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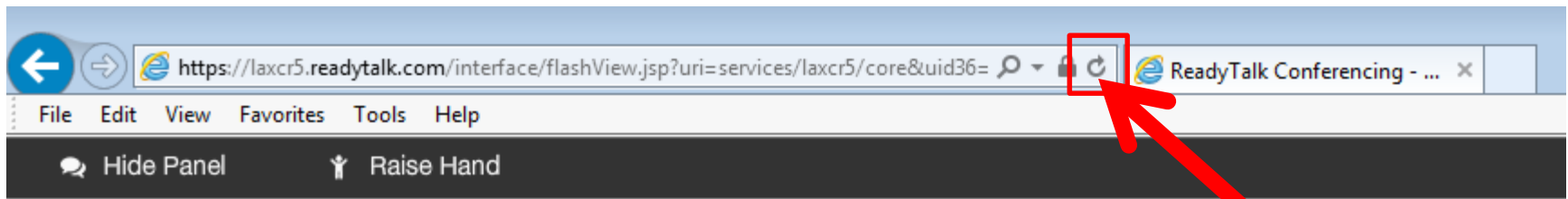
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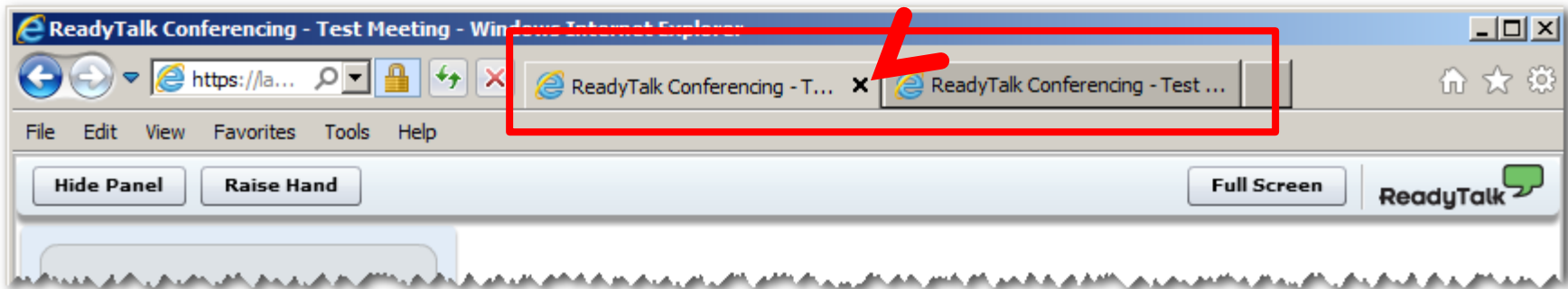
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FY 2017 Inpatient Prospective Payment System (IPPS) Final Rule

Grace H. Im, JD, MPH

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August 29, 2016

Purpose

This presentation will provide participants with the Fiscal Year (FY) 2017 IPPS hospital quality program finalized proposals. It will also address the Final Rule's impact on the following programs:

- Hospital Inpatient Quality Reporting Program
- Hospital Value-Based Purchasing Program
- Hospital-Acquired Condition Reduction Program
- Hospital Readmissions Reduction Program

Objectives

Participants will be able to:

- Locate the FY 2017 IPPS Final Rule text
- Identify changes within the FY 2017 IPPS Final Rule

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

GRACE H. IM, JD, MPH

Removal of Measures in the Hospital IQR Program

CMS finalized the removal of 15 measures for the FY 2019 payment determination and subsequent years.

Removal of Chart-Abstracted Measures in the Hospital IQR Program

Measure	Criteria
STK-4: Thrombolytic Therapy	Topped-Out
VTE-5: VTE Discharge Instructions	Topped-Out

Required Chart-Abstracted Measures for FY 2019

Short Name	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
PC-01	Elective Delivery
SEP-1	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)
VTE-6	Incidence of Potentially Preventable Venous Thromboembolism

Removal of Structural Measures for the Hospital IQR Program

Measure	Criteria
Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	Performance does not result in better patient outcomes
Participation in a Systematic Clinical Database Registry for General Surgery	Performance does not result in better patient outcomes

Removal of the electronic Clinical Quality (eCQM) Measures for the Hospital IQR Program

