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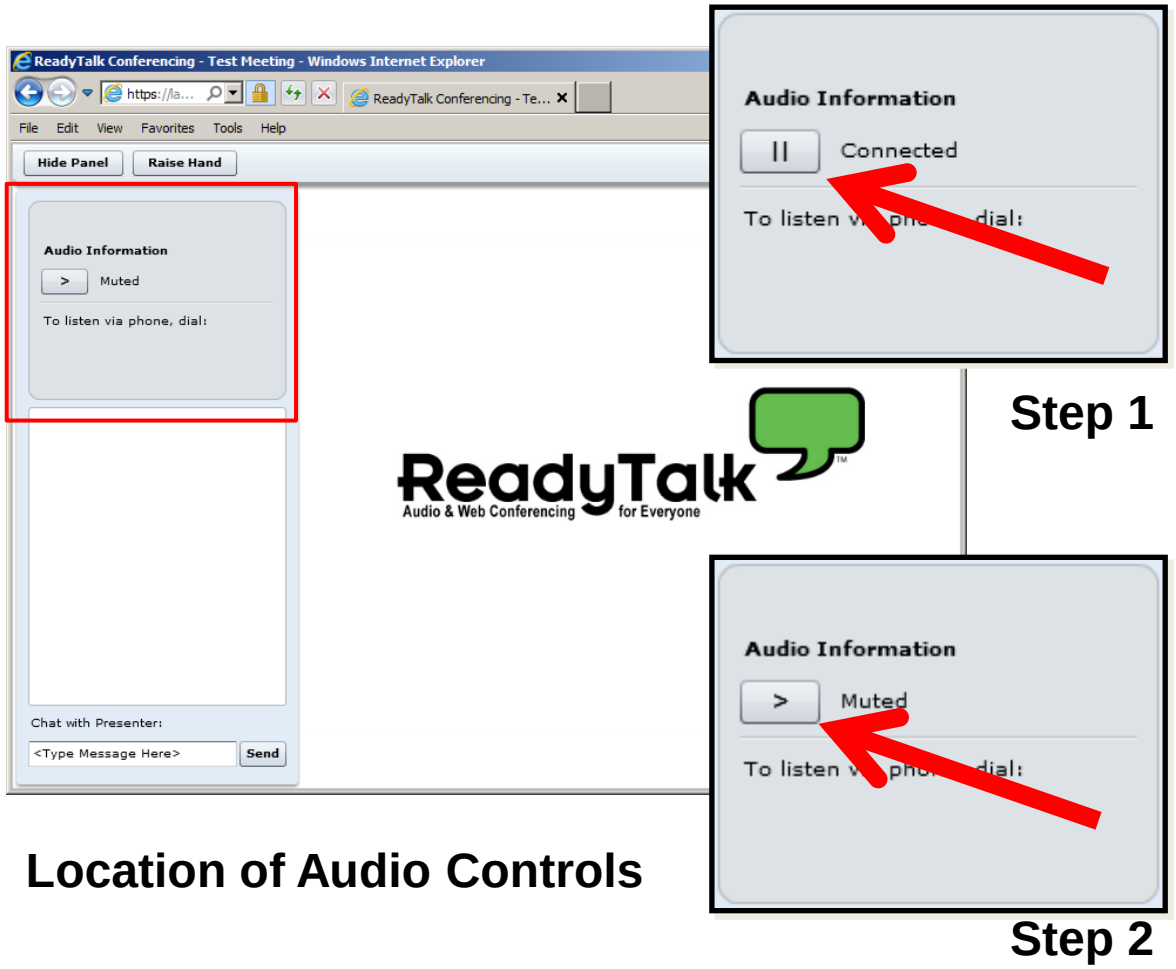

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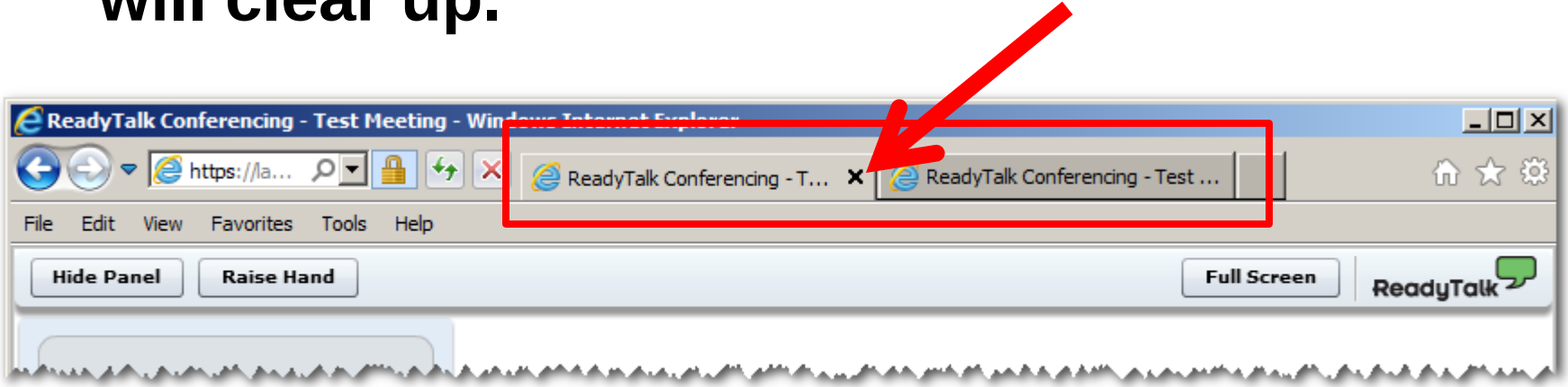

