



# 2015 Hospital IPPS Final Rule



## **Center for Clinical Standards and Quality**

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# Purpose

Provide participants with an overview of the Fiscal Year (FY) 2015 Inpatient Prospective Payment System (IPPS) CMS quality program Final Rule changes for:

- PPS-Exempt Cancer Hospital Quality Reporting (PCH)
- Hospital Inpatient Quality Reporting (IQR) Program
- Alignment of the Hospital IQR Program and Electronic Health Record (EHR) Incentive Program
- Hospital Value-Based Purchasing (VBP)

# Objectives

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

- Find the Fiscal Year (FY) 2015 Final Rule text
  - Currently on display at:  
<http://federalregister.gov/a/2014-18545>
- Identify changes within the FY 2015 Final Rule



# PPS-Exempt Cancer Hospital Quality Reporting Program Policy Updates

*Barbara Choo, RN, FNP, PhD*

Program Lead of PCHQR

Center for Clinical Standards and Quality, CMS

# PPS-Exempt Cancer Hospital Quality Reporting: Policy Updates

## Program requirements:

- Add one measure – the External Beam Radiotherapy (EBRT) for Bone Metastases Measure for the fiscal year 2017 and subsequent years,
- EBRT sampling, and
- Public reporting:
  - One cancer-specific treatment (Adjuvant Hormonal Therapy) measure in 2015 and
  - CLABSI and CAUTI no later than 2017.

# PPS-Exempt Cancer Hospital Quality Reporting: Policy Updates

## Data submission

Measure	Data Submission Mode
Surgical Care Improvement Project (SCIP)	1) Authorized vendor submits an external data file or 2) <b>Leverage current infrastructure via QualityNet</b>
Cancer-Specific Treatment	1) <b>Authorized vendor submits an external data file or</b> 2) CMS contractor
Oncology Care Measures (OCM)	1) Authorized vendor submits an external data file or 2) CMS web-based tool
External Beam Radiotherapy (EBRT)	1) <b>Authorized vendor submits an external data file or</b> 2) <b>CMS web-based tool</b>
CLABSI, CAUTI, SSI	1) Authorized vendor submits an external data file
HCAHPS	1) Authorized vendor submits an external data file

For additional information, please contact FMQAI/HSAG Support Contractor: Henrietta Hight at [Henrietta.Hight@HCQIS.org](mailto:Henrietta.Hight@HCQIS.org).



# Summary: 19 PCHQR Measures & Program Requirements

## SCIP (6)

- Surgery Patients who Received Appropriate VTE Prophylaxis within 24 Hrs Prior to Surgery to 24 Hrs After Surgery End Time
- Urinary Catheter Removed on Post-Operative Day 1 or Post-Operative Day 2 with Day of Surgery Being Day Zero
- Prophylactic Antibiotic Received Within 1 Hr Prior to Surgical Incision
- Prophylactic Antibiotic Selection for Surgical Patients
- Prophylactic Antibiotics Discontinued Within 24 Hrs After Surgery End Time
- Surgery Patients on Beta Blocker Therapy Prior to Admission who Received a Beta Blocker During the Perioperative Period

❖ Program requirement: Sampling

## Oncology Care Measures (5)

- Oncology-Radiation Dose Limits to Normal Tissues
- Oncology: Plan of Care for Pain
- Oncology: Pain Intensity Quantified
- Prostate Cancer-Adjuvant Hormonal Therapy for High-Risk Patients
- Prostate Cancer-Avoidance of Overuse Measure-Bone Scan for Staging Low-Risk Patients
- EBRT for Bone Metastases

❖ Program requirement: Sampling

## Patient Engagement / Experience of Care (1)

- NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure
- NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure
- Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure

## Cancer-specific Treatment (3)

- Adjuvant Chemotherapy is Considered/Administered Within 4 Months of Diagnosis to Patients Under the Age of 80 with AJCC III (lymph node positive) Colon Cancer
- Combination Chemotherapy is Considered/Administered Within 4 Months of Diagnosis for Women Under 70 with AJCC T1c, or Stage II or III Hormone Receptor Negative Breast Cancer
- Adjuvant Hormonal Therapy

## Patient Engagement / Experience of Care (1)

- HCAHPS

❖ Program requirement: Sampling

## Clinical Effectiveness Measure (1)

- External Beam Radiotherapy for Bone Metastases

❖ Program requirement: Sampling



# Hospital IQR Program Policy Update

*Sharon McNeill, RN, MS, CHTS*

Program Lead of Hospital IQR

Center for Clinical Standards and Quality, CMS



# Hospital IQR Program

## New Measures (slide 1 of 2)

### FY 2017

- **Claims-Based**

- Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following CABG surgery
- Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following CABG surgery
- Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia
- Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure

# Hospital IQR Program

## New Measures (slide 2 of 2)

**FY 2017**

- **Chart-Abstracted**
  - Severe sepsis and septic shock: management bundle\*

\*Note: Communication sent Friday 8/22/14 suspends collection of this data until further notice.

