Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

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

Presentation Transcript

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Candace Jackson: Good afternoon and welcome to the Fiscal Year 2021 IPPS/Long-Term Care Hospital PPS Final Rule Overview for Hospital Quality Programs webinar. My name is Candace Jackson, and I am the Inpatient Quality Reporting Program Lead at CMS' Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be hosting today's event. Before we begin, I would like to make a few announcements. This program is being recorded. A transcript of the presentation, along with the question-and-answer summaries, will be posted to the inpatient web site, www.QualityReportingCenter.com, in the upcoming weeks. If you registered for this event, a reminder e-mail and a link to the slides were sent out to your e-mail a few hours ago. If you did not receive that e-mail, you can download the slides at, again, www.QualityReportingCenter.com. This webinar has been approved for one continuing education credit. If you would like to complete the survey after today's event, please stay on until the conclusion of the event. After the question-and-answer session, we will display a link to the survey that you will need to complete to receive the continuing education credit. The survey will no longer automatically be available if you leave the event early. If you do need to leave prior to the conclusion of the event, a link to the survey will be available in the summary e-mail sent out one to two business days after the event. If you have questions, as we move through the webinar, please type your question into the Ask A Question window with the slide number associated, and we will answer as many questions as time allows after the event.

I would like to welcome our speakers for this webinar: Julia Venanzi, Program Lead for the Hospital IQR Program and Hospital VBP Program; Dylan Podson, the Social Science Research Analyst for the Medicare and Medicaid Promoting Interoperability Program; Lang Le, the Program Lead for the Hospital-Acquired Condition Reduction Program; and Gail Sexton, the Program Lead for the Hospital Readmissions Reduction Program. All are with the Centers for Medicare & Medicaid Services, Quality Measurement Value-Based Incentives Group within the Center for Clinical Standards and Quality. Also, Alex Feilmeier is the Lead Solutions Specialist with the Value, Incentives, and Quality Reporting Center Validations Support Contractor.

The purpose of the event is to provide an overview of the Fiscal Year 2021 Inpatient Prospective Payment System/Long-Term Care Hospital Prospective Payment System Final Rule as it relates to the Hospital IQR, VBP, HAC Reduction, Readmissions Reduction, and the Medicare & Medicaid Promoting Interoperability Program.

At the end of the presentation, participants will be able to locate the FY 2021 final rule text and identify finalized program changes within the final rule.

This slide just lists the acronyms that are used throughout the presentation.

As CMS recognizes the significant impact that the COVID-19 pandemic has had on healthcare providers, CMS limited the annual rulemaking to focus primarily on essential proposals to reduce provider burden and assist providers in the COVID-19 response. As such, CMS did not propose to add new measures or remove measures in this final rule.

Due to the COVID-19 public health emergency, CMS has granted several exceptions and extensions for certain deadlines under its ECE policy to assist healthcare providers, who are directing their resources towards caring for patients and ensuring the health and safety of staff.

This slide lists the different resources that outline the exceptions that were granted.

In the next few slides, I'll highlight some of the exceptions that were granted. For the hospital reporting programs, hospitals may elect to submit some, or all, accepted data. CMS is encouraging hospitals to continue to submit as part of monitoring quality of care on key metrics. As such, the submission of measure data for Q4 2019, Q1 2020, and Q2 2020 are optional. For the value-based purchasing programs, optionally submitted Q4 2019 HCAHPS and HAI measure data will be used for measure calculations and program scoring as this data reflects a time period before the COVID-19 Public Health Emergency.

Optionally submitted Q1 2020 and Q2 2020 measure data will not be used in measure calculations for program scoring. However, the data will be included in confidential hospital reporting feedback reports through the Hospital Quality Reporting system for quality improvement purposes. Claims from Q1 2020 and Q2 2020 will not be used in the claims-based measure calculations. CMS will automatically exclude claims for measure calculation and scoring from the excepted time period. However, hospitals should continue to submit claims for reimbursement. I would like to note just a few things. Hospitals do not need to request an ECE for measures and submissions covered under the COVID-19 exception. If a hospital believes that performance continues to be adversely impacted by this extraordinary circumstance through Q3 and Q4 of 2020, they can submit an individual ECE request to CMS for the hospital reporting and value-based purchasing programs within 90 days of the date of the extraordinary circumstance. Please note, for the Hospital VBP Program, a granted individual ECE would exclude the hospital from the Hospital VBP Program in the fiscal year in which performance was impacted. As an excluded hospital, the hospital would not incur the 2 percent reduction in payment, but it would also not receive incentive payments for the fiscal year.