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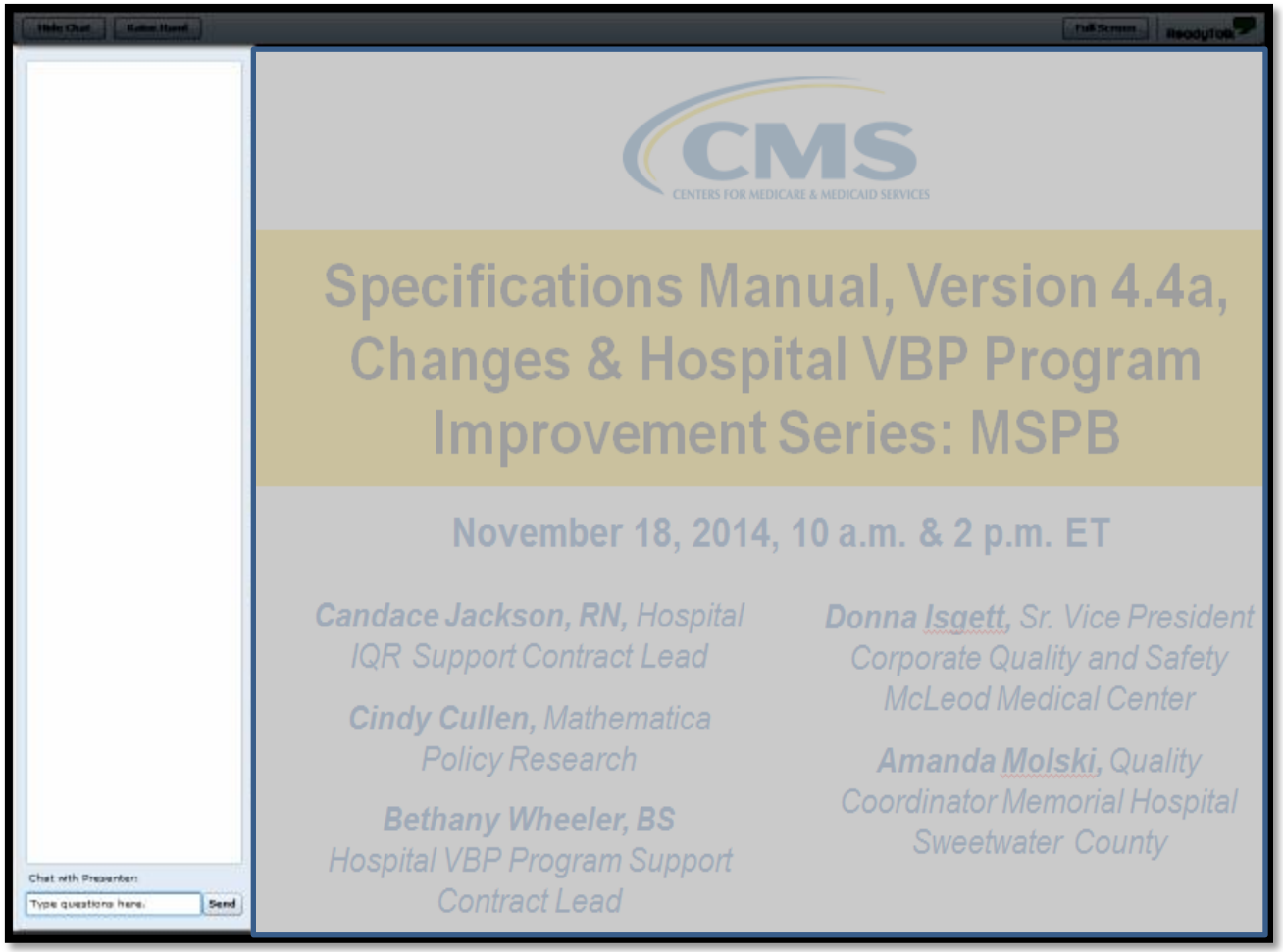

FY 2016 IQR Hospital IPPS Final Rule

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September 2, 2015

Purpose

Provide participants with a summary of the key program changes in the Fiscal Year (FY) 2016 Inpatient Prospective Payment Systems (IPPS) Final Rule for the following programs:

- Hospital Inpatient Quality Reporting (IQR)
- Electronic Health Record (EHR) Incentive
- Hospital Value-Based Purchasing (VBP)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital-Acquired Condition (HAC) Reduction
- Long Term Care Hospitals (LTCHs)
- Inpatient Rehabilitation Facilities (IRFs)

Objectives

At the conclusion of this presentation, participants will be able to:

- Find the FY 2016 Final Rule text
- Identify changes within the FY 2016 Final Rule

Final Rule FY 2016

Impact on Hospital IQR

Hospital IQR Program Measures

Addition of two new factors for retention/removal of measures:

Measure Removal Factors	Measure Retention Factors
It is not feasible to implement the measure specifications	Measure aligns with other CMS and Health and Human Services (HHS) policy goals.

Removal of Measures in the Hospital IQR Program

Measure	Measure Name	Criteria
STK-01	Venous Thromboembolism (VTE) Prophylaxis	Topped Out
STK-06*	Discharged on Statin Medication	Topped Out
STK-08*	Stroke Education	Topped Out
VTE-1*	Venous Thromboembolism Prophylaxis	Topped Out
VTE-2*	Intensive Care Unit VTE Prophylaxis	Topped Out
VTE-3*	VTE Patients with Anticoagulation Overlap Therapy	Topped Out
IMM-1	Pneumococcal Immunization	Infeasibility to Implement
AMI-7a*	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	Does not result in better patient outcomes
SCIP-Inf-4	Cardiac Surgery Patients with Controlled Postoperative Blood Glucose	Leads to negative unintended consequences

* Retained as Electronic Clinical Quality Measure (eCQM)

Required Chart-Abstracted Measures for FY 2018

Measure ID	Measure Name
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients
IMM-2	Influenza Immunization
SEP-1	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)
STK-04	Thrombolytic Therapy
VTE-5	Venous Thromboembolism Discharge Instructions
VTE-6	Incidence of Potentially Preventable Venous Thromboembolism
PC-01	Elective Delivery (Collected in aggregate and submitted via Web-based tool)

Refinements to Existing Measures

Refinements for the following expanded measure cohorts:

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization
- Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization

RSRR and RSMR Refinements

- Diagnosis Categories Include:
  - Principal discharge diagnosis of pneumonia (current cohort)
  - Principal discharge diagnosis of aspiration pneumonia
  - Principal discharge diagnosis of sepsis (excluding severe sepsis) with a secondary diagnosis coded as present on admission (POA)
- Not including patients with the most severe illnesses:
  - Principal discharge diagnosis of respiratory failure with a secondary diagnosis of pneumonia POA
  - Principal discharge diagnosis of sepsis (including septic shock) with a secondary diagnosis of pneumonia POA

New Measures for FY 2018 and Subsequent Years

Short Name	Measure Name	Measure Type
Patient Safety Culture	Hospital Survey on Patient Safety Culture	Structural
AMI Excess Days	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	Claims
HF Excess Days	Excess Days in Acute care after Hospitalization for Heart Failure	Claims
THA/TKA Payment	Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective Total Hip Arthroplasty and/or Total Knee Arthroplasty	Claims

Additional Measures for FY 2019 and Subsequent Years

Short Name	Measure Name	Measure Type
Kidney/UTI Payment	Kidney/Urinary Tract Infection Clinical Episode-Based Payment measure	Claims
Cellulitis Payment	Cellulitis Clinical Episode-Based Payment measure	Claims
GI Payment	Gastrointestinal Hemorrhage Clinical Episode-Based Payment measure	Claims

NOTE: Hospitals will be provided with confidential hospital-specific feedback reports containing performance data on these three measures during the FY 2018 payment determination prior to inclusion for public reporting.

Population and Sampling

Hospitals will be required to submit population and sample size data **only for those measures submitted as chart-abstracted** under the Hospital IQR Program.

Changes to Existing Processes for Validation of Chart-Abstracted Measures

- Removed the separate immunization validation stratum
  - Included the Influenza Immunization Measure in the Clinical Process of Care Measure Validation stratum
- Apply the chart-abstracted measure validation processes only to measures that are required under the Hospital IQR Program in a chart-abstracted form

Changes to Validation Process Weighting

Finalized weighting to combine scores for Confidence Interval calculation:

Measure Set	Weight
Healthcare-Associated Infection (HAI)	66.7%
Other/Clinical Process of Care (Emergency Department [ED], Immunization [IMM], Stroke [STK], Venous Thromboembolism [VTE], Sepsis)	33.3%

Impact on Electronic Health Record Incentive (EHR) and IQR Alignment (eCQMs)

IQR eCQM Reporting Requirement

- A hospital will be required to report a minimum of 4 of the 28 available eCQMs for CY2016 reporting.
- Require hospitals to report for only one quarter (Q3 or Q4) of CY2016/FY2018 payment determination.
- Submission deadline: February 28, 2017
- National Quality Strategy Domain distribution will not be required.