# Topped-Out Measures

## Acute Myocardial Infarction (AMI)

- AMI-1:** Aspirin at arrival
- AMI-3:** ACEI or ARB for left ventricular systolic dysfunction
- AMI-5:** Beta-Blocker at Discharge
- AMI-8a:** Primary PCI received within 90 min of hospital arrival

## Heart Failure (HF)

- HF-2:** Evaluation of left ventricular systolic function

## Pneumonia (PN)

- PN-6:** Initial antibiotic selection for community-acquired pneumonia in immunocompetent patients

## Surgical Care Improvement Project (SCIP)

- SCIP-Card-2:** Surgery patients on beta blocker therapy prior to arrival who received a beta blocker during the perioperative period
- SCIP-INF-1:** Prophylactic antibiotic received within 1 hour prior to surgical incision
- SCIP-INF-2:** Prophylactic antibiotic selection for surgical patients
- SCIP-INF-3:** Prophylactic antibiotics discontinued within 24 hours after surgery end time
- SCIP-INF-6:** Surgery patients with appropriate hair removal
- SCIP-INF-9:** Urinary catheter removed on postoperative day 1 or postoperative day 2 with day of surgery being day zero
- SCIP-VTE-2:** Surgery Patients Who Received Appropriate Venous Thromboembolism (VTE) Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery

## Stroke (STK)

- STK-2:** Discharged on anti-thrombotic therapy
- STK-3:** Anticoagulation therapy for atrial fibrillation/flutter
- STK-5:** Antithrombotic therapy by end of hospital day 2
- STK-10:** Assessed for rehabilitation

## Venous Thromboembolism (VTE)

- VTE-4:** VTE patients receiving unfractionated Heparin with doses/labs monitored by protocol

## Structural Measure

- Participation in a systematic database for cardiac surgery (NQF #0113)

# Clarification Regarding Influenza Vaccination for Healthcare Personnel

- CMS received public comments regarding the burden of separately collecting and reporting healthcare personnel influenza immunization statuses for both the inpatient and outpatient settings
- Hospitals will report single HCP influenza count for each healthcare facility enrolled in NHSN by facility Org ID

# Change to Claims-based Measures

## FY 2017

- **Finalized using 3 years of data to calculate current and future condition-specific, claims-based measures:**
  - Mortality Measures (AMI, HF, PN, Stroke, COPD)
  - Readmission Measures (AMI, HF, PN, Total Hip/Knee, Stroke, COPD)
  - Hip/Knee Complication Measure



# Hospital IQR Program Validation Policy Update

*Nancy Sonnenfeld, PhD*

Validation Lead, Hospital Inpatient Quality  
Reporting Program

Center for Clinical Standards and Quality, CMS

# Submission of HAI Measure Data

## Clarify data reporting and submission requirements

- Hospitals report patient-level data elements “required” for NHSN
- Required data shared with CMS for Hospital IQR Program and Hospital VBP Program

## Receive access to voluntarily submitted name and race identifying information

- Use to match patient charts to NHSN
- Use for Program evaluation

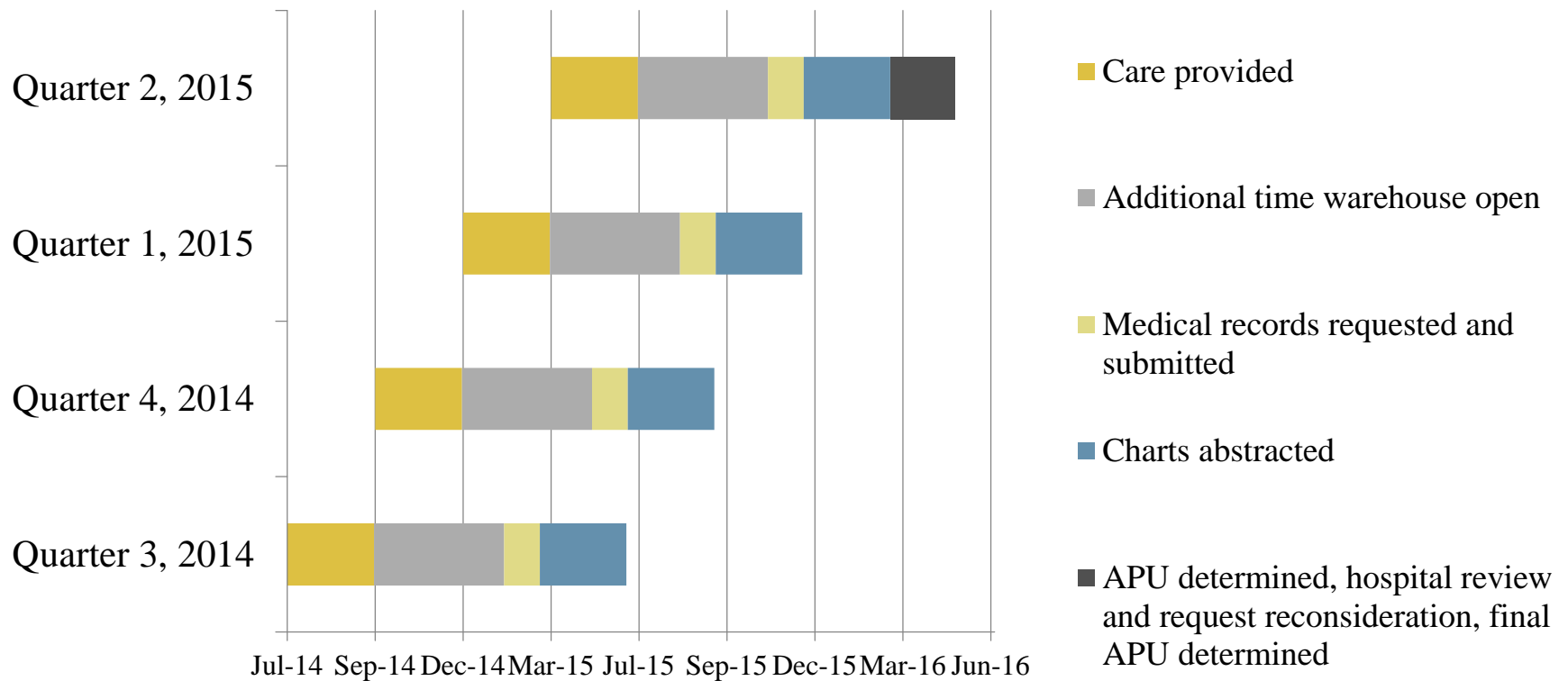
# Hospital IQR Program Validation of Chart-Abstracted Records Overview (slide 1 of 2)

- CMS selects hospitals for validation
  - 400 random
  - Up to 200 targeted
- CMS selects a subset of patient medical charts to be validated from:
  - Clinical data warehouse for process of care
  - Validation templates for healthcare associated infection (HAI)
- Clinical data abstraction contractor (CDAC) requests medical records in writing
- Hospitals submit requested medical records within 30 days
- CDAC conducts validation
- CMS makes APU determination (75% reliability required)



# Hospital IQR Program Validation of Chart-Abstracted Records Overview (slide 2 of 2)

## FY 2017 Payment Determination



# Validation Process:

## Validation-Eligible Hospital Definition

- **For FY 2017 payment determination (and future years):**
  - Change definition of validation-eligible hospitals
- **What this means for hospitals:**
  - Hospitals can expect to be notified of selection for random sample 2 – 3 months earlier than in previous year.

# Validation Process: Number of Charts to Submit

- **FY 2017 Payment Determination (and future years)**
- **Submit a total of 72 charts (reduced from 96) per year**
- **18 charts submitted for validation each quarter:**
  - 10 charts for Healthcare Associated Infection (HAI) measures (1 more per quarter)
  - 8 charts for clinical process of care measures (7 fewer per quarter )

# Validation Process: Clinical Process of Care Case Sample

- Fundamental design change: No longer sample separately each quarter for each topic area
- For FY2017 payment determination and future years
  - Immunization (IMM)
  - “All other”

Note: “Other” category includes all topic areas containing required measures aside from those in the Immunization and Perinatal care topic areas.

# Validation Process: Clinical Process of Care Case Sample

- **FY2017 payment determination and future years**
- **8 total per quarter, 32 per year**
  - Quarters 4 and 1: Randomly select 5 cases for Immunization (IMM) and 3 cases from the “other” category
  - Quarters 2 and 3: Randomly select 8 cases from “other” category

# Validation Process: Changes to Weighting

- Weighting to Combine Scores for Confidence Interval calculation

Measure Sets	Weight
HAI	66.7%
IMM	22.2%
Other	11.1%
Total	100%

# Validation Process: Submitting Medical Records

**Expand options for secure transmission of electronic versions of patient medical records.  
Hospitals may submit records:**

- In paper format
- As digital images (PDFs) on portable media such as CD-ROMs, DVDs, and flash drives
- Using a Secure File Transfer Portal on the QualityNet Web site

# Validation Process: Plan to Validate eCQM Data

- Three Key threat categories to data accuracy:
  1. EHR product design (vendor specifications and hospital customization)
  2. Hospital and provider documentation practice
  3. EHR and eCQM standards and specifications
- Plans for pilot test of up to 100 volunteer hospitals:
  - Must meet EHR Incentive Program Stage 2 criteria
  - Able to produce QRDA-1 Revision 2 extracted data for at least 6 of the 16 measures in STK, VTE, ED, and PC measure sets



# Validation Process:

## Goals of eCQM Validation Pilot

### Goals of 100 hospital pilot

- Assess accuracy of eCQM data
- Assess Hospital IQR Program readiness for eCQM reporting
- Identify needs for updates to measure specifications
- Plan future validation requirements

# Validation Process: Overview eCQM Validation Pilot (slide 1 of 2)

*Highly interactive*

## **Hospitals will:**

- Allow CDAC to view records remotely real-time
- Navigate through the EHR system for selected records

## **Hospitals will also:**

- Generate patient lists
- Generate QRDA Category 1 files

## **CDAC will:**

- Abstract data from up to 10 different sources for elements specified in eCQM
- Abstract data following chart-abstracted manual specifications
- Compare abstracted data from 10 different sources with both the chart-abstracted manual process and with QRDA file data
- Assess and refine operational processes



# Validation Process: Overview eCQM

## Validation ilot (slide 2 of 2)

### **CMS and its contractors will:**

- Determine reliability between extracted and abstracted measures
- Work with measure stewards to refine specifications
- Share conflicting findings with hospitals
- Publicize common patterns of conflicting findings
- Produce statistics to estimate sample size
- Reimburse hospitals for burden



# EHR Incentive and Hospital IQR Program Updates

*Cindy Tourison, MSHI*

Program Lead, Alignment of Hospital IQR Program &  
Value-Based Purchasing Program  
Center for Clinical Standards and Quality, CMS

# Timelines: EHR Incentive Program and Hospital IQR Program

- Align reporting and submission periods for clinical quality measures
  - Medicare EHR Incentive Program: Fiscal year
  - Hospital IQR Program: Calendar year
- Final: **Calendar year**
- File Submission Deadline: **November 30, 2015**

# 28 EHR Incentive Program eCQM Measures (1 of 3)

## Acute Myocardial Infarction (AMI)

- AMI-2-Aspirin prescribed at discharge
- AMI-7a- Fibrinolytic therapy received within 30 minutes of hospital arrival
- AMI-8a- Primary PCI received within 90 minutes of hospital arrival
- AMI-10- Statin prescribed at discharge

## Emergency Department (ED)

- ED-1- Median time from ED arrival departure for admitted ED patients
- ED-2- Admit decision time to ED departure time for admitted patients

## Pneumonia (PN)

- PN-6- Initial antibiotic selection for community-acquired pneumonia in immunocompetent patients

# 28 EHR Incentive Program eCQM Measures (2 of 3)

## Perinatal Care (PC) + Healthy Term Newborn (HTN)

- PC-01- Effective delivery prior to 39 completed weeks gestation
- PC-05- Exclusive breast milk feeding
- HTN- Healthy Term Newborn

## Stroke (STK)

- STK-2- Discharged on anti-thrombotic therapy
- STK-3- Anticoagulation therapy for atrial fibrillation/flutter
- STK-4- Thrombolytic therapy
- STK-5- Antithrombotic therapy by end of hospital day 2
- STK-6- Discharged on statin medication
- STK-8- Stroke education
- STK-10- Assessed for rehabilitation

## Venous Thromboembolism (VTE)

- VTE-1-VTE prophylaxis
- VTE-2- Intensive Care Unit VTE prophylaxis
- VTE-3- VTE patients with anticoagulation overlap therapy
- VTE-4- VTE patients receiving unfractionated Heparin with dosages/platelet count monitoring by protocol (or normogram)
- VTE-5- VTE discharge instructions
- VTE-6- Incidence of potentially preventable VTE

# 28 EHR Incentive Program eCQM Measures (3 of 3)

## Surgical Care Improvement Project (SCIP)

- SCIP-INF-1a- Prophylactic antibiotic received within 1 hour prior to surgical incision
- SCIP-INF-2a- Prophylactic antibiotic selection for surgical patients
- SCIP-INF-9- Urinary catheter removed on postoperative day 1 or postoperative day 2 with day of surgery being day zero

## Hearing Screening (EHDI)

- EHDI-1a- Hearing screening before hospital discharge

## Home Management Plan of Care (CAC)

- CAC-3- HMPC document given to patient/caregiver



# Hospital IQR and Voluntary eCQM Data Submission Alignment

## **FY 2017 Payment Determination:**

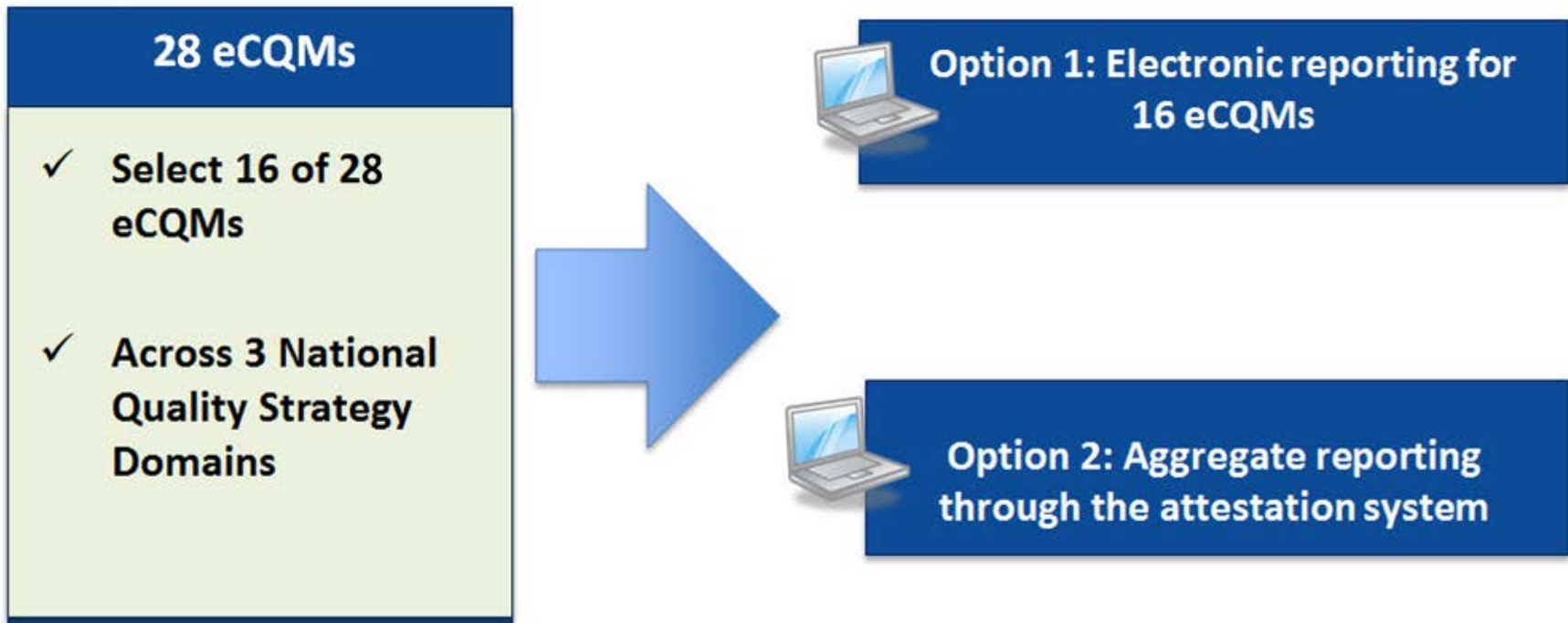
- Electronically report any 16 of the 28 Hospital IQR eCQMs that align with the Medicare EHR incentive program and span 3 different **National Quality Strategy (NQS)** domains
- There are 12 measures which are required under IQR that are available as chart-abstracted or eCQMs.

# 12 Required IQR Measures

(electronic submission or chart-abstraction)

AMI -7a	VTE -3
STK-4	VTE-5
STK-6	VTE-6
STK-8	ED-1
VTE-1	ED-2
VTE-2	PC-01

# Meaningful Use eCQM Submission Options



# Submission Scenario 1 (Slide 1 of 2)

## Select 16 CQMs which fulfill 3 National Quality Strategy Domains

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

### Legend: National Quality Strategy Domains

**Orange** = Population and Public Health

**Yellow** = Clinical Process/Effectiveness

**Red** = Efficient Use of Healthcare Resources

**Blue** = Care Coordination

**Green** = Patient and Family Engagement

**Pink** = Patient Safety

# Submission Scenario 1 (Slide 2 of 2)

Example of how the following 16 CQMs fulfill at least 3 of the 6 National Quality Strategy Domains

## Care Coordination

## Clinical Process/Effectiveness

## Efficient Use of Healthcare Resources

STK-2    STK-3  
STK-4    PC-01  
AMI-7a    AMI-2  
AMI-8    AMI-10

SCIP-Inf-2a  
PN-6

## Patient and Family Engagement

ED-1  
ED-2  
VTE-5

## Patient Safety

VTE-6  
SCIP-Inf-1a  
SCIP-Inf-9

## Population and Public Health

# Voluntary eCQM Data Submission Requirements

## **FY 2017 Payment Determination:**

- Report names of hospitals who successfully submit Q1, Q2, or Q3 electronic data
  - November 30, 2015
  - Symbol on Hospital Compare
  - Not publicly reporting actual data at this time;
  - Not include a preview period; and
  - Not provide hospitals an option to suppress their participation

# EHR Incentive and Hospital IQR Program Alignment Reporting Timeline

## CY 2015/FY2017 Electronic Clinical Quality Measures Data Reporting Periods and Finalized Submission Deadlines

CY 2015 Quarter	Reporting Period (2015)	Finalized Submission Deadlines
1	January 1 - March 31	November 30, 2015
2	April 1 - June 30	November 30, 2015
3	July 1 - September 30	November 30, 2015

# Medicare EHR Incentive Program

## Submission Options

- Finalized: Two options to submit CQMs for the EHR Incentive Program Stage 2
  - Option 1: QRDA-I:
    - Electronically submit patient-level data using QRDA-1 reporting
    - CY Q1, CY Q2, or CY Q3
  - Option 2: Aggregate:
    - Report aggregate CQM results **through the CMS Registration and Attestation System**
    - Submit one full year (not quarter) CQM data (October 1, 2014 – September 30, 2015)
    - Medicare EHR Incentive Program only

Please Note: QRDA-III, not feasible to collect in 2015 for eligible hospitals and CAHs under the Medicare EHR Program



# Electronically Specified Clinical Quality Measures (CQMs) Reporting for 2015

- Eligible hospitals and CAHs that seek to report CQMs *electronically* under the Medicare EHR Incentive Program **must use** the April 2014 version of the electronic specifications for the CQMs
- \*\*CEHRT that is tested and certified to the most recent version of the electronic specifications for the CQMs
- April 2014 Version of annual update

# EHR Incentive and Hospital IQR Program: Zero Denominator Declaration Clarification

- **Zero denominator can be used when:**
  - The hospital's EHR is certified for an eCQM; and
  - The hospital does not have patients that meet the denominator criteria of that CQM.
- **Submitting a zero denominator**
  - Counts as a successful submission for that eCQM for both EHR Incentive Program and Hospital IQR Program

# EHR Incentive Program Requirement Updates: Changes for 2014 and 2015

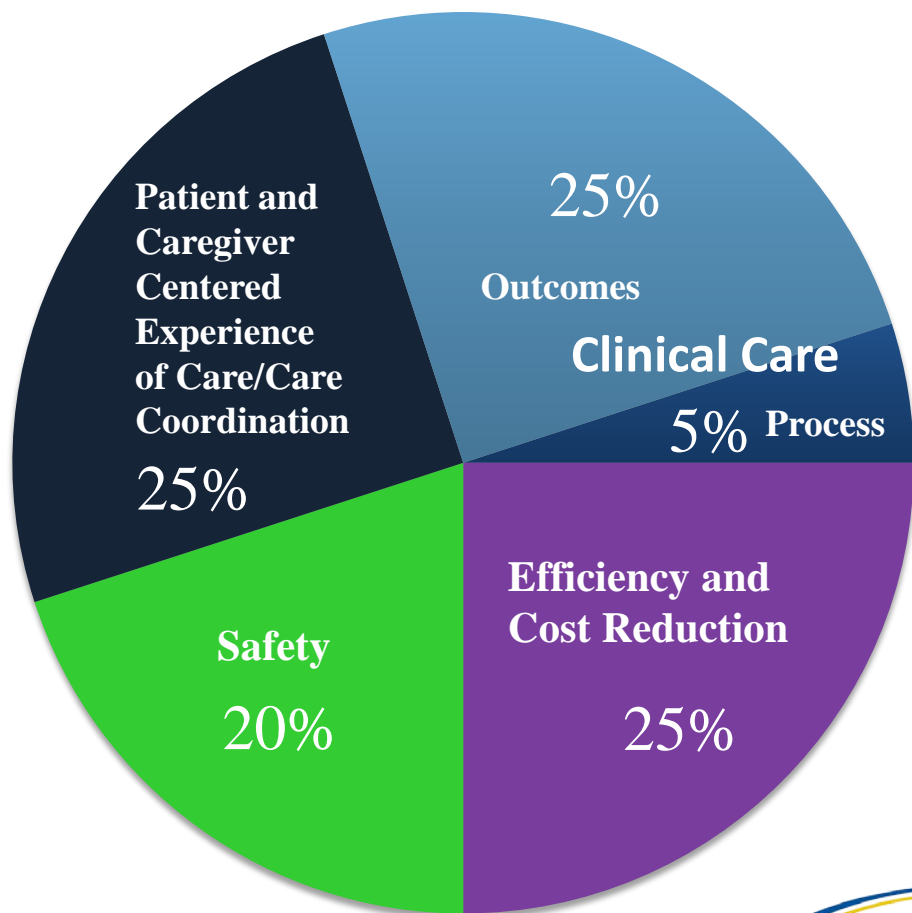
1. Case Threshold Exemption can be used when (EHR Incentive Program):
  - The hospital's EHR system is certified to report data
    - Five or fewer discharges during the relevant EHR reporting period (if attesting to a 90-day EHR reporting period), or
    - Twenty or fewer discharges during the year (if attesting to a full year EHR reporting period) as defined by the CQM's denominator population

# EHR Incentive Program Requirement Updates: Changes for 2014 and 2015 (Cont.)

2. Beginning in 2014 (interim final rule):
  - Eligible hospitals/CAHs would need to qualify for more than 13 CQMs to report fewer than 16 required
  - If the eligible hospital/CAH does not meet criteria:
    - Would be able to report at least 16 CQMs
  - Must choose another CQM to submit data or continue to invoke exemption until it exceeds 13 cases
    - Reporting fewer than 16 CQMs
  
3. Beginning in 2015: threshold exception policy changes:
  - If eligible hospital or CAH qualifies for exemption for CQM
  - Count toward the 16 required CQMs

# Hospital VBP Program: FY 2017 Domain Weights & Measures

## Domain Weights



## Patient and Caregiver Centered Experience of Care/Care Coordination

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

### Clinical Care

#### Outcomes

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

#### Process

AMI-7a  
IMM-2  
PC-01\*

### Efficiency and Cost Reduction

MSPB-1

### Safety

CLABSI  
CAUTI  
SSI: Colon Surgery  
and Abdominal

Hysterectomy  
MRSA\*  
C-difficile\*  
AHRQ PSI-90

# Hospital VBP Program: Added and Removed Measures

- **Measures Added for FY 2017**
  - MRSA Bacteremia (Safety Domain)
  - *C. difficile* infection (Safety Domain)
  - PC-01: Elective Delivery Prior to 39 Completed Weeks Gestation (Clinical Care/Process Domain)
- **Measures Removed in FY 2017**
  - PN-6 (Clinical Process of Care)
  - SCIP-CARD-2 (Clinical Process of Care)
  - SCIP-Inf-2 (Clinical Process of Care)
  - SCIP-Inf-3 (Clinical Process of Care)
  - SCIP-Inf-9 (Clinical Process of Care)
  - SCIP-VTE-2 (Clinical Process of Care)

# Hospital VBP Program: FY 2017 Reporting Periods

Domain	Baseline Period	Performance Period
<b>Safety</b> <ul style="list-style-type: none"> <li>Healthcare Associated Infections</li> <li>AHRQ PSI-90</li> </ul>	1/1/2013 – 12/31/2013 10/1/2010 – 6/30/2012	1/1/2015 – 12/31/2015 10/1/2013 – 6/30/2015
<b>Clinical Care</b> <ul style="list-style-type: none"> <li>Process</li> <li>Outcomes</li> </ul>	1/1/2013 – 12/31/2013 10/1/2010 – 6/30/2012	1/1/2015 – 12/31/2015 10/1/2013 – 6/30/2015
Efficiency and Cost Reduction	1/1/2013 – 12/31/2013	1/1/2015 – 12/31/2015
Patient and Caregiver-Centered Experience of Care/Care Coordination (HCAHPS)	1/1/2013 – 12/31/2013	1/1/2015 – 12/31/2015

# Hospital VBP Program: FY 2017 Performance Standards (1 of 2)

Domain	Measure	Achievement Threshold	Benchmark	Floor
Safety	CAUTI	0.845	0.000	N/A
	CLABSI	0.457	0.000	N/A
	C. difficile	0.750	0.000	N/A
	MRSA Bacteremia	0.799	0.000	N/A
	PSI-90	0.577321	0.397051	N/A
Clinical Care Outcomes	MORT-30-AMI	0.851458	0.871669	N/A
	MORT-30-HF	0.881794	0.903985	N/A
	MORT-30-PN	0.882986	0.908124	N/A
Clinical Care Process	AMI-7a	0.954545	1.000000	N/A
	IMM-2	0.951607	0.997739	N/A
	PC-01	0.031250	0.000000	N/A



# Hospital VBP Program: FY 2017 Performance Standards (2 of 2)

Domain	Measure	Achievement Threshold	Benchmark	Floor
Efficiency and Cost Reduction	MSPB-1	Median Medicare Spending per Beneficiary ratio across all hospitals during the performance period	Mean of the lowest decile Medicare Spending per Beneficiary ratios across all hospitals during the performance period	N/A
Patient and Caregiver-Centered Experience of Care/Care Coordination Domain	Communication with Nurses	78.19	86.61	58.14
	Communication with Doctors	80.51	88.80	63.58
	Responsiveness of Hospital Staff	65.05	80.01	37.29
	Pain Management	70.28	78.33	49.53
	Communication about Medicines	62.88	73.36	41.42
	Hospital Cleanliness & Quietness	65.30	79.39	44.32
	Discharge Information	85.91	91.23	64.09
	Overall Rating of Hospital	70.02	84.60	35.99

# Hospital VBP Program:

## FY 2017 Minimum Requirements (1 of 2)

Domain	Domain Minimum	Measure	Measure Minimum
Safety	3 of 6 Measures	CAUTI	1.000 Predicted Infections
		CLABSI	1.000 Predicted Infections
		C. difficile	1.000 Predicted Infections
		MRSA Bacteremia	1.000 Predicted Infections
		SSI	1.000 Predicted Infections on either Abdominal Hysterectomy or Colon
		PSI-90	3 Cases in Any One Underlying Indicator
Clinical Care Outcome	2 of 3 Measures	MORT-30-AMI	25 Cases
		MORT-30-HF	25 Cases
		MORT-30-PN	25 Cases
Clinical Care Process	1 of 3 Measures	AMI-7a	10 Cases
		IMM-2	10 Cases
		PC-01	10 Cases

# Hospital VBP Program:

## FY 2017 Minimum Requirements (2 of 2)

Domain	Domain Minimum	Measure	Measure Minimum
<b>Efficiency and Cost Reduction</b>	<b>1 of 1 Measure</b>	<b>MSPB-1</b>	<b>25 Episodes of Care</b>
Patient and Caregiver-Centered Experience of Care/Care Coordination Domain	100 Completed Surveys	Communication with Nurses	100 Completed Surveys
		Communication with Doctors	
		Responsiveness of Hospital Staff	
		Pain Management	
		Communication about Medicines	
		Hospital Cleanliness & Quietness	
		Discharge Information	
		Overall Rating of Hospital	

# Hospital VBP Program: Domain Reweighting Changes

- Hospitals must receive domain scores on at least 3 of the 4 quality domains to receive a Total Performance Score (TPS)
- Clinical Care domain – Process or Outcome subdomains considered as one domain
- Only reweight a hospital's TPS once:
  - If a hospital does not have sufficient data for 1 of the 2 Clinical Care subdomains
  - Will not reallocate weighting of the 2 clinical subdomains within the Clinical Care domain
  - The weighting of the subdomain without sufficient data will be proportionately reallocated across all domains



# Questions?

This material was prepared by the Hospital Inpatient Value Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. HHSM-500-2013-13007I, FL-IQR-Ch8-08252014-01

# 2015 Final Rule

Details regarding various quality reporting programs begin on the Final Rule pages noted:

- Hospital Value-Based Purchasing (VBP) Program – p. 822
- Hospital Inpatient Quality Reporting (IQR) Program - p. 1443
- Electronic Health Records (EHRs) – p. 1908
- PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program – p.1745

# CE Credit Process

- Compete the WebEx survey that will automatically pop up at the end of our presentation
- At the end of the survey, click **Done**, and then click **New User** or **Existing User** to access the Learning Management Center for your CE Certificate
  - A one time registration is required
  - The facility must allow automatic emails. If not, please contact your IT department to open the following domain: [lmc@hsag.com](mailto:lmc@hsag.com)

# Continuing Education Approval

- This program has been approved for 1.0 continuing education (CE) credit given by CE Provider #50-747 for the following professions:
  - Florida Board of Nursing
  - 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
- Professionals licensed in other states will receive a Certificate of Completion to submit to their licensing Boards.