Inpatient Quality Reporting (IQR) Program

Support Contractor

FY 2016 IPPS Final Rule

Presentation Transcript

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Matt McDonough: Good afternoon and welcome to today's webinar. My name is Matt McDonough and I'll be your virtual training host for today's event.

And, before we start today's event, I do want to cover some housekeeping items with you so that you understand how today's event is going to work from an audio perspective. Now, we are streaming audio over the Internet. If you hear my voice, then you obviously know that. However, we do have a limited number of dial-in lines. If you do need a dial-in line, if streaming is not working for you for some reason, please send us a Chat message, and we'll get that number out to you immediately. Also, as a standard matter, this event is being recorded.

Now, if you're streaming audio over your computer, you may notice the audio might suddenly break up or stop completely. You can resolve this

by yourself. In the upper left corner of your screen, click the "Pause" button, wait approximately five seconds, and then click the "Play" button. Your audio stream should resume. If it happens again, simply follow this process again to resume your audio stream.

Now, if you hear a very bad echo on the call, like you hear my voice twice, it's probably because you're connected multiple times to this event and you're hearing multiple audio feeds. So, close all but one of those browser tabs or browsers, and the echo will clear itself up.

Also, at any time, if you want to just restart your audio feed, again, you can either do that [with the] pause button or simply click the F5 key in Internet Explorer, and it will reload your tab and reconnect you to the event.

Now, we're all in a listen-only mode today, but that doesn't mean you can't send questions to our subject matter experts today. Simply type your question in the left side of your screen, write where it says, "Chat with the Presenter," and then click the "Send" button. When you click "Send," your question will be sent to all of our presenters, and, as time and as resources allow, we'll answer the most commonly asked questions at the end of today's event. But please do know that all of our questions are being archived to be addressed at a later time.

That's going to do it for my brief introduction. So, without further ado, I'm going to hand it over to our first speaker of the day.

Candace Jackson: Thank you, Matt. Hello everyone and welcome to the Fiscal Year 2016 IQR Hospital IPPS Final Rule presentation. My name is Candace Jackson and I will be your host for today's event. Before we begin, I'd like to make a few announcements. This program is being recorded. A transcript of the presentation, along with the Qs & As, will be posted to our Inpatient website, www.qualityreportingcenter.com, within two days and will be posted to *QualityNet* at a later date.

If you registered for this event, a reminder email, as well as the slides, was sent out to your email one hour ago. If you didn't receive the email, you

can download the slides at our Inpatient website, again at www.qualityreportingcenter.com.

And now, I would like to introduce our guest speakers. Cindy Tourison leads the Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing Program. She oversees each program including policy making, education and outreach, and operationalizing the requirements for each program. She has worked on aligning IQR and HVBP to the EHR Incentive Program quality measures since she has joined CMS in 2011. Prior to joining CMS, Cindy worked on the vendor side of health care as a client services manager overseeing support for several product lines. She received her Masters of Science degree in Healthcare Administration Informatics from University of Maryland University College in 2008.

Grace Im, JD, MPH, is the program leader for the Hospital Readmissions Reduction Program, CMS, Centers for Clinical Standards and Quality, Quality Measurement and Value-Based Incentive Group. Grace is responsible for all aspects of implementing the Hospital Readmissions Reduction Program and works in close collaboration with the Centers for Medicare, as well as other hospital quality programs and major developments made to acute care settings. Grace received her JD from the University of Virginia School of Law and MPH in Health Policy from the George Washington University, Milken Institute School of Public Health.

Dr. Houseal currently serves as a program and policy lead for the Centers for Clinical Standards and Quality, Hospital-Acquired Condition Reduction Program. Before moving to CCSQ, Dr. Houseal led the Centers for Medicare & Medicaid Intervention, "Work and Pay for Success" models, and served as a project officer for two health care innovation awards focused on community-based asthma and Hepatitis C prevention and control. Prior to joining CMS, Dr. Houseal served as a program director for the National Institute of Diabetes and Digestive and Kidney Diseases' short-term research education program for under-represented persons. His research and professional interests include advancing prevention and population health improvement by addressing the social and environmental determinants of health. Both of her advanced degrees

are in Public Health and Health Promotion Disease Prevention and Community Health.

Charles Padgett, R.N., currently serves as a health insurance specialist for the Office of Clinical Standards and Quality in the Division of Chronic and Post Acute Care with the Centers for Medicare & Medicaid Services.

Cindy, the floor is now yours.

Cindy Tourison: Good afternoon and welcome to CMS' FY 2016 IQR Hospital IPPS Final Rule presentation. The purpose of today's webinar is to provide a summary of The Final Rule changes for the FY 2016 Inpatient Prospective Payment System's Final Rule, as it pertains to those Quality Reporting and Value-Based Programs listed on this slide. At the conclusion of this presentation, participants will be able to locate the FY 2016 Final Rule text and ask questions pertaining to these policy changes.

Next, we'll talk about the changes to the Hospital Inpatient Quality Reporting Program. We finalized the addition of factors to be considered for measure removal and also included factors to consider in order to retain measures. But, basically, we will take into consideration the feasibility to implement the measure specifications when determining whether a measure should be removed. We will also take into consideration the following factor in determining whether a measure should be retained; that is, if the measure aligns with other CMS and HHS policy goals, such as the National Quality Strategy or the CMS Quality Strategy Goals.

We finalized the removal of nine measures, either in their entirety or just the chart-abstracted form, from the Hospital IQR Program measure set for the FY 2018 payment determination and subsequent years. We finalized the removal of the chart-abstracted versions of STK-01, -06, -08, VTE -1, -2, and -3 on the basis of these measures are "topped out." However, we are retaining STK-06, -08, VTE -1, -2, and -3 as electronic Clinical Quality Measures to align the Hospital IQR and EHR Incentive Program. For IMM-1, based on the continued lack of ready access to comprehensive

patient-level immunization data by hospital staff and the continued infeasibility to implement or align this measure with current clinical guidelines or practice, we are removing this measure from Hospital IQR.

We are finalizing the removal of AMI-7a as a chart-abstracted measure because performance on this measure does not result in better patient outcomes. In addition, we believe that the burden of requiring all hospitals to report data on this measure when only a few facilities report enough cases to be publicly reported outweighs the benefit of retaining the chart-abstracted version of this measure. However, we did finalize to retain AMI-7a as an electronic Clinical Quality Measure to align the Hospital IQR and EHR Incentive Program. We also finalized the removal of SCIP-Inf-4, as the measure does not result in better patient outcomes, does not align with current clinical guidelines or practices, and public reporting of this measure leads to negative or unintended consequences and patient harm.