Measure	Criteria
AMI-2: Aspirin Prescribed at Discharge for AMI	Topped-out
AMI-7a: Fibrinolytic Therapy Received Within 30 minutes of Hospital Arrival	Performance or improvement does not result in better patient outcomes
AMI-10: Statin Prescribed at Discharge	Topped-out
HTN: Healthy Term Newborn	No longer feasible to implement the measure specifications
PN-6: Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients	No longer feasible to implement the measure specifications
SCIP-Inf-1a: Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	Topped-out
SCIP-Inf-2a: Prophylactic Antibiotic Selection for Surgical Patients	Topped-out

Removal of eCQM Measures for the Hospital IQR Program

Measure	Criteria
SCIP-Inf-9: Urinary Catheter Removed on Postoperative Day 1 or Postoperative Day 2 with Day of Surgery Being Day Zero	No longer feasible to implement the measure specifications
*STK-4: Thrombolytic Therapy	Topped-out
VTE-3: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy	No longer feasible to implement the measure specifications
VTE-4: Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol (or Nomogram)	No longer feasible to implement the measure specifications
*VTE-5: Venous Thromboembolism Discharge Instructions	No longer feasible to implement the measure specifications
**VTE-6: Incidence of Potentially Preventable Venous Thromboembolism	No longer feasible to implement the measure specifications
*Removal in both eCQM and chart-abstracted forms * * Removal of only the eCQM form	

Refinements
to Existing Measures

CMS finalized refinements for the following measures:

- Pneumonia (PN) Payment: Hospital-Level, Risk-Standardized 30-Day Episode-of-Care Payment Measure for Pneumonia
- Patient Safety Indicator, PSI 90: Patient Safety and Adverse Events Composite

PN Payment Measure

PN Payment Measure refinements will:

- Include expansion to include hospitalization for patients with a principal diagnosis of:
  - Aspiration pneumonia
  - Sepsis or respiratory failure who also have a secondary diagnosis of pneumonia present on admission

- Be effective for FY 2018 payment determination and subsequent years
- Align with the measure cohorts for PN Mortality and PN Readmission measures finalized in last year's rule.

PSI 90 Measure

PSI 90 measure adjustments include the following:

- Changed name to "Patient Safety and Adverse Events Composite"

- Addition of three indicators:
  - PSI 09 Perioperative Hemorrhage or Hematoma Rate
  - PSI 10 Physiologic and Metabolic Derangement Rate
  - PSI 11 Postoperative Respiratory Failure Rate

- Re-specification of two indicators:
  - PSI 12, Perioperative Pulmonary Edema or Deep Vein Thrombosis Rate
  - PSI 15, Accidental Puncture or Laceration Rate

- Removal of PSI 07 Central Venous Catheter-Related Blood Stream Infection Rate

- Re-weighting of component indicators in the modified PSI 90 measure is based not only on the volume of each of the patient safety and adverse events, but also the harms associated with the events

PSI 90 Reporting Periods

CMS finalized the modification to the reporting periods for FY 2018 and FY 2019 payment determinations.

- FY 2018
    - 15-month reporting period spanning July 1, 2014, through September 30, 2015
    - Would only use ICD-9 data

- FY 2019
    - 21-month reporting period spanning October 1, 2015, through June 30, 2017
    - Would only use ICD-10 data
- FY 2020 and subsequent years
    - Return to 24-month reporting periods

New Hospital IQR Program Measures for FY 2019

CMS finalized the addition of four new claims-based measures to the Hospital IQR Program for the FY 2019 payment determination and subsequent years:

- Three clinical episode-based payment measures
  - Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure
  - Cholecystectomy and Common Duct Exploration Clinical Episode-Based Payment Measure
  - Spinal Fusion Clinical Episode-Based Payment Measure

- One outcome measure

  Excess Days in Acute Care after Hospitalization for Pneumonia

eCQM Certification Policies for the IQR Program

- For the calendar year (CY) 2017 reporting period / FY 2019 payment determination only, Hospitals must report using EHR technology certified to either the 2014 or 2015 Edition of Certified EHR Technology (CEHRT).
- For the CY 2017 reporting period / FY 2019 payment determination and subsequent years:
  - Hospitals must submit eCQM data via Quality Reporting Document Architecture (QRDA) Category I files.
  - Hospitals may continue to use a third party to submit QRDA Category I files on their behalf.
  - Hospitals may continue to either use abstraction or pull the data from non-certified sources in order to then input these data into CEHRT for capture and reporting QRDA I files.
- Beginning with the CY 2018 reporting period / FY 2020 payment determination and subsequent years, Hospitals must report using EHR technology certified to the 2015 Edition of CEHRT.

