Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

FY 2019 IPPS Final Rule
Acute Care Hospital
Quality Reporting Programs Overview

Presentation Transcript

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Candace Jackson: Thank you, everyone, for joining today's presentation titled, Fiscal Year 2019 Inpatient Prospective Payment System Final Rule Acute Care Hospital Quality Reporting Programs Overview. I am Candace Jackson, the Project Lead for the Hospital Inpatient Quality Reporting Program for the Hospital Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be the moderator for today's event. Before we begin, I would like to make our first few regular announcements. This program is being recorded. A transcript of the presentation, along with the questions and answers, will be posted to the inpatient website http://www.QualityReportingCenter.com and to the *QualityNet* site at a later date. If you are registered for this event, a reminder email, as well as the slides, were sent out to your email about a few hours ago. If you did not receive that email, you can download the slides at our inpatient website. Again, that's *www.QualityReportingCenter.com*. If you have a question as we move through the webinar, please type your question into the chat window. We will not be using the raised hand feature for today's webinar. For presenters to best answer your questions, we request that, at the beginning of your question, please type the slide number into the chat window with it. As time allows, we will have an answer-and-question session at the conclusion of the webinar. Applicable questions that are not answered during the question-and-answer session at the end of the webinar will be posted to the *QualityReportingCenter.com* website at a later date.

I would now like to welcome and introduce our guest speakers for today from the Centers for Medicare & Medicaid Services: Grace Snyder, Program Lead for the Hospital Inpatient Quality Reporting Program and Hospital Value-Based Purchasing Program, Nekeshia McInnis, Subject-Matter Expert for the Hospital IQR and VBP Programs, and Erin Patton, Program Lead for the Hospital Readmissions Reduction Program.

Today's presentation will provide participants with an overview of the Fiscal Year 2019 finalized requirements for the Hospital Inpatient Quality Reporting Program, the Hospital Value-Based Purchasing Program, the Hospital-Acquired Condition Reduction Program, and the Hospital

Readmissions Reduction Program, as addressed in the recently released inpatient prospective payment system final rule.

At the end of today's presentation, participants will be able to locate the Fiscal Year 2019 IPPS Final Rule and identify the finalized program changes.

This is just a list of the acronyms that will be used throughout the presentation today.

I would now like to turn the presentation over to Grace Snyder. Grace, the floor is yours.

Grace Snyder: Thank you, Candace, and welcome everyone. Thank you for joining us today. Next slide, please. Before we dive into program-specific changes that we finalized in the IPPS final rule, my colleagues and I at CMS want to present a quick overview of the framework we applied called Meaningful Measures in evaluating each of our programs' measure sets and how we decided which measures to propose to remove and, together with the public comments we received, how we decided which measures to finalize for removal. Please note, this is not just a framework for removing measures. It's really to view the measures that we currently use in our programs, as well as future measures within our larger measurement goals and objectives. Next slide, please.

Those cross-cutting goals and objectives focus on high impact measures that are meaningful to both patients and their providers and caregivers, and we've set a preference for measures that focus on patient outcomes over processes whenever possible. In other words, we want to focus on the quality of the quality measures we use, not on the quantity of measures. Next slide, please.

This slide, which many of you may have seen before, summarizes the Meaningful Measures areas, and they include promoting effective communication and coordination of care, promoting effective prevention and treatment, strengthening person and family engagement in the care, working with communities to promote best practices of healthy living,

making care safer by reducing harms caused in the delivery of care, and making care affordable. It also provides more concrete examples of measurement areas within the context of the six larger measurement areas. So, for example, under the promoting effective prevention and treatment of chronic disease Meaningful Measures area on the top-right corner of the slide, you can see that some of the more specific examples include preventive care; management of chronic conditions; prevention, treatment and management of mental health; prevention and treatment of opioid and substance use disorders; and risk-adjusted mortality. So, this is not meant to be an exhaustive list, but to provide some clear examples of the kinds of measurement areas we're looking at when we talk about promoting effective prevention and treatment. Next slide, please.

We see the Meaningful Measures Initiative as a living framework to be continuously refined as we incorporate more and more of your input and feedback. So, please reach out to us using the email address on this slide: MeaningfulmeasuresQA@cme.hhs.gov. We genuinely want to hear from you and to be able to incorporate your feedback into the Meaningful Measures Initiative and this framework. Next slide, please.

Now, I'd like to turn to specific changes that we finalized for the Hospital Inpatient Quality Reporting Program, or IQR program. Next slide please.

To start with a high-level summary, we finalized the removal of 39 measures under the IQR program, which will be implemented over the next several years. Approximately half of the 39 IQR measures are being removed altogether from CMS programs, and approximately the other half are being removed from IQR because they will continue to be used in another CMS quality program such as the Hospital Value-Based Purchasing Program, the Hospital-Acquired Condition Reduction Program, or the Readmissions Reduction Program. This is what we mean by describing them as being "de-duplicated." Please note that we finalized keeping the five healthcare-associated infection measures and the Patient Safety in Adverse Events composite measure, known as PSI 90, in the Hospital Value-Based Purchasing Program, which I'll discuss further when we get to that portion of the presentation. Next slide, please.