For the FY 2018, which will be calendar year 2016, hospitals will be required to submit the eight listed chart-abstracted measures to meet IQR requirements. In the Proposed Rule, it was suggested that hospitals would have a choice; however, based on public comments, we have finalized that these chart-abstracted measures will be required for the entire year based on the chart-abstracted deadlines for FY 2018 payment determinations.

We are finalizing a modified version of the measure refinements or expanded measure cohorts for the FY 2017 payment determination and subsequent years for both the Hospital 30-day, All-cause, Risk-Standardized Readmission Rate Following Pneumonia Hospitalization, and the Hospital 30-day, All-cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization.

We finalized only three categories listed on the slide. Also listed are the two patient groups that we did not finalize. As a result, we did not finalize the proposal to risk-adjust with respect to these two conditions present during the index admission. We find that this modified cohort expansion produces a measure that does not favor or disadvantage hospitals on the

basis of their coding practices. We believe the modified version of the measure requirements, as finalized, effectively broadens the cohort of patients included to be more closely comprehensive than that of the current reported measures. By limiting the measure expansion without including risk adjustment for these alternate principal diagnosis (i.e., severe sepsis and respiratory failure), we brought in a large portion of patients currently excluded from the measures, but mitigated the biases introduced by hospital coding practices.

In the FY 2016 Proposed Rule, we proposed to add eight new measures, seven claims-based and one structural, to the Hospital IQR Program for FY 2018 payment determination and subsequent years. After consideration of the public comments received, we are finalizing adoption of six of these measures, including the structural measure, to survey patients' basic culture and the claims-based measures on AMI and Heart Failure Excess Days for the FY 2018 payment determination and subsequent years. Additionally, we finalized the Total Hip and Total Knee Arthroplasty Payment measure for FY 2018.

After consideration of the public comments that we received, we are finalizing a modification of our proposals on the episodic payment measures. We finalized three of the four measures, as listed on the slide. We did not finalize the Lumbar Spine Fusion/Refusion Clinical Episode-Based Payment measure. Additionally, we are postponing implementation of the Kidney/UTI, Cellulitis, and GI Payment measures for the FY 2019 payment determination and subsequent years. We will provide hospitals with confidential hospital-specific feedback reports containing performance data on these three measures during the FY 2018 payment determination prior to inclusion for public reporting.

Currently, hospitals must submit to CMS quarterly aggregate population and sample counts for Medicare and non-Medicare discharges for all measures in the topic areas for which chart-abstracted data must be submitted. In accordance with these policies, hospitals that have not treated patients in specific topic areas must still submit the quarterly population and sample counts. We proposed to revise this policy so that

hospitals will be required to submit population and sample size data only for those measures that a hospital submits their chart-abstracted measures under the Hospital IQR Program. After consideration of public comments that we received, we are finalizing our policy that hospitals will be required to submit population and sample size data only for those measures that a hospital submits as chart-abstracted measures under IQR. Look for more specific information in the addendum to The *Specifications Manual for National Hospital Inpatient Quality Measures* (a.k.a, the Specification Manual) collaboratively produced by CMS and The Joint Commission around October of this year.

We finalized modification to the existing processes for validation of chart-abstracted measures, specifically for the Influenza Immunization measure. In the FY 2015 IPPS Final Rule, we finalized a validation process, which included a separate validation stratum for the Influenza Immunization measure. In this Final Rule, we will remove the separate immunization validation stratum and include the Influenza Immunization measure in the Clinical Process of Care measure validation stratum. Under this Final Rule, we would continue to apply our chart-abstracted measure validation processes only to those chart-abstracted measures that are required under IQR in a chart-abstracted form. This policy is consistent with our finalized policy to require population and sample data for those measures that are required under IQR.

In the FY 2015 IPPS Final Rule, we outlined the weighting of these three validation topic areas: Health Care Associated Infections at 66.7 percent, Immunization at 22.2 percent, and Other/Clinical Process of care at 11.1 percent. This table shows the final effect on the topic area weighting of our finalized change to remove the immunization measure validation stratum and to move the Influenza Immunization Measure to the Clinical Process of Care validation stratum.

Okay, now, we're going to move into the section of IQR related to electronic Clinical Quality Measures and the alignment to the EHR Incentive Program.

In response to public comments, CMS modified its proposal to require 16 to 28 measures to require hospitals to report four of 28 Electronic Clinical Quality Measures for Calendar Year 2016 reporting. We believe that requiring hospitals to report a minimum of four is reasonable because it significantly reduces burden for hospitals from the 16 proposed, but still allows for the collection of data derived from EHR to further plan for electronic data collection and validation. Further, instead of requiring hospitals to report two quarters of data within two months following the reporting period as proposed, hospitals will be required to report the four electronic Clinical Quality Measures for just one quarter, either quarter three or quarter four, of the Calendar Year 2016 or FY 2018 payment determination with a submission deadline of February 28 of 2017. We believe this will allow more time for hospitals to overcome vendor issues, such as mapping and testing. In addition, instead of requiring that a hospital select and report electronic Clinical Quality measures across the three NQF domains as proposed, our finalized policy will not require that any of the four eCQMs fall under any particular NQF domain.

There are 29 electronic Clinical Quality Measures. Twenty-eight of these are available to be submitted for the Hospital Inpatient Quality Reporting Program. ED-3 is an Outpatient measure and therefore not applicable for submission to IQR.

We are retaining a variety of electronic Clinical Quality Measures in order to ensure that hospitals have flexibility and choice in determining which electronic measures to report. We believe that the collection of electronic Clinical Quality Measure data will enable hospitals to efficiently capture and calculate quality data. We will make note of the issues raised in the comments for next year's Proposed Rule, and we may consider removing the electronic Clinical Quality Measures listed in the table from the Hospital IQR Program.

We recognize that there may be special circumstances that prevent a hospital from reporting electronic Clinical Quality Measures. As such, we are finalizing a policy that allows hospitals to utilize the existing Extraordinary Circumstance Extensions/Exemption form to request an

exemption from the Hospital IQR Program eCQM recording requirement for the applicable program year based on hardships preventing hospitals from electronically reporting. Such hardships could include, but are not limited to, infrastructure challenges, such as insufficient Internet access, or unpredictable instances, such as vendor issues outside of the hospital's control. In addition, hospitals newly participating in the Hospital IQR Program may also be considered undergoing hardship and can apply for the exemption. We will also allow hospitals to apply the Zero Denominator and Case Threshold Exemption as prescribed for the FY 2015 IPPS Final Rule. We had received many questions on applying for hardship via the Extraordinary Circumstance form. We will be further educating hospitals in the December/January timeframe, and we will issue FAQs to provide clarification on deadline dates, scenarios, etc.