Available eCQMs

ED-1	STK-5	AMI-8a	VTE-5	SCIP-INF-2a
ED-2	STK-6	AMI-10	VTE-6	SCIP-INF-9
ED-3*	STK-8	VTE-1	PC-01	EHDI-1a
STK-2	STK-10	VTE-2	PC-05	HTN
STK-3	AMI-2	VTE-3	CAC-3	PN-6
STK-4	AMI-7a	VTE-4	SCIP-INF-1a	blank

*ED-3 is an outpatient measure and not applicable for IQR.

Consideration of eCQMs for Removal in CY2017/FY2019

VTE-3	AMI-2a	SCIP-INF-1a
VTE-4	AMI-7a	SCIP-INF-2
VTE-5	AMI-10	SCIP-INF-9
VTE-6	CAC-3	Blank
PN-6	HTN	Blank

Extraordinary Circumstances Extensions or Exemptions

- Include an exemption for hospitals that demonstrate hardship in reporting eCQMs
- Inclusion of new exemption to be effective starting with the FY 2018 payment determination

Public Reporting of eCQMs

- For CY 2016/FY 2018 reporting, any data submitted as an eCQM **will not be posted** on the *Hospital Compare* website.
- Public Reporting of eCQM data will be addressed in the CY 2017/FY 2019 rule following the conclusion and assessment of the validation pilot.

Future Considerations for Electronically Specified Measures

In response to feedback and continuing with the goal to move toward the use of EHRs for electronic quality measure reporting throughout CMS programs, where feasible, CMS is considering:

- Use of core clinical data elements derived from EHRs for use in future quality measures
- Collection of additional administrative linkage variables to link a patient's episode-of-care from EHR data with administrative claim data
- Use of content exchange standards

CEHRT and eCQM Specifications

- For CY2015/FY2018 payment determination:
  - Hospitals can report using either the 2014 or 2015 edition of Certified Electronic Health Record Technology (CEHRT)
  - CMS will require payment determination hospitals to submit eCQMs using the 2015 Annual Update.
  - Use of the 2016 CMS Implementation Guide for Quality Reporting Document Architecture Category I and Category III Supplementary Implementation Guide

Impact On Hospital VBP

Hospital VBP Program
FY 2018 Changes to Quality Measures

New Measure	Removed Measures	Moved Measure
CTM-3: Three-Item Care Transition Measure (NQF #0228) in PCCECC/CC Domain.	**AMI-7a:** Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	**PC-01:** Elective Delivery Prior to 39 Completed Weeks Gestation (Clinical Care/Process Domain to Safety Domain)
	IMM-2: Influenza Immunization	
Removed Domain		
Clinical Care – Process Subdomain		

Hospital VBP Program Normalization of PCCEC/CC Domain

CMS adopted the “normalization” approach to scoring the PCCEC/CC domain.

- The new CTM-3 dimension will be calculated in the same manner as the eight existing Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) dimensions.
- The “prenormalized base score” (a maximum of 90 points) will be multiplied by 8/9 (0.88888) and rounded.
- Each of the nine dimensions will be of equal weight, so the normalized HCAHPS Base Score would range from 0–80 points.
- Consistency Points are still calculated in the same manner as before and would continue to range from 0–20 points.

Hospital VBP Program
FY 2018 Baseline and Performance Periods

Domain	Baseline Period	Performance Period
Clinical Care	October 1, 2009–June 30, 2012	October 1, 2013–June 30, 2016
PCCEC/CC	January 1–December 31, 2014	January 1–December 31, 2016
Safety • AHRQ PSI-90 Composite • PC-01 • HAI Measures	July 1, 2010–June 30, 2012 January 1–December 31, 2014 January 1–December 31, 2014	July 1, 2014–June 30, 2016 January 1–December 31, 2016 January 1–December 31, 2016
Efficiency and Cost Reduction	January 1–December 31, 2014	January 1–December 31, 2016

Hospital VBP Program
FY 2018 Minimum Requirements

Domain/Measure/TPS	Minimum Requirement
PCCEC/CC Domain Score	100 HCAHPS Surveys
Efficiency and Cost Reduction Domain Score	25 Episodes of Care in the Medicare Spending per Beneficiary (MSPB) Measure
Clinical Care Domain	Two Mortality Measures with a minimum of 25 cases
Safety Domain	Minimum of three measure scores: • AHRQ PSI-90: Three cases for any one underlying indicator • HAI Measures: One predicted infection • PC-01: 10 cases
Total Performance Score	A minimum of three of the four domains receiving domain scores

Hospital VBP Program
NHSN Measures Standard Population Data

Routine Maintenance

- CDC is updating the "standard population data" (a.k.a. "national baseline") to ensure the NHSN measures' number of predicted infections reflect the current state of HAIs in the United States.
  - CAUTI standard population data is CY 2009
  - CLABSI and SSI standard population data is CY 2006–2008
  - CDI and MRSA standard population data is CY 2010–2011
- Beginning in 2015, CDC will collect data in order to update the standard population for all measures listed above.

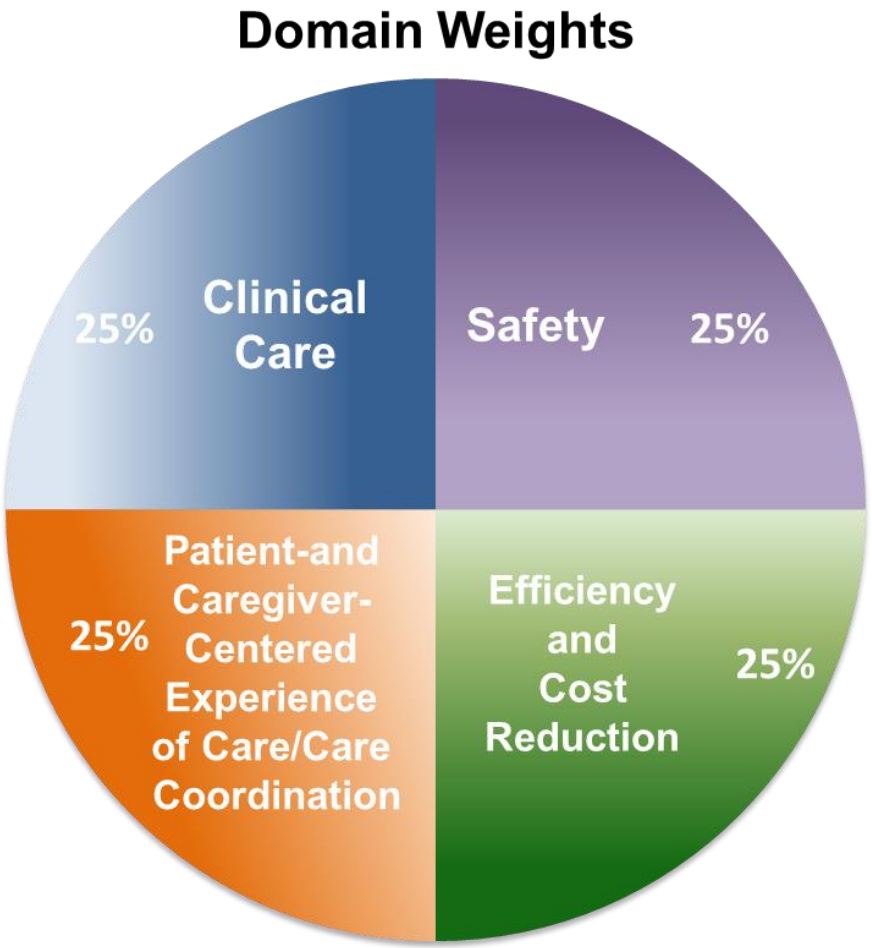
Data Period	FY 2017 Program Year	FY 2018 Program Year	FY 2019 Program Year	FY 2020 Program Year
NHSN Measures **Baseline** Period	Current standard population data	Current standard population data	New standard population data	New standard population data
NHSN Measures **Performance** Period	Current standard population data	Current standard population data	New standard population data	New standard population data