CY 2017 IQR eCQM Reporting Requirements

- Self-select a minimum of **8** of the **16** available eCQMs
  - This is a modification from the original rule proposal based on the public comments received

- Report four quarters of data on a quarterly, bi-annual, or annual basis from a certified EHR

- All data must by submitted **February 28, 2018 by 11:59 PM PT**

  - IQR eCQM requirement fulfillment also satisfies the eCQM reporting option requirement for the Medicare EHR Incentive Program
  - CY 2017 reporting will apply to FY 2019 payment determination for IPPS hospitals

Note: The submission of eCQMs does not meet complete program requirements for the Hospital IQR Program or Medicare EHR Incentive Program.

CQM Measures for Electronic Reporting to the Hospital IQR and EHR Incentive Programs

ED-1 CMS55v5 *Median Time from ED Arrival to ED Departure for Admitted ED Patients*	**ED-2** CMS111v5 *Admit Decision Time to ED Departure Time for Admitted Patients*	**ED-3*** CMS32v6 *Median Time from ED Arrival to ED Departure for Discharged ED Patients*	**STK -2** CMS104v5 *Discharged on Antithrombotic Therapy*	**STK-3** CMS71v6 *Anticoagulation Therapy for Atrial Fibrillation/Flutter*	**STK-5** CMS72v5 *Antithrombotic Therapy by the End of Hospital Day Two*
STK-6 CMS105v5 *Discharged on Statin Medication*	**STK-8** CMS107v5 *Stroke Education*	**STK-10** CMS102v5 *Assessed for Rehabilitation*	**AMI-8a** CMS53v5 *Primary PCI Received Within 90 Minutes of Hospital Arrival*	**VTE-1** CMS108v5 *Venous Thromboembolism Prophylaxis*	**VTE-2** CMS190v5 *Intensive Care Unit Venous Thromboembolism Prophylaxis*
PC-01 CMS113v5 *Elective Delivery*	**PC-05** CMS9v5 *Exclusive Breast Milk Feeding*	**CAC-3** CMS26v4 *Home Management Plan of Care Document Given to Patient/Caregiver*	**EHDI-1a** CMS31v5 *Hearing Screening Prior to Hospital Discharge*	* ED-3 is an Outpatient measure and is not applicable for IQR aligned credit.	

Expansion of Validation Process for Hospital IQR Data

Finalized the expansion of the validation process beginning with the FY 2020 payment determination:

- Continue to include up to 600 hospitals for chart-abstracted validation

- Include up to 200 additional hospitals for eCQM validation

- Require submission of timely and complete medical record information from the Electronic Health Record (EHR) for at least 75 percent of sampled records

eCQM Validation: Number and Selection of Hospitals

- eCQM validation of CY 2017 reported eCQM data begins Spring 2018 for FY 2020 payment determination

- Up to **200** hospitals will be selected for eCQM validation via random sample. The following hospitals will be excluded:
  - Any hospital selected for chart-abstracted measure validation
  - Any hospital that has been granted a Hospital IQR Program Extraordinary Circumstances Exemption (ECE) for the applicable eCQM reporting period

eCQM Validation: Number of Cases

CMS finalized the proposal specifying that:

- 32 cases (individual patient-level reports) be randomly selected from the QRDA Category I file submitted per hospital selected for validation

- Each selected hospital would submit the randomly selected cases to the Clinical Data Warehouse within 30 days of the medical records request date

eCQM Validation: Submission Requirements

- CMS finalized the proposal to require sufficient patient level information necessary to match the requested medical record to the original submitted eCQM measure data.

- Sufficient patient level information is defined as the entire medical record that sufficiently documents the eCQM measure data elements, including but not limited to:
    - Arrival date and time
    - Inpatient admission date
    - Discharge date from inpatient episode of care

eCQM Validation: Scoring

- The accuracy of eCQM data (i.e., the extent to which data abstracted for validation matches the data submitted in the QRDA I files) that is submitted for validation, will not affect a hospital's validation score for the FY 2020 payment determination.

  Note: This applies for FY 2020 payment determination only.