We previously proposed that measures reported by electronic Clinical Quality Measure would be marked as a footnote on *Hospital Compare*. We are finalizing instead, that any data submitted electronically will not be posted on the *Hospital Compare* website. Public reporting of electronic data will be addressed in next year's rulemaking, following the conclusion and assessment of the eCQM Validation Pilot.

We've implemented several claims-based measures comparing hospital performance on the 30-day Mortality, 30-day Readmission, and Complication Following Hospitalization for several conditions and procedures in Hospital IQR, Hospital Readmissions Reductions, and Hospital Value-Based Purchasing Programs. Although these measures have been shown to provide valid information about hospital performance, the clinical community continued to express the opinion that data gathered directly from patients and used by clinicians to guide diagnostic decisions in treatment are preferable for risk adjustment of hospital outcome measures.

In response to public comment periods during the measure development and keeping with our goals to move toward this in Electronic Health Records or electronic quality measure reporting through CMS programs, where feasible, we are considering the use of: core clinical data elements

derived from EHRs for use in the future quality measures (for example, risk adjustment of outcome measures); the collection of additional administrative linkage variables to link a patient episode-of-care from the EHR data with administrative claims data; and, use of content exchange standards. We anticipated that EHRs will continue to improve, capturing relevant clinical data, and we also anticipate further expansion of core clinical data elements.

In response to comments, we finalized, for Calendar Year 2016/FY 2018, hospitals can report electronic Clinical Quality Measures using either the 2014 or the 2015 edition of CEHRT. We believe that requiring the use of the most recent electronic measure specification is important in allowing us to collect electronic data. We feel that the modified policies, later reporting period, and an extended submission deadline provide hospitals with additional time to update the most recent measure specification. The 2015 measure specifications are required whether hospitals use a 2014 or 2015 version of CEHRT. Regardless of the CEHRT edition, we are requiring reviews of the 2015 CMS Implementation Guide or Quality Reporting Document Architecture Category I and Category III Supplementary Implementation Guide available on our website.

And now, we're going to move on to changes to the Hospital Value-Based Purchasing Program.

This slide depicts measures added, removed and moved for the FY 2018 payment determination. In the FY 2016 IPPS Final Rule, we finalized the addition of the CTM-3, the Three-Item Care Transition Measure, because the Patient- and Caregiver-Centered Experience of Care/Care Coordination domain, which increases the total HCAHPS® dimension, measured from eight to nine, and we'll look a little more into specs later. Two measures removed for FY 2018 were AMI-7a and IMM-2, formerly under the Clinical Care–Process Domain. The remaining measure in the Clinical Care Process Domain, the PC-01 measure, was moved to the Safety domain. The MAP Hospital Workgroup has included PC-01 as an "obstetrical adverse event" measure in its Safety family of measures. So, we think it's appropriate to move this measure to the safety domain.

Because there were no measures remaining in the Clinical Care–Process Sub-Domain, we finalized the removal of the sub-domain, and the Clinical Care Domain now only includes the three 30-Day Mortality Measures.

In the Final Rule, we adopted the "normalization" approach to scoring the Patient- and Caregiver-Centered Experiences of Care/Care Coordination domain, which will introduce only minor changes to the original scoring formula as follows. For the purposes of HCAHPS® Base Scores, the new CTM-3 dimension would be calculated in the same manner as the eight existing HCAHPS® dimensions. For each of the nine dimensions, achievement points (0–10 points) and improvement points (0–9 points) would be calculated, the larger of which would be summed across the nine dimensions to create a pre-normalized HCAHPS® Base Score, zero to 90 points, as compared to the zero to 80 points, when only eight dimensions were included previously. The normalized HCAHPS® Base Score would then be multiplied by 0.8888 and rounded according to the standard values of 0.5, and higher values are rounded up and values below 0.5 rounding down to create the normalized HCAHPS® Base Score. Each of the nine dimensions would be equal weight so that, as before, the normalized HCAHPS® Base Score would range from zero to 80 points. HCAHPS® Consistency Points would then be calculated in the same manner as before and would continue to range from zero to 20 points. The Consistency Points would now consider scores across all nine of the (PPCEC/CC) dimensions. And, the final element of the scoring formula would be the sum of the HCAHPS® Base Score and the HCAHPS® Consistency Points and will range from zero to 100 points, as before.

The FY 2018, Hospital Value-Based Purchasing Program adopted baseline performance periods are listed on this slide. The Clinical Care domain containing the 30-day Mortality measures has their baseline period of October 1, 2009, through June 30, 2012, and a performance period of October 1, 2013 through June 30 of 2016. The AHRQ Patient Safety Indicator, PSI-90 Composite in the Safety Domain has a baseline period of July 1, 2010 through June 30, 2012, and performance period of July 1, 2014 through June 30, 2016.

The remaining domains and measures utilize a baseline period of January 1, 2014 through December 31, 2014, and a performance period of January 1, 2016 through December 31, 2016. We are not proposing any changes to the minimum number of pieces and measures that we have previously adopted and that are listed on this slide.

The NHSN measures are calculated by the Centers for Disease Control and currently include the CAUTI, CLABSI, MRSA bacteremia, CDI, and Colon and Abdominal Hysterectomy SSI measures in the FY 2017 program year and the subsequent program years. They measure the occurrence of these HAIs in the hospitals participating in the Hospital VBP Program. In order to calculate the NHSN measures for use in both IQR and VBP, CDC must go through several steps. First, CDC determines each NHSN measure's number of predicted infections, 0.58, and CDC determines the number of predicted infections using both specific care location's characteristics (for example, number of days in which a patient in an ICU has a central line) and infection rates that occurred among a standard population (sometimes referred to by CDC as a "national baseline" but referred to here and in the Final Rule as "standard population data"). Finally, for each NHSN measure, CDC calculates the Standardized Infection Ratio, or SIR, by comparing your hospital's observed number of HAIs with the number of HAIs predicted for the hospital, adjusting for several risk factors.

Beginning in 2015, CDC will collect data in order to update the new standard population data for all of these NHSN measures. The FY 2015 standard population data for HAI measures will hereinafter be referred to as the new "standard population data." Because VBP calculates Improvement Points using comparisons between data collected from hospitals and a baseline period and data collected in the performance period, VBP must treat CDC standard population data updates differently than other quality programs. We've determined that we cannot equally compare CDC's new standard population data to the current standard population data in order to calculate Improvement Points. If we do not address the CDC's measure update, we will be unable to compare the

baseline and performance period for NHSN measures in FY 2017 and 2018 program years.