Okay. So, the next set of slides will dive into the specific measures that will be removed and when. So, this slide focuses on the chart-abstracted clinical process measures. We will be removing the ED-1, IMM-2, and VTE-6 measures, beginning with the 2019 reporting period. This means that hospitals will no longer need to abstract and report data to CMS for these measures for discharges after December 31, 2018. So, to put it another way, this 2018 calendar year will be the last measurement period for these measures. In terms of submission deadlines for this last fourth quarter 2018 data, the submission deadline for the population and sampling data is May 1 of 2019. Then the submission deadline for the clinical data will be May 15, 2019. After that, no more data for these three measures will need to be reported to CMS. For the ED-2 measure, it will be removed a year later. So, this means hospitals will no longer need to abstract and report data to CMS for the ED-2 measure for discharges after December 31, 2019. So, again, in other words, the last quarter of data to report to us for the ED-2 measure will be fourth quarter 2019 data, and the submission deadline will be May 1, 2020, for the population sampling and data, and May 15, 2020, for the clinical data for the ED-2 measure. Next slide, please.

For the two structural measures that we had in the IQR program (the Hospital Survey on Patient Safety Culture measure and the Safe Surgery Checklist Use measure), hospitals will no longer have to collect or submit data for these measures. Actually, the last data submission period was this past spring for the May 15, 2018 submission deadline, and data will not have to be submitted in 2019 or any year after that. Next slide, please.

For the healthcare-associated infection measures, or HAI measures, hospitals will need to continue reporting HAI data to the CDC's National Healthcare Safety Network, as the data will continue to be used in the Hospital-Acquired Condition Reduction Program, or HAC Reduction Program, and the Hospital Value-Based Purchasing Program, or VBP program. When the HAI measures come out of the IQR program after the end of the 2019 measurement period, the validation of the HAI measure data will be conducted under the HAC Reduction Program. My

colleague will provide more details on the transition of the HAI validation process later in this webinar. Please note, the validation of the remaining IQR measures will continue as they have been. In terms of the HAI data that are available on the *Hospital Compare* website, that will continue without interruption, including refreshing the data four times a year. Now, these HAI measures, these are part of the measures that we proposed to de-duplicate from our CMS quality programs because we've been using them in three quality programs: IQR, VBP, and the HAC Reduction Programs. So now, starting with the 2020 measurement periods, these measures will be removed from IQR, but they will continue to be used in the two pay-for-performance programs, specifically the HAC Reduction and Hospital VBP Programs. We had initially proposed to use these measures in just one program, the HAC Reduction Program, but we heard from many commenters about the need to maintain a strong financial incentive to do well on these measures in order to improve patient safety. So, we ultimately decided to keep these measures in the Hospital VBP Program, as well as the HAC Reduction Program. However, again, they will be removed from the IQR program at the end of 2019. That's after the conclusion of the Calendar Year 2019 measurement period. Next slide, please.

Now, the following claims-based measures on this slide focus on 30-day mortality and safety and are also being de-duplicated from the IQR program. So, again, de-duplicated meaning, while they're being removed from the IQR program, they'll continue to be used in a different CMS quality program. Specifically, the PSI 90 measure will continue to be used in the HAC Reduction Program, and we will begin to use the PSI 90 measure in the Hospital VBP Program beginning with the FY 2023 VBP program. The mortality measures, as well as the complication measure, will be removed from IQR as they begin to be used in the VBP program, which is why there's a staggered timeline for when the mortality measures will be removed from IQR. So, due to the fact that, for example the COPD and the CABG mortality measures, we have not yet begun using them in the Hospital VBP Program, but when they do start to be used in the Hospital VBP Program, we're timing the removal of those same measures

from the IQR program. I want to note that, for all of these measures, again we are committed to continuing to make the measure data available on the *Hospital Compare* website without interruption. Next slide, please.

On this slide, all of the following readmission measures, except for the stroke readmission measure at the bottom, are also being de-duplicated from the IQR program, and they will continue to be used in the Hospital Readmissions Reduction Program. The stroke readmission measure, which is not used in the Readmissions Reduction Program, is being removed completely. Again, for the de-duplicated readmission measures that we're continuing to use in the readmissions reduction program, we are committed to continuing to make the measure data available on *Hospital Compare* website without interruption. Next slide, please.

Among the following payment measures that are listed on this slide, we are de-duplicating the Medicare Spending per Beneficiary measure, or MSPB, measure from the IQR program while continuing to use it in the Hospital VBP Program. However, for these other payment measures, we're removing them completely. Next slide, please.

Then, for our last set of measure removals from the IQR program, this slide lists the eCQMs, or electronic clinical quality measures, that will be removed from both the IQR program and the Promoting Interoperability program eCQM measure set, and these removals will come into effect after the end of the 2019 reporting period. So, that means, for this current 2018 reporting period as well as next year 2019 reporting periods, all these measures listed here will still be available for reporting, but, then, for 2020 reporting, these seven measures will no longer be available. To note, there will still be eight other eCQMs for hospitals to choose from to meet their eCQM reporting requirements for 2020 and afterwards. Next slide, please.

So, now turning to the eCQM reporting requirements, we finalized for the 2019 eCQM reporting period to continue the same requirement of selecting and reporting on four eCQMs and sending us one calendar quarter of data, and the submission deadline for the 2019 reporting period will be February 29, 2020, a leap year. Please note that, beginning with the

2019 reporting period, everyone will need to use the 2015 Edition of Certified EHR Technology. I'd also like to actually take a quick moment here to announce that, for the 2018 eCQM reporting period, the CMS system is now actually accepting 2018 eCQM data via the *QualityNet Secure Portal*. Shortly, we'll be making a broader announcement, but I definitely wanted to take a moment to share this news with you all. Next slide, please.