Hospital VBP Program
Newly Finalized Measures for FY 2019, 2021, and Subsequent Program Years

There is an intent to propose, in future rulemaking, inclusion of selected ward (non-Intensive Care Unit [ICU]) locations in certain NHSN Measures beginning with the FY 2019 program year.

Data Period	FY 2017 Program Year	FY 2018 Program Year	FY 2019 Program Year	FY 2020 Program Year
Hospital VBP Program **Baseline** Period	**CLABSI:** Adult, Pediatric, and Neonatal ICU locations **CAUTI**: Adult and Pediatric ICU locations	**CLABSI:** Adult, Pediatric, and Neonatal ICU locations **CAUTI**: Adult and Pediatric ICU locations	**CLABSI:** Adult, Pediatric, and Neonatal ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards **CAUTI**: Adult and Pediatric ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards	**CLABSI:** Adult, Pediatric, and Neonatal ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards **CAUTI**: Adult and Pediatric ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards
Hospital VBP Program **Performance** Period	**CLABSI:** Adult, Pediatric, and Neonatal ICU locations **CAUTI**: Adult and Pediatric ICU locations	**CLABSI:** Adult, Pediatric, and Neonatal ICU locations **CAUTI**: Adult and Pediatric ICU locations	**CLABSI:** Adult, Pediatric, and Neonatal ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards **CAUTI**: Adult and Pediatric ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards	**CLABSI:** Adult, Pediatric, and Neonatal ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards **CAUTI**: Adult and Pediatric ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards

Hospital VBP Program
FY 2018 Domains and Measures



Patient- and Caregiver-Centered Experience of Care/Care Coordination (PCCEC/CC)

HCAHPS Survey

Clinical Care

MORT-30-AMI
MORT-30-HF
MORT-30-PN

Safety

Central Line-Associated Bloodstream Infections (CLABSI)
Catheter-Associated Urinary Tract Infections (CAUTI)
Surgical Site Infections (SSI) (Colon & Abdominal Hysterectomy)
Methicillin-resistant *Staphylococcus aureus* (*MRSA*) Infections
C. difficile Infections (CDI)
AHRQ PSI-90
PC-01

Efficiency and Cost Reduction

MSPB-1

Hospital VBP Program
Newly Finalized Measures for FY 2019, 2021, and Subsequent Program Years (cont.)

- CMS adopted a new measure for the FY 2021 Program Year:
  - Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (NQF #1893)
- Initial measure data posted on *Hospital Compare* December 2014
- Adoption into the Clinical Care domain proposed for the Hospital VBP Program in FY 2021

Final Rule FY 2016

Impact on the Hospital Readmissions Reduction Program

Finalized Rules for the HRRP

- Effective FY 2016:
  - Adoption of an Extraordinary Circumstance Exception policy
- Effective FY 2017:
  - Expansion of the cohort for the pneumonia readmission measure

Extraordinary Circumstance Exception Policy

- Beginning October 1, 2015, this policy allows a hospital that has experienced an extraordinary circumstance (*e.g.*, hurricane or flood) to request a waiver of certain periods of data from inclusion in the calculation of its excess readmission ratio for a given fiscal year due to the extraordinary circumstance
- An extraordinary circumstance might affect a hospital's ability to accurately or timely submit all of its claims data
- An Extraordinary Circumstance Exception Request Form will soon be made available on the *QualityNet* website (similar to the request form used in the Hospital IQR and VBP programs)

Requesting an Extraordinary Circumstance Exception

At a minimum, the following information will be required in order to request an exception:

- Hospital CMS Certification Number (CCN)
- Hospital name
- Hospital CEO and any other designated personnel contact information, including name, email address, telephone number, and mailing address
- Hospital's reason for requesting an exception, including:
  - CMS program name (Hospital Readmissions Reduction Program)
  - Measure(s) and submission quarter(s) affected by the extraordinary circumstance that the hospital is seeking an exception for accompanied by the specific reasons why the exception is being sought
  - How the extraordinary circumstance negatively impacted performance on the measure(s) for which an exception is being sought
- Evidence of the impact of the extraordinary circumstances, including but not limited to, photographs, and newspaper and other media articles
- Request form must be signed by the hospital's CEO or designated non-CEO contact and submitted to CMS

Pneumonia Readmission Measure Cohort Expansion

- Begins with the FY 2017 Program
- Finalized a modified version of the expanded cohort from what was proposed that includes the addition of more pneumonia diagnoses, as follows:
  - [*Current*] Patients with a principle discharge diagnosis of pneumonia
  - [*New*] Patients with a principle discharge diagnosis of aspiration pneumonia
  - [*New*] Patients with a principle discharge diagnosis of sepsis, with a secondary diagnosis of pneumonia present on admission
  - [*Not finalized*] Patients with respiratory failure or coded as having severe sepsis
- Developed in response to changing trends in hospital coding practices for pneumonia and to address potential bias related to variations in coding practices
- Provides a more complete picture of a hospital's performance on readmissions with respect to its pneumonia patients and allows for better comparison of performance across hospitals

Readmission Measures in the Hospital Readmissions Reduction Program

Readmission Measures	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Acute myocardial infarction	✓	✓	✓	✓	✓
Heart failure	✓	✓	✓	✓	✓
Pneumonia	✓	✓	✓	✓	✓
Chronic obstructive pulmonary disease			✓	✓	✓
Total hip arthroplasty/ Total knee arthroplasty			✓	✓	✓
Coronary artery bypass graft surgery					✓

Resources on Reducing Hospital Readmissions

General Program Information:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458

HRRP General Inquiries:
HRRP@lantanagroup.com

HRRP Measure Methodology Inquiries:
cmsreadmissionmeasures@yale.edu

More Program and Payment Adjustment Information:
http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html/

Readmission Measures:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1219069855273

Initiatives to Reduce Readmissions:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228766331358

Final Rule FY 2016

Hospital-Acquired Condition (HAC) Reduction Program

HAC Reduction Program Measures

Measure	FY 2015	FY 2016	FY 2017
Patient Safety Indicator (PSI) 90 Composite	X	X	X
Central line-associated bloodstream infection (CLABSI)	X	X	X
Catheter associated urinary tract infection (CAUTI)	X	X	X
Surgical site infection (SSI) (colon and hysterectomy)	blank	X	X
Methicillin-resistant Staphylococcus (MRSA) bacteremia	Blank	Blank	X
Clostridium difficile			X

Implementation of the HAC Reduction Program for FY 2016

- No proposed changes to the policies previously implemented in the HAC Reduction Program for FY 2016
- Updates to Measures Previously Finalized
  - AHRQ PSI-90 Composite measure is undergoing NQF maintenance review. AHRQ is considering revisions to the composite weighting system as well as the addition of the following:
    - PSI-9 Perioperative Hemorrhage Rate,
    - PSI-10 Postoperative physiologic and metabolic derangement rate,
    - PSI-11 Postoperative respiratory failure rate measures,
    - Or a combination of these three measures
  - CDC NHSN CAUTI and CLABSI measures completed the NQF maintenance review process, and modified versions of the measures were re-endorsed by NQF
    - Re-endorsed versions of the measures included a new statistical option for calculating the measure result, the Adjusted Ranking Metric (ARM), in addition to the SIR statistical options
      - CMS will continue to use the CDC NHSN CLABSI and CAUTI measures as previously finalized for the program with use of the SIR
      - We will be working with CDC in the future to determine if the newly available ARM would be appropriate for use in the HACRP

Extraordinary Circumstance Exception Policy for the HAC Reduction Program Effective with FY 2016

- Beginning in FY 2016, CMS will provide relief for a hospital whose ability to accurately collect quality measure data and/or to report that data in a timely manner has been negatively impacted as a direct result of experiencing a significant disaster or other extraordinary circumstance beyond the control of the hospital.
- This policy is not intended to allow a hospital to request exclusion from the HAC Reduction Program in its entirety for any given fiscal year(s) solely because of experiencing an extraordinary circumstance.
- This will enable affected hospitals to continue to participate in the HAC Reduction Program for a given fiscal year if they otherwise continue to meet applicable measure minimum threshold requirements.

Implementation of the HAC Reduction Program for FY 2017

- CMS will use the following applicable Time Periods for the FY 2017 HAC Reduction Program:
  - **Domain 1 measure**, AHRQ PSI-90 Composite measure
    - July 1, 2013–June 30, 2015
  - **CDC NHSN measures**, CLABSI, CAUTI, Colon and Abdominal Hysterectomy SSI, MRSA Bacteremia, and CDI
    - CYs 2014 and 2015
- Narrative Rule Used in Calculation of the Domain 2 Score
  - Current narrative rules for Domain 2 assign a score for each Domain 2 measure and the measure scores are averaged to provide a Domain 2 Score
  - The new rule will treat each Domain 2 measure independently when determining if a score of 10 (maximal score) should be assigned to the measure for non-submission of data without a waiver, if applicable
    - For example, if a hospital does not submit data for the Colon and Abdominal Hysterectomy SSI measure and does not have a valid waiver for non-reporting, the measure would receive a score of 10

Implementation of the HAC Reduction Program for FY 2017 (cont.)

- Domain 1 and Domain 2 Weights for the FY 2017 HAC Reduction Program
  - Domain 1 will be reduced to 15 percent and Domain 2 will be increased to 85 percent of the Total HAC Score
    - The decrease of Domain 1 occurred for two reasons:
      - With the implementation of the CDC MRSA Bacteremia and CDI measures in the FY 2017 program, the weighting of both domains is being adjusted to reflect the addition of the fifth and sixth measures in Domain 2.
      - CMS considered the MedPAC and other stakeholders recommendations to increase the Domain 2 weighting because the CDC NHSN chart-abstracted measures in Domain 2 are more reliable and actionable than claims-based measures.

HAC Reduction Program Updates

- Measure Refinements for the FY 2018 HAC Reduction Program
  - Inclusion of Select Ward (Non-Intensive Care Unit [ICU]) Locations in Certain CDC NHSN Measures Beginning in the FY 2018 Program Year
    - CMS will include data from pediatric and adult medical ward, surgical ward, and medical/surgical ward locations, in addition to data from adult and pediatric ICU locations for the CDC NHSN CLABSI and CAUTI measures beginning with the FY 2018 HAC Reduction Program
- Update to CDC NHSN Measures Standard Population Data
  - For each NHSN measure, The CDC calculates the SIR, which compares a hospital's observed number of HAIs to the number of infections predicted for the hospital, adjusting for several risk factors
  - As part of routine measure maintenance, the CDC will be updating the standard population data to ensure the NHSN measures' number of predicted infections reflects the current state of HAIs in the United States
  - The new standard population data will affect the HAC Reduction Program beginning in FY 2018 when the applicable period for the CDC NHSN measures included in the program will include CY 2015 and CY 2016 data

HAC Reduction Program Public Reporting

- HAC Reduction Program-related information for each hospital is available publicly on:
  - *Hospital Compare* at www.medicare.gov/hospitalcompare/HAC-reduction-program.html
    - Measure scores
    - Domain scores
    - Total HAC score
- More information is available on:
  - *CMS.gov* at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html
    - Total HAC score
    - Payment adjustment category (Y/N)

HAC Reduction Program Additional Resources

HAC Reduction Program Methodology & General Information

- *QualityNet* HAC Reduction Program: www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166

Scores

- Medicare.gov *Hospital Compare* HAC Reduction Program: www.medicare.gov/hospitalcompare/HAC-reduction-program.html
- *CMS.gov HAC Reduction Program:* http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html

Patient Safety Indicators 90

- *QualityNet* AHRQ Indicators: www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228695321101
- AHRQ Quality Indicator Support: www.qualityindicators.ahrq.gov/

CLABSI, CAUTI, SSI, MRSA and *C. difficile*

- Healthcare-Associated Infections: www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228760487021
- National Health Safety Network: nhsn@cdc.gov

Long Term Care Hospitals (LTCHs)

LTCH Quality Reporting Program Overview – 1

CMS has adopted 13 quality measures for the LTCH QRP:

- Three quality measures for data collection and reporting for FY 2014 and FY 2015 payment update determination
- Two additional measures for FY 2016 payment update determination
- Three additional measures for FY 2017 payment update determination
- Five additional measures for FY 2018 payment update determination

LTCH Quality Reporting Program Overview – 2

Quality Measure	Data Collection Start Date	Data Collection Method	Payment Year Update Determination
Percent of Patients or Residents with Pressure Ulcers That Are New or Worsened (NQF #0678)	October 1, 2012	LTCH CARE Data Set*	FY 2014 and subsequent
NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)	October 1, 2012	CDC NHSN**	
NHSN Central Line-associated Blood Stream Infection (CLABSI) Outcome Measure (NQF #0139)	October 1, 2012	CDC NHSN	

* LTCH CARE Data Set: Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set
** Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN): http://www.cdc.gov/nhsn
***Highlighted measures were finalized in the FY 2016 IPPS/LTCH PPS Final Rule

LTCH Quality Reporting Program Overview – 3

Quality Measure (NQF #)	Data Collection Start Date	Data Collection Method	Payment Year Update Determination
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)	October 1, 2014	LTCH CARE Data Set	FY 2016, FY 2018 and subsequent
Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431)	October 1, 2014	CDC NHSN	FY 2016 and subsequent
All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (NQF #2512)	N/A**	N/A**	For Future Public Reporting

**This is a Medicare Fee-For-Service claims-based measure; hence, no LTCH QRP specific data submission is required by LTCHs.

*Highlighted measures were finalized in the FY 2016 IPPS/LTCH PPS Final Rule

LTCH Quality Reporting Program Overview – 4

Quality Measure	Data Collection Start Date	Data Collection Method	Payment Year Update Determination
NHSN Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)	January 1, 2015	CDC NHSN	FY 2017 and subsequent
NHSN Facility-Wide Inpatient Hospital-Onset Clostridium Difficile Infection (CDI) Outcome Measure (NQF #1717)	January 1, 2015	CDC NHSN	
NHSN Ventilator-Associated Event (VAE) Outcome Measure	January 1, 2016	CDC NHSN	FY 2018 and subsequent

LTCH Quality Reporting Program Overview – 5

Quality Measure	Data Collection Start Date	Data Collection Method	Payment Year Update Determination
Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)	April 1, 2016	LTCH CARE Data Set	FY 2018 and subsequent
Functional Outcome Measure: Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF #2632)	April 1, 2016	LTCH CARE Data Set	
Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)	April 1, 2016	LTCH CARE Data Set	
Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)	April 1, 2016	LTCH CARE Data Set	

*Highlighted measures were finalized in the FY 2016 IPPS/LTCH PPS Final Rule

LTCH CARE Data Set

The LTCH CARE Data Set must be completed for all patients admitted and discharged from an LTCH.

Version #	Effective Start Date	Items to Collect Data for Quality Measures
Version 1.01	October 1, 2012	Pressure Ulcer
Version 2.01	July 1, 2014	Pressure Ulcer and Patient Influenza Vaccination Status
Version 3.00*	April 1, 2016	Pressure Ulcer, Patient Influenza Vaccination Status, and Falls with Major Injury

* LTCH CARE Data Set Version 3.00 is available for download on the following CMS LTCH QRP Web page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Measures-Information.html.

CDC NHSN

- CDC's NHSN is the data submission mechanism for the CAUTI, CLABSI, MRSA, CDI, and Influenza Vaccination Coverage Among Healthcare Personnel quality measures.
- As of January 1, 2016, CDC's NHSN will also be the data submission mechanism for the Ventilator Associated Event (VAE) Outcome Measure.
- For further information on data collection and submission for these measures, please visit www.cdc.gov/nhsn/.

Data Submission Deadlines for Payment Update Determination

- LTCHs must submit quality data for each quarter by the quarterly data submission deadline*.
- Data submitted after the quarterly data submission deadline will not be accepted for LTCH QRP compliance determination.
- Missing one or more of these deadlines may lead to a finding of non-compliance.

*For Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431), the expansion of the quarterly submission deadline is not applicable. The data submission deadline will remain May 15 of each year for quality data related to this measure.

Newly Adopted Data Submission Deadlines for the LTCH QRP

- Beginning with Quarter 4 (October 1–December 31, 2015), the data submission deadlines for quality measures, except Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431), have been expanded to give facilities additional time to submit, review, and correct data.
- These deadlines apply to the payment determinations for FY 2017, FY 2018, and subsequent years.
- LTCHs will have four and a half months (approximately 135 days) after the end of each quarter to submit required quality data.
- Current submission deadlines allow LTCHs to submit data within one and one half months (approximately 45 days) after the end of each quarter.

Newly Adopted Public Reporting Policy for the LTCH QRP

- Public reporting of LTCH QRP quality data:
  - Scheduled to begin in Fall 2016
  - Includes a period for review and correction of quality data prior to the public display of LTCH performance data
- Initial data will include:
  - **NQF #0678** Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay)
  - **NQF #0138** NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure
  - **NQF #0139** NHSN Central-Line Associated Bloodstream Infections (CLABSI) Outcome Measure
  - **NQF #2512** All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from Long-Term Care Hospitals

Newly Adopted Public Reporting Policy for the LTCH QRP (Cont.)

- A list of LTCHs that successfully meet the reporting requirements for the applicable payment determination will be published on the LTCH QRP Web site.
  - The list will be updated after reconsideration requests are processed on an annual basis.

LTCH Quality Reporting Program Federal Rulemaking Resources

- FY 2012 IPPS/LTCH PPS Final Rule
  - http://www.gpo.gov/fdsys/pkg/FR-2011-08-18/pdf/2011-19719.pdf
- FY 2013 IPPS/LTCH PPS Final Rule
  - http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/2012-19079.pdf
- FY 2014 IPPS/LTCH PPS Final Rule
  - http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf
- FY 2015 IPPS/LTCH PPS Final Rule
  - http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf
- FY 2016 IPPS/LTCH PPS Final Rule
  - http://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf

Announcements

- A PDF version of the agenda and meeting materials, including the LTCH QRP Manual Version 3.0, as well as an expanded version of this presentation, will be available online, for download at http://cms.hhs.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html.
- To support NHSN Ventilator Associated Event (VAE) Outcome Measure implementation, starting on January 1, 2016, CMS will be releasing guidance for CDC's NHSN quality measures and so we request that you monitor the LTCH QRP website.

Final Rule FY 2016

Inpatient Rehabilitation Facilities (IRFs)

Quality Measures Previously Adopted and Currently Used in the IRF QRP

NQF Measure ID	Quality Measure Title	Data Submission Mechanism
NQF #0138	National Health Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	CDC NHSN
NQF #0431	Influenza Vaccination Coverage among Healthcare Personnel	CDC NHSN
NQF #0680	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)	IRF-PAI
NQF #0678	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)	IRF-PAI
NQF #2502	All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from Inpatient Rehabilitation Facilities*	Claims-Based
NQF #1716	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure	CDC NHSN
NQF #1717	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure	CDC NHSN

Quality Measures Previously Adopted for IRF QRP and finalized for the FY 2018 Payment Determination and Subsequent Years via the FY 2016 IRF PPS Final Rule

For the FY 2018 payment determination and subsequent years, we adopted two quality measures to reflect NQF endorsement or to meet the requirements of the IMPACT Act:

1. **NQF #2502** All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs
2. **NQF #0678** An application of Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened

Newly finalized Quality Measures for the FY 2018 Payment Determination and Subsequent Years: IMPACT Act

- **Domain 1** Skin integrity and changes in skin integrity
  - **Quality Measure:** "Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened" (Short-Stay) (NQF #0678)
- **Domain 2** Functional status, cognitive function, and changes in function and cognitive function
  - **Quality Measure:** Application of the "Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function" (NQF #2631; under review)
- **Domain 3** Incidence of major falls
  - **Quality Measure:** Application of the "Percent of Residents Experiencing One or More Falls with Major Injury" (Long-Stay) (NQF #0674)

Newly Finalized Quality Measures for the FY 2018 Payment Determination and Subsequent Years: Function

The four adopted functional outcome measures are:

1. Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633; under review)
2. Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634; under review)
3. Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635; endorsed)
4. Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636; endorsed)

Revision to the Previously Adopted Data Collection Timelines and Submission Deadlines

- Quality measures in the IRF QRP will have a data collection time frame based on the calendar year, unless there is a clinical reason for an alternative data collection time frame.
  - For example, if the data collection period is tied to the influenza vaccination season
- When additional quality measures that use IRF-Patient Assessment Instruments (PAIs) as the data collection mechanism are adopted for future use in the IRF QRP, the first data collection time frame for those newly-adopted measures will be three months (October–December) and subsequent data collection periods would follow a calendar year data collection time frame

Data Submission Mechanism: IRF-PAI Version 1.4

- Effective October1, 2016
- Includes:
  - Modified pressure ulcer items collected at admission and discharge
  - New fall items collected at discharge
  - New self care and mobility functional status items collected at admission and discharge
  - New risk factor items for the self-care and mobility measures collected at admission
- Available at http://www.cms.gov/Medicare/Quality-Initiatives-PatientAssessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-MeasuresInformation-.html

Timing for New IRFs to Begin Submitting Quality Data

To ensure that all IRFs have a minimum amount of time to prepare to submit quality data to CMS under the requirements of the IRF QRP, a new IRF is required to begin reporting quality data under the IRF QRP by no later than the first day of the calendar quarter subsequent to 30 days after the date on its CCN notification letter.

Suspension of the IRF QRP Data Validation Process for the FY 2016 Payment Determination and Subsequent Years

- Finalized decision will temporarily suspend the implementation of a process to validate the data submitted for quality purposes, finalized in the FY 2015 IRF PPS rule
- Data accuracy validation will have no bearing on the applicable FY annual increase factor reduction for FY 2016 and subsequent years unless and until we propose to either reenact this policy or propose to adopt a new validation policy through future rulemaking
- Development of a more comprehensive data validation policy that is aligned across the PAC quality reporting programs is in progress, as well as consideration of ways to reduce the labor and cost burden on IRFs

Other Policy Updates

- CMS has finalized its proposal to codify Data Submission Exception and Extension Requirements at §412.634
- CMS will continue using the IRF QRP Reconsideration and Appeals Procedures that were adopted in the FY 2015 IRF PPS Final Rule (79 FR 45919 through 45920) for the FY 2017 payment determination and subsequent years, with the addition of notifying non-compliant IRF providers using the Quality Improvement Evaluation System (QIES) in addition to USPS.

Public Display of IRF QRP Quality Measure Data

- CMS will display performance information regarding the quality measures, as applicable, required by the IRF QRP by fall 2016 on a CMS website after a 30-day preview period.
- The initial display of information will contain IRF provider performance on three quality measures:
  - Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678).
  - NHSN CAUTI Outcome Measure (NQF #0138)
  - All-Cause Unplanned Readmission Measure for 30 Days Post Discharge From IRFs (NQF #2502).

IRF-PAI Submission Requirements

For more information about collection and submission of IRF quality measure data using the IRF-PAI quality indicator items, please visit:

- IRF Quality Reporting Program webpage http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html

IRF QRP Website and Email Resources

- IRF QRP website and email address:
  - Web: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html
  - Email: IRF.questions@cms.hhs.gov
- For questions about CDC/NHSN data or submission:
  - Email: NHSN@cdc.gov
- To receive mailing list notices and announcements about the IRF QRP, sign up at:
  - https://public.govdelivery.com/accounts/USCMS/subscriber/new

IRF QRP Help Desk Resources

- Technical issues regarding the IRF-PAI:
  - Email: IRFTechIssues@cms.hhs.gov
- Questions regarding access to QIES, IRVEN submission, and Certification And Survey Provider Enhanced Reports (CASPERs) go to QIES Technical Support
  - Email: help@qtso.com
  - Telephone: 800.339.9313
- Questions regarding clinical non-quality items on the IRF-PAI go to QIES Technical Support
  - Email: help@qtso.com
  - Telephone: 800.339.9313

Continuing Education Credit Process

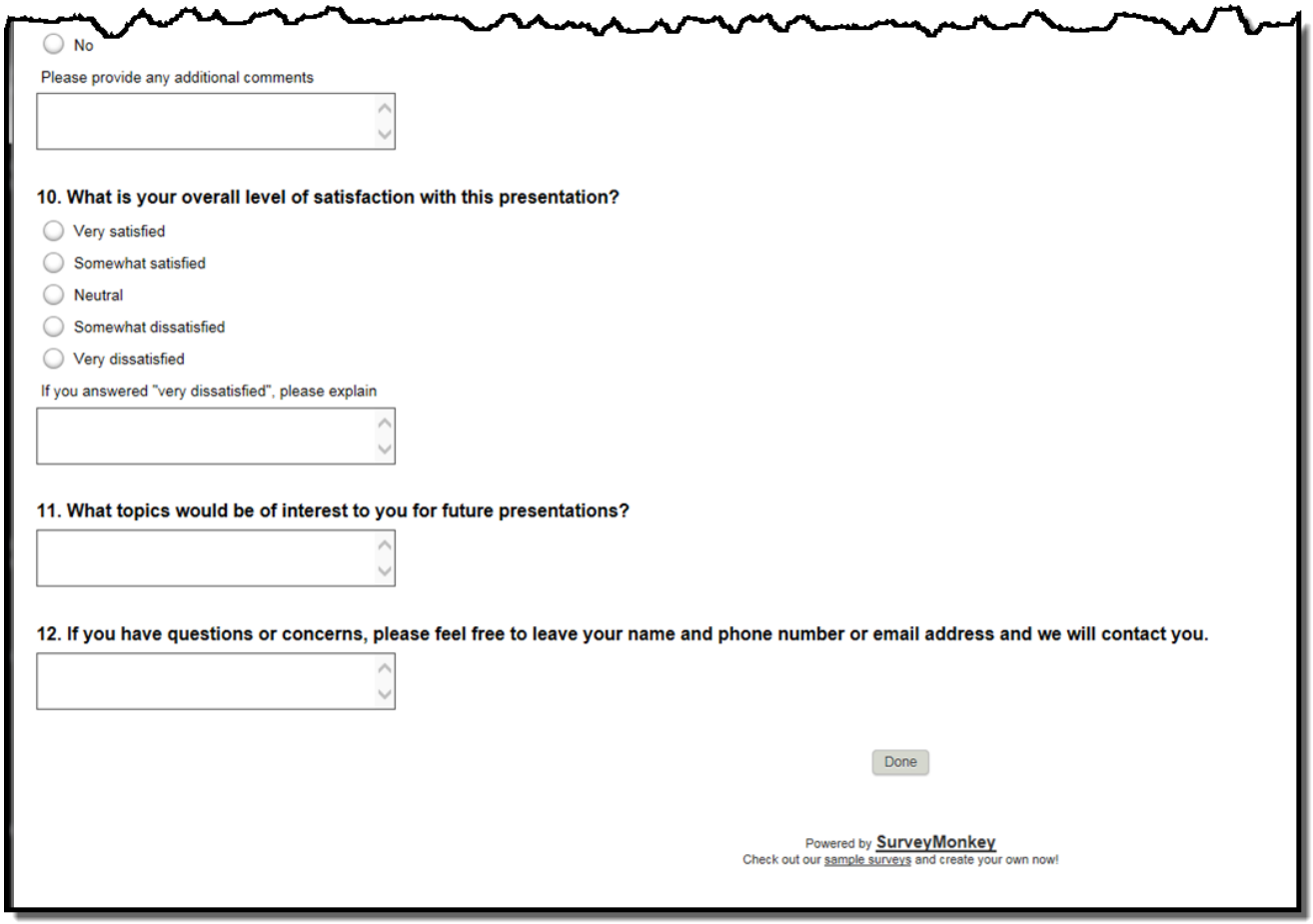
Continuing Education Approval

- This program has been approved for 1.0 continuing education (CE) unit for the following professional boards:
  - Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling
  - Florida Board of Nursing Home Administrators
  - Florida Council of Dietetics
  - Florida Board of Pharmacy
  - Board of Registered Nursing (Provider #16578)
    - It is your responsibility to submit this form to your accrediting body for credit.