So, in order to address the problem, we will use the current standard population to calculate performance standards and to calculate and publicly report measure scores until the FY 2019 program year, as depicted in the table. For the FY 2019 program year and subsequent years, VBP will use the new standard population data to calculate performance standards and to calculate and publicly report measure scores.

In the FY 2015 IPPS Final Rule, we signaled our intent to consider using data from selected ward (non-ICU) locations for the Hospital Value-Based Purchasing Program beginning in FY 2019 program year, for purposes of calculating performance standards for CAUTI and CLABSI measures. In the Final Rule, we signal our intent to propose including selected ward or non-ICU locations in the CAUTI, CLABSI measures beginning with the FY 2019 program year in future rulemaking. We intend to propose to adopt the baseline of January 1, 2015, through December 31 of 2015, and a performance period of January 1, 2017, through December 31 of 2017, for CAUTI and CLABSI measures. This expansion of CAUTI and CLABSI measures would be consistent with the NQF re-endorsement update to these measures, which allows application of measures beyond ICUs. We believe this expansion of measures will allow hospitals that do not have ICU locations to use tools and resources of the NHSN for quality improvement and public reporting effort.

The scoring methodology for a Hospital Value-Based Purchasing for FY 2018 Program Year was finalized in the FY 2016 Final Rule. In the Final Rule, we continued our adoption of the four domains listed on this slide. Each of the domains for the FY 2018 program year will be equally weighted at 25 percent of the total performance score. We also maintained our policy that a hospital must receive scores in at least three of the four domains in order to be eligible to incur payment adjustments under Value-Based Purchasing.

Hospital 30-day, All-Cause, RSMR following COPD hospitalization is a risk-adjusted, NQF-endorsed Mortality Measure monitoring mortality rates following COPD hospitalization. We finalized the addition of the measure to the Clinical Care domain for the FY 2021 Hospital VBP Program year.

Chronic lower respiratory disease, including COPD, is the third leading cause of death in the United State. Between 1998 and 2008, the number of patients hospitalized annually for acute observations of COPD increased by approximately 18 percent. Moreover, COPD is one of the top 20 conditions contributing to Medicare costs. The medium 30-day Risk-Standardized Mortality Rate following admission for COPD between July of 2010 and June 2013 was 7.8 percent with variation in mortality rates ranging from 5.5 percent to 12.4 percent across over 27,000 hospitals. The MAP supported the inclusion of this measure in VBP, as detailed in the *Spreadsheet of MAP 2015 Final Recommendations*. In addition, the measure is appropriate for VBP because it addresses a high value, high-cost condition, and chronic lower respiratory disease, including COPD, is the third leading cause of mortality in the United States. This measure aligns with the CMS Quality Strategy Goal of effective prevention and treatment.

And now, I'll turn the presentation over to my colleague, Grace Im, who will present the Hospital Readmissions Reduction Program.

Grace Im: Good afternoon. My name is Grace Im, and I'm the program lead for the Hospital Readmissions Reduction Program here at CMS.

Today, I will be presenting the main updates to the Hospital Readmissions Reduction Program and we'll finalize in the FY 2016 IPPS Final Rule. And so, I will be touching on two main updates to the program. The first, that will become effective in FY 2016, so October 1 of 2016, is the adoption of an Extraordinary Circumstance Exception Policy. And then, effective for FY 2017, will be the expansion of the cohort for the Pneumonia Readmission Measure.

So, the Extraordinary Circumstance Exception Policy, as I mentioned, it will go into effect beginning October 1 of 2016, and this policy will now allow hospitals to experience an extraordinary circumstance. And this, as an example – it could be major hurricane or severe floods, for example. The hospital may request a waiver of certain periods of data from inclusion and calculation of its excess readmission ratio for a given fiscal year. The extraordinary circumstance might affect also the ability to accurately or timely submit all the claims data. And soon, we will have available a request form to request an Extraordinary Circumstance Exception that will become available on the *QualityNet* website in the section that covers the Hospital Readmissions Reduction Program, and the request form will be very similar to the request form that we currently use in the Hospital Inpatient Quality Reporting Program and the Hospital Value-Based Purchasing Program. Also, as another speaker will mention, in the Hospital-Acquired Condition Reduction Program, they've also finalized [a] very similar Extraordinary Circumstance Exception Policy. So now, across the Acute Care Hospital Quality Reporting and Payment Programs, we will be able to provide a very similar type of extraordinary circumstance exception waiver that is very similar in terms of the requirements.

In this slide, this provides a little bit more detail of the kinds of information that we'll be asking for in a request form for an extraordinary circumstance exception. And, I just want to highlight the fourth bullet. We'll be asking for a hospital's reason for requesting an exception. And then also, the fifth main bullet, we'll also ask the hospital for evidence of the impact of the extraordinary circumstance. I'd also like to note that a hospital will need to submit a request for an extraordinary circumstance exception within 90 days of the occurrence of the extraordinary circumstance.

The other main update that we've made to the Hospital Readmissions Reduction Program is the finalizing of an expansion for the Pneumonia Readmission Measure. We currently have a Pneumonia Readmission Measure in the Hospital Readmissions Reduction Program. And so, this is

a modification to the specification for that measure, and the modifications will come into effect with the FY 2017 program. So, this will affect the measure results and will be reported in the hospital-specific reports that will become available to hospitals in the summer of 2016, next summer. And, what we finalized in the IPPS Rule is actually a modified version of what we had proposed or referred. So, just to clarify, the current Pneumonia Measure that we viewed includes patients with a principal discharge diagnosis of pneumonia. With the modification to this measure, we will also include patients with a principal discharge diagnosis of aspiration pneumonia, and also patients with a principal discharge diagnosis of Sepsis with a secondary diagnosis of Pneumonia Present on Admission. However, this will not include patients that are coded as having Severe Sepsis or Septic Shock. What has been proposed but not finalized in the IPPS Rule, is including a patient with respiratory failure or, as I mentioned, Severe Sepsis. We finalized an update to this measure in response to changing trends in hospital coding practices and to address the potential coding variation that we've seen. And, we believe that by including more pneumonia patients into the Readmission Measure, it will provide a more complete picture for the hospital performance on readmission with respect to the pneumonia patients.

