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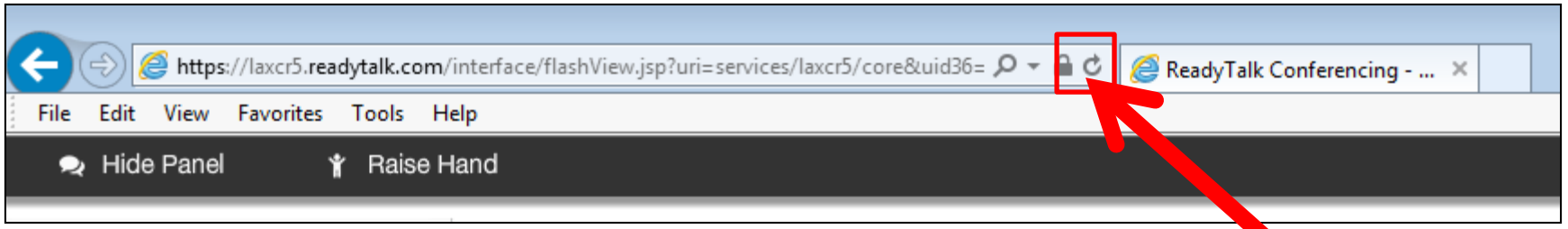

Location of Buttons

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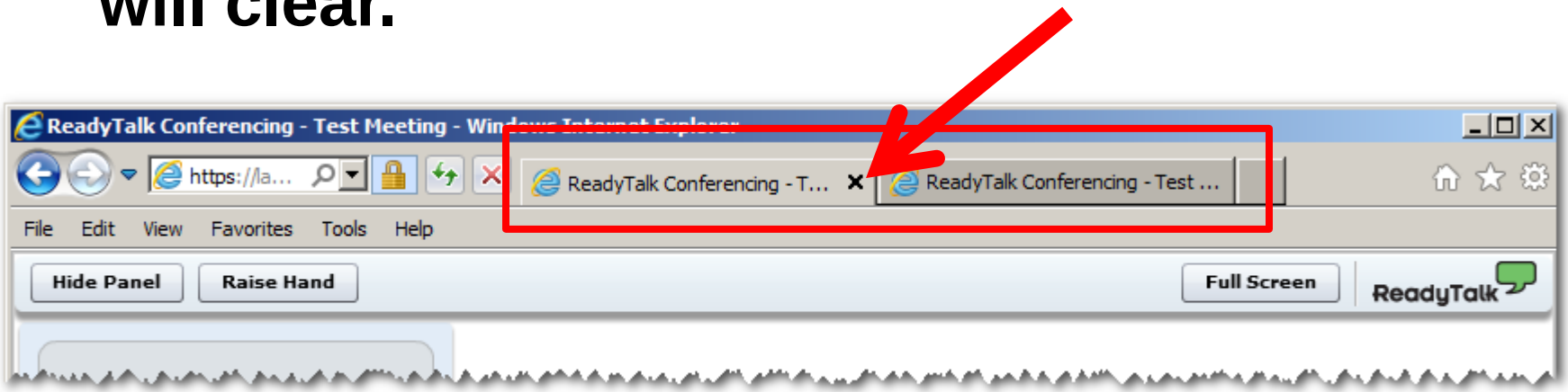

Example of Two Browser Tabs Open to Same Event

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Type questions in the "Chat with Presenter" section, located in the bottom-left corner of your screen.

Inpatient Hospital Quality Programs: Payment Updates and Overview

October 11, 2017

Speakers

Nekeshia McInnis, MSPH
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Program Lead, Hospital-Acquired Condition (HAC) Reduction Program
QMVIG, CCSQ, CMS

Moderator
Bethany Wheeler-Bunch, MSHA
Project Lead, Hospital VBP Program
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)

Purpose

This event will provide an overview of how the CMS adjusts payments for the following inpatient hospital quality programs:

- Hospital Inpatient Quality Reporting (IQR) Program
- Electronic Health Record (EHR) Incentive Program
- Hospital Value-Based Purchasing (VBP) Program
- Hospital Readmissions Reduction Program (HRRP)
- Hospital-Acquired Condition (HAC) Reduction Program

Objectives

Participants will be able to perform the following:

- Identify the portion of CMS payments applicable for payment adjustments
- Discuss how CMS calculates payment adjustments for each of the programs
- Recall the location of CMS publicly reported payment files

Acronyms

ACA	Affordable Care Act
ACH	acute care hospital
AMI	acute myocardial infarction
APU	annual payment update
ARRA	American Recovery and Reinvestment Act
CABG	coronary artery bypass grafting
CAUTI	catheter-associated urinary tract infection
CAH	critical access hospital
CCN	CMS Certification Number
CDC	Centers for Disease Control and Prevention
CDI	Clostridium difficile infection
CLABSI	central line-associated bloodstream infection
CMS	Centers for Medicare & Medicaid Services
COPD	chronic obstructive pulmonary disease
eCQM	electronic clinical quality measure
DACA	Data Accuracy and Completeness Acknowledgement
DRG	diagnosis-related group
DME	durable medical equipment
DSH	disproportionate share hospital
EH	eligible hospital
EHR	electronic health record
ERR	excess readmission ratio
FFS	fee-for-service
FR	Federal Register
FY	fiscal year
HAC	hospital-acquired condition
HAI	healthcare-associated infection
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCP	healthcare professional
HF	heart failure
HHS	Department of Health and Human Services
HITECH	Health Information Technology for Economic and Clinical Health Act
HRRP	Hospital Readmissions Reduction Program
HSR	hospital specific report
IME	indirect medical education
IPPS	inpatient prospective payment system
IQR	Inpatient Quality Reporting
LTCH	long-term care hospital
MAC	Medicare Administrative Contractor
MAO	Medicare Advantage Organization
MBU	market basket update
MRSA	methicillin-resistant Staphylococcus aureus
MS	Medicare Severity
NHSN	National Healthcare Safety Network
NOP	Notice of Participation
PPS	prospective payment system
PSI	Patient Safety Indicator
SA	system administrator
SSI	surgical site infection
TEP	Technical Expert Panel
TPS	Total Performance Score
VBP	Value-Based Purchasing

Hospital Inpatient Quality Reporting (IQR) Program

Nekeshia McInnis, MSPH
Subject-Matter Expert, Hospital IQR and Hospital VBP Programs
QMVIG, CCSQ, CMS

Hospital IQR Program Purpose

Hospital Inpatient Quality Reporting (IQR) Program

- Established to provide transparency about the quality and safety of America's hospitals
- Equips consumers with quality of care information to make more informed decisions about their choice of healthcare providers
- Improves the quality of inpatient care provided to all patients
  - Data published on CMS *Hospital Compare* website
  - Financially incentivizes hospitals to report quality of care measure data

Hospital IQR Program
FY 2018 Program Requirements

- Complete and maintain Notice of Participation (NOP).
- Maintain a *QualityNet* Security Administrator (SA).
- Collect and report data as required in the *Federal Register*:
  - Clinical data (both chart-abstracted measures and electronic clinical quality measures [eCQMs])
  - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data
  - Healthcare-Associated Infection (HAI) and Healthcare Personnel (HCP) Influenza Vaccination measures reported through the National Healthcare Safety Network (NHSN)
  - Structural measures
  - Data Accuracy and Completeness Acknowledgement (DACA)
- Submit complete data by the established deadlines.
- Submit aggregate population and sample size counts.
- If selected for validation, meet validation requirements.
- Display quality data on *Hospital Compare.*

Hospital IQR Program History of Payments

- Section 501(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003
  - FY 2005–FY 2006
  - The reduction in the applicable percentage increase for hospitals that fail to submit quality information is 0.4 percentage points to the applicable market basket update (MBU).
- Section 5001(a) of the Deficit Reduction Act of 2005
  - FY 2007–FY 2014
  - The reduction in the applicable percentage increase for hospitals that fail to submit quality information is 2.0 percentage points to the applicable MBU.
- Section 1886(b)(3)(B)(viii) of the Social Security Act as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act
  - FY 2015 and subsequent fiscal years
  - The reduction in the applicable percentage increase for hospitals that fail to submit quality information is ¼ of the applicable percentage or ¼ of the applicable MBU.

Fiscal Years	Potential Reduction to MBU
FY 2005–FY 2006	0.4 Percentage Points
FY 2007–FY 2014	2.0 Percentage Points
FY 2015 and subsequent FYs	1/4 MBU

Hospital IQR Program Market Basket Update

Q: What is the market basket update?

A: The market basket is described as a fixed-weight index because it answers the question of how much more or less it would cost, at a later time, to purchase the same mix of goods and services that was purchased in a base period. As such, it measures "pure" price changes only. A market basket is constructed in three steps. First, a base period is selected and total base period expenditures are estimated for mutually exclusive and exhaustive spending categories based upon type of expenditure. Then, the proportion for total costs that each spending category represents is determined. These proportions are called cost or expenditure weights. The second step is to match each expenditure category to an appropriate price/wage variable, called a price proxy. In the third and final step, the price level for each spending category price proxy is multiplied by the expenditure weight for that category. The sum of these products (i.e., weights multiplied by proxied index levels) for all cost categories yields the composite index level in the market basket in a given year.

Hospital IQR Program Market Basket Update

Q: What is the market basket update used for?

A: The CMS market baskets are used to update payments and cost limits in the various CMS payment systems. The CMS market baskets reflect input price inflation facing providers in the provision of medical services.

Note: For purposes of the Hospital IQR Program, CMS uses the terms market basket update (MBU) and annual payment update (APU) to describe the payments impacted by the Hospital IQR Program.

Hospital IQR Program
FY 2018 Market Basket Update

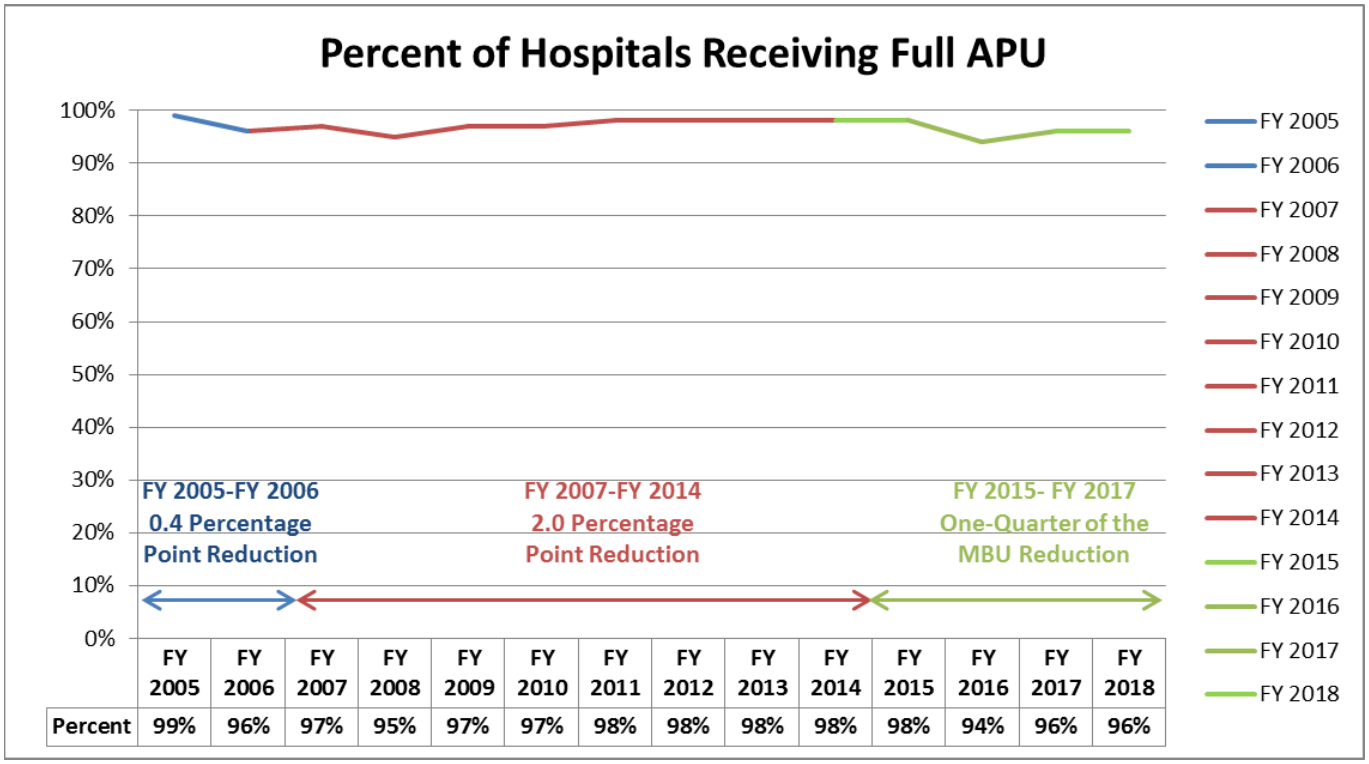
FY 2018 APPLICABLE PERCENTAGE INCREASES FOR THE IPPS

FY 2018	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is not a meaningful EHR user	Hospital did not submit quality data and is a meaningful EHR user	Hospital did not submit quality data and is not a meaningful EHR user
Market Basket Rate-of-Increase	2.7	2.7	2.7	2.7
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	−0.675	−0.675
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0.0	−2.025	0.0	−2.025
MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	−0.6	−0.6	−0.6	−0.6
Statutory Adjustment under Section 1886(b)(3)(B)(xii) of the Act	−0.75	−0.75	−0.75	−0.75
Applicable Percentage Increase Applied to Standardized Amount	1.35	−0.675	0.675	−1.35

For more information on the FY 2018 market basket update, reference the FY 2018 IPPS/LTCH PPS Final Rule (82 Federal Register [FR] 38177–38178) at https://www.gpo.gov/fdsys/pkg/FR-2017-08-14/pdf/2017-16434.pdf.

Hospital IQR Program Participation Rates

CMS posts a list of hospitals and their Hospital IQR Program status by fiscal year on *QualityNet* at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1154977996543.



	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Percent	99%	96%	97%	95%	97%	97%	98%	98%	98%	98%	98%	94%	96%	96%

Hospital IQR Program
Hospital Compare

Hospital Compare has information about the quality of care at more than 4,000 Medicare-certified hospitals across the country. You can use *Hospital Compare* to **find hospitals** and **compare the quality of their care**.

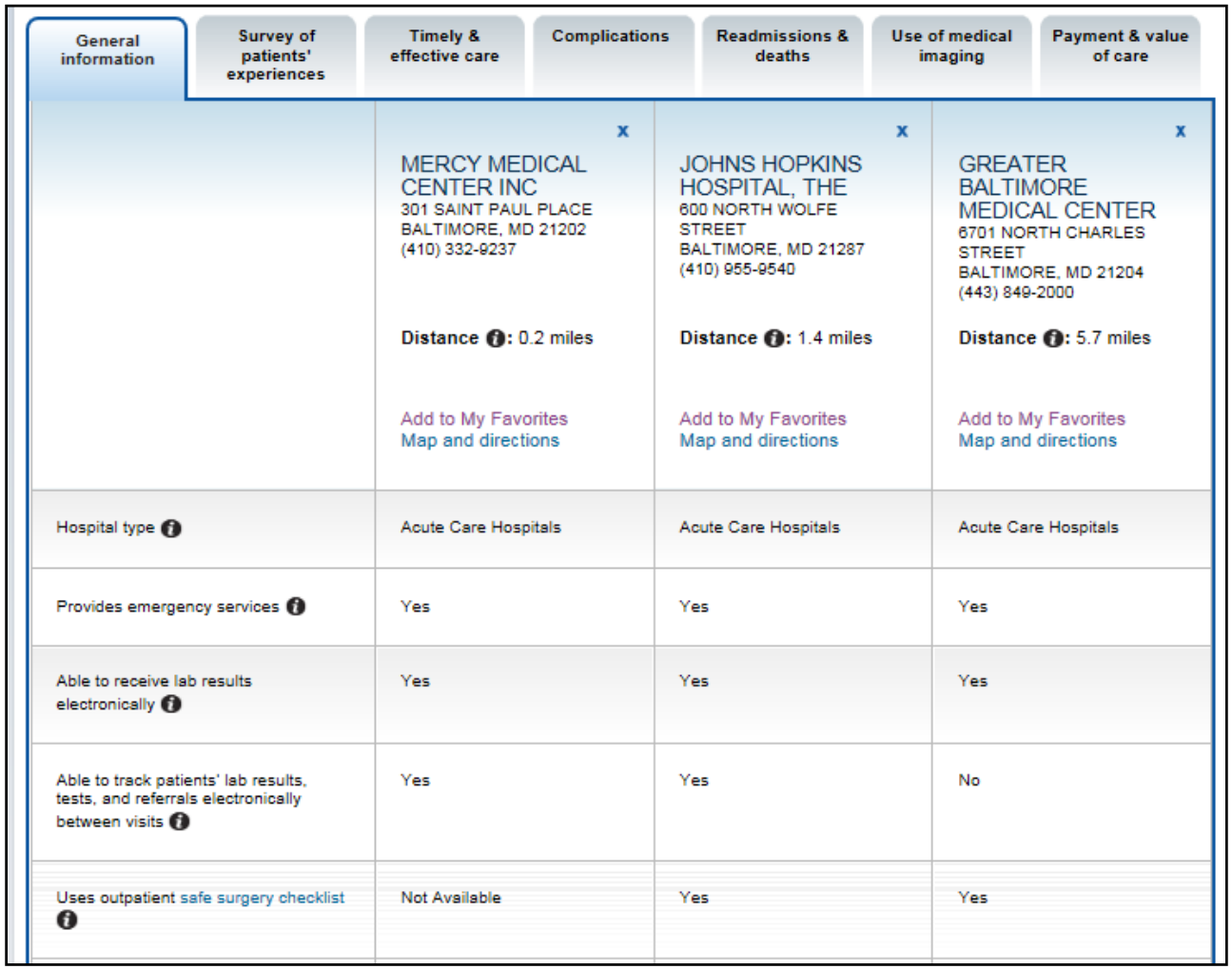
The information on *Hospital Compare*:

- **Helps you make decisions** about where you get your healthcare.
- Encourages hospitals to **improve the quality of care** they provide.

Hospital Compare was created through the efforts of CMS in collaboration with organizations representing consumers, hospitals, doctors, employers, accrediting organizations, and other federal agencies.

Note: Public display of eCQM data will be addressed in a future CMS inpatient prospective payment system (IPPS) rule.

Hospital IQR Program
Hospital Compare



General information | Survey of patients' experiences | Timely & effective care | Complications | Readmissions & deaths | Use of medical imaging | Payment & value of care

	MERCY MEDICAL CENTER INC 301 SAINT PAUL PLACE BALTIMORE, MD 21202 (410) 332-9237 **Distance**: 0.2 miles Add to My Favorites Map and directions	JOHNS HOPKINS HOSPITAL, THE 600 NORTH WOLFE STREET BALTIMORE, MD 21287 (410) 955-9540 **Distance**: 1.4 miles Add to My Favorites Map and directions	GREATER BALTIMORE MEDICAL CENTER 6701 NORTH CHARLES STREET BALTIMORE, MD 21204 (443) 849-2000 **Distance**: 5.7 miles Add to My Favorites Map and directions
Hospital type	Acute Care Hospitals	Acute Care Hospitals	Acute Care Hospitals
Provides emergency services	Yes	Yes	Yes
Able to receive lab results electronically	Yes	Yes	Yes
Able to track patients' lab results, tests, and referrals electronically between visits	Yes	Yes	No
Uses outpatient safe surgery checklist	Not Available	Yes	Yes

Hospital IQR Program Resources

Technical questions or issues related to accessing reports

- Email the *QualityNet* Help Desk at qnetsupport@HCQIS.org.
- Call the *QualityNet* Help Desk at (866) 288-8912.

Ask questions or access Frequently Asked Questions (FAQs) about the Hospital IQR Program

- Submit questions or access the FAQs via the Hospital Inpatient Questions and Answers tool at https://cms-ip.custhelp.com.
- Call the Program at (844) 472-4477.

Hospital IQR Program general information

- https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1138115987129

Hospital IQR Program ListServes and discussions

- Register at https://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic/ListServe/Register.

Hospital IQR Program monthly webinars

- Find archived webinars, webinar schedules, and register at http://www.qualityreportingcenter.com.

Hospital IQR Program on *Hospital Compare*

- View data at https://www.medicare.gov/hospitalcompare/search.html.

Medicare Electronic Health Record (EHR) Incentive Program

Nichole Davick
Health Insurance Specialist, EHR Incentive Programs
Division of Health Information Technology, CCSQ, CMS

EHR Incentive Program Authorizing Legislation

The American Recovery and Reinvestment Act (ARRA) of 2009 included the Health Information Technology for Economic and Clinical Health Act (HITECH Act) to authorize incentive payments and Medicare Payment Adjustments for the following:

- Eligible Hospitals (EHs)
- Critical Access Hospitals (CAHs)
- Medicare Advantage Organizations (MAOs)

EHR Incentive Program
Medicare EHs and CAHs

EHs and CAHs receive incentive payment through 2016:

- Subsection (d) hospitals:
  50 States or DC that are paid under the IPPS
- Critical Access Hospitals
- Medicare Advantage (MA-affiliated) hospitals

Puerto Rico hospitals:

- Section 602 of the Consolidated Appropriations Act
- Subsection (d) hospitals in Puerto Rico
- Participation in 2016–2020
- Negative payment adjustments in 2022

EHR Incentive Program Payment Adjustments

Eligible Hospitals

EHR Reporting Period	2013	2014	2015	2016	2017
Payment Adjustment Year	2015	2016	2017	2018	2019

Critical Access Hospitals

EHR Reporting Period Determining Adjustment	2015	2016	2017	2018	2019	2020
Payment Adjustment Year	2015	2016	2017	2018	2019	2020

EHR Incentive Program Eligible Hospitals

Hospital Adjustment to the MBU	2015 Payment Adjustment	2016 Payment Adjustment	2017+ Payment Adjustment
% Decrease	25%	50%	75%

This payment adjustment is applied as a reduction to the applicable percentage increase to the IPPS payment rate reducing the update to the IPPS standardized amount for these hospitals.

EHR Incentive Program
FY 2018 Market Basket Update

FY 2018 APPLICABLE PERCENTAGE INCREASES FOR THE IPPS

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EHR Incentive Program
Critical Access Hospitals

Fiscal Year	2015	2016	2017	2018	2019	2020+
% of reasonable costs	100.66%	100.33%	100%	100%	100%	100%

The payment adjustment applies to the Medicare reimbursement for inpatient services during the cost reporting period in which the CAH failed to demonstrate meaningful use.

EHR Incentive Program Hardships

EHs and CAHs:

- **Infrastructure** — Eligible hospitals must demonstrate that they are in an area without sufficient Internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband).
- **New eligible hospitals** — Eligible hospitals with new CMS Certification Numbers (CCNs) that do not have time to become meaningful EHR users can apply for an exception for one full cost reporting period.
- **Unforeseen circumstances** — Examples may include a natural disaster or other unforeseeable barrier.
- **2014 EHR vendor issues** — An eligible hospital's EHR vendor was unable to obtain 2014 certification or the hospital was unable to implement meaningful use due to 2014 EHR certification delays.
- **Exception for decertified EHR technology** — The EH or CAH certified EHR technology was decertified under the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program during the 12 months preceding the applicable EHR reporting period.

EHR Incentive Program Resources

Information regarding payment adjustments and hardships

- https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html

Questions regarding EHR hardship

- E-mail ehrhardship@provider-resources.com

You can also stay up to date on the latest EHR Incentive Program news and updates by following us on Twitter and by subscribing to the EHR ListServe.

The EHR Information Center is open to assist you with all of your registration and attestation system inquiries.

- **EHR Information Center hours of operation:**
  - 9 a.m. to 5 p.m. CT, Monday through Friday, except federal holidays
  - 1-888-734-6433 (primary number – press option 1) or (888) 734-6563 (TYY number)

Hospital Value-Based Purchasing (VBP) Program

Nekeshia McInnis, MSPH
Subject-Matter Expert, Hospital IQR and Hospital VBP Programs
QMVIG, CCSQ, CMS

Hospital VBP Program Origin and Program Intent

The Hospital VBP Program is authorized by Section 1886(o) of the Social Security Act.

The Hospital VBP Program is designed to promote better clinical outcomes for hospital patients, as well as improve their experience of care during hospital stays. Specifically, the Hospital VBP Program seeks to encourage hospitals to improve the quality and safety of care that Medicare beneficiaries and all patients receive during acute-care inpatient stays by:

- Eliminating or reducing the occurrence of adverse events (healthcare errors resulting in patient harm).
- Adopting evidence-based care standards and protocols that result in the best outcomes for the most patients.
- Re-engineering hospital processes that improve patients' experience of care.
- Increasing the transparency of care for consumers.
- Recognizing hospitals that are involved in the provision of high-quality care at a lower cost to Medicare.

Hospital VBP Program Eligibility

- **Eligible hospitals include** subsection (d) hospitals as defined in Social Security Act 1886(d)(1)(B).
- **Ineligible hospitals include** those excluded from IPPS, such as psychiatric, rehabilitation, long-term care, children's, 11 prospective payment system (PPS)-exempt cancer hospitals, and CAHs.
- **Excluded hospitals include those:**
  - Subject to payment reductions under the Hospital IQR Program.
  - Cited for three or more deficiencies during the performance period that pose immediate jeopardy to the health or safety of patients.
  - With an approved extraordinary circumstance exception specific to the Hospital VBP Program.
  - Without the minimum number of domains calculated for the applicable fiscal year.
  - Short-term acute care hospitals in Maryland.

Hospitals **excluded** from the Hospital VBP Program **will not** have their base operating diagnosis-related group (DRG) payments reduced by the withhold percentage.

Hospital VBP Program
FY 2018

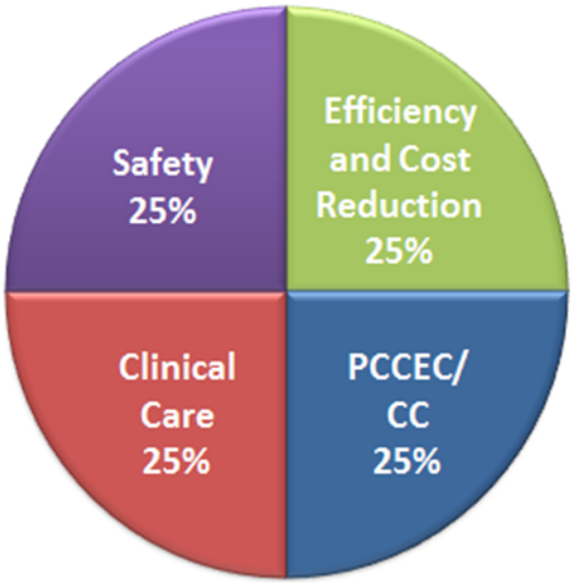
SAFETY

1. **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 Bloodstream Infection
5. **MRSA**: Methicillin-resistant Staphylococcus aureus Bacteremia
6. **SSI**: Surgical Site Infection Colon Surgery and Abdominal Hysterectomy
7. **PC-01**: Elective Delivery Prior to 39 Completed Weeks Gestation

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

Domain Weights



An asterisk (*) indicates a newly adopted measure for the Hospital VBP Program.

EFFICIENCY AND COST REDUCTION

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

PATIENT- AND CAREGIVER-CENTERED EXPERIENCE OF CARE/CARE COORDINATION (Experience of Care)

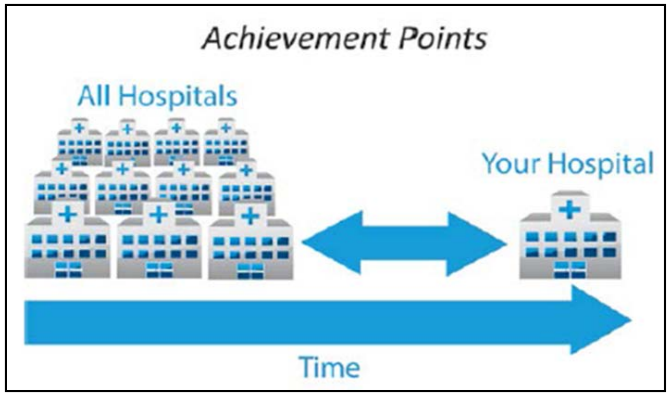
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Dimensions:

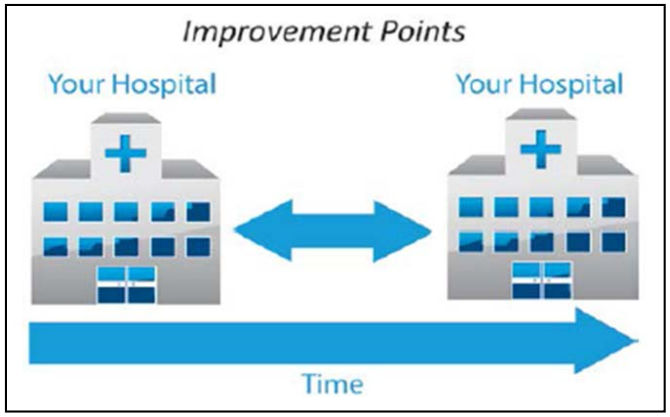
1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Communication about Medicines
5. Cleanliness and Quietness of Hospital Environment
6. Discharge Information
7. Care Transition*
8. Overall Rating of Hospital

Hospital VBP Program Scoring

Value-based incentive payments are based on a hospital's Total Performance Scores (TPS). The TPS is determined by calculating a hospital's achievement and improvement points for each measure within each domain and summing weighted domain scores.