CE Credit Process

- Complete the ReadyTalk® survey that will pop up after the webinar, or wait for the survey that will be sent to all registrants within the next 48 hours.
- After completion of the survey, click “done” at the bottom of the screen.
- Another page will open that asks you to register in HSAG’s Learning Management Center.
  - This is a separate registration from ReadyTalk
  - Please use your PERSONAL email so you can receive your certificate
  - Healthcare facilities have firewalls up that block our certificates

CE Credit Process: Survey



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12. If you have questions or concerns, please feel free to leave your name and phone number or email address and we will contact you.

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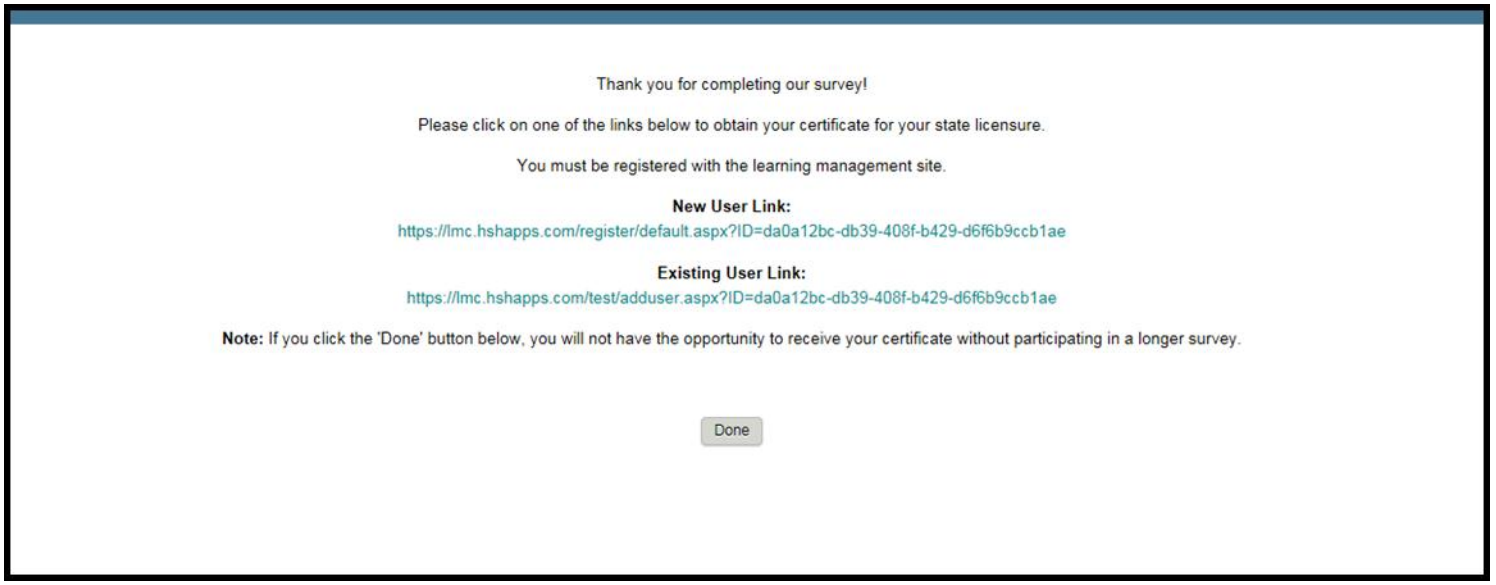
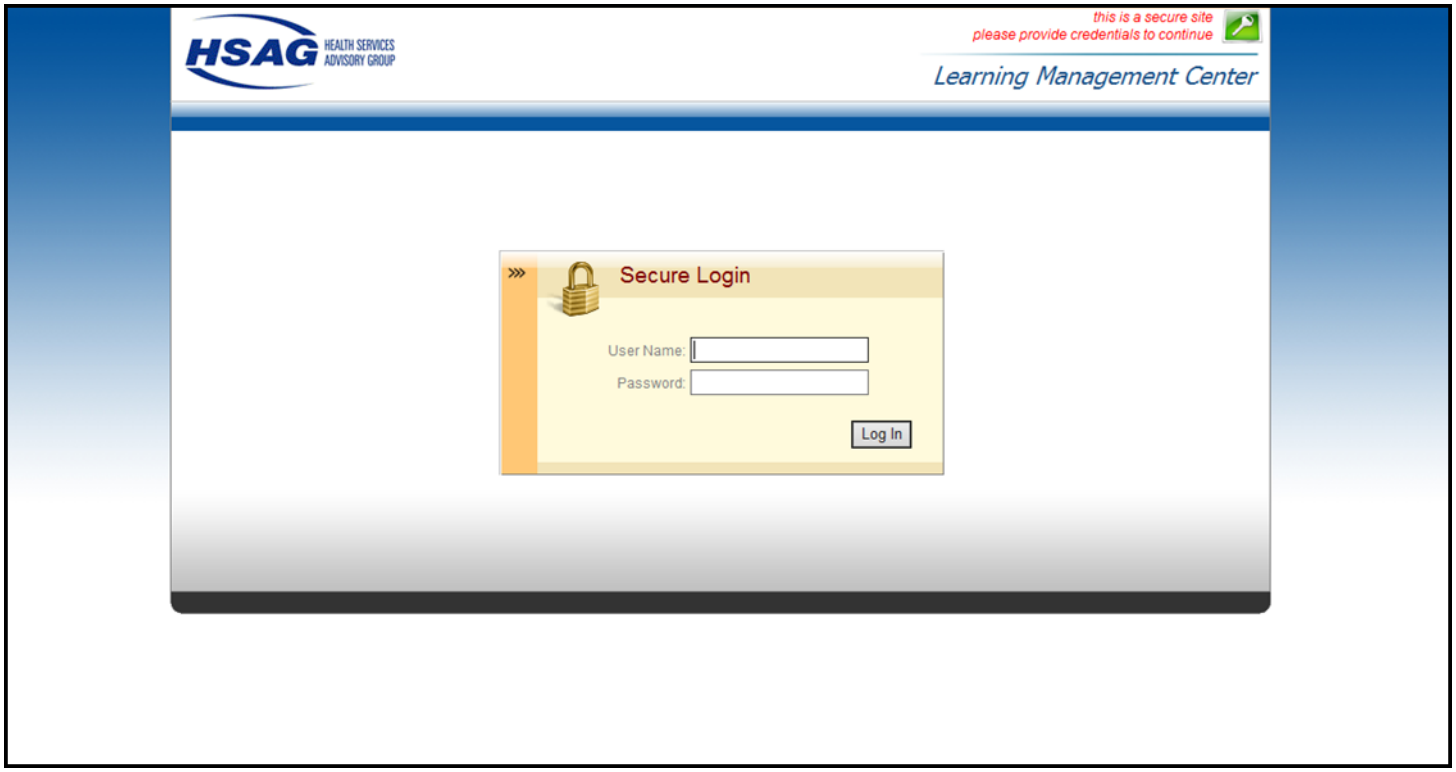


CE Credit Process: New User

CE Credit Process: Existing User



QUESTIONS?