And, this slide just provides the summary of all of the Readmission Measures that we use in the Hospital Readmissions Reduction Program. And, as participants of today's webinar, focus on the last column for FY 2017, when the updates to the Pneumonia Measure and the expansion of the cohort will actually come into effect. And also, I want to note for participants, that in the same program year, we will also be using, for the first time, the Readmission Measure for admissions following Coronary Artery Bypass Graft Surgery, the CABG. So, that will be a new measure in the program which we had previously finalized in the FY 2015 IPPS Rule. But, in the FY 2017 program, we'll be using it for the first time, as well as the modified Pneumonia Measure with the extended patient cohort that we just finalized in the FY 2016 IPPS Rule.

Now, this final slide for the Hospital Readmissions Reduction Program just provides a list several resources for more information on the Hospital Readmissions Reduction Program, as well as the measures, the Readmission Measures that we use with the program.

Thank you for your time and attention. I will now turn it over to our next speaker.

Delia Houseal: Thank you for the warm welcome. Again, my name is Delia Houseal, and I am the program lead for the Hospital-Acquired Condition Reduction Program.

On the next set of slides, we'll discuss pertinent changes to the Hospital-Acquired Reduction Program that were finalized in the Fiscal Year 2016 Final Rule.

Before we dive into the changes, I'd like to quickly review the HAC Reduction Program measures that have already been finalized in prior rules. As you can see from the slide, in Fiscal Year 2016, the HAC Reduction Program included the addition of the Surgical Site Infection Measures. And, for the 2017 HAC Reduction Program, we plan to extend our measure set to include MRSA and Clostridium *difficile*.

In the Final Rule, there are no proposed changes to policy that were previously implemented in the HAC Reduction Program for Fiscal Year 2016. However, there were several non-substantive updates to the measures that were previously finalized. Mainly, the AHRQ PSI-90 Composite Measure is undergoing NQF maintenance review. During the review, AHRQ is considering revisions to the Composite that includes the addition of three measures, PSI-9, PSI-10, and PSI-11. Additionally, the CDC NHSN CAUTI and CLABSI measures completed the NQF maintenance review process. During the process, NQF re-endorsed a modified version of the measures that included the ARM, which is a new statistical action for calculating the measure result. Although this version was endorsed by NQF, it's important to note that the HAC Reduction Program is currently working to determine the appropriateness of using

the ARM versus the SIR and will not make any decisions regarding the utilization of the arm, and so we gather additional information.

Along with other hospital reporting programs, the HAC Reduction Program finalized an Extraordinary Circumstance Exception Policy. The policy will provide release of hospitals who believe that their ability to accurately collect or report quality measure data has been negatively impacted as a direct result of experiencing a significant disaster or other extraordinary circumstance that is beyond the hospital's control. It's important to know that the policy is not intended to allow a hospital to request exclusion from the HAC Reduction Program in its entirety for a given fiscal year, and in fact, the goal is to enable affected hospitals to continue to participate in the program if they continue to meet applicable measurement among threshold requirements.

We also finalized the applicable time periods for the Fiscal Year 2017 HAC Reduction Program. The Domain 1 measure, our PSI-90 Composite Measure time period will be from July 1, 2013 through June 30, 2015. For the CDC NHSN measures, CLABSI, CAUTI, SSI, MRSA and Clostridium *difficile*, the applicable time period will be calendar year 2014 and 2015. Additionally, we revised our approach to how we calculate the Domain 2 score. In our current Rule, we assign a score for each Domain 2 measure and the measure scores are averaged to provide a Domain 2 score. In the Final Rule, in the Fiscal Year 2016 Final Rule, we will treat each Domain 2 measure independently when determining if a score of 10 should be assigned to the measures.

In the Fiscal Year 2016 Final Rule, we finalized changes to the domain weight for the Fiscal Year 2017 HAC Reduction Program. Domain 1 will be reduced to 15 percent, and Domain 2 will be increased to 85 percent of the total HAC score. The changes in the domain weights were finalized in response to stakeholder recommendations and the addition of MRSA and Clostridium *difficile* to Domain 2.

In the Fiscal Year 2016 Final Rule, two measure-related updates for the Fiscal Year 2018 HAC Reduction Program were finalized. The first

measure refinement includes the inclusion of non-intensive care unit locations for CDC NHSN CLABSI and CAUTI measures. In addition to data from adult and pediatric ICU locations, the HAC Reduction Program will include data from pediatric and adult medical wards, surgical wards, and medical surgical wards. As mentioned during my colleague's discussion, the Hospital VBP Program, beginning in 2015, CDC will collect data in order to update the standard population data for all NHSN measures. However, unlike the Hospital VBP Program, the HAC Reduction Program will use CDC new standard population data in the Fiscal Year 2018 HAC Reduction Program.

In the Fiscal Year 2016 Final Rule, there were no changes for the public reporting requirements for the HAC Reduction Program. Information pertaining to the program would still be publicly reported on *Hospital Compare*. For additional information on the HAC Reduction Program, I encourage you to visit cms.gov.

We also have additional links on the following slide that provide you with more resources on the HAC Reduction Program. If you have additional questions pertaining to the information presented today, I encourage you to submit them through the Chat and they'll be published through the question and answers document.

Thank you so much for your time. And now, I'd like to turn it over to my colleague, Charles Padgett.

Charles Padgett: Thank you, Delia.

My name is Charles Padgett, and I am going to cover the changes to the Long-Term Care Hospital Quality Reporting Program that we finalized in the Fiscal Year 2016 IPPS LTCH PPS Final Rule.

The first slide essentially talks about what has happened in the LTCH Quality Reporting Program to date. And to date, CMS has adopted 13 quality measures for the LTCH Quality Reporting Program. Three of those quality measures were data collection and reporting for the Fiscal Year 2014 and Fiscal Year 2015 payment update determinations. We adopted

two additional measures for the Fiscal Year 2016 payment update determination, three additional measures for the Fiscal Year 2017 payment update determination, and a total of five additional measures for the Fiscal Year 2018 payment update determination.

I'm going to cover all of the measures that are currently reported under the requirements of the LTCH Quality Reporting Program. And in this slide deck, you'll notice that some of the measures are highlighted. The highlighted measures, as I go through these measures, are the ones that were proposed and finalized in this year's Final Rule. The first is the pPercent of Patients or Residents with Pressure Ulcers that are New or Worsened, NQF number 0678. This measure was actually re-proposed this year to establish its use as a cross-setting measure that satisfies the IMPACT Act of 2014. Beyond that, LTCH should be currently collecting NHSN Catheter-Associated Urinary Tract Infection Outcome Measures and the NHSN Central-Line Associated Bloodstream Infection or CLABSI Outcome Measure. Additionally, LTCH should currently be reporting Percent of Residents or Patients Who Were Assessed Appropriately Given the Seasonal Influenza Vaccine (Short Stay) Measure. Influenza Vaccination Coverage Among Healthcare Personnel, which is NQF number 0431, that should be currently collected between dates of October 1 and March 31 each year, which is considered influenza vaccination season. And you'll notice, the next measure, which is All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals, is highlighted in yellow. This measure was, again, re-proposed this year in the Proposed Rule and we finalized it in this year's Final Rule, and this was proposed to establish the NQF-endorsed version of the measure. This measure was endorsed by NQF in December of 2014.