- Achievement Points are awarded by comparing an individual hospital's rates during the Performance Period with all hospitals' rates from the Baseline Period.
  - Rate at or above the Benchmark: 10 points
  - Rate less than the Achievement Threshold: 0 points
  - Rate somewhere at or above the Threshold but less than the Benchmark: 1–9 points
- Improvement Points are awarded by comparing a hospital's rates during the Performance Period to that same hospital's rates from the Baseline Period.
  - Rate at or above the Benchmark: 9 points
  - Rate less than or equal to Baseline Period Rate: 0 points
  - Rate between the Baseline Period Rate and the Benchmark: 0–9 points





Hospital VBP Program
Future Policies

Future program policies include additional claims-based measures focusing on clinical care outcomes and efficiencies:

- Adoption of the Total Hip Arthroplasty and/or Total Knee Arthroplasty Complication measure in FY 2019
- Removal of the Patient Safety of Selected Indicators Composite (PSI 90) measure in FY 2019
- Adoption of Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Measure in FY 2021
- Updating the Pneumonia 30-Day Mortality Measure cohort to include patients with a principal discharge diagnosis of aspiration pneumonia and patients with a principal discharge diagnosis of sepsis (excluding severe sepsis) with a secondary diagnosis of pneumonia coded as present on admission in FY 2021
- Adoption of Acute Myocardial Infarction (AMI) Payment Measure in FY 2021
- Adoption of Heart Failure (HF) Payment Measure in FY 2021
- Adoption of Pneumonia Payment Measure in FY 2022
- Adoption of Coronary Artery Bypass Grafting (CABG) 30-Day Mortality Measure in FY 2022
- Adoption of the Patient Safety and Adverse Events Composite (PSI 90) measure in FY 2023

Hospital VBP Program Funding

- The Hospital VBP Program is an estimated budget neutral program.
- The Hospital VBP Program is funded by reductions from participating hospitals' base-operating DRG payments.
- The resulting funds are redistributed to hospitals based on their TPS.
  - The actual amount earned by hospitals will depend on the range and distribution of all eligible/participating hospitals' TPS scores for a fiscal year.
  - A hospital may earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that program year.

Fiscal Year	Percentage Withhold	Total Value-Based Incentive Payments
FY 2013	1.00%	$963 million (est.)
FY 2014	1.25%	$1.1 billion (est.)
FY 2015	1.50%	$1.4 billion (est.)
FY 2016	1.75%	$1.5 billion (est.)
FY 2017	2.00%	$1.8 billion (est.)
FY 2018	2.00%	$1.9 billion (est.)

Hospital VBP Program Translating TPS to Payments

Step 1: Calculate your hospital's value-based incentive percentage

- Defined as the percentage of the base-operating DRG payment amount for each Medicare discharge that a hospital has earned, with respect to a fiscal year, based on its TPS for that fiscal year
- Value-Based Incentive Payment Percentage formula:

$$= \%\ Reduction \times \left(\frac{TPS}{100}\right) \times\ linear\ exchange\ function\ slope$$

- Value-based incentive percentage can be multiplied by the base-operating DRG payment amount to calculate the value-based incentive payment amount
- The sum of all value-based incentive payment amounts across all hospitals is estimated to be equal, by statute, to the total amount available for value-based incentive payments to all hospitals (or the total amount of base-operating DRG payment amount reductions across all hospitals in that fiscal year)

Hospital VBP Program Translating TPS to Payments

Step 2: Compute the net percentage change in the hospital's base operating DRG payment amount for each Medicare discharge

- Calculated as an interim step, in order to calculate the value-based multiplier (value-based incentive payment adjustment factor)
- The net percentage change formula:

$$= Hospital's\ Value - Based\ Incentive\ Payment\ \% - Applicable\ \%\ Payment\ Reduction$$

Hospital VBP Program
Translating TPS to Payments

Step 3: Compute the value-based multiplier

- The number that CMS multiplies by the base operating DRG payment amount for each Medicare discharge in the fiscal year
- Represents the total effect of the applicable percent reduction and the value-based incentive payment percentage on the base operating DRG payment amount
- May be greater than, equal to, or less than 1
- Value-Based Multiplier formula:

$$= 1 + Net\ \%\ Change\ in\ Base\ Operating\ DRG\ Payment\ Amount$$

Note: The net percentage change in base operating DRG payments must be converted to a numerical value instead of a percent value before being used in the value-based multiplier calculation.

Hospital VBP Program Payment Example

Payment example:

- Hospital has a TPS of 60.
- Hospital has an annual total of $10,000,000 of base-operating DRG payments for FY 2018.
- Hospital has one claim of $1,000 of base-operating DRG payments in FY 2018.
- Exchange function slope is 2.8908851882 in FY 2018.
- Percent reduction (withhold) in FY 2018 is 2.0 percent.

Hospital VBP Program Payment Example

Step 1: Value-Based Incentive Percentage

$$= \%\ Reduction \times \left(\frac{TPS}{100}\right) \times Linear\ Exchange\ Function\ Slope$$

$$= 2.0 \times \left(\frac{60}{100}\right) \times 2.8908851882$$

$$= \mathbf{3.4690622258\%}$$

Step 2: Net Percentage Change

$$= Hospital's\ Value - Based\ Incentive\ Percentage\ - \%\ Reduction$$

$$= 3.4690622258\% - \ 2.0\%$$

$$= \mathbf{1.4690622258\%\ OR\ 0.0146906222584}$$

Step 3: Value-Based Multiplier (Payment Adjustment Factor)

$$= Net\ Percentage\ Change\ Amount + 1$$

$$= 0.0146906222584 + 1$$

$$= \mathbf{1.0146906223}$$

Hospital VBP Program Payment Example

Results:

- The hospital's FY 2018 base-operating DRG payment amount for each discharge will be multiplied by **1.0146906223** under the Hospital VBP Program. This is a **1.47% increase**.
- This hospital's annual base operating DRG payment amount of $10,000,000 would be increased to $10,146,906 — an estimated $146,906 total increase for the fiscal year.
- The hospital's one claim base-operating DRG payment of $1,000 would be increased to $1,014.69 — an estimated $14.69 increase to the payment amount.

Hospital VBP Program Tables 16, 16A, and 16B

Table 16 (Proxy Adjustment Factors)

- Available in the FY 2018 IPPS/LTCH PPS Proposed Rule tables
- Based on TPSs from FY 2017

Table 16A (Updated Proxy Adjustment Factors)

- CMS updated Table 16 as Table 16A in the FY 2018 IPPS/LTCH PPS Final Rule to reflect changes based on more updated MedPAR data and FY 2017 TPSs.
- Available on CMS.gov at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-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 2018, CMS intends to display Table 16B in the fall of 2017.
  - Actual value-based incentive payment adjustment factors
  - Exchange function slope
  - Estimated amount available for the FY 2018 program year

Hospital VBP Program
Hospital Compare

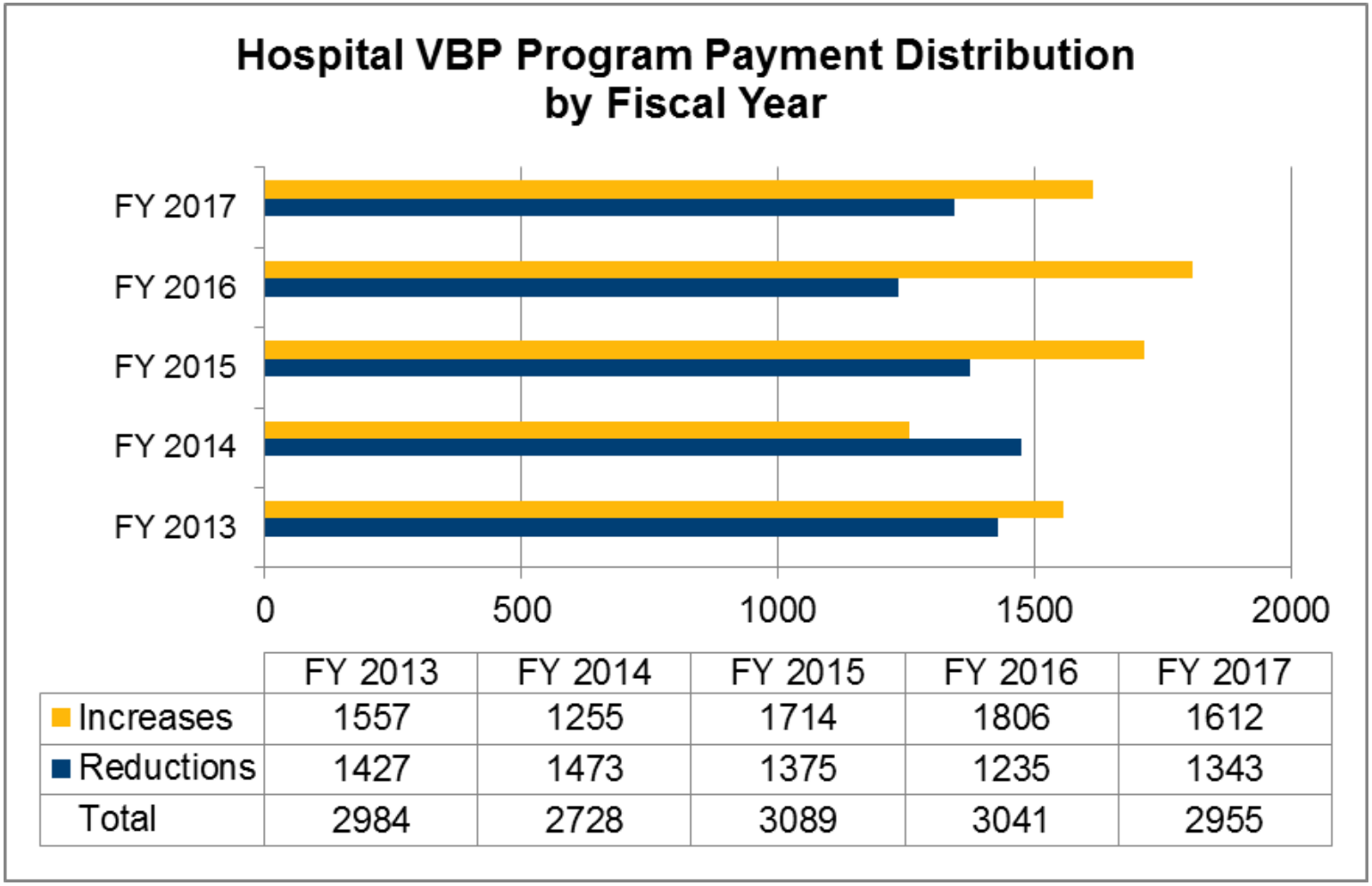
Aggregate Payment Data

- CMS publishes actual aggregate payment adjustment data after each fiscal year on *Hospital Compare* at https://www.medicare.gov/HospitalCompare/Data/payment-adjustments.html.
- The aggregate payment adjustment data includes tables for the following:
  - Net change in base operating DRG payment amount
  - Distribution of net change in base operating DRG payment amount
  - Percent change in base operating DRG payment amount
  - Value-based incentive payment amount
- Note: Data is in an aggregate form, not at the individual CMS Certification Number (CCN) level.
- CMS is currently displaying FY 2015 data and anticipates posting FY 2016 aggregate payment adjustment tables in December 2017.

Hospital Specific Data and Scoring

- CMS publishes the data and scoring after each fiscal year on *Hospital Compare at* https://www.medicare.gov/hospitalcompare/data/hospital-vbp.html.
- CMS is currently displaying FY 2017 data and anticipates posting FY 2018 data and scoring in December 2017.

Hospital VBP Program Payment Distribution



	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Increases	1557	1255	1714	1806	1612
Reductions	1427	1473	1375	1235	1343
Total	2984	2728	3089	3041	2955

Hospital VBP Program Resources

Technical questions or issues related to accessing reports

- Email the *QualityNet* Help Desk at qnetsupport@HCQIS.org.
- Call the *QualityNet* Help Desk at (866) 288-8912.

Ask questions or access Frequently Asked Questions (FAQs) about the Hospital VBP Program

- Submit questions or access the FAQs via the Hospital Inpatient Questions and Answers tool at https://cms-ip.custhelp.com.
- Call the hospital inpatient program at (844) 472-4477.

Hospital VBP Program general information

- https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937

Hospital VBP Program ListServes and discussions

- Register at https://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic/ListServe/Register.

Hospital VBP Program monthly webinars

- Find archived webinars and future webinar schedule and registration at http://www.qualityreportingcenter.com.

Hospital VBP Program data and scoring on *Hospital Compare*

- View data up to FY 2017 at http://www.medicare.gov/hospitalcompare/data/hospital-vbp.html.

Hospital Readmissions Reduction Program (HRRP)

James Poyer
Director, Division of Value Incentives and Quality Reporting
QMVIG, CCSQ, CMS

HRRP Introduction

- Program Overview
- FY 2018 Measures
- FY 2018 Methodology
- FY 2018 IPPS/LTCH PPS Final Rule: HRRP Supplemental Data File
- 21st Century Cures Act
- Resources

HRRP
Program Overview

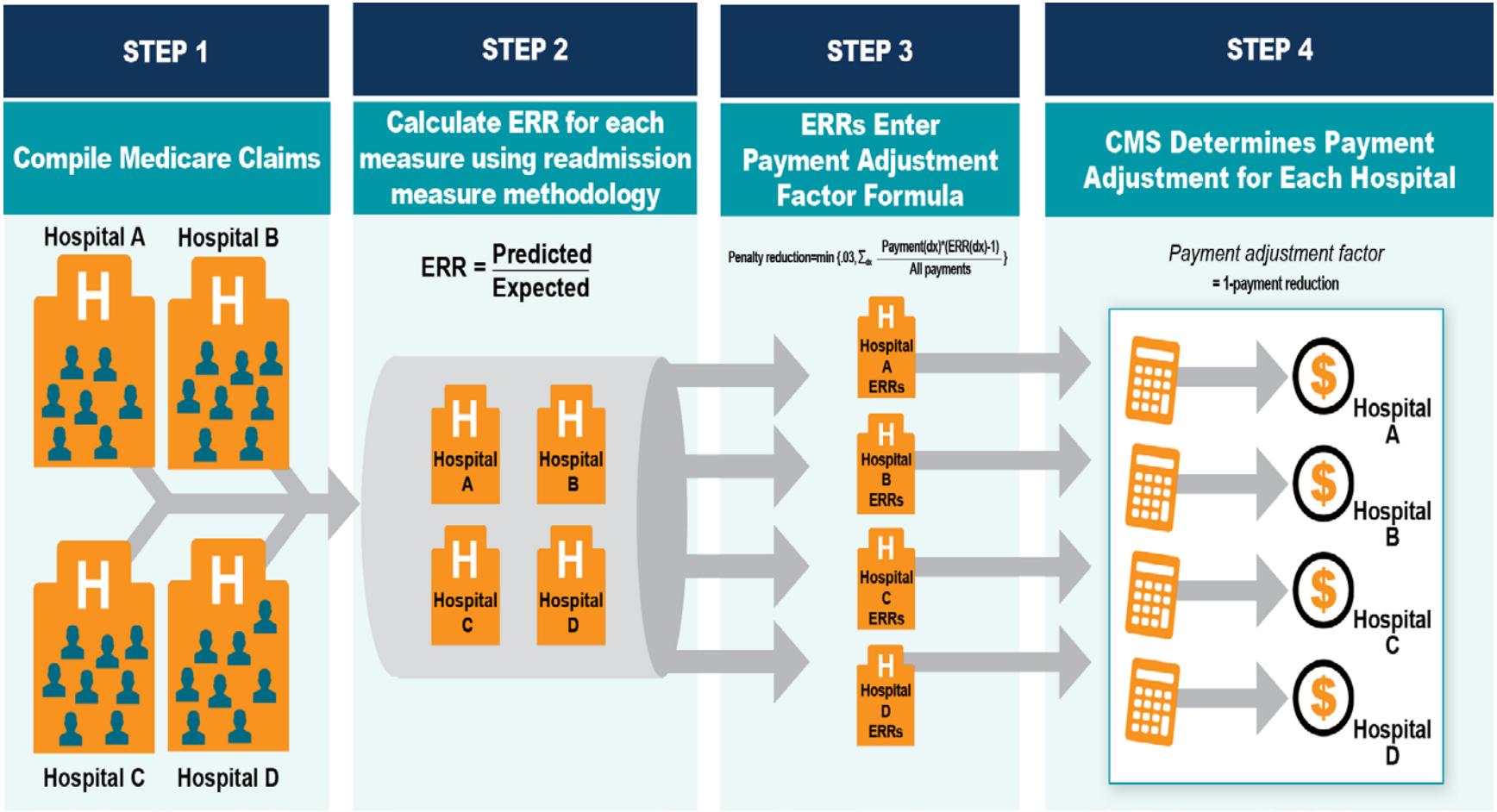
- Section 3025 of the 2010 Affordable Care Act (ACA) (Public Law 111–148) required the Secretary of the Department of Health and Human Services (HHS) to establish the HRRP. Beginning with FY 2013, the legislation mandates the Secretary reduce IPPS payments to hospitals for excess readmissions on or after October 1, 2012.
- The maximum payment adjustment reduction is 3 percent per fiscal year.

HRRP
FY 2018 Measures

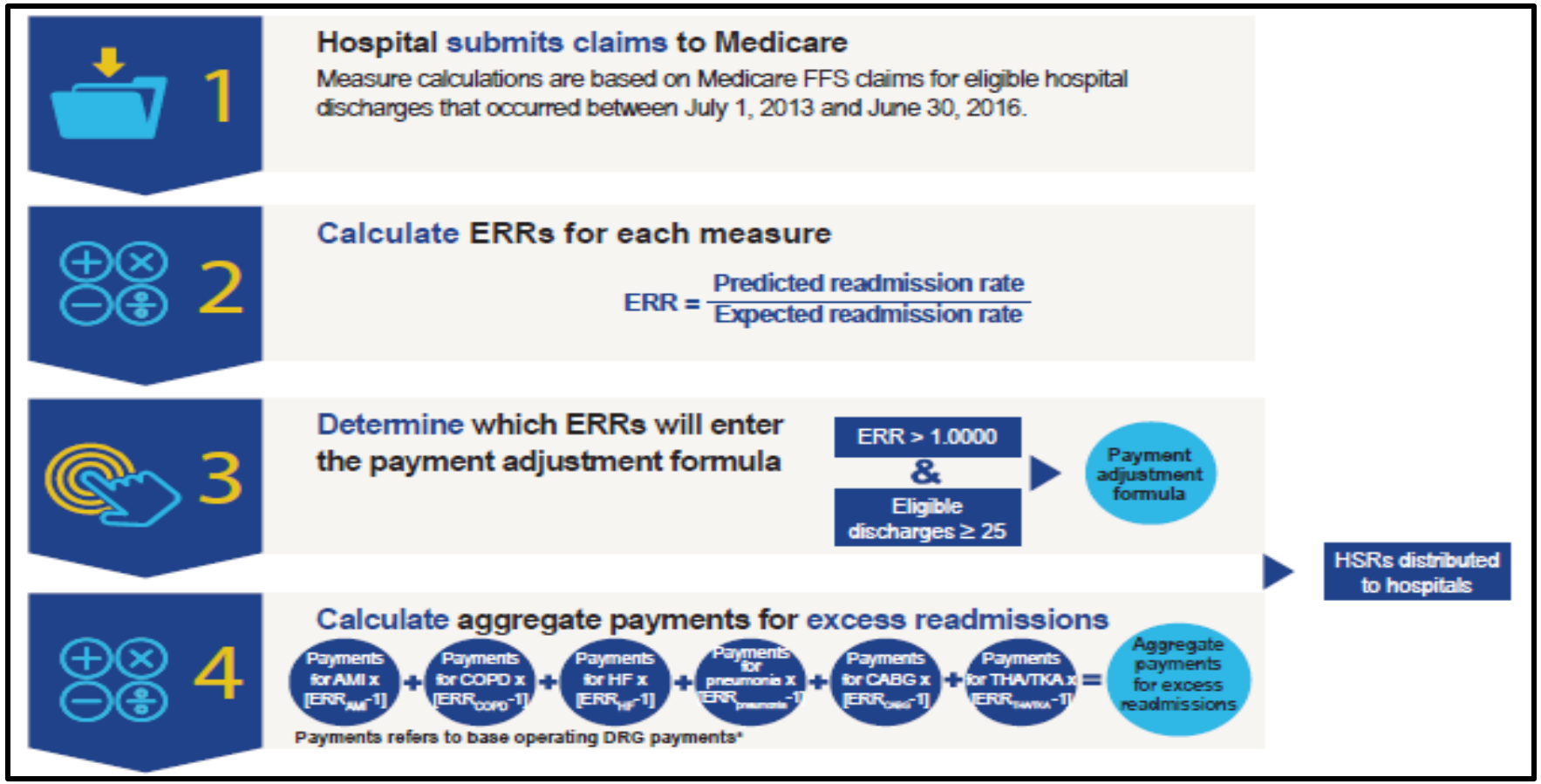
Claims-Based Readmission Measures	NQF Measure Number	FY 2018 Reporting Period
Acute myocardial infarction	NQF #0505	July 1, 2013 - June 30, 2016
Heart failure	NQF #0330	July 1, 2013 - June 30, 2016
Pneumonia	NQF #0506	July 1, 2013 - June 30, 2016
Chronic obstructive pulmonary disease	NQF #1891	July 1, 2013 - June 30, 2016
Elective primary total hip arthroplasty and/or total knee arthroplasty	NQF #1551	July 1, 2013 - June 30, 2016
Coronary artery bypass graft surgery	NQF #2515	July 1, 2013 - June 30, 2016

Discharge diagnoses for each applicable condition are based on a list of specific ICD-9-CM or ICD-10-CM and ICD-10-PCS code sets.

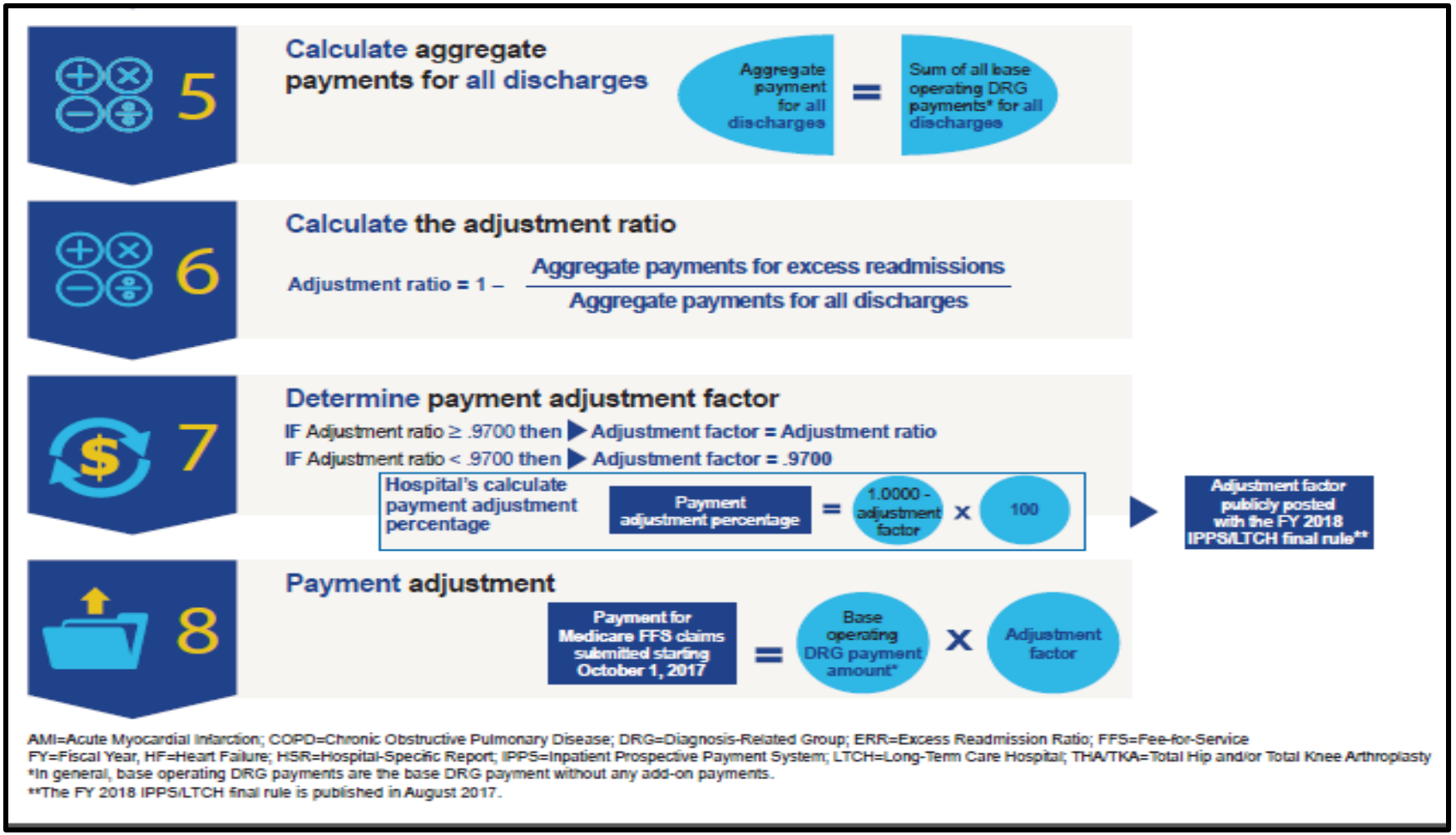
HRRP FY 2018 Payment Methodology



HRRP FY 2018 Payment Methodology



HRRP FY 2018 Payment Methodology



AMI=Acute Myocardial Infarction; COPD=Chronic Obstructive Pulmonary Disease; DRG=Diagnosis-Related Group; ERR=Excess Readmission Ratio; FFS=Fee-for-Service FY=Fiscal Year, HF=Heart Failure; HSR=Hospital-Specific Report; IPPS=Inpatient Prospective Payment System; LTCH=Long-Term Care Hospital; THA/TKA=Total Hip and/or Total Knee Arthroplasty

*In general, base operating DRG payments are the base DRG payment without any add-on payments.

**The FY 2018 IPPS/LTCH final rule is published in August 2017.

HRRP
FY 2018 IPPS/LTCH PPS Final Rule: HRRP Supplemental Data File

- Payment adjustment factors
- Number of cases and ERRs for the six conditions (heart failure, pneumonia, acute myocardial infarction, chronic obstructive pulmonary disease, total hip/total knee arthroplasty, and coronary artery bypass grafting) used to calculate the payment adjustment factors
- Number of cases for each of the applicable conditions excluded in the calculation of the readmission payment adjustment factors
- Medicare Severity (MS) DRG case-mix information to estimate the payment adjustment factors
- FY2018 IPPS Final Rule: Hospital Readmissions Reduction Program Supplemental Data File

HRRP
21st Century Cures Act Provisions for HRRP

The 21st Century Cures Act statute and finalized policy provision to assess performance relative to other hospitals with a similar proportion of dual-eligible patients will not be implemented until FY 2019 payment.

HRRP Resources

General program information

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

HRRP general inquiries

- qnetsupport@hcqis.org

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

Hospital-Acquired Condition (HAC) Reduction Program

Elizabeth Bainger, DNP, RN, CPHQ
Program Lead, HAC Reduction Program
QMVIG, CCSQ, CMS

HAC Reduction Program Background

- HAC Reduction Program was established to incentivize hospitals to reduce the number of HACs.
- HACs include patient safety events and healthcare-associated infections.
- The program was mandated by section 3008 of the 2010 ACA. CMS started applying payment adjustments with FY 2015 discharges (beginning October 1, 2014).

HAC Reduction Program Measures

Measure	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Recalibrated PSI 90 Composite: Patient Safety for Selected Indicators	√	√	√		
Modified Recalibrated PSI 90 Composite: Patient Safety and Adverse Events Composite				√	√
Central Line-Associated Bloodstream Infection (CLABSI)	√	√	√	√	√
Catheter-Associated Urinary Tract Infection (CAUTI)	√	√	√	√	√
Surgical Site Infection (Abdominal Hysterectomy and Colon Procedures) (SSI)		√	√	√	√
Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia			√	√	√
Clostridium difficile Infection (CDI)			√	√	√

HAC Reduction Program Performance Periods and Domain Weights

Fiscal Year	Measures Included	Performance Period	Domain Weighting
FY 2018	**Domain 1:** Modified Recalibrated PSI 90 Composite **Domain 2:** CDC NHSN Measures (CLABSI, CAUTI, SSI, MRSA, CDI)	**Domain 1:** 7/1/2014–9/30/2015* **Domain 2:** 1/1/2015–12/31/2016 * Shortened period	**Domain 1:** 15% **Domain 2:** 85% If a hospital has only one domain score, CMS applies a weight of 100% to that domain.
FY 2019	**Domain 1:** Modified Recalibrated PSI 90 Composite **Domain 2:** CDC NHSN Measures (CLABSI, CAUTI, SSI, MRSA, CDI)	**Domain 1:** 10/1/2015–6/30/2017* **Domain 2:** 1/1/2016–12/31/2017 *Shortened period	**Domain 1:** 15% **Domain 2:** 85% If a hospital has only one domain score, CMS applies a weight of 100% to that domain.

HAC Reduction Program Review and Corrections Period

- CMS distributes HAC Reduction Program Hospital-Specific Reports (HSRs) via the *QualityNet Secure Portal.*
- Hospitals have 30 days to review their results and submit correction requests to CMS.
- Hospitals may review and request recalculation of the following calculations:
  - Recalibrated PSI 90 Composite measure results and measure scores
  - CDC NHSN measure scores
  - Domain 1 and Domain 2 scores
  - Total HAC scores
- If CMS confirms a calculation error, CMS will issue an updated HSR with corrected results.

HAC Reduction Program
Reviewing the Recalibrated PSI 90 Composite

- CMS does not accept additional corrections to the underlying claims data for the Recalibrated PSI 90 Composite or new claims to the data extract.
- A hospital's results will only reflect edits that comply with the time limits in the Medicare Claims Processing Manual. The deadline for FY 2018 was September 30, 2016.
- If a hospital submits a corrected claim after the September 30, 2016 deadline, the hospital's HSR results will not include the corrected claim data.

HAC Reduction Program
Reviewing the NHSN CDC Measures

- CDC calculates the CLABSI, CAUTI, SSI, MRSA, and CDI HAI measures using chart-abstracted data submitted by hospitals via NHSN.
- Under the Hospital IQR Program, hospitals can submit, review, and correct the chart-abstracted information CMS used to calculate the CLABSI, CAUTI, SSI, MRSA, and CDI HAI measures.
- CMS does not receive or use data entered into NHSN after the submission deadline.

HAC Reduction Program FY 2018 Payment Adjustments

- Worst-performing 25 percent of all subsection (d) hospitals will receive a 1.0 percent payment adjustment of what could have been otherwise paid.
- Reduction applies to all Medicare discharges and occurs when CMS pays hospital claims.

HAC Reduction Program
FY 2018 Payment Adjustments

CMS applies payment adjustments in the following order:

- Disproportionate share hospital (DSH) and indirect medical education (IME)
- Hospital VBP Program payment adjustment
- HRRP payment adjustment
- HAC Reduction Program payment reduction

Example:

If both the Hospital VBP and HRRP payment adjustments are based on a $1,000,000 base operating DRG payment amount (e.g., if the hospital has a 2 percent reduction for Hospital VBP and a 2 percent reduction for HRRP), then the net would be $960,000. If the hospital is also subject to the HAC Reduction Program adjustment, then CMS bases the 1 percent reduction on the $960,000.

HAC Reduction Program
Public Reporting and Payment Penalty File

- *Hospital Compare* and the payment penalty file include payment indicators specifying whether the HAC Reduction Program penalty applies.
- CMS publishes the *Hospital Compare* file at https://www.medicare.gov/hospitalcompare/HAC-reduction-program.html.
- Payment penalty file posted on CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html.

HAC Reduction Program Resources

HAC Reduction Program general information on *QualityNet*

- www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166

Fiscal Year 2017 IPPS/LTCH PPS Final Rule

- https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf

HAC Reduction Program scoring methodology reevaluation Technical Expert Panel (TEP) materials

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/TechnicalExpertPanels.html#6

HAC Reduction Program review and corrections overview

- https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228774298670

Rebaseline resources

- http://www.cdc.gov/nhsn/2015rebaseline/index.html

Recalibrated PSI 90 resources

- http://www.qualityindicators.ahrq.gov/News/PSI90_Factsheet_FAQ.pdf

Stakeholder questions

- Email hacrp@lantanagroup.com or via the Hospital Inpatient Q&A Tool at https://cms-ip.custhelp.com/

Inpatient Hospital Quality Programs

Bethany Wheeler-Bunch, MSHA
Project Lead, Hospital VBP Program
Hospital Inpatient VIQR Outreach and Education SC

Summary of Payments

Fiscal Year	Hospital IQR Program	EHR Incentive Program	Hospital VBP Program	HAC Reduction Program	HRRP
2013	2.0 Percentage Point Reduction to MBU	N/A	1.00% withhold to base-operating DRG Payment Amount	N/A	1.00% maximum reduction to base-operating DRG Payment Amount
2014	2.0 Percentage Point Reduction to MBU	N/A	1.25% withhold to base-operating DRG Payment Amount	N/A	2.00% maximum reduction to base-operating DRG Payment Amount
2015	¼ reduction to the applicable MBU	¼ reduction to the applicable MBU	1.50% withhold to base-operating DRG Payment Amount	1.00% reduction to base-operating DRG payment amount and add-on payments	3.00% maximum reduction to base-operating DRG Payment Amount
2016	¼ reduction to the applicable MBU	½ reduction to the applicable MBU	1.75% withhold to base-operating DRG Payment Amount	1.00% reduction to base-operating DRG payment amount and add-on payments	3.00% maximum reduction to base-operating DRG Payment Amount
2017	¼ reduction to the applicable MBU	¾ reduction to the applicable MBU	2.00% withhold to base-operating DRG Payment Amount	1.00% reduction to base-operating DRG payment amount and add-on payments	3.00% maximum reduction to base-operating DRG Payment Amount
2018	¼ reduction to the applicable MBU	¾ reduction to the applicable MBU	2.00% withhold to base-operating DRG Payment Amount	1.00% reduction to base-operating DRG payment amount and add-on payments	3.00% maximum reduction to base-operating DRG Payment Amount

Medicare Administrative Contractors (MACs)

Q: I have a question regarding my hospital's payment from one of CMS's inpatient quality programs. Whom should I ask?

A: For payment-related questions, we recommend contacting your Medicare Administrative Contractor (MAC).

- A MAC is a private healthcare insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries. CMS relies on a network of MACs to serve as the primary operational contact between the Medicare FFS program and the healthcare providers enrolled in the program.
- Who are the MACs?
  - https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs.html

Inpatient Hospital Quality Programs: Payment Updates and Overview

Question & Answer Session

Continuing Education Approval

This program has been approved for 1.5 continuing education (CE) units for the following professional boards:

- **National**
  - Board of Registered Nursing (Provider #16578)
- **Florida**
  - Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling
  - Board of Nursing Home Administrators
  - Board of Dietetics and Nutrition Practice Council
  - Board of Pharmacy

Please Note: To verify CE approval for any other state, license or certification, please check with your licensing or certification board.

CE Credit Process

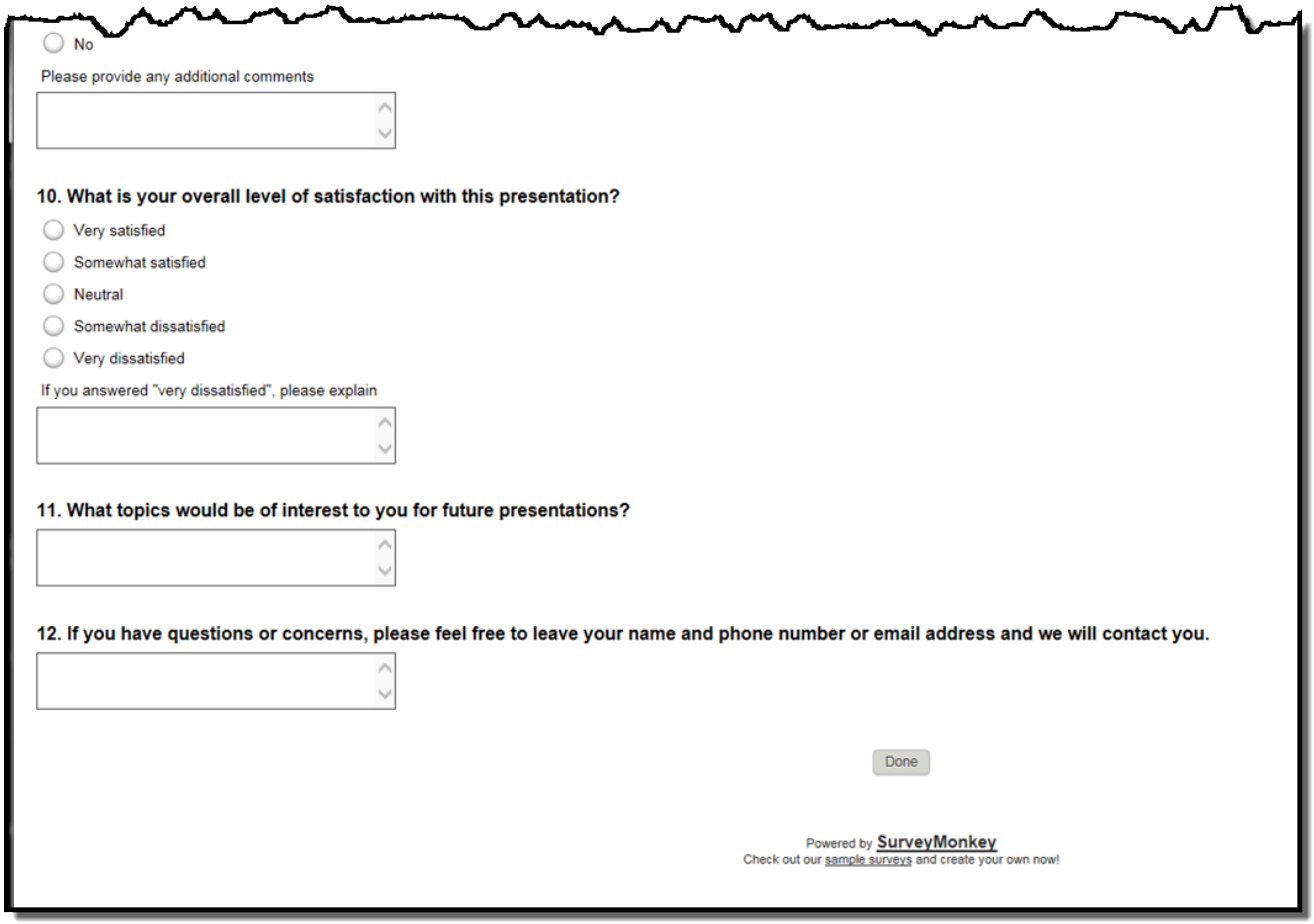
- Complete the ReadyTalk® survey that will pop up after the webinar, or wait for the survey that will be sent to all registrants within the next 48 hours.
- After completion of the survey, click “Done” at the bottom of the screen.
- Another page will open that asks you to register in the HSAG Learning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

CE Certificate Problems

- If you do not **immediately** 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 was sent.

- Please go back to the **New User** link and register your personal email account.
  - Personal emails do not have firewalls.

CE Credit Process: Survey



No

Please provide any additional comments

10. What is your overall level of satisfaction with this presentation?

- Very satisfied
- Somewhat satisfied
- Neutral
- Somewhat dissatisfied
- Very dissatisfied

If you answered "very dissatisfied", please explain

11. What topics would be of interest to you for future presentations?

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.