I will now turn the presentation over to Julia to provide the Hospital IQR Program finalized changes. Julia, the floor is yours.

Julia Venanzi: Thank you, Candace. I would like to welcome everyone to our webinar today. Thank you all for taking the time out of your day to join us. I appreciate this opportunity to share with you the finalized proposals for the Hospital Inpatient Quality Reporting Program, or the [Hospital] IQR Program, from this year's fiscal year '21 final IPPS rule.

Before I get to the policies finalized in the fiscal year '21 IPPS rule, I want to first also note a policy we proposed in the calendar year '21 Physician Fee Schedule rule earlier this year. In that rule, we propose to allow hospitals to use technology certified to either the 2015 Edition criteria for certified EHR technology or the updated 2015 Edition criteria that ONC, the Office of the National Coordinator, released via the 21st Century Cures Act earlier this year. The intent and urgency of proposing this in the

PFS rule rather than our normal IPPS rule was to allow early adopters of the newly updated version to be able to still fulfill the Hospital IQR Program requirements. We received comments on this rule. The comment period closed on October 5, and we will be releasing the PFS final rule soon. As mentioned in the proposed rule, we will address when using only the updated 2015 edition will become mandatory in the Hospital IQR Program in an upcoming IPPS rule.

Turning now back to the policies we finalized in the fiscal year '21 IPPS rule, here we have listed the five proposals that we finalized, as proposed in the fiscal year '21 proposed Rule. These finalized proposals include: one, updating the QRDA Category I file format to add the EHR submitter ID to the list of key elements; two, finalizing the certification and file format requirements for hybrid measures; three, progressively increasing the number of required reporting quarters for electronic clinical quality measures, or eCQMs; four, publicly displaying those eCQMs beginning with the calendar year 2021 reporting period, which is associated with the fiscal year 2023 payment determination; and, lastly, finalizing a number of changes to streamline the validation process.

So, to talk through the first finalized policy, for some background, in the fiscal year 2016 and 2017 final rule, we had previously finalized eCQM file format requirements for the IQR program. Under these requirements we had specified that hospitals one, must submit eCQM data via the Quality Reporting Document Architecture Category I, so QRDA I, file format; two, hospitals may use third parties to submit QRDA files on their behalf; and, three, hospitals may either use abstraction or pull the data from noncertified sources in order to then input that data in the correct format to capture and then report as a QRDA file. Hospitals can continue to meet the reporting requirements by submitting data via QRDA files, zero denominator declaration, or case threshold exemption. So, specifically around these QRDA files, we had previously finalized in the fiscal year 2017 IPPS rule that we expect QRDA I files to reflect data for one patient per file per quarter and that they should contain the following four key elements that are intended to help identify the file: the CMS

Certification Number, the CCN; the CMS Program Name; the EHR Patient ID; and then the Reporting Period. So, in this final rule, we are finalizing the policies to add EHR submitter ID to that list of four key elements, as the fifth key element, for file identification, beginning with the calendar year '21 reporting period, which is associated with the fiscal year 2023 payment determination. An EHR submitter ID is the ID that is assigned by *QualityNet* to submitters upon registering into the Hospital Quality Reporting system. For vendors, the EHR submitter ID is their vendor ID. For hospitals, the EHR submitter ID is their hospital CCN. So, in situations where a hospital uses one or more vendors to submit QRDA files via the *QualityNet Secure Portal*, this additional element helps prevent the risk of a previously submitted file being overwritten by a different vendor unintentionally. Many hospitals already use this EHR submitter ID in their QRDA file submission as we had previously recommended hospitals to do so in the CMS implementation guide, but this year we are finalizing that it should be included in that list of now five key elements.