Continuing with the quality measures that are currently reported in the quality reporting program, there's: NHSN Facility-Wide Inpatient Hospital-Onset, Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia Outcome Measure; NHSN Facility-Wide Inpatient Hospital-Onset Clostridium *difficile* Infection (CDI) Outcome Measure; and, NHSN Ventilator-Associated Event Outcome Measure, and reporting for that

measure actually will not begin until January 1, 2016, but this measure has been previously finalized and adopted into the program.

Continuing along, Percent of Residents Experiencing One or More Falls with Major Injury, which is the Long-Stay Measure, NQF number 0674. This measure was re-proposed this year in order to establish its use as a cross-setting measure that satisfies the IMPACT Act of 2014 requirement. Beginning April 1, 2016, LTCHs will begin collecting Functional Outcome Measure, Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support, and also a percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function. This year, we also proposed the measure that you'll see highlighted at the bottom of this slide, which is Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function. And this measure, as an application, is a bit different from the previous measure I mentioned in that it uses a subset of those items and reestablishes this measure's use as a cross-setting measure that satisfies the IMPACT Act of 2014 requirement.

On the next slide, you'll find LTCH Care Data Set. The LTCH Care Data Set must be completed for all patients admitted and discharged from an LTCH. And, this data set is used to collect and submit all data on all quality measures that are assessment-based. I'll just go over each version that we've seen at the LTCH Care Data Set. The first version was version 1.01. LTCHs began using this version on October 1, 2012 and a Pressure Ulcer Measure was the only measure collected using that version of the item set. We moved on to version 2.01, and LTCHs began using that version on July 1 of 2014 and, beyond the Pressure Ulcer Measure, we added a Patient Influenza Vaccination Status Measure for the data set. Beginning in April 1, 2016, we'll move to version 3.00 of the LTCH Care Data Set, and that version will contain not only the Pressure Ulcer Measure and the Patient Influenza Vaccination Status Measure, but will additionally add the Falls with Major Injury Measure to that data set.

Beyond the use of the LTCH Care Data Set, some of our measures are submitted via the CDC's NHSN. It's the mechanism for the submission of CAUTI, CLABSI, MRSA, CDI and Influenza Vaccination Coverage Among Healthcare Personnel Quality Measure. As of January 1, 2016, the CDC's NHSN will also be the data submission mechanism for the Ventilator-Associated Event Outcome Measure. You can find further information on data collection and submission for these measures at the CDC's NHSN website, which is www.cdc.gov/nhsn.

The data submission deadlines for the payment update determinations – I'm not going to review those in detail. I will say, I'm going to go over some of this information. We do offer an expanded live deck on our websites of this presentation, which includes detailed information about the data submission deadlines for each payment update determination, and I'll go over where you can find that towards the end of this presentation. But currently, LTCHs must submit quality data for each quarter by the established quarterly data submission deadlines. Data submitted after the quarterly data submission deadline will not be accepted for LTCH Quality Reporting Program compliance determinations. Missing one or more of these deadlines may lead to a filing of noncompliance. And I'd like to note, for the Influenza Vaccination Coverage Among Healthcare Personnel, the extension of the quarterly submission deadlines which took place in this Rule is not applicable. The data submission deadline will remain May 15 of each year for quality data related to that measure.

I'm going to cover the newly adopted data submission deadlines for the LTCH Quality Reporting Program which were finalized in this year's Rule. Beginning with quarter four, which is October 1 through December 31, 2015, the data submission deadlines for quality measures, except the Influenza Vaccination Coverage Among Healthcare Personnel measure, have been expanded to give facilities additional time to submit, review and correct data. These deadlines apply for payment determinations for Fiscal Year 2017, Fiscal Year 2018 and subsequent years, and, LTCHs will have four and a half months, or approximately 135 days after the end of each quarter, to submit required quality data to CMS. The current submission

deadlines, as I've said, allow LTCHs to submit data within one and a half months, which is approximately 45 days after the end of each quarter.

In this year's Rule, we also adopted policy related to public reporting for the LTCH Quality Reporting Program. Public reporting of the LTCH quality data is scheduled to begin in Fall of 2016 and includes a period for review and correction of quality data prior to the public display of that data. And, the initial data that we display will include the following four measures: Percent of Residents with Pressure Ulcers That Are New or Worsened; the NHSN Catheter-Associated Urinary Tract Infection or CAUTI Outcome Measure; the NHSN Central-Line Associated Bloodstream Infection or CLABSI Outcome Measure; and finally, the All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from Long-Term Care Hospital.

This year, we also adopted a policy to post a list of LTCHs that successfully meet with the reporting requirements for the applicable payment determination, and, when finalized, that we will publish this list on the LTCH Quality Reporting website. We will, of course, update that list following the end of the reconsideration process on an annual basis.

The next slide lists resources and lists links that you can use to find each of the Final Rules that we have published related to the LTCH Quality Reporting Program. I'm not going to go over each link, however, this is a great slide. It gives you direct access to each of our Rules beginning with Fiscal Year 2012 and ending with the Fiscal Year 2016 IPPS LTCH PPS Final Rule which was just recently published.

A few announcements I'd like to go over – a PDF version of the agenda and meeting materials, including the LTCH Quality Reporting Program Manual Version 3.0, as well as an expanded version of this presentation will be available online for download at the LTCH Quality Reporting Program website that you see here listed. Additionally, in order to support the NHSN Ventilator-Associated Event Outcome Measure implementation which begins on January 1, 2016, CMS will be releasing guidance for the

CDC's NHSN quality measures, and we request that you continue to monitor our website for details related to that.

Okay, that wraps up the LTCH Quality Reporting Program presentation. I am going to move onto the IRF Quality Reporting Program.

The Inpatient Rehabilitation Facility Quality Reporting Program updates were made in this year's Fiscal Year 2016 IRF PPS Final Rule, which is different than the Rule that the LTCH requirements were published in. But, I'm going to go over the changes that were finalized per that Rule.