In this past rule, we also invited comment on some potential new measures for the Hospital IQR Program and, in some cases, also for the Promoting Interoperability program, specifically a claims-only hospital-wide mortality measure as well as a hybrid version of the hospital-wide mortality measure that uses EHR data, also a Hospital Harm-Opioid-Related Adverse Events measure. That is an eCQM. Thank you to everyone who provided feedback on these measures. We're continuing to assess the feedback, and, please note, that any new measures for the IQR program would first be proposed through rulemaking in the future. Next slide, please.

We also sought feedback on additional aspects of eCQM development and eCQM reporting. Thank you again to everyone who provided feedback, which we've also shared with our colleagues in the Office of National Coordinator for Health IT, or ONC. We have included a summary of the public comments that we received in the IPPS final rule. So, we direct you there for a summary of those comments. It's a little bit too long and extensive for this webinar but wanted to let you know where you can view those comment summaries. Next slide, please.

Before I conclude on the IQR program, I want to make sure you all know that we have a proposal in the Calendar Year 2019 outpatient prospective payment system proposed rule to remove the new Communication about Pain questions from the HCAHPS Patient Experience Survey. That would be effective with January 2022 discharges. So, please submit your comments on this proposal before the September 24 comment period deadline. Next slide, please.

Okay. Now, I will turn to specific changes that we finalized for the Hospital Value-Based Purchasing Program, or VBP program. Next slide, please.

On this slide, a quick reminder that the Social Security Act requires that we withhold 2.00 percent of Medicare fee-for-service payments to hospitals to fund the incentive payments made under the Hospital VBP Program, which amounts to approximately $1.9 billion that are awarded back to hospitals based on their performance in this program. Next slide, please.

This slide describes the different tables of the payment adjustment factors and their relationship to each other because I know, sometimes, this can be a little bit of a source of confusion. So, basically, Table 16, which was published with the proposed rule, and Table 16A, which was published with the final rule and was an update to Table 16 using more updated claims information, they are still both only estimates of the payment adjustment factors using the Fiscal Year 2018 Total Performance Scores for hospitals. Table 16B will be the actual payment adjustment factors that are based on Fiscal Year 2019 Total Performance Scores. If you're with a hospital, the FY 2019 Percentage Payment Summary Reports were recently made available in August for viewing. We anticipate posting Table 16B again, which are the actual payment adjustment factors for Fiscal Year 2019 on our *CMS.gov* website around late October this year. So, please keep an eye out for that. Next slide, please.

This slide lists the original 10 hospital VBP measures that we had proposed to remove, and all of them were for the purpose of de-duplicating them since they were being used in other CMS quality programs. We received many comments during the public comment period, especially about the healthcare-associated infection measures and the PSI 90 measures. Again, thank you for all of that great feedback. If we could please turn to the next slide.

So, this slide shows the list of measures that we actually ended up finalizing for removal, and you'll note that the five infection measures and the PSI 90 measure are not included on this list. Next slide, please.

Just to make it very clear, this slide lists the measures that we had proposed but did not finalize for removal. So again, thank you to everyone who provided your feedback about whether or not to de-duplicate these patient safety measures. As I mentioned earlier, we had initially proposed to keep these measures in just one CMS program, namely the HAC Reduction Program, but we heard from many commenters about the need to maintain a strong financial incentive to do well on these measures in order to continue improving on patient safety and build upon the tremendous improvements that have already been made, and we want to continue that momentum. So, ultimately, we did decide to keep these measures in the Hospital VBP Program, as well as in the HAC Reduction Program. Next slide, please.

This slide shows the domain weights for the Hospital VBP Program, which were previously finalized in past rules. Because we are not removing the HAI measures or the PSI 90 measure, we finalized to not remove the Safety domain. So, in keeping the Safety domain in the program, we will also continue to weight it at 25 percent of the Total Performance Score, and the other three domains will also continue to be weighted at 25 percent each. In addition, if a hospital can only be scored on three of the four domains, we'll continue our domain re-weighting policy so that each domain would then be worth, constitute, 33.3, or a third, of the total performance score. Next slide, please.

This slide shows a summary of the minimum case and minimum measure requirements for the Hospital VBP Program. So, for each measure, there is a minimum amount of data that we need to be able to calculate the measure. Then, for each domain, we have a minimum number of measure scores that we need in order to be able to calculate domain score. In this most recent final rule, we did not make any changes to these minimum requirements. Next slide, please.

Okay, the next set of slides that I'll present are meant to provide a summary of the measures and the domain weights for the next several fiscal years. So, this slide shows Fiscal Year 2019. We did not make any changes from what we had previously finalized, and so there will continue

to be four domains, each weighted at 25 percent of the Total Performance Score. You can see all the measures listed for each specific domain. Next slide, please.

Also for Fiscal Year 2019, this slide summarizes the measurement periods. So, the baseline period is where we look at historical performance, and the performance periods allow us to reach measures, look for improvements over time. Focusing on the performance period, being able to calculate achievement points. Next slide, please.

Okay, this slide summarizes the requirements and the measures we're using for the Fiscal Year 2020 program year, and, again, we didn't make any changes from what we had previously finalized in past rules. So, we'll continue to have four domains, each equally weighted at 25 percent, and you can see each of the specific measures for each domain. Next slide, please.

This slide summarizes the measurement periods, baseline, and performance periods for the Fiscal Year 2020 program. So, again, we did not make any changes from what we had previously finalized. Next slide, please.

All right. So, for the Fiscal Year 2021 program, this is where we start to see some changes. So, again, we'll continue to have four domains, each equally weighted at 25 percent of the Total Performance Score, but, please note, in terms of the measures listed under the Safety domain, the PC-01 measure is no longer listed there, as we finalized the removal of this measure from the Hospital VBP Program. I also want to note that under the Clinical Outcomes domain, Fiscal Year 2021 is when we will first begin to use the COPD mortality measure. This is also the year when we begin to use the updated pneumonia mortality measure with the expanded cohort. Next slide, please.

This slide summarizes the baseline and performance periods for the Fiscal Year 2021 VBP program. Next slide, please.

So, for the Fiscal Year 2022 program year, the important change to note, compared to Fiscal Year 2021, will be the addition of the CABG mortality measure in the Clinical Outcomes domain. Next slide, please.

Again, for the Fiscal Year 2022 program year, this slide summarizes the baseline and performance periods for each of the measures. Next slide, please.

Okay. Finally, for the Fiscal Year 2023 program, this slide summarizes the domains, the domain weights, and the measures that will be used in each domain. I think the biggest change here from the prior program year that I want to point out is the addition of the PSI 90 measure in the Safety domain. This is when we will begin to use the updated PSI 90 measure that we are using today in the Hospital-Acquired Condition Reduction Program. All right. Next slide, please.

Then, finally, for the Hospital VBP Program, this slide summarizes the baseline and performance periods for the Fiscal Year 2023 program year. Next slide, please.

Now, I'll hand things over to my colleague to present on the HAC Reduction Program. Thank you.

Nekeshia McInnis: I want to thank everyone for joining us today. I'm pleased to have this opportunity to speak with you about the recently published final rule as it relates to the Hospital-Acquired Condition, or HAC Reduction Program. I'm only going to provide a very high-level overview during this webinar because of time constraints. I expect that you'll have questions and want details that I'm not able to provide today. So, I encourage you to read the rule for more information.

As Grace has previously described, the Meaningful Measure initiative is intended to provide for the most harmonious and least burdensome measure set. We've taken a holistic approach to evaluating the appropriateness of the HAC Reduction Program's current measures in the context of the measures used in the other inpatient value-based programs.

As the program's name conveys, among quality reporting programs, the HAC Reduction Program is the flagship for patient safety. It focuses on reducing harm caused in the delivery of inpatient care. Therefore, we have determined that all the measures currently included in the program should be retained because these measures address the performance gap in patient safety and reducing harm caused in the delivery of care. CMS did not add nor remove any measures from the HAC Reduction Program. However, in an effort to eliminate duplicative measures and as already discussed in this webinar, the Hospital IQR Program will remove the six healthcare-associated infections, HAI, patient safety measures that are being de-duplicated in Calendar Year 2020, which is a one year later than originally proposed. After considering comments or input, we did not finalize our proposal to remove these measurements from the Hospital Value-Based Purchasing Program. Retaining these measures in both the HAC Reduction and Hospital Value-Based Purchasing Programs will ensure that hospitals are incentivized to continually strive for both improvement and high performance.

In last year's rule, the HAC Reduction Program finalized a return to a 24-month data collection period. We continue to believe that using 24 months of data for the CMS PSI 90 and the NHSN HAI measure balances the program's needs against the burden imposed on hospital data collection processes and allows for sufficient time to process the data for each measure and calculate the measure result. The applicable period for the Fiscal Year 2021 HAC Reduction Program for the CMS PSI 90 is a 24-month period from July 1, 2017, through June 30, 2019. The applicable period for NHSN HAI measures is the 24-month period from January 1, 2018, through December 31, 2019.

Specifically, with respect to the HAI measure data, the HAC Reduction Program has historically relied on Hospital IQR Program processes for administrative support. So, we propose policies related to data collection requirements. We are adopting data collection processes for the HAC Reduction Program beginning with January 1, 2020 infection events. Reporting requirements, including reporting frequency and deadlines, will

not change from current Hospital IQR Program requirements. It's our intention that this change will be seamless from the hospital perspective. We're also adopting the Hospital IQR Program's exception policy to reporting and data submission requirements for the CAUTI, CLABSI, and colon and abdominal hysterectomy SSI measure. If a hospital does not have adequate locations or procedures, it should submit the Measure Exception Form to the HAC Reduction Program beginning on January 1, 2020. As has been the case, under the Hospital IQR Program, hospitals seeking an exception must admit this form at least annually to be considered. We've provided the *QualityNet* link to the Measure Exception Form on the resource slide at the end of the HAC Reduction Program's part of the presentation.

Beginning in Calendar Year 2020, the HAC Reduction Program will provide the same HAI measure quarterly reports that stakeholders are accustomed to under the Hospital IQR Program. However, some hospitals that elected not to participate in the Hospital IQR Program may be unfamiliar with them. They provide their facilities' quarterly measure data, as well as facility-, state-, and national-level results for the measures. To access your report, hospitals must register for a *QualityNet Secure Portal* account. Here's one area where you the stakeholder will see a difference with this changeover from Hospital IQR to the HAC Reduction Program. Hospitals will receive reports from both the HAC Reduction Program and the Hospital IQR Program for the respective measures adopted in each program. So, you will now receive multiple reports.

In the Fiscal Year 2014 final rule, we detailed the process for the submission, review, and correction of claims-based data, and we did not make any changes. Hospitals are encouraged to review and correct their claims data in compliance with the time limits and the Medicare claims processing manual. So, with respect to the HAC Reduction Program, the deadline for Fiscal Year 2019 has passed. The deadline for the Fiscal Year 2020 will be September 28, 2018. The HAC Reduction Program previously addressed the submission, review, and correction of HAI data, both in the Fiscal Year 2014 and Fiscal Year 2018 final rules, and we are

not proposing any changes to our policies. For the purposes of fulfilling CMS quality measurement reporting requirements, each facility's data must be entered into NHSN no later than four and a half months after the end of the reporting quarter because CMS does not receive or use data entered into NHSN after that deadline. Hospitals are encouraged to submit data early in the submission schedule, not only to allow you sufficient time to identify errors and resubmit data before the quarterly submission deadline, but also to identify opportunities for continued improvement.