So, next, I'll talk through our finalized updates to the certification and file format requirements for hybrid measures. So, previously, in the Fiscal Year 2020 IPPS Final Rule, we had finalized a requirement that hospitals use EHR technology that is certified through the 2015 Edition to submit on the Hybrid Hospital-Wide Readmission measure. In addition, we had also finalized that the core clinical data element and the linking variables identified in the hybrid measures specification must be submitted using the QRDA I file format. This QRDA file standard enables the creation of an individual patient-level quality report that then contains quality data for one patient, for one or more of the quality measures.

Here, we're finalizing the policy that requires hospitals to use EHR technology certified to the 2015 Edition to submit data on the Hybrid Hospital-Wide Readmission measure and to expand this requirement to apply to any future hybrid measures that are adopted into the Hospital IQR Program measure set.

We're also clarifying that core clinical data elements and linking variables must be submitted using the QRDA file format for future hybrid measures in the program.

So, next, I'll move to our two finalized policies related to eCQMs. Before doing so, I did just want to note, here on this slide, this is our eCQM measure set for the calendar year 2021, which we finalized in previous rules. We did not add or remove any eCQMs in this year's proposed or final rule.

So, first is our finalized proposal to progressively increase reporting quarters for eCQM. I did also want to note here that this policy was also finalized in the Promoting Interoperability Program in order to keep the two programs aligned. So, the current reporting and submission requirements were established for eCQMs in the Fiscal Year 2018 IPPS Final Rule. In that final rule, we finalized the eCQM reporting and submission requirements that hospitals were required to report only one self-selected calendar quarter of data for four self-selected eCQMs for the calendar year 2018 reporting period. Those reporting requirements were extended to the calendar year 2019 reporting period in the Fiscal Year 2019 IPPS Final Rule, as well as for the calendar year 2020 reporting period and the calendar year 2021 reporting period in the fiscal year 2020 IPPS rule. Also, in the Fiscal Year 2020 IPPS [Final] Rule, we finalized that for the calendar year 2022 reporting period, hospitals would be required to report one self-selected calendar quarter of data for three self-selected eCQMs, then for the Safe Use of Opioids–Concurrent Prescribing eCQM, for a total of four eCQMs. In the fiscal year 2021 final rule, this year we are finalizing our proposal to progressively increase the number of quarters for which hospitals are required to report eCQM data from the current requirement of one self-selected quarter of data to four quarters of data over a three year period. So, we believe that increasing the number of quarters for which hospitals are required to report eCQM data will produce more comprehensive and reliable quality measure data for both patients and providers. Evaluating multiple quarters of data would provide a more reliable and accurate picture of overall performance and is more reliable.

Further, reporting multiple quarters of data will also provide hospitals with a more continuous information stream to help monitor their levels of performance during the year. Ongoing timely data analysis can help better identify a change in performance that may necessitate investigation or potentially a corrective action by hospitals. Taking this incremental approach over a three-year period will help give hospitals and their vendors time to plan in advance and build upon and utilize investments that they've already made in their EHR infrastructure so far.

So, next, I'll cover our finalized proposal to begin publicly reporting eCQMs. As eCQM reporting for the Hospital IQR Program continues to advance and hospitals have gained several years of experience with successfully collecting and reporting eCQM data, we believe it is important to further our policy goals of leveraging EHR-based clinical quality measure reporting in order to incentivize data accuracy, promote interoperability, increase transparency, and reduce long-term provider burden by providing public access to the reported eCQM data. Originally, as we incorporated eCQMs into the Hospital IQR Program on a voluntary basis, we had stated that we would need time to assess the data submitted by hospitals in order to determine the optimal timing and transition strategy for publicly reporting eCQM data. Based on our validation of eCQM data submitted from calendar year 2017 and 2018 and in alignment with our goals to encourage data accuracy and transparency, in the final rule, we finalized our proposal to begin publicly reporting eCQM data, beginning with the eCQM data that are reported by hospitals for the calendar year 2021 reporting period and for subsequent years. These data could be made available to the public as early as the fall of 2022. As with other Hospital IQR Program measures, hospitals would have the opportunity to review their data before they are made public during the 30-day preview period. As clarification, I did want to note that we are planning to initially publish calendar year '21 reporting period data first on Data.Medicare.gov or its successor website before publishing on *Hospital Compare* or its successor sometime later in the future. So, now I will turn it over to Alex to talk through the validation proposals.

Alex Feilmeier: Thanks, Julia. My name is Alex Feilmeier with the Validation Support Contractor, and I'll be outlining at a high-level the ways in which CMS has finalized policy to better streamline validation processes under the Hospital IQR Program. We will incrementally combine the validation process for chart-abstracted measure data and eCQM data, including the related policies in a stepwise process. These incremental changes to CMS data validation affect fiscal year 2023 and fiscal year 2024 payment determinations. Now, I will explain how we will do this.

The finalized changes to fiscal year 2023 payment determination will effect validation in the following way: Instead of validating chart-abstracted measure data from Q3 2020 through Q2 2021, as the current process would have it, we will instead validate measure data only from Q3 and Q4 of 2020. We will not require facilities to submit data for chart-abstracted validation for Q1 and Q2 2021 for fiscal year 2023 payment determination. As you can see on the slide, eCQM validation quarters will remain unchanged, still validating calendar year 2020 data to effect fiscal year 2023 payment determination. I'll explain the reason for this in the next slides.

Now, for fiscal year 2024 payment determination, because we will only utilize two quarters for the previous fiscal year, we can now align data submission quarters between chart-abstracted and eCQM validation, all associated with a full calendar year, instead of crossing calendar year quarters, like it does currently under the chart-abstracted validation program. So, as you can see in the table on this slide, we will use Q1 through Q4 of calendar year 2021 for data validation efforts affecting fiscal year 2024 payment determination.

The reason for the stepwise alignment of the quarters used in validation is twofold. CMS has finalized one single sample of hospitals to be selected through random selection and one sample of hospitals to be selected using targeted criteria for both chart-abstracted measures and eCQMs. What this means is there would not be two separate groups of hospitals selected for chart-abstracted validation and eCQM validation, but rather one sample of hospitals selected for both types. When aligning the two samples, chart-abstracted and eCQM, into one sample, this will naturally mean that all of

the random selection and, more specifically, targeted selection processes would go into effect for eCQMs as well, not just chart-abstracted clinical process of care measures. Lastly, and one of the biggest reasons for this alignment of the two samples, CMS has finalized a reduction in the total number of randomly selected hospitals from 400 to up to 200.

To provide a visual of the finalized changes to combine the validation samples, as well as reduce the total number of hospitals selected for all inpatient data validation efforts, you can see on this slide a table which displays a random selection of up to 200 hospitals and a targeted selection of up to 200 hospitals, totaling up to 400 hospitals selected for validation for both chart-abstracted clinical processes of care and eCQM measure types. Under the aligned validation process, any hospital selected for validation will be expected to submit data to be validated for both chart-abstracted clinical processes of care measures, as well as eCQMs.

With an alignment of the two samples comes a combining of scoring processes, and, beginning with fiscal year 2024, CMS has finalized the combined validation score. This single score will reflect a weighted combination of the hospital's validation performance for chart-abstracted clinical processes of care measures and eCQMs. The eCQM portion of the combined agreement rate will be multiplied by a weight of 0 percent and chart-abstracted measure agreement rate will be weighed at 100 percent. So, although the accuracy of eCQM data and the validation of measure reporting will not affect payment at this time, hospitals will pass or fail the eCQM validation criteria based on the timely and complete submission of at least 75 percent of the records CMS requests. For example, if eight medical records are requested, at least six complete medical records must be submitted to meet the 75 percent requirement.

