of the Hospital IQR Program and into the HAC Reduction Program, the underlying validation processes will continue to occur in the same manner as they have previously under the Hospital IQR Program by the same validation contractors.

Medicare and Medicaid Promoting Interoperability Program

Question 28: **Slide 35. Can you clarify the note at the bottom of the slide where it states that submitting the eCQM data meets the Promoting Interoperability measure?**

The successful reporting of electronic clinical quality measures (eCQMs), based on the requirements of the applicable reporting period, provides aligned credit to the Hospital IQR and the Medicare portion of the Medicare and Medicaid Promoting Interoperability Programs with one submission. eCQM reporting is only one reporting portion of each program; please visit each respective program webpage to ensure all reporting requirements are being met.

The Hospital IQR Program reporting requirements are available on the *QualityNet* website at https://qualitynet.org/inpatient. The Promoting Interoperability Program reporting information is posted on CMS.gov at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.

Question 29: **For the Promoting Interoperability Provider to Patient Exchange objective, we are limiting patient exposure during the COVID-19 PHE. We have not been going into patient rooms to sign them up for the patient portal, which is very important to meeting the measure criteria. Should we request a hardship?**

We would first recommend that you review the measure specification sheet and read the policy definitions to see if you could still meet the measure without going into individual patient rooms, as there are no exclusions for this measure. The definition of providing access to patients, under which the numerator and denominator is ultimately calculated, reads: "When a

patient possesses all of the necessary information needed to view, download, or transmit their information. This could include providing patients with instructions on how to access their health information, the website address they must visit for online access, a unique and registered username or password, instructions on how to create a login, or any other instructions, tools, or materials that patients need in order to view, download, or transmit their information." Please see the following link for additional information: https://www.cms.gov/files/document/medicare-eh-2020-provide-patients-electronic-access-their-health-information.pdf

If you are still unable to report on the Provide Patients Electronic Access to Their Health Information measure under the Provider to Patient Exchange objective, hardship applications are available. We would like to note that under the Promoting Interoperability Program, hospitals and CAHs are limited to five (5) total hardships. For more information on the Promoting Interoperability Program's hardship application process, please see the following link for additional information: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship

Question 30: **For the Promoting Interoperability Program is a score of 50 still a target to meet the requirement.**

Yes, achieving a minimum of 50 out of 100 total points across the four objectives is the threshold that must be met in order to be considered a meaningful user in the Promoting Interoperability Program to avoid a downward payment adjustment. Any changes to the minimum score threshold would be discussed and proposed in a future rule.

Hospital Value-Based Purchasing (VBP) Program

Question 31: **Slide 43. The performance period dates for Q1 and Q2 2020 do not have an asterisk. Will those quarters be included in the FY 2022 Hospital VBP Program?**

Q1 2020 and Q2 2020 will not be included in the measure calculations for any of the measures included in the FY 2022 Hospital VBP Program performance period.

Question 32: **Slide 44. Is the Patient Safety Indicator (PSI) 90 measure for FY 2023 onwards a new addition?**

The PSI 90 composite measure underwent National Quality Forum maintenance review and re-endorsement in 2015, leading to several substantive measure changes. Due to statutory requirements in the Hospital VBP Program, CMS was unable to adopt the newly re-endorsed version of the PSI 90 measure into the Hospital VBP Program for FY 2019 through FY 2022. As a result, CMS finalized the removal of the older version PSI 90 measure, Patient Safety for Selected Indicators, from the Hospital VBP Program for FY 2019 and subsequent fiscal years in the FY 2018 IPPS/LTCH PPS Final Rule (82 FR 38244). Additionally, CMS adopted the modified updated version of CMS PSI 90 in the Hospital VBP Program for FY 2023 and subsequent fiscal years in the FY 2018 IPPS/LTCH PPS Final Rule (82 FR 38251–38256). The inclusion of this measure in the FY 2023 Hospital VBP Program was not a new proposal in the FY 2021 IPPS/LTCH PPS Final Rule.