Done

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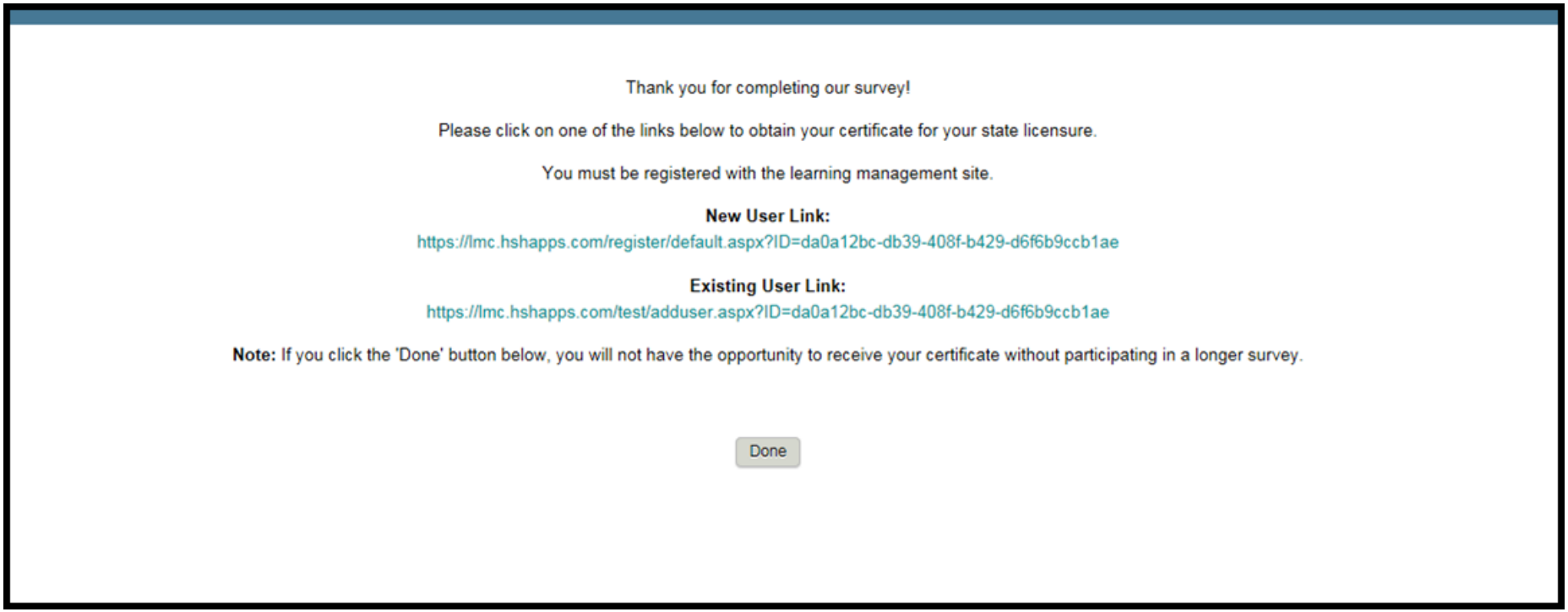
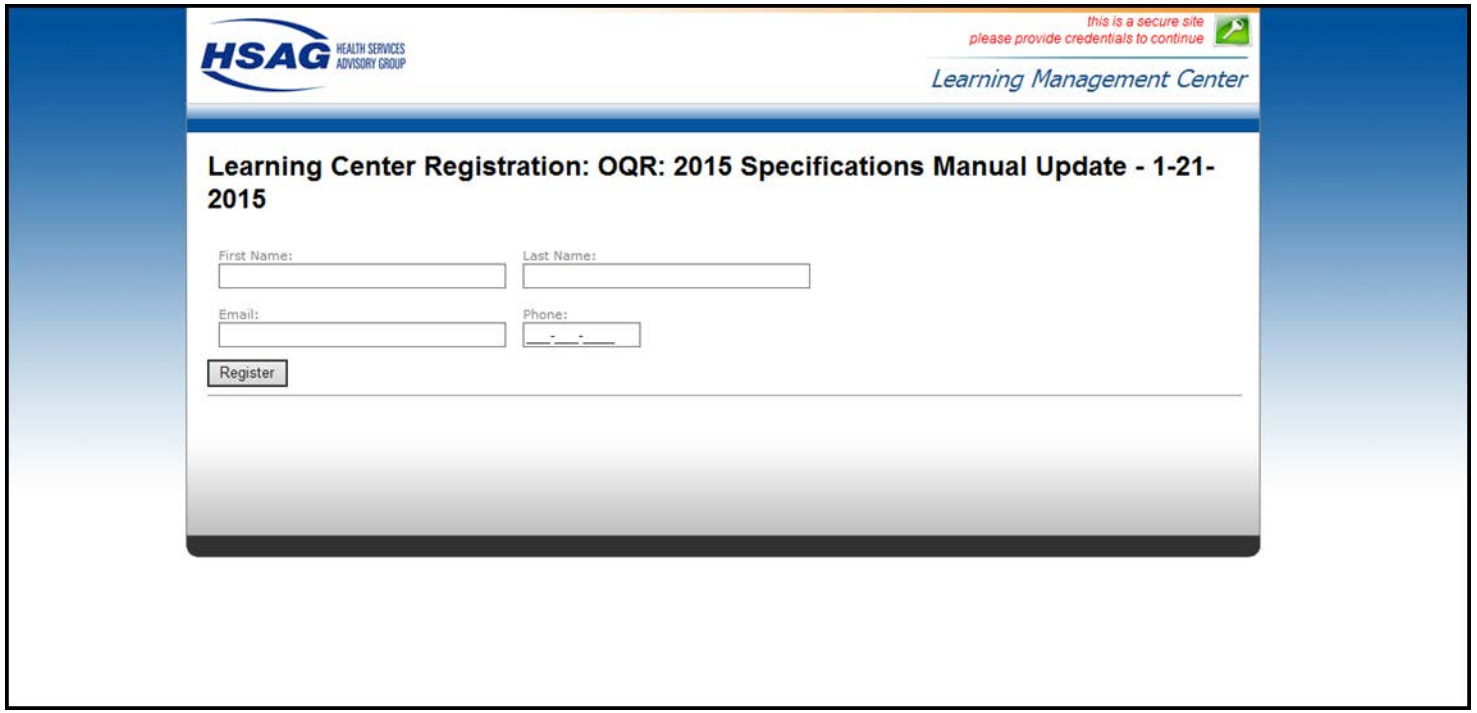
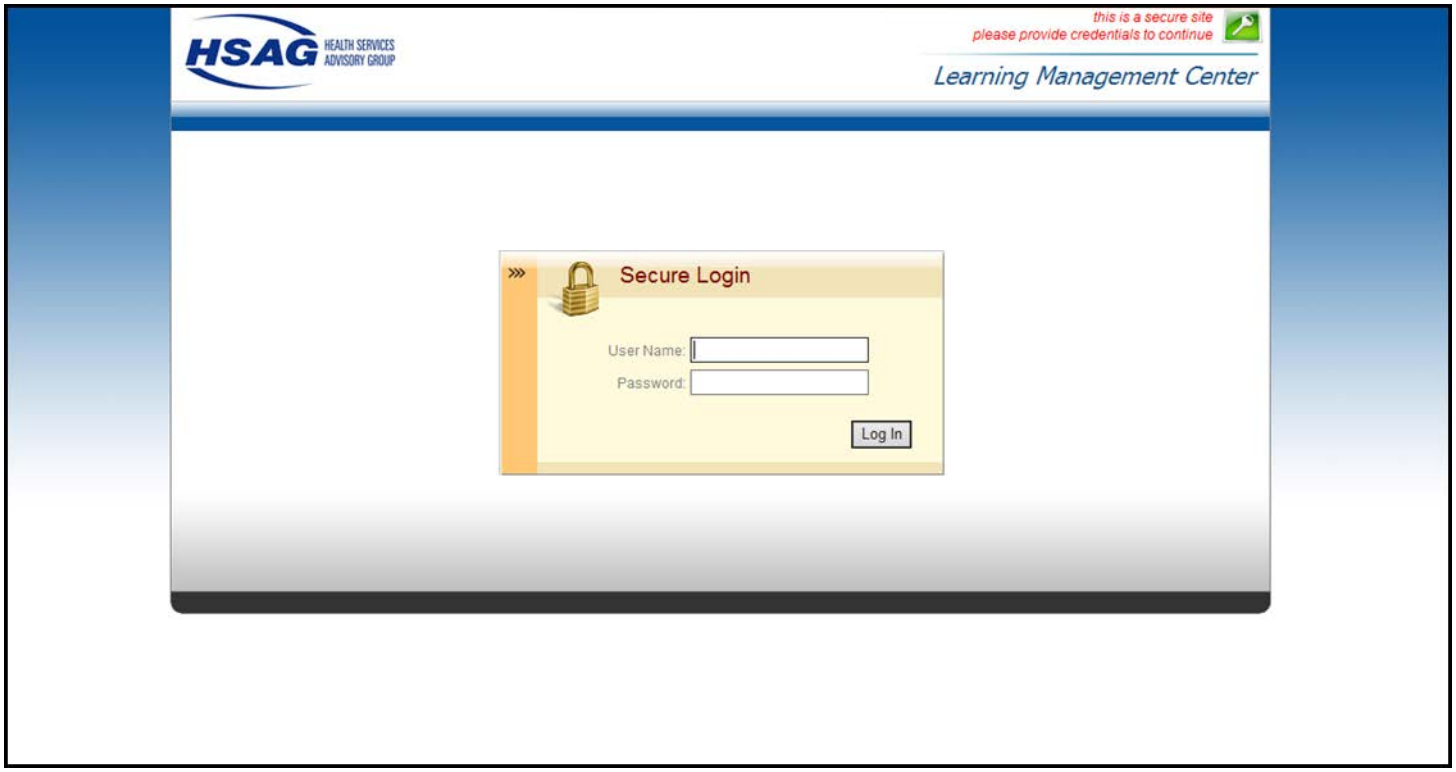
CE Credit Process: Certificate



CE Credit Process: New User



CE Credit Process: Existing User



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