- Selected hospitals must submit at least 75 percent of sampled eCQM measure medical records within 30 days of the date listed on the Clinical Data Abstracting Center (CDAC) medical records request, or would be subject to payment reduction.

Extraordinary Circumstances Extensions or Exemptions (ECE) Policy

CMS finalized the proposal to update the ECE policy by:

- Extending the request deadline for non-eCQM circumstances from 30 to 90 calendar days following an extraordinary circumstance

    The deadline for ECE requests would apply for extraordinary circumstance events that occur on or after October 1, 2016

- Established a separate submission deadline for ECE requests related to eCQM reporting circumstances to be April 1 following the end of the reporting calendar year

    As an example, for data collected for the CY 2016 reporting period (through December 31, 2016), hospitals would have until April 1, 2017 to submit an ECE request.

Possible New Quality Measures and Measure Topics

CMS sought public comment on possible new quality measures and measure topics:

- Stroke (STK) Mortality Measure update with inclusion of National Institute of Health (NIH) Stroke Scale data for risk adjustment

- New National Healthcare Safety Network (NHSN) Antimicrobial Use Measure

- Potential measures of behavioral health

- Potential public reporting of quality measures data stratified by race, ethnicity, sex, and disability and future hospital quality measures that incorporate health equity

IQR & EHR Incentive Program Resources

IQR General Program Questions – Including eCQM Reporting

- https://cms-ip.custhelp.com
- 866.800.8765 or 844.472.4477, 7 a.m. – 7 p.m. CT Monday through Friday (except holidays)

***QualityNet* Help Desk – PSVA and Data Upload**

- Qnetsupport@hcqis.org
- 1.866.288.8912, 7 a.m. – 7 p.m. CT, Monday through Friday

EHR (Meaningful Use) Information Center – EHR Incentive Program

888.734.6433, 7:30 a.m. – 6:30 p.m., CT Monday through Friday

The JIRA – Office of the National Coordinator (ONC) Project Tracking

http://oncprojectracking.org Resource to submit questions and comments regarding:

- o Issues identified with eCQM logic
- o Clarification on specifications
- o The Combined QRDA IG for 2016

FY 2017 Inpatient Prospective Payment System (IPPS) Final Rule

HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM

GRACE H. IM, JD, MPH

FY 2017 Estimated Funds

- Under section 1886(o)(7)(C)(iv) of the Social Security Act, the applicable percent for the FY 2017 program year is **2.00** percent.

- CMS estimates that the total amount available for value-based incentive payments for FY 2017 is approximately **$1.8 billion**.

FY 2017 Tables 16, 16A, 16B

Table 16 (Proxy Adjustment Factors)

- Based on the Total Performance Scores (TPSs) from FY 2016

Table 16A (Updated Proxy Adjustment Factors)

CMS updated Table 16 as Table 16A in the IPPS Final Rule to reflect changes based on more updated MedPAR data

- Available on CMS.gov at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

Table 16B (Actual Adjustment Factors)

After hospitals have been given an opportunity to review and correct their actual TPSs for FY 2017, CMS intends to display in October:

- Actual value-based incentive payment adjustment factors
- Exchange function slope
- Estimated amount available for the FY 2017 program year

Agency for Healthcare Research and Quality (AHRQ) PSI-90 FY 2018 Performance Period

- CMS finalized the proposal to use a shortened 15-month performance period from July 1, 2014, through September 30, 2015, for the FY 2018 program year.

- CMS intends to propose to remove the PSI-90 measure from the Hospital VBP Program beginning with the FY 2019 program year in next year's rulemaking because a risk adjusted ICD-10 version of the PSI 90 software is not expected to be available until late CY 2017

Proposed Policy	Baseline Period (No Change)	Performance Period
Previously Finalized	July 1, 2010–June 30, 2012	July 1, 2014–June 30, 2016
Newly Finalized	July 1, 2010–June 30, 2012	July 1, 2014–September 30, 2015

Domains and CMS Quality Strategy

Domain Name Modification

CMS finalized the proposal to change the *Patient- and Caregiver-Centered Experience of Care/Care Coordination* domain name to *Person and Community Engagement,* beginning with the FY 2019 program year.

Linking Hospital VBP Program Domains to CMS Quality Strategy Goals

Hospital VBP Program Domain	CMS Quality Strategy Goal
Safety	• Make Care Safer by Reducing Harm Caused in the Delivery of Care
Efficiency and Cost Reduction	• Make Care Affordable
Clinical Care	• Promote Effective Prevention and Treatment of Chronic Disease
Person and Community Engagement	• Promote Effective Communication and Coordination of Care • Strengthen Persons and Their Families as Partners in Their Care

FY 2019 CLABSI and CAUTI Measures

Central Line-Associated Bloodstream Infection (CLABSI) and Catheter-Associated Urinary Tract Infection (**CAUTI) Inclusion of Select Ward (non-ICU) Locations**

- Finalized proposal to include selected ward (non-intensive care unit) locations in the CLABSI and CAUTI measures beginning with the FY 2019 program year.
- No proposed changes to the baseline or performance periods.

Data Period	FY 2017 Program Year	FY 2018 Program Year	FY 2019 Program Year
Baseline Periods	**January 1–December 31, 2013** **CLABSI:** Adult, Pediatric, and Neonatal ICU locations **CAUTI**: Adult and Pediatric ICU locations	**January 1–December 31, 2014** **CLABSI:** Adult, Pediatric, and Neonatal ICU locations **CAUTI**: Adult and Pediatric ICU locations	**January 1–December 31, 2015** **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
Performance Periods	**January 1–December 31, 2015** **CLABSI:** Adult, Pediatric, and Neonatal ICU locations **CAUTI**: Adult and Pediatric ICU locations	**January 1–December 31, 2016** **CLABSI:** Adult, Pediatric, and Neonatal ICU locations **CAUTI**: Adult and Pediatric ICU locations	**January 1–December 31, 2017** **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

FY 2019 Domains and Measures

SAFETY

1. **AHRQ PSI-90****: Complication/patient safety for selected indicators (composite)
2. **CDI**: Clostridium difficile Infection
3. **CAUTI***: Catheter-Associated Urinary Tract Infection
4. **CLABSI***: Central Line-Associated Blood Stream Infection
5. **MRSA**: Methicillin-Resistant Staphylococcus aureus Bacteremia
6. **SSI**: Surgical Site Infection Colon Surgery & Abdominal Hysterectomy
7. **PC-01**: Elective Delivery Prior to 39 Completed Weeks Gestation

EFFICIENCY AND COST REDUCTION

1. **MSPB-1:** Medicare Spending per Beneficiary (MSPB)

Domain Weights

An asterisk (*) indicates a newly adopted measure for the Hospital VBP Program or that CMS has finalized a cohort expansion.

A double asterisk (**) indicates that CMS intends to propose the removal of the measure in future rule making.

A triple asterisk (***) indicates that CMS has proposed to remove the dimension in the CY 2017 OPPS Proposed Rule.

CLINICAL CARE

1. **MORT-30-AMI**: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
2. **MORT-30-HF**: Heart Failure (HF) 30-Day Mortality Rate
3. **MORT-30-PN**: Pneumonia (PN) 30-Day Mortality Rate
4. **THA/TKA**: Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate*

Person and Community Engagement

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Dimensions:

1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Pain Management***
5. Communication about Medicines
6. Cleanliness and Quietness of Hospital Environment
7. Discharge Information
8. 3-Item Care Transition
9. Overall Rating of Hospital

FY 2019 Baseline and Performance Periods

Domain	Baseline Period	Performance Period
Clinical Care • Mortality (MORT-30-AMI, MORT-30-HF, MORT-30-PN) • THA/TKA	July 1, 2009 – June 30, 2012 July 1, 2010 – June 30, 2013	July 1, 2014 – June 30, 2017 January 1, 2015 – June 30, 2017
Person and Community Engagement	January 1–December 31, 2015	January 1–December 31, 2017
Safety • AHRQ PSI-90 Composite • PC-01 • HAI Measures	July 1, 2011–June 30, 2013 January 1–December 31, 2015 January 1–December 31, 2015	July 1, 2015–June 30, 2017 January 1–December 31, 2017 January 1–December 31, 2017
Efficiency and Cost Reduction	January 1–December 31, 2015	January 1–December 31, 2017

FY 2019 Minimum Data Requirements

Domain/Measure/TPS	Minimum Requirement
Person and Community Engagement Domain Score	100 HCAHPS Surveys
Efficiency and Cost Reduction Domain Score	25 Episodes of Care in the MSPB Measure
Clinical Care Domain	Two measure scores with a minimum of 25 cases in each of the three 30-Day Morality measures and THA/TKA measure
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

FY 2021 Update to Pneumonia Mortality (MORT) Measure

Hospital 30-Day, All-Cause, RSMR Following Pneumonia Hospitalization (NQF #0468)

MORT-30-PN (updated cohort) measure is a risk-adjusted, NQF-endorsed mortality measure monitoring mortality rates following PN hospitalizations.