Now, I'd like to move on to validation. As noted, we are delaying removal of the NHSN HAI measures from the Hospital IQR Program until the Calendar Year 2020 reporting period, Fiscal Year 2022 payment determination. For this reason, we are also delaying adoption of the NHSN HAI measure validation processes into the HAC Reduction Program. While the HAC Reduction Program cannot adopt the Hospital IQR Program process as is, we intend for the HAC Reduction Program's processes to reflect, to the greatest extent possible, the current processes previously established in the Hospital IQR Program. CMS validates, or estimates, accuracy of data submitted to NHSN as reproduced by a trained abstractor using a standardized NHSN HAI measure extraction protocol that was created by CDC and CMS. It's posted on the *QualityNet* website. I provide the link on the resource slide. All subsection (d) hospitals, subject to the HAC Reduction Program, will be subject to validation. This is a bit of a change. Under the Hospital IQR Program, only hospitals with active Notices of Participation were included in the validation sample. Under HACRP, all subsection (d) hospitals subject to the program, will be included. In addition, hospitals would have to electronically acknowledge the data submitted are accurate and complete to the best of their knowledge. Hospitals will be required to complete and sign the DACA on an annual basis via the *QualityNet Secure Portal*, which is https://cportal.qualitynet.org/QNet/pgm_select.jsp. The HAC Reduction Program finalized the first annual DACA signing and completing period to be April 1 through May 15, 2021, for Calendar Year 2020 data.

The previous slide indicated that 200 hospitals will be targeted for validation. This is in keeping with the process under hospital IQR, but the Hospital IQR Program currently assesses the accuracy of eCQM data and of chart-abstracted data. That includes clinical process of care measures, as well as HAI measures. The HAC Reduction Program does not currently include eCQMs. We don't include clinical process of care measures. So, the targeting criteria that we are implementing, while similar to what IQR has previously finalized, is different. We are implementing the following targeting criteria for the HAC Reduction Program. One: any hospital that submits data to NHSN after the HAC Reduction Program data submission deadline has passed. Two: any hospital that has not been randomly selected for validation in the past three years. Three: any hospital that has failed validation the previous year. Four: any hospital that passed validation in the previous year but had a two-tailed confidence interval that included 75 percent. Five: any hospital which failed to report to NHSN at least half of the actual HAI events detected as determined during the previous year's validation effort. Let me focus on that fourth bullet for a moment. That bullet talks about the confidence interval. We will devise a two-tailed confidence interval formula using only HAI measures for the HAC Reduction Program. This will be posted to the *QualityNet* website. So, with regard to the validation confidence interval, at a high level, this is how it will work. First, we will score hospitals based on an agreement rate between hospital-reported infections, compared to events identified as infections by a trained CMS abstractor using a standardized protocol. Next, we will compute the confidence interval. Then, if the upper bound of this conference interval is 75 percent or higher, the hospital will pass the HAC Reduction Program validation requirement; but, if the upper bound is below 75 percent, the hospital will fail the HAC Reduction Program validation requirement. In addition, CMS finalized proposals that the hospitals that fail the validation requirements will receive the maximum Winsorized z-score only for the set of measures CMS has validated. We believe this aligns with the current HAC Reduction Program policy of assigning the maximum Winsorized z-score if hospitals did not submit data to NHSN for a given HAI measure.

Within 30 days of validation results being posted on the *QualityNet Secure Portal*, if a hospital has a question or needs further clarification on a particular outcome, then you may request an educational review, but here's the difference between the current hospital IQR policy and the updated HAC Reduction Program policy. Under IQR, educational reviews can only be requested for the first three validation quarters. CMS finalized hospitals can request educational reviews for all four validation quarters under the HAC Reduction Program. If an educational review is requested in a timely manner, and that review indicates an error on the CMS side, then the corrected quarterly score will be used to compute the final confidence interval. Again, we note we are delaying adoption of the Hospital IQR Program NHSN HAI measure validation process to begin with quarter three 2020 discharges for Fiscal Year 2023.

Currently, the HAC Reduction Program utilizes NHSN HAI data from two calendar years to calculate measure results. For example, the Fiscal Year 2023 measure reporting quarters include quarter one 2020 through quarter four 2021, and that's what you see in the first column of this table. The HAC Reduction Program validation period will include the four middle quarters in the HAC Reduction Program performance period. That is third quarter through second quarter. You see those rows bolded on the table. The HAC Reduction Program will begin validation of NHSN HAI measure data with July 2020 infection event data.

Now, I'd like you to recall how I had mentioned previously when you can submit and correct your underlying claims data or HAI data for use in the HAC Reduction Program. Using that data each year, CMS calculates your hospital safety composite measure results and measure scores, your CLABSI, CAUTI, SSI, MRSA and CDI measure scores, and your hospital's total HAC score. These scores are included in Hospital-Specific Reports, or HSRs, which are distributed via the *QualityNet Secure Portal*, usually in July. After the scores are calculated and the HSRs are distributed, you have 30 days to review and request recalculation of your hospital score. CMS renamed this annual 30-day period to the Scoring Calculation Review and Correction Period because we believe the new

name will more clearly convey both the intent and limitation. The intent is to allow hospitals an opportunity to review and correct score calculations. The limitation in this 30-day period does not allow you an opportunity to correct underlying data. The naming convention will further distinguish this period from early opportunities during which hospitals can review and correct their underlying data. We did not change any of our policies surrounding the 30-day review period. We are simply changing the name to make it more clear.

CMS has finalized adopting the Equal Measure Weights approach to address the impact of disproportionate weighting at the measure level for the subset of hospitals with relatively few NHSN HAI measures. The Equal Measure Weight policy removes the domains and applies an equal weight to each measure for which a hospital has a measure score.

As I mentioned in the previous slide, we will remove domains from the HAC Reduction Program and simply assign equal weights to each measure for which the hospital has a measure score. We will calculate each hospital's total HAC score as the equally weighted average of the hospital's measure scores. The table displays the weights applied to each measure under this approach. For example, if a hospital has a CMS PSI 90 measure score and only one HAI measure with a measure score, then CMS will apply a weight of 50 percent to their hospital CMS PSI 90 measure score and a weight of 50 percent to the hospital's one HAI measure score. Alternatively, if a hospital has CMS PSI 90 measure score and two HAI measures with a measure score, then CMS will apply a weight of 33.3 percent to the hospital CMS PSI 90 measure score and a weight of 33.3 percent to each of the hospital's two HAI measure scores. All other aspects of the HAC Reduction Program scoring methodology will remain the same, including the calculation of measured scores as Winsorized z-scores, determination of the 75th percentile total HAC score, and the determination of the worst performing quartile. This policy aligns with the original program design to apply a similar weight to each measure. Also, if we add or remove measures from the program in the future, we would not need to modify the weighting scheme under the Equal Measure Weight

approach. CMS believes this policy will not impact the reporting burden on hospitals.

This slide provides links to valuable resources regarding the HAC Reduction Program. Please note that the last two links are for stakeholder questions. Thank you for your time and your attention, and, now, I'll turn it over to Miss. Erin Patton. Thank you.

Erin Patton: Thank you, Nekeshia, and thank you to everyone who was able to join us today. I'm pleased to have the opportunity to talk with you about the Fiscal Year 2019 Hospital Readmissions Reduction Program final rule that has recently published.

Today, I will provide a high-level overview of the Hospital Readmissions Reduction Program, or HRRP, final rule. I encourage you to reference the published rule for additional details. The FY 2019 rule included a Meaningful Measures initiative, applicable time periods for Fiscal Year 2019, Fiscal Year 2020, Fiscal Year 2021, and a codification of previously finalized definitions.

As was stated earlier, after careful review as a part of the Meaningful Measures initiative, it was decided that we will retain all of the six measures in the Hospital Readmissions Reduction Program listed here, including acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, total hip and total knee arthroplasty, and coronary artery bypass graft surgery.

The final rule identified the following applicable periods for HRRP. The applicable periods will use three years of claims data as has been in past periods. For Fiscal Year 2019, the applicable period is July 1, 2014, through June 30, 2017. For Fiscal Year 2020, the period is July 1, 2015, to June 30, 2018, and for Fiscal Year 2021, the period is July 1, 2016, through June 30, 2019.

The FY 2019 HRRP rule also codified the following previously finalized definitions. First: dual eligible, which is identified as a full-benefit dual, that is Medicare fee-for-service and Medicare Advantage patients in data

from the state Medicare Modernization Act, or MMA, file. Dual proportion is the number of dual-eligible among all Medicare fee-for-service and Medicare Advantage stays during the applicable period. Applicable Period for Dual Eligibility is a three-year measure performance period which will account for social risk factors in the ERR, or Excess Readmission Ratio. The applicable period for dual eligibility is the same as applicable period for the program.

This slide summarizes the updates for FY 2019 for HRRP, including the list of final measures and their performance periods. Discharge diagnosis for each applicable condition are based on a list of specific ICD-9 or ICD-10 code sets. As CMS moves forward in its consideration of options to address social risk in its value-based purchasing programs, dual eligibility will be used as a proxy measure of social risk.

The use of dual eligibility as a proxy measure is founded on a recent ASPE report that found dual eligibility to be the most powerful predictor of adverse health outcomes of social risk factors compared in the study. With this measure being available for all HRRP hospitals, it allows for the improvement of health disparities through increased transparency and CMS being able to compare disparities across hospitals.

Thank you again for your time and attention today. Please use the information on this slide to access helpful resources related to the Hospital Readmissions Reduction Program. I will now turn the presentation over to Candace Jackson.

Candace Jackson: Thank you, Erin, and also thank you to Nekeshia and Grace for providing the information for today's webinar.

In the next slides, you will find a summary of the measures included in all of the inpatient quality programs, which programs they are included in, and the fiscal year that they are applicable for. This slide outlines the chart-abstracted clinical process of care measures.

This slide focuses on the eCQMs.

This slide addresses the healthcare-associated infection measures.

This slide goes over the claims-based patient safety measures.

This slide outlines the claims-based mortality outcome measures.

This slide focuses on the claims-based readmission measures.

The excess days and acute care measures are outlined in this slide.

The claims-based payment measures are addressed in this slide.

This slide goes over the structural patient safety measures.

And this slide is for the patient experience of care survey or HCAHPS measure.

This slide provides you with a direct link to the Fiscal Year 2019 IPPS final rule and the pages for each of the specific programs.

Now we do have time to do a brief Q&A session. Again, we will not be able to get to all questions submitted through the chat feature today, but those questions will be responded to and posted on the *QualityReportingCenter.com* and *QualityNet* website at a later date. So, we will go ahead and start with the Q&A session at this time.

The first question: If you did not finalize to remove PSI 90 from the HVBP program, should it be on the graph? I am confused if it is part of the HVBP program before Fiscal Year 2023.

Grace Snyder: This is Grace. I can respond to that question. So, in last year's, the FY 2018 IPPS final rule, we finalized two things actually: the removal from the VBP program of the old version of the PSI 90 measure, which only used ICD-9 data. Then, also in last year's rule, the second thing that we did was to finalize an updated version or new version of the PSI 90 measure, which is the same measure that's currently being used in the Hospital IQR Program and for which we recently published on the *Hospital Compare* website with the July *Hospital Compare* refresh, the

most recent measure data, and same measure, also the new version of PSI 90 is now being used in the HAC Reduction Program. But, for the Hospital VBP Program, because of the nature of this program and having to, one, the Social Security Act requires any measures used for the Hospital VBP Program have been publicly reported for, like, at least a year. So, there's that requirement for hospital VBP, as well as to establish a baseline period. So, for any new measures that we use in the hospital VBP, there's always an unfortunate little bit of this time lag, which is why we won't be using the new version of PSI 90 until the Fiscal Year 2023 program. So, actually, if we can go back to the Fiscal Year 2023 measurement period slide, I believe that is slide 45. So, if you look in the third row down for the Safety domain, the PSI 90 measure, you can see the baseline periods and then what the performance period will be. The baseline period has already past October 1, 2015, through June 30, 2017. And then the performance period will begin next year July 1, 2019, through June 30, 2021. So, I know it's a little bit confusing, but hopefully that helps clarify a bit. Okay. Thanks, Candace.

Candace Jackson: Okay. Thank you, Grace. Our next question and we've received numerous questions in regard to the chart-abstraction and removal of the IMM-2 measure. The basic question was asking if the IMM-2 measure will be last abstracted in the fourth quarter 2018, or will they continue to abstract the IMM-2 measure through first quarter 2019.

Grace Snyder: So, this is Grace. Candace, I can take this one again. So, the very last quarter of IMM-2 data that used to be abstracted and then reported to CMS is fourth quarter 2018 data. So, that is from October 1 to December 31, 2018, and I know it's a little bit confusing because it is halfway through the flu season, which we generally consider in fourth quarter and first quarter of the following year. So, I know that that gets confusing and might not make sense exactly why we're removing the measure at that point. So, mainly the reason is for purposes of APU determinations for the Hospital IQR Program. The reporting periods usually begin with the beginning of the calendar year, and so, there wasn't really a clean way to be able to accommodate both. Otherwise, we start getting into, if we had

also required, if we had required continued reporting of the first quarter 2019 data, we'd be getting into the next fiscal payment determination year. So, we sort of erred on the side of removing the measure sooner with the end of Calendar Year 2018 rather than require an additional quarter of reporting data for that measure. So, hopefully, that helps. I know there are definitely several questions about this. So, hopefully, that will help.

Candace Jackson: Thank you, Grace. Another question that we received numerous questions on was if the measure removals from the IQR program will impact public reporting, *Hospital Compare*, and the star ratings. Would we have some other guidance in relation to that?

Grace Snyder: Thanks, Candace. This is Grace again. So, I think we tried to explain during the presentation, and we are happy to repeat here, that for those measures that are being de-duplicated, so to speak, we talked about how, especially with the IQR program, about half of the measures we're removing from IQR, are going to be removed from the program altogether, but there's another half of the measures that are really going to stay in another program. For example, most of the mortality and readmission measures, as well as the healthcare-associated infections measures. So, again, we are very committed to keeping that information available on *Hospital Compare* website without any interruptions, and especially for all the members of the public that have come to rely on the information on *Hospital Compare*, we want to continue that reporting. Also, with that, we'll continue to use that publicly reported data to calculate the star ratings. Now, there are other activities going on with the star ratings methodology and so forth which I won't be able to address here in this presentation, but in terms of the measures and the data sources, we'll continue to use the publicly reported data for the star ratings calculation.

Candace Jackson: Thank you, Grace. Our next question is in regard to slide 21. The question: Will the readmission measures that are remaining in the hospital readmission reduction program be only reported as a hospital Excess Readmission Ratio only, or will the RSRR value from the current IQR program readmission measures be added to the HRRP HSRs in the future?

Grace Snyder: So, this is Grace. I can take on that question. So, right now, hospitals are receiving a Hospital-Specific Report for the readmission measures and this Hospital-Specific Report, or HSR, is a confidential report for each hospital and their measure information. Right now, the reports that you've been getting under the IQR program provide a lot of great detail on patient-level information and ICD codes that we know many of you find very useful. So, we are in the process of determining what's the best way to continue to provide that information, even if these measures are now only in the readmissions reduction program. So, we are working on that, but we also do know and we've heard from you that the detailed information is very useful, and so, we do want to be able to continue providing that information.

Candace Jackson: Thank you, Grace. Next question. Is it possible for hospitals to be selected for IQR validation and have validation in the same year?

Mihir Patel: Hi. Mihir here and I can take on for that question. Technically, no, we're trying to avoid having to participate in multiple validations, but if you have any specific questions related to a specific year, I would encourage you to submit a question to the validation support contractor and they will be able to assist you specifically based on specific years. So, you can reach them at validation@HCQIS.org. Thank you.

Candace Jackson: Okay. Thank you, Mihir. On that same note, will chart-abstracted core measures in IQR score be validated? If not, will this discontinue?

Mihir Patel: So, any measures that are part of IQR that are chart-abstracted will still be part of validation - IQR chart-abstracted validation.

Candace Jackson: Thank you, Mihir. Our next question. When are the CMS claims data snapshots for the calendar years identified?

Grace Snyder: I'm sorry, Candace. This is Grace. Candace, could you repeat that last part?

Candace Jackson: They are asking, when do the claims data snapshot for each of the quarters in a calendar year?

Katie Michael: So, this is Katie. The claims data snapshot for Fiscal Year 2019, or for 2020, is going to be in September. I believe it is September 28, 2018.

Candace Jackson: Thank you, Katie.

Katie: Correct. Yes, it is September 28, 2018.

Grace Snyder: Okay, and this is Grace. I would add, for the claims-based outcome measures, we calculate them on an annual basis. So, the snapshot is only taken once a year around, right around this time, not on a quarterly basis. So, just want to make that clarification.

Candace Jackson: Thank you, Grace. We have several questions asking if we could define dual-eligibility.

Kristin Mauer: Hi. This is Kristin. For the Hospital Readmissions Reduction Program, dual-eligibility refers to Medicare fee-for-service or Medicare Advantage patients that are also eligible for full benefits under Medicaid. and in the program, we use the month of discharge from the hospital too as the basis for determining if the patient is dual eligible.

Candace Jackson: Thank you. We do have time for just a couple more questions. Our next one: I understand that the hybrid hospital-wide readmission measure was removed in the final rule. Should we still submit our 2018 data?

Grace Snyder: So, this is Grace. For the hybrid hospital-wide readmission measure, we're actually right in the middle of the submission period for the core clinical data elements, or CCDEs, that are derived directly from hospitals EHR systems. So, we highly encourage you to participate. This is a voluntary reporting effort, so optional, not mandatory, but we would love to have you participate and also provide this opportunity for you to gain experience with collecting and reporting data for this measure. And so, it's, again, it's a voluntary reporting effort. So, I guess we didn't technically remove it from the IQR program. So, again, I encourage you to, there's still time to participate. The submission period is open through mid-December and we also have a lot of education outreach materials

available, both on the eCQI Resource Center, as well our *QualityNet* website for additional details. So, thank you.

Candace Jackson: Thank you, Grace. Our next question, we have a couple questions in regard to PC-01, asking if the PC-01 measure is being removed only for HVBP and not from any of the other hospital reporting programs as a whole.

Grace Snyder: This is Grace. So, first of all, I apologize. This can get kind of confusing. One, there are sort of two versions of the PC-01 measure that we had been using. There's a chart-abstracted clinical process, excuse me, chart-abstracted form of the PC-01 measure that we had been using in both the IQR program and the Hospital VBP Program. So, in this final rule, we are removing the PC-01 measure from the Hospital VBP Program. The Calendar Year 2018 performance period will be the last performance period using this measure, and that will impact Fiscal Year 2020 payment adjustments. However, we are keeping the chart-abstracted PC-01 measure for public reporting under the Hospital IQR Program. Just sort of as a side note, I want to mention there is an eCQM version of the PC-01 measure that is part of the eCQM measure set that we use for IQR and Promoting Interoperability programs. That eCQM version of the measure we have finalized for removal. So, this year 2018 and next year 2019 reporting periods will be the last time that the PC-01 eCQM measure will be available to use for, specifically, for the eCQM reporting requirements. So, I just wanted to provide a thorough response on that question.

Candace Jackson: Thank you, Grace. That concludes our question-and-answer session for today. Again, I'll remind you that all questions submitted will be responded to and posted at a later date. I would like to thank everyone for joining our webinar today and hopefully that you found the information useful and beneficial. I'll now turn the presentation over to Dr. Debra Price to do a brief summary of our CEU process. Deb?

Dr. Debra Price: Hi everyone. Thanks for attending today's event. The presentation has been approved for continuing education credits by the boards listed on this slide. If your board is not one of those boards listed, you can forward the

certificate to your own board and see if they accept this certificate across state lines. Now, you can always reach out to me if you have issues.

There are three easy steps for completing your credits. The first step: Complete the survey at the end of this event. It'll automatically pop up. The second step: Register either as a New User or an Existing User on our HSAG Learning Management Center website. The third step: Print out your certificate from the website.

One precaution for everyone is that this is a separate registration than the one that you used to get into the ReadyTalk and the webinar. Also, we prefer that you use your personal email because your healthcare emails have blocks that seem to be blocking our automatic links.

Okay. This is what will pop up at the end of our slides. It's the bottom of the survey, and what you do is you finish the survey and click that grey button on the right-hand bottom that says "Done," and…

This page will pop up. You note that there are two green links. The first one is the New User link, and please use that if you have had any kind of issues before or if you are a new user. The second link is the Existing User link. Use that if you haven't had any issues before.

Depending on the link that you clicked on, you'll be taken to one of these screens. For the New User screen on the left, use your personal email and the personal phone number. If you've had any problems getting your credits, please go back and use this New User screen. The Existing User screen on the right is for you to complete if you haven't had any problems with past events. Your complete email is your user name and that includes whatever is after the @ sign.

Finally, we would like to thank everyone for attending today's event. If we didn't get to your question, all submitted questions relating to this webinar will be posted to our *QualityReportingCenter.com* website at a later date. Now, we hope you learned something today. Thank you and enjoy the rest of your day. Goodbye, everyone.