Question 33: **Slide 44. For the PSI 90 measure, how will the scores be calculated?**

For information on the PSI 90 measure calculations, we recommend referencing *QualityNet* at https://qualitynet.org/inpatient/measures/psi. If your specific question regarding calculation of the measure is not addressed, please submit your question(s) to the Inpatient Q&A tool on *QualityNet*: https://cmsqualitysupport.servicenowservices.com/qnet_qa. When completing the Ask a Question form for a PSI 90 measure question, select Inpatient Claims-Based Measures in the program drop-down. Then, select the most appropriate category under Patient Safety Indicators (PSI) in the topic drop-down.

Question 34: **What is the difference between a baseline period and a performance period?**

CMS scores hospitals on each measure based on a hospital's achievement and improvement. Achievement points are awarded by comparing a hospital's performance period value (a more recent time period) in comparison to all hospitals via the benchmark and achievement threshold. Improvement points are awarded by comparing a hospital's performance period value (a more recent time period) in comparison to that same hospital's baseline period value (an older time period than the performance period) in addition to benchmark. For improvement points, the comparison of the baseline period to the performance period for a hospital is used to determine how much the hospital has improved in the measure over time.

Question 35: **Are baseline measurements re-calibrated based on updated definitions that are established after the baseline period concludes? For example, for PSIs, there are measure definition updates after the baseline period.**

Is the baseline re-calculated based on new definitions so the baseline and performance periods use the same measure definition?

For the PSI 90 measure, CMS historically has used the same PSI software version for the baseline period, performance standards, and performance period calculations within a fiscal year. Changes to any measure that are considered substantive would be reviewed by CMS prior to inclusion in the Hospital VBP Program.

Question 36: **Does CMS have plans to add 30-day stroke mortality to the Hospital VBP Program in the next three to five years?**

CMS has not made a proposal to include this measure in the Hospital VBP Program at this time.

Question 37: **Does "the fiscal year in which performance is impacted," mean the Hospital VBP Program fiscal year in which the performance is measured?**

If submitting an ECE request, a hospital would detail the time period and measure(s) that were adversely impacted by the extraordinary circumstance. That time period for the measure would correlate to a performance period in a fiscal year (the time period in which payment adjustments will be applied) of the Hospital VBP Program. When reviewing a request, CMS will work with hospitals to determine which fiscal year the hospital is requesting an exception in the Hospital VBP Program.

Hospital Readmission Reduction Program (HRRP)

Question 38: **In HRRP, does CMS exclude planned surgeries from the "unplanned readmission" counts? Planned surgeries can be coded using Discharge Disposition codes "81–94" in the index admission as follows:**

- **81 - Discharged to home or self-care with a planned acute care hospital inpatient readmission**
- **82 - Discharged/transferred to a short-term general hospital with a planned acute care hospital inpatient readmission**
- **83 - Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission**

- **84 - Discharged/transferred to a facility that provides custodial or supportive care (includes Intermediate Care Facility) with a planned acute care hospital inpatient readmission**
- **85 - Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission**
- **86 - Discharged/transferred to home under care of an organized home health service organization with a planned acute care hospital inpatient readmission**
- **87 - Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission**
- **88 - Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission**
- **89 - Discharged/transferred to a hospital-based Medicare approved swing bed with planned acute care hospital inpatient readmission**
- **90 - Discharged/transferred to an inpatient rehabilitation facility (IRF) including a rehabilitation distinct part unit of a hospital with a planned acute care hospital inpatient readmission**
- **91 - Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission**
- **92 - Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare with a planned acute care hospital inpatient readmission**
- **93 - Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission**
- **94 - Discharged/transferred to a Critical Access Hospital (CAH) with a planned acute care hospital inpatient readmission**

CMS “excludes” planned surgery admissions from the unplanned readmission “counts” depending on the circumstances: To be excluded, admissions must meet criteria set by an algorithm that uses both ICD-10 procedure and diagnosis codes on the readmission Medicare claim, and not the discharge disposition code. Below is a summary of the planned readmission algorithm methodology and specifications:

- The planned readmission algorithm identifies admissions that are typically planned and may occur within 30 days of discharge from the hospital. The algorithm is based on three principles:
    - A few specific, limited types of care are always considered planned (transplant surgery, maintenance chemotherapy/immunotherapy, rehabilitation);
    - Otherwise, a planned readmission is defined as a non-acute readmission for a scheduled procedure; and
    - Admissions for acute illness or for complications of care are never planned.
- The algorithm classifies a readmission as "planned" if any of the following occurs during readmission:
    - A performed procedure is included in one of the procedure categories that are always planned regardless of diagnosis;
    - The principal diagnosis is included in one of the diagnosis categories that are always planned; or,
    - A performed procedure is listed as one of the potentially planned procedures and the principal diagnosis is **not** in the list of acute discharge diagnoses.
- The algorithm uses ICD-10 code-based Agency for Healthcare Research and Quality (AHRQ) Clinical Classification Software (CCS) categories and singular ICD-10 codes to define the procedures and diagnoses discussed above. These specifications are detailed in Tables PR.1–PR.4 in the measure-specific Code Specifications supplemental files posted on *QualityNet* at: https://www.qualitynet.org/inpatient/measures/readmission/methodology.
- You can find the AHRQ mappings of ICD-10 codes to the CCS procedure and diagnoses categories at the locations below. Please note, these crosswalks contain all CCS procedure and diagnoses categories and are not specific to the categories used in the planned readmission algorithm.
    - Crosswalks of CCS procedure categories to ICD-10 codes are available at:
        1. https://www.hcup-us.ahrq.gov/toolssoftware/ccs10/ccs10.jsp

2. Scroll to "Archives for Earlier Versions of the CCS for ICD-10-PCS"

3. Locate "Version 2019.1" which contains the single-level procedure crosswalk

- Crosswalks of CCS diagnosis categories to ICD-10 codes are available at:

1. https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp

2. Scroll to "Archives for Previous Beta Versions of the CCS for ICD-10-CM Diagnoses"

3. Locate "Version 2019.1" which contains the single-level diagnosis crosswalk

For more information on the readmission outcome, please refer to Section 2.2.3 and Appendix E of the 2020 condition-specific and procedure-specific readmission measures updates and specifications reports posted on *QualityNet*, adjacent to the supplemental files described above. A flowchart illustrating the overall structure of the planned readmission algorithm is available in Figure PR.1 in Appendix E in these reports.

Other

Question 39: **Most of the elective total hip arthroplasty (THA) and total knee arthroplasty (TKA) are done on an outpatient basis resulting in a very low denominator. Has CMS addressed this?**

The finalized changes in the CY 2018 and CY 2020 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Final Rules together make THA and TKA procedures eligible to be paid by Medicare in the hospital outpatient setting and the ASC setting (in the case of TKAs), in addition to the hospital inpatient setting.

CMS understands this has led to an increased volume of THA/TKA procedures performed in the outpatient setting.

In terms of the current inpatient claims-based TKA/THA complication, readmission, and payment measures, please note the following:

- CMS uses multiple years of data to calculate the results. This increases the sample size, allowing for more precise measure estimates and categorization of hospital results, and increases the number of hospitals whose results are eligible for public reporting.

- The measure data that are currently publicly reported on *Hospital Compare*/Care Compare (https://data.medicare.gov/) and in the annual specifications and updates reports produced by CMS, which are based on eligible discharges from April 1, 2016 through March 31, 2019 (or July 1, 2016 through June 30, 2019 for the THA/TKA readmission measure), suggest that roughly 80 percent of hospitals have had a sufficient number of cases to allow for public reporting and fair comparison to other hospitals. Furthermore, in comparing the volume of THA/TKA cases in the first year of this data (prior to any final rule changes) versus the last year of these data (where the changes in CY 2018 final rule are in effect), the national-level volume reduction averaged only around 13 percent. CMS recognizes the growing impact of the THA/TKA procedures performed on an outpatient basis on the inpatient THA/TKA measure denominators, and that the final rule changes referenced above may affect some hospitals more than others.

Lastly, if you are interested in reviewing the complication, readmission, and payment measures annual updates and specification reports referenced above, they are posted on *QualityNet* at: Hospitals – Inpatient > Measures > Complication Measure (or Readmission Measures or Payment Measures) > Methodology.

Question 40: **I have access to HQR and NHSN, but I am unclear as to what information I need to manually input and what is sent electronically.**

For further assistance, please contact the Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Team at CMS ServiceNow Q&A Tool or (844) 472-4477.