- CMS finalized proposal to add the measure to the *Clinical Care* domain beginning with the FY 2021 program year

- The MORT-30-PN measure underwent a substantive revision, which expanded the measure cohort to include:
    - Patients with a principal discharge diagnosis of pneumonia (currently reported cohort)
    - Patients with a principal discharge diagnosis of aspiration pneumonia
    - Patients with a principal discharge diagnosis of sepsis (excluding severe sepsis) with a secondary diagnosis of pneumonia coded as present on admission

- The non-updated cohort version of the measure will remain in the Hospital VBP Program in fiscal years prior to FY 2021

FY 2021 Acute Myocardial Infarction (AMI) Payment Measure

Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for AMI

AMI Payment is an National Quality Forum (NQF) endorsed measure assessing hospital risk-standardized payment associated with a 30-day episode-of-care for AMI.

- **Domain**: Will be added to the *Efficiency and Cost Reduction* domain, aligning with the CMS Quality Strategy Goal of Making Care Affordable
- **Performance Standards**: Calculated based on data from the performance period **not** the baseline period

FY 2021 Heart Failure (HF) Payment Measure

Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for HF

HF Payment is an NQF-endorsed measure assessing hospital risk-standardized Medicare payment associated with a 30-day episode-of-care for heart failure.

- **Domain**: Will be added to the *Efficiency and Cost Reduction* domain, aligning with the CMS Quality Strategy Goal of Making Care Affordable

- **Performance Standards**: Calculated based on data from the performance period **not** the baseline period

FY 2021 Previously Adopted and Newly Finalized Baseline and Performance Periods

Domain	Baseline Period	Performance Period
Clinical Care • Mortality (MORT-30-AMI, MORT-30-HF, MORT-30-COPD) • THA/TKA • **MORT-30-PN (updated cohort)**	July 1, 2011–June 30, 2014 April 1, 2011–March 31, 2014 July 1, 2012–June 30, 2015	July 1, 2016–June 30, 2019 April 1, 2016–March 31, 2019 September 1, 2017–June 30, 2019
Efficiency and Cost Reduction • **Payment (AMI Payment and HF Payment)** • MSPB	July 1, 2012–June 30, 2015 January 1–December 31, 2017	July 1, 2017–June 30, 2019 January 1–December 31, 2019

FY 2022 Coronary Artery Bypass Graft (CABG) Mortality Measure

Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following CABG Surgery

MORT-30-CABG measure is a risk-adjusted, NQF-endorsed mortality measure monitoring mortality rates following CABG hospitalizations.

- **Domain:** Will be added to the *Clinical Care* domain, aligning with the CMS Quality Strategy Goal of Effective Prevention and Treatment of Chronic Disease

FY 2022 Previously Adopted and Newly Finalized Baseline and Performance Periods

Domain	Baseline Period	Performance Period
Clinical Care • Mortality (MORT-30-AMI, MORT-30-HF, MORT-30-COPD, **MORT-30-CABG**) • THA/TKA • MORT-30-PN (updated cohort)	July 1, 2012–June 30, 2015 April 1, 2012–March 31, 2015 July 1, 2012–June 30, 2015	July 1, 2017–June 30, 2020 April 1, 2017–March 31, 2020 September 1, 2017–June 30, 2020

Updates to Immediate Jeopardy Exclusion

Volume of Citations Required for Exclusion

- CMS finalized proposal to amend regulations to change the definition of the term "Cited for deficiencies that pose immediate jeopardy" to increase the number of surveys on which a hospital must be cited for immediate jeopardy before being excluded from the Hospital VBP Program from **two to three**.

- The effective date of this change will be October 1, 2016, (the first day of the FY 2017 Hospital VBP program year), only hospitals that were cited three times during the performance period that applies to the FY 2017 program year will be excluded from the Hospital VBP Program.

EMTALA-related Immediate Jeopardy Citations

- In the case of Emergency Medical Treatment and Labor Act (EMTALA) related immediate jeopardy citations only, CMS is proposing to change the policy regarding the date of the immediate jeopardy citation for possible exclusion from the Hospital VBP Program from the survey end date generated in Automated Survey Processing Environment (ASPEN) to the date of CMS' final issuance of Form CMS-2567 to the hospital.

HOSPITAL-ACQUIRED CONDITION REDUCTION PROGRAM (HACRP)

DELIA L. HOUSEAL, PHD, MPH

Clarification of Complete Data Requirements for Domain 1

CMS clarified the term "complete data" in order for a hospital to receive a PSI 90 measure score within Domain 1:

- They must have three or more eligible discharges for at least one component indicator
- They must have 12 months or more of data

Newly Opened Hospitals

CMS finalized the following NHSN Healthcare-Associated Infection (HAI) data submission requirements for newly opened hospitals:

- If a hospital files a notice of participation (NOP) with the Hospital IQR Program within six months of opening, the hospital would be required to begin submitting data for the CDC NHSN HAI measures no later than the first day of the quarter following the NOP.

- If a hospital does not file a NOP with the Hospital IQR Program within six months of opening, the hospital would be required to begin submitting data for the CDC NHSN HAI measures on the first day of the quarter following the end of the six-month period to file the NOP.

Adoption of Modified PSI 90: Patient Safety and Adverse Events Composite

CMS finalized adopting the modified PSI 90 for the Hospital-Acquired Condition (HAC) Reduction Program beginning with the FY 2018 payment determination and subsequent years. The changes include:

- Addition of three indicators:
    - PSI 09, Perioperative Hemorrhage or Hematoma Rate
    - PSI 10, Physiologic and Metabolic Derangement Rate
    - PSI 11, Postoperative Respiratory Failure Rate
- Re-specification of two indicators:
    - PSI 12, Perioperative Pulmonary Edema or Deep Vein Thrombosis Rate
    - PSI 15, Accidental Puncture or Laceration Rate, have been re-specified
- Removal of PSI 07 Central Venous Catheter-Related Blood Stream Infection Rate
- Re-weighting of component indicators in the modified PSI 90 measure is based, not only on the volume of each of the patient safety and adverse events, but also on the harms associated with the events.

Applicable Time Periods for the FY 2018 and FY 2019 HAC Reduction Program

To minimize the reporting burden and program disruption with the implementation of ICD-10, CMS finalized the shortened Domain 1 data collection periods:

- FY 2018
    - New performance period is July 1, 2014, through September 30, 2015
    - Uses only ICD-9 data

- FY 2019
    - New performance period is October 1, 2015, through June 30, 2017
    - Uses only ICD-10 data

Changes to the HAC Reduction Program Scoring Methodology

CMS finalized changes to the HAC Scoring Methodology. The changes include moving from a decile-based scoring methodology to a continuous scoring methodology (Winsorized z-score).

Concerns with Decile-based Scoring Methodology

Concerns with the current decile-based scoring methodology include:

- Ties at the penalty threshold
- Difficulty distinguishing performance among hospitals with a limited amount of data
- Situations in which hospitals with no adverse events and no Domain 2 score are eligible for penalty

Revised Scoring Methodology: Winsorizing Z-Score

- The Winsorized *z*-score method (*z*-score) uses a continuous measure score rather than grouping measure results into deciles.

$$Z\text{-}Score = \frac{(Hospital's\ Measure\ Performance - Mean\ Performance\ for\ All\ Hospitals)}{Standard\ Deviation\ for\ All\ Hospitals}$$

- Poor performing hospitals earn a positive *z*-score, reflecting measure values above the national mean.

- Better performing hospitals earn a negative *z*-score, reflecting measure values below the national mean.

Scoring Methodology: Winzorizing

The Winsorized *z*-score method:

- Eliminates the situation in which hospitals with no adverse events and no Domain 2 score are eligible for a penalty

- Makes it easier to distinguish performance across hospitals

- Substantially reduces ties of total HAC scores

- Creates a more level playing field for hospitals with data in only one Domain

HACRP Resources

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

- **HAC Reduction Program Results**
  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

- **PSI 90 Composite**
  QualityNet AHRQ Indicators:
  www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228695321101

- **CLABSI, CAUTI, SSI, MRSA and CDI**
  HAIs:
  www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228760487021

- **HAC Scoring Methodology Reevaluation**
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/TechnicalExpertPanels.html

HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP)

DELIA L. HOUSEAL, PHD, MPH

Finalized Rules for the HRRP Program

Effective FY 2017

- Updated the applicable period for the program year
- Updated the formula for calculating Aggregate Payments
- Changed the public reporting timeline

Updated Formula for Calculating Aggregate Payments for Excess Readmissions

Added CABG to the Existing Formula

FORMULAS TO CALCULATE THE READMISSIONS ADJUSTMENT FACTOR FOR FY 2017

Aggregate payments for excess readmissions = [sum of base operating DRG payments for AMI x (Excess Readmissions Ratio for AMI-1)] + [sum of base operating DRG payments for HF x (Excess Readmissions Ratio for HF-1)] + [sum of base operating DRG payments for PN x (Excess Readmissions Ratio for PN-1)] + [sum of base operating DRG payments for COPD) x (Excess Readmissions Ratio for COPD-1)] + [sum of base operating DRG payments for THA/TKA x (Excess Readmissions Ratio for THA/TKA-1)] + [sum of base operating DRG payments for CABG x (Excess Readmissions Ratio for CABG-1)].

*We note that if a hospital's excess readmissions ratio for a condition is less than/equal to 1, there are no aggregate payments for excess readmissions for that condition included in this calculation.

Aggregate payments for all discharges = sum of base operating DRG payments for all discharges.

Ratio = 1- (Aggregate payments for excess readmissions/Aggregate payments for all discharges).

Proposed Readmissions Adjustment Factor for FY 2017 is the higher of the ratio or 0.9700.

*Based on claims data from July 1, 2012 to June 30, 2015 for FY 2017.

HRRP Readmission Measures

Claims-Based Readmission Measures	NQF Measure Number	FY 2018 Applicable Hospital Discharge Period
Acute Myocardial Infarction	NQF #0505	July 1, 2012-June 30, 2015
Heart Failure	NQF #0330	July 1, 2012-June 30, 2015
Pneumonia	NQF #0506	July 1, 2012-June 30, 2015
Chronic obstructive pulmonary disease	NQF #1891	July 1, 2012-June 30, 2015
Elective primary total hip arthroplasty and/or total knee arthroplasty	NQF #1551	July 1, 2012-June 30, 2015
Coronary artery bypass graft surgery	NQF #2515	July 1, 2012-June 30, 2015

Public Reporting Timeline Shift

Public reporting of the excess readmission ratios on *Hospital Compare*

- Annual reporting following the review period
- Data refreshed annually in December
- Alignment with other quality reporting and performance programs

Resources for 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:
https://www.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

FY 2017 IPPS Final Rule Page Directory

Download the Final Rule from the *Federal Register* on or after 8/22. Details regarding various quality reporting programs can be found on the pages listed below:

- Hospital Readmissions Reduction Program pp. 885–909
- Hospital Value-Based Purchasing (VBP) Program pp. 910–1037
- Hospital-Acquired Condition (HAC) Reduction Program pp. 1038–1099
- Hospital IQR Program pp. 1459–1756
- PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program pp. 1757–1798
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP) pp. 1799–1974
- Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program pp. 1975–2026
- Clinical Quality Measurement for Eligible Hospitals and Critical Access Hospitals (CAHs) Participating in the EHR Incentive Programs in 2017 pp. 2027–2058

Continuing Education Approval

This program has been approved for 1.5 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 Certificate Problems?

- If you do not <u>immediately</u> receive a response to the email that you signed up with in the Learning Management Center, you have a firewall up that is blocking the link that is sent out.

- Please go back to the **New User** link and register your personal email account.

  - Personal emails do not have firewalls.

CE Credit Process: Survey

CE Credit Process

Thank you for completing our survey!

Please click on one of the links below to obtain your certificate for your state licensure.

You must be registered with the learning management site.

New User Link:
https://lmc.hshapps.com/register/default.aspx?ID=da0a12bc-db39-408f-b429-d6f6b9ccb1ae

Existing User Link:
https://lmc.hshapps.com/test/adduser.aspx?ID=da0a12bc-db39-408f-b429-d6f6b9ccb1ae

Note: If you click the 'Done' button below, you will not have the opportunity to receive your certificate without participating in a longer survey.

Done

CE Credit Process: New User

CE Credit Process: Existing User

QUESTIONS?