An additional validation process change is related to the submission of medical records; whereas, in the current chart-abstracted validation process, hospitals are allowed to submit paper copies of medical records or copies on digital portable media such as CD, DVD, or flash drive, beginning with the fiscal year 2024 payment determination and Q1 of 2021, these will no longer be submission options. Similar to how the

eCQM validation process currently works, hospitals will be required to submit PDF copies of medical records using direct electronic file submission via a CMS-approved secure file transmission process.

Lastly for validation, CMS has finalized an increase in the number of eCQM cases randomly selected for validation, in a stepwise fashion, relative to the eCQM reporting requirements. As the number of reporting quarters for eCQMs increases, the case selection for validation will also increase. As can be seen on this slide, the number of cases randomly selected per quarter remains steady at eight, but the total number of cases selected in a given calendar year will increase relative to the number of reported quarters. That's all I have for validation. Now, I will pass it off to Mr. Dylan Podson.

Dylan Podson: Thank you, Alex. I appreciate the transition there. Hi, everyone. My name is Dylan Podson, and, over the next few slides, I will briefly be going over the most pertinent aspects to the FY 2021 IPPS Final Rule changes which are specific to the Medicare Promoting Interoperability Program.

The rule did not include many drastic changes, we believe. The majority of its policies should sound familiar enough from previous years. As you will notice on this slide, the topics we would like to draw the most attention to are as follows: the adoption of an EHR reporting period consisting of a minimum of any continuous 90-day period in calendar year 2022; second, maintaining the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program measure as optional and worth five bonus points in calendar year 2021; and third, a slight new name change to the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure. So, with the one word of "Reconciling" italicized there, it changes so that it more closely aligns with the intended real-world function of the measure; however, just to be clear, no other aspects besides the measure title will be impacted. I think it is important just to note here that the first few topics specifically listed concerning the EHR reporting and the Query of PDMP are more or less an extension of the Promoting Interoperability policies from the FY 2020 final rule.

In other words, it could be said that the self-selected continuous 90-day period and the optional bonus PDMP measure are one-year continuations of the current policy that's already in place.

Now that we have concluded Promoting Interoperability's unique proposals specific to the program, the following slides will contain several eCQM changes which were finalized to align with CMS' Hospital IQR Program. Given that the aligned eCQM portions have already been stated and described earlier during this presentation, I will not be going into as much detail on each. However, they have been replicated here and included for clarity and consistency's sake. I would note that this finalized alignment is not to indicate duplicative work would be expected or that each of the programs would require independent or parallel eCQM reporting, since reporting one would adequately cover both programs required.

Here we included this chart to help visualize how the Medicare Promoting Interoperability Program will progressively increase the number of quarters for which hospitals are required to report eCQM data from one self-selected calendar quarter of data to four calendar quarters of data over a three-year period, more specifically, to require two self-selected calendar quarters of data from 2021, three self-selected calendar quarters of data from 2022, and four calendar quarters of data beginning with 2023. Increasing the number of quarters for which hospitals are required to report eCQM data, we believe, will produce more comprehensive and reliable quality measure data for patients and for providers. Taking an incremental approach over a three-year period, we will allow hospitals and their vendors time to plan in advance to build upon and utilize investments that they have already made in and around their EHR infrastructure. One last note is that, as finalized in the FY 2020 IPPS Final Rule, attestation is no longer a method for reporting CQMs for the Medicare Promoting Interoperability Program beginning with the reporting period in calendar year 2023. Instead, all Eligible Hospitals and CAHs are required to submit their eCQM data electronically through the reporting methods available for the Hospital IQR Program.

Additionally, we finalized the submission period for the Medicare Promoting Interoperability Program would be the two months following the close of the respective calendar year. So, with all of that said, for example, calendar year 2023 would end February 28, 2024, and so on.

So, on this slide, we will be moving to another aligned change with the Hospital IQR Program, which begins publicly reporting eCQMs. Electronic reporting serves to further the CMS and HHS policy goals to promote quality performance measurement and, in the long-term, improve the accuracy of the data and reduce reporting burden for providers. Over time, hospitals will continue to leverage EHRs to capture, calculate, and electronically submit quality data, build and refine their EHR systems, and gain more familiarity with reporting of eCQM data. Therefore, the Promoting Interoperability Program finalized publicly reporting eCQM data submitted from calendar year 2017 and calendar year 2018. Additionally, in alignment with our goal to encourage data accuracy and transparency, we also finalized an update to begin publicly reporting eCQM data beginning with the eCQM data reported by hospitals for the calendar year 2021 reporting period, as well as for subsequent years.

By publicly reporting quality measure data, this demonstrates CMS' commitment to providing data to patients, consumers, and providers as quickly as possible in order that they're empowered to make informed decisions about their own, and their patients' healthcare. This also reflects the meaningful use of certified EHR technology by collecting and reporting quality data and the effort of continued alignment with the Hospital IQR Program. As eCQM reporting continues to advance and hospitals have gained several years of experience with successfully collecting and reporting eCQM data, it is important to further our policy goals of leveraging EHR-based quality measure reporting, in order to incentivize data accuracy, promote interoperability, increase transparency, and reduce long-term provider burden by providing public access to the reported eCQM data.

Before concluding this section on Promoting Interoperability, I would actually like to make one mention of some proposed changes to the 2015 Edition CEHRT requirement. While not yet finalized, the pending

Physician Fee Schedule rule does include edits which would allow hospitals the flexibility moving forward to use either technology certified to the 2015 Edition CEHRT criteria for CEHRT as previously finalized or an alternative route of technology certified through the 2015 Edition Cures update, as finalized in the 21st Century Cures Act final rule, with citation pages included here. Even though the PFS rule is currently in its comment period, more detailed information from CMS would be made available if these proposals were to be finalized. However, in the meantime, providers with questions are encouraged to read the cited section above from the 21st Century Cures Act final rule. That is it for the Medicare Promoting Interoperability portion of this presentation. So, thank you for your time, and I believe I'll be handing it over to Julia, who will continue along next. Thank you very much.

Julia Venanzi: Thank you, Dylan. I will now review the finalized proposals in the Hospital Value-Based Purchasing Program for this year. As a reminder, we did not propose to add or remove any measures for the HVBP program for this year.

So, to start out, I'll give just a little bit of background on the statutory requirements of the Hospital VBP Program. So, the Social Security Act requires the HVBP program to withhold 2 percent of participating hospitals' DRG payments and then redistribute that 2 percent as value-based incentive payments to hospitals, depending on how they perform in the HVBP program in a given year. So, for the fiscal year 2021, we estimate that the total amount of those 2 percent withholds will create an incentive pot of approximately $1.9 billion for the HVBP program.

So, here, we layout the various versions of Table 16. So, Table 16 holds the payment adjustment factors for each of the participating hospitals in the HVBP program.

We published Table 16 and 16a earlier this year. Those include proxy payment adjustment factors. We will be posting the Table 16B this fall, which displays the actual payment adjustment factors for each participating hospital for fiscal year 2021.

So, this slide outlines our previously finalized measures and domains in the HVBP program. Again, I'll note that we did not make any proposals to add or remove programs to the HVBP program for this year. The domains and measures on the screen now represent those that we have previously finalized. So, there are four domains in the HVBP program: the Safety domain, the Clinical Outcomes domain, the Person and Community Engagement domain, and the Efficiency and Cost Reduction domain. Within each of these domains are their associated quality measures.

So, on this slide, we outlined the baseline period and the performance period for each of those measures that will be used for the fiscal year 2022 measurement period. So, that would be calendar year 2020. We use hospitals' performance during the baseline period to establish the performance standards, the benchmark, and achievement threshold that we used for scoring in the HVBP program. For each measure, we used the higher of either the hospital's improvement score or their achievement score. The improvement score is how well a hospital did during the performance period, compared to their own performance during the baseline period. The achievement score is how well a hospital does during the performance period relative to other hospitals on the same measure during the performance period.

So, this slide shows, again, the same domains looking at the fiscal year 2023 through 2026 program years. Again, these four domains stay the same here. We didn't make any proposals to change these moving forward.

So, the next couple of slides show the same information, the baseline period and performance period for some of the upcoming fiscal years.

So, this slide has information for fiscal year 2023.

Here is the baseline period and performance period for fiscal year 2024.

This is for fiscal year 2025.

Then, lastly, that same info for fiscal year 2026. So, I will now turn it over to Lang Le to talk through the Hospital-Acquired Condition Reduction Program changes.

Lang Le: Thank you, Julia. My name is Lang Le, and I am the Program Lead for the HAC Reduction Program at CMS.

On this slide, this is a summary of the fiscal year 2021 finalized proposals. First, the HAC Reduction Program automatically adopted the applicable periods beginning with the fiscal year 2023 program year. CMS will automatically advance the performance periods for the measures included in the program by one year every subsequent program year. We also updated the definition of the applicable period at 42 CFR 412.170 to align with the automatic adoption policy.

We also aligned with the hospital data submission quarters with the Hospital IQR Program validation. Additionally, we aligned the hospital selection process with the Hospital IQR Program and reduced the pool of hospitals selected for the validation from up to 600 to up to 400, beginning with the calendar year 2021 validation. We also require the electronic submission of records for validation via CMS-approved secure file transmission process beginning with calendar year 2021 validation.

This slide presents general program information where we have resources for stakeholders to access.

I am passing along to my colleague Gail Sexton to discuss the Hospital Readmissions Reduction Program. Thank you.

Gail Sexton: Thank you, Lang. This is Gail Sexton, Program Lead for the Hospital Readmissions Reduction Program, or HRRP.

This section of the presentation focuses on the finalized policy for the HRRP in the Fiscal Year 2021 IPPS Final Rule. In this final rule, CMS received public comments on and finalized two proposed policies.

The first is the policy to automatically adopt applicable periods beginning with the fiscal year 2023 program year. Under this policy, CMS would advance the three-year performance period for program calculation by one year every subsequent program year. The second policy is to update the definition of applicable periods to align with this policy.

This slide contains more detailed resources on the HRRP and resources on reducing hospital readmission. You can submit questions about HRRP via the *QualityNet* Question and Answer tool, which can be found via the *QualityNet* website. Now, I'll pass it back to Candace.

Candace Jackson: I would like to thank each of the speakers for providing the finalized changes for each of their programs.

The final rule can be downloaded at the link provided on this slide. Additionally, the slide provides the pages that the finalized changes for each of the programs can be found on.

The next few slides will go over the measures that will be included in each of the programs for fiscal year 2021 through fiscal year 2025.

This slide goes over the Claims-Based Coordination of Care Excess Days in Acute Care measures.

This slide goes over the Readmission Claims-Based Coordination of Care measures.

On this slide, it lists the Claims-Based Mortality Outcome measures.

On this slide is the Claims-Based Patient Safety measures.

On this slide, it lists the Claims-Based Payment measures.

Listed on this slide is the Chart-Abstracted Clinical Process of Care measures.

This slide lists the EHR-Based Clinical Process of Care, eCQM, measures.

This slide is a continuation of the eCQM measures.

The HAI measures are listed on this slide.

This slide lists the hybrid measure.

This slide lists the HCAHPS Patient Experience of Care Survey measure. Next slide.

We do have time for a very short question-and-answer session. We will try to address a few of the questions that were submitted during the webinar today. If we did not get to your question today, all questions and responses will be posted to the Quality Reporting Center web site in the near future. So, we'll go ahead and begin with our first question.

Our first question is, "Please clarify for slide 15. Will submitted data for Q1 and Q2 be used to calculate payments for value-based purchasing or other pay-for-performance programs?" I don't know if someone from CMS, Julia, are you able to respond to that question?

Julia Venanzi: I'm sorry, Candace. Can you repeat the question?

Candace Jackson: Yes, of course. Please clarify on slide 15. Will submitted data for Q1 and Q2 2020 be used to calculate payments for value-based purchasing or other pay-for-performance programs?

Julia Venanzi: Got it. Thank you for repeating that. So, the answer is no. Q1 and Q2 2020 data will not be used in those programs. So, we release a number of guidance memos. I can send a link in the chat, but there was one sent out on March 27 that we further clarified in an interim final rule, or IFC, that came out in the beginning of September. The short answer is no; Q1 and Q2 2020 will not be used.

Candace Jackson: Thank you, Julia. We have a question in regard to eCQMs. Does the EHR submitter ID need to be in the QRDA I file? Do I have…

Julia Venanzi: This is Julia. I can answer. Yes, that will be one of the now five required pieces of information in the QRDA file.

Candace Jackson: On the same line for eCQMs, can the four eCQMs selected be the same for each quarter for 2021? This is, I think, in reference to slide 22.

Julia Venanzi: Sorry, hold on one second. I'm just looking at the slide. Yes, so, the four eCQMs, they can be self-selected, all four can be self-selected for calendar

year 2021. For calendar year '22, and then moving forward, it is three self-selected eCQMs, and then there's one required eCQM, the Safe Use of Opioids eCQM.

Candace Jackson: Thank you, Julia. Going to a couple of validation questions now. Our first question is, "Do Critical Access Hospitals get validated for measures?"

Alex Feilmeier: This is Alex with the validation support contractor. No, Critical Access Hospitals are not subject to CMS data validation requirements.

Candace Jackson: Alex, while you're answering, is HAI removed for validation?

Alex Feilmeier: The HAI measures were removed from the Hospital IQR Program in fiscal year 2022 payment determination. They've been transitioned into the HAC Reduction Program, beginning with fiscal year 2023 payment determination. That said, validation of the HAI measures will occur under the HAC Reduction Program, beginning with Q3 2020 discharges for the fiscal year 2023 program year, but, although, they have been transitioned into the HAC Reduction Program, the actual validation process itself is going to occur in the same manner that hospitals are used to, in conjunction with the Hospital IQR Program.

Candace Jackson: Alright. Thank you. Can we go to slide 25, please? The question for this is, "If you submitted eCQM data for Q1 or Q2 in 2020 and are selected for validation, how will this impact your validation, if only using Q3 and Q4?"

Alex Feilmeier: It's a good question. So, while chart-abstracted quarters of validation will only be based off of that third and fourth quarter, for the fiscal year 2023 payment determination, we'll still utilize any and all quarters submitted for eCQM for that payment year. So, as you can see on the slide, the quarters included in calendar year for eCQM validation are, though different, they still affect the same payment determination for validation purposes.

Candace Jackson: Thank you, Alex. We'll go with one more question, and I can't… I'm not sure what's going on with our slides, but the next question was in reference to slide 29. It says, "Validation will be 100 percent passed or failed by the

chart-abstracted chart review of at least 75 percent. Is that correct? How is the submission of eCQMs factored into the validation pass or fail?"

Alex Feilmeier: At this time, all the hospitals will only actually be "scored" on their performance of the Chart-Abstracted Clinical Processes of Care measures in the [Hospital] IQR Program. The eCQM performance accuracy will not be used in scoring, but the hospitals will be still required to submit at least 75 percent of the records that CMS requests for eCQM cases. So, as long as you submit 75 percent of the eCQM record requests, then you will meet the requirement for validation of eCQMs, but the actual scoring and your payment determination will be based on the Clinical Processes of Care Chart-Abstracted measures only at this time.

Candace Jackson: Thank you, Alex. We'll go to a VBP question, and this will probably be our last question. What is the difference between baseline period and performance period? Do I have Julia or Bethany that would be able to respond to that question?

Julia Venanzi: I'm not sure Bethany is on, but, I was just going to say, this is Julia. Maybe this is one we can follow up on since we're running out of time.

Candace Jackson: That sounds wonderful. Thank you. We can go to the next slide, please.

As this will conclude our Q&A session for this event, again, I would like to thank our webinar speakers. As we indicated, this slide has been approved for one CEU credit, and you can click on the link to get the information that you will need to obtain your CEU. We can go to the next slide…

The next slide…

Then, our last slide…

So that we can continue to provide the information you need to successfully meet the reporting requirements, we ask that you complete the survey by clicking on the link provided on the slide. I would like to conclude with thanking everyone for joining us today. We hope that you have a great day.