I'm first going to just quickly cover the quality measures that were previously adopted and that are currently used in the IRF Quality Reporting Program, and those include: the NHSN Catheter-Associated Urinary Tract Infection, or CAUTI Outcome Measure; Influenza Vaccination Coverage Among Healthcare Personnel; the Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine; Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened; All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from Inpatient Rehabilitation Facilities; National Healthcare Safety Network Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus Aureus, or MRSA, Bacteremia Outcome Measure; and then National Healthcare Safety Network Facility-Wide Inpatient Hospital-Onset Clostridium *difficile* Infection, or CDI, Outcome Measure.

Now, I'm going to talk about the measures that were proposed this year, or I should say, re-proposed for various reasons and finalized again this year for the Fiscal Year 2018 payment determination and subsequent years. And, we actually re-proposed two quality measures, the first which is All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRF. We re-proposed this measure in order to establish the use of the endorsed version, the NQF-endorsed version of this measure. This measure was endorsed by NQF as of December 2014. And, the second quality measure that we re-proposed this year was the Application or Percent of Residents or Patients with Pressure Ulcers that are New or

Worsened. And our point of re-proposing this measure was to establish it to use as a cross-setting measure that satisfies the IMPACT Act of 2014 mandated requirements.

The IMPACT Act of 2014 required that CMS adopt quality measures that satisfy the following quality domains. The first, which was Skin Integrity and Changes in Skin Integrity, and in order to satisfy that domain, we re-proposed and adopted, as I just talked about, the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened. The second domain that was required is Functional Status, Cognitive Function and Changes in Function and Cognitive Function; and, in order to satisfy that requirement, we proposed and finalized the measure Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function. That measure is currently under review at NQF. And lastly, the third domain that was required was Incidents of Major Falls. In order to satisfy that required domain, we proposed an Application of the Percent of Residents Experiencing One or More Falls with Major Injury.

In addition to those measures, we proposed four additional Functional Measures. The four adopted Functional Outcome Measures are as follows: Change in Self-Care for Medical Rehabilitation Patients (That measure is currently under review at NQF.); Change in Mobility Score for Medical Rehabilitation Patients (That measure is currently under review at NQF.); Discharged Self-Score for Medical Rehabilitation Patients, which is NQF 2635 (It was recently endorsed.); and lastly, Discharged Mobility Score for Medical Rehabilitation Patients, that's NQF 2636, and again, that was recently endorsed by NQF.

The next few slides in the presentation cover policy issues or new policies that we've adopted with The 2016 IRF PPS Final Rule. The first of which covers the data submission timeframe. This year we adopted a new policy related to data collection timeframes for the IRF Quality Reporting Program. Previously, IRF data collection has been based on the fiscal year. However, we have now proposed and finalized the policy that states that data collection timeframes will be based on the calendar year unless

there's a clinical reason for an alternative data collection timeframe. And such an example would be the two influenza vaccination measures that are collected by IRF. One additional quality measure that uses the IRF patient assessment instrument, or the IRF PAI, as a data collection mechanism are adopted for a future use in the IRF QRP. The first data collection timeframe for those newly adopted measures will be only three months, October through December, and, subsequent data collection periods would follow the calendar year data collection timeframe. So, for example, the IRF PAI is always released in October, so any new measures that begin with that IRF PAI release will only be collected for the first three months related to the APU that year end. So, for example, the next year, for Calendar Year 2016, you will be collecting data as usual. On October 1 of 2016, a new IRF PAI will be released and with new data items related to newly finalized measures. So, the Fiscal Year 2017 APU, or I should say, the Fiscal Year 2018 APU, for those measures, will only be based on the first three months of data collection, which will be October through December.

Of all the new IRF PAI quality measures that we finalized in this year's Final Rule, they will use IRF PAI version 1.4. This version of the IRF PAI will be effective as of October 1, 2016. It specifically includes: modified Pressure Ulcer items, which will be collected at admission and discharge; New Fall items, which will be collected at discharge; new Self-Care Mobility/Functional Status items, collected at admission and discharge; and new Risk Factor items for the Self-Care/Mobility Measures collected at admission. And, you can find the new version of the IRF PAI on our Quality Reporting website. That link is listed here at the bottom of the slide.

This year, we also finalized a policy related to new IRFs that open. So, when the IRF opens midyear, there's always a question as to when they should begin reporting quality data. So in order to ensure that all IRFs have a minimum amount of time to prepare to submit quality data to CMS under the requirements of the IRF Quality Reporting Program, our new policy states that a new IRF is required to begin reporting quality data by

no later than the first day of a calendar year quarter subsequent to 30 days after the date on a CCN notification letter. So again, IRFs are required to begin reporting quality data under the IRF Quality Reporting Program no later than the first day of the calendar year quarter subsequent to 30 days after the date on a CCN notification letter. So, for example, if you get your CCN notification letter in March of 2016, the date on that letter – so you got it March 15 – the date on that letter, March 15, you will add 30 days to that, which takes you to April 15. And then, you would then be required to begin reporting quality data beginning with the first day of the calendar year quarter that follows that date. So April 15 – the next calendar year quarter would be calendar year quarter three, which would begin July 1. So, if you got your letter on March 15, you would then be required to begin reporting quality data to CMS on July 1.

This year, we also have proposed and finalized a policy that states we're going to suspend the implementation of a process to validate the data that's submitted for quality purposes. We originally finalized this policy in the Fiscal Year 2015 IRF PPS Final Rule. So, data accuracy validation will have no bearing on the applicable fiscal year annual increase factor reduction for the Fiscal Year 2016 and subsequent years, unless and until we propose to either reenact this policy or to propose a new validation policy in the future rulemaking. I will tell you that we are working to develop a more comprehensive data validation policy that's aligned across all the post-acute care quality reporting programs and reduces the labor and burden of cost on IRFs, you know, in comparison to our previously finalized policy.

A few other policy updates: CMS has finalized its proposal to codify data submission exception and extension requirement. CMS will continue using the IRF Quality Reporting Program reconsideration and appeals procedures that were adopted in the Fiscal Year 2015 and IRF PPS Final Rule, and the exact citation is listed here for you, if you would like to look that up. For the Fiscal Year 2017 payment determination and subsequent years, with the addition of notifying non-compliant [IRFs], the IRF Program is using the quality improvement evaluation system in addition to

the United States Postal Service. So previously, when we communicated with providers regarding compliance determinations and reconsideration determinations, we only used the U.S. Postal Service and sent out a certified letter. We decided, beginning with the Fiscal Year 2017 payment determination, that we will, on top of that, be posting your letters electronically inside your system folders that are located within the QIES system. And we'll be releasing a lot more detail related to this policy, of course, on our Quality Reporting Program website. You can continue to check that for updates.

This year, we have proposed and finalized a policy for public reporting related to the IRF Quality Reporting Program. CMS will display performance information regarding the quality measures required by the IRF Quality Reporting Program by Fall of 2016, and it's going to be on a CMS website after a 30-day preview period. The initial display of information is going to contain provider performance data on three quality measures. Those three measures are Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened, the NHSN CAUTI Outcome Measure, and the All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge From IRFs.

There's some information here about IRF PAI submission requirements. So, for additional information about collection and submission of IRF quality measure data using the IRF PAI, we invite you to visit our quality reporting program webpage. We've added a link here for you. I'm not going to go over that link, but it is available for you at the bottom of this slide.

A few IRF QRP website and email resources: here, again, we have our main IRF Quality Reporting Program website listed. Also, there is a quality program email help desk that you can email questions to, and that is irf.questions@cms.hhs.gov. The questions about the CDC or NHSN data submission – they have their own help desk, which is nhsn@cdc.gov. And, if you're interested in receiving mailings with notices and announcements, you can sign up on our ListServes, and the link to do so is located at the bottom of this slide.

A few more help desk resources are listed here. If you have technical questions regarding the IRF PAI, the technical help desk is listed here. If you have questions regarding access to the QIES system, which is used for submission of the IRF PAI, the IRVEN submission and certification survey provider enhanced reports or which are called CASPER reports, you can go to the QIES technical support help desk. The email for the help desk is listed here and there's also a toll free number listed here, which is 1800-339-9313. And questions regarding clinical non-quality items on the IRF PAI go to the QIES technical support help desk which is help@qtso.com. There's also the telephone number that I was just saying – that I just went over before, listed at the bottom of this slide.

And that sort of wraps it up for the IRF Quality Reporting Program. Again, I just want to let folks know that we have posted an expanded version of this presentation on the IRF Quality Reporting Program website. You can go there. There's a lot more information, not only about the quality measures that we proposed and finalized this year, but there's information surrounding the exact data submission timeframes and deadlines for all of the measures and various fiscal year payment determinations.

And that's all I have today. Thank you so much.

Debra Price: Okay, thank you.

Today's webinar has been approved for one continuing education credit by the boards listed on this slide. We are now a nationally accredited nursing provider, and as such, all nurses report their own credit to their board using our national provider number, 16578. It's on the slide in front of you.

We now have an online CE certificate process. You can receive your certificates two ways: one, if you registered for the webinar through ReadyTalk®, a survey will automatically pop up when the webinar closes. The survey will allow you to get your certificate; and the second way is, we will be sending out a survey link in an email to all participants within

the next 48 hours. If there are others listening to the event that are not registered in ReadyTalk®, pass this survey to them.

After completion of the survey, click "Done" at the bottom of the survey screen. Another page will open that asks you to register in our learning management center. This is a completely separate registration from the one you used in ReadyTalk®. Please use your personal email, like Yahoo, or Gmail, or ATT in this separate registration, so you will not have a problem receiving the certificate. What we have found is that healthcare facilities have firewalls that block our links from entering your computer.

This is what the survey will look like. It will pop up at the end of the event, and again, will be sent to you within 48 hours. You notice at the bottom, there's a little gray box that says, "Done," and your option is to click that box.

This is what pops up after you click "Done" in the survey. If you already attended our webinars and received CEs, click "Existing User." If this is your first webinar for credit, you would click "New User." Remember again that this is a separate registration process from the actual webinar that you have attended.

This is what the new user screen looks like. We register a personal email like Yahoo, or Gmail, or ATT, since those are not blocked by hospital firewall. Remember your password since you will use it for all of our events.

This is what the "Existing User" screen looks like. Use your complete email address as your user ID.

And now, I want to turn the webinar back to our host for any questions. Thank you for your time.

Candace Jackson: Thank you. This is Candace Jackson again, and I'd like to thank all of our speakers today, as well as the information that they presented.

We do have time to go over some frequently asked questions that we received during the webinar. And I'm going to start out the questions that we've got.

[We have] several questions regarding "… the requirements for the critical access hospitals and if they are required to submit data for the IQR and the eCQM program?" in addition to, "Are they still exempt from the HAC Reduction and HRRP Programs?" And I'll address those questions to Cindy and Grace.

Cindy Tourison: Okay, thank you Candace.

This is a question that we get very frequently. And Critical Access Hospitals are not required to submit data through Inpatient Quality Reporting. However, if they choose to report eCQM data through IQR, they can satisfy that portion of the EHR Incentive Program.

Grace, I'll let you handle for HRRP and HAC.

Grace Im: Thanks, Cindy.

So, for the Readmissions Reduction Program, as well as the Hospital-Acquired Condition Reduction Program, Critical Access Hospitals are not included in those programs.

Candace Jackson: Thank you.

Additional questions that we received quite frequently was in reference to "What does Fiscal Year 2018 stand for? When you refer to Fiscal Year 2018, could you please specify which calendar dates this corresponds to?"

Cindy Tourison: Thanks, Candace. I'll take that one.

So, it depends on the measure and the measurement period. We are currently vetting and finalizing a spreadsheet that will capture all of our FY 18 measures to include the measurement periods across our quality reporting program from the acute perspective. So, we anticipate having that posted to the web in approximately the October timeframe.

Candace Jackson: Thank you, Cindy.

In addition to some of the fiscal year questions that we received, we also received several questions for – the question is, "For COPD mortality for proposed Fiscal Year 2021, what will be the performance period?"

Cindy Tourison: You know, I'm not certain if we didn't have that captured in a slide, I think we're going to have to answer that in the transcripts that we post with the recording of this presentation.

Candace Jackson: Thank you, Cindy. And, maybe for Grace, we got a couple of questions regarding "What is the performance period for HRRP readmissions for Fiscal Year 2017?"

Grace Im: Thanks, Candace.

So, for the FY 2017 program year for the Readmissions Reduction Program, the performance period for the Readmission Measures includes discharges from July 1, 2012 through June 30, 2015.

And then also, if I could just maybe provide some more clarifying information – So again, for the FY 2017 program year, it means that hospitals will receive their hospital specific reports through the *QualityNet Secure Portal* in the summer of2016, so next summer. And then also, the payment adjustment that is calculated, you know, based on those measures, the payment adjustment will go into effect beginning October 1 of 2016, which is the beginning of the federal Fiscal Year 2017.

Candace Jackson: Thank you, Grace.

Cindy, we have several questions where there is a lot of confusion in regards to the chart-abstracted measures that are required and the submission of the four CQMs. For example, "If we choose a required chart-abstracted measure to also submit as eCQM, do we need to still submit that chart-abstracted measure?"

Cindy Tourison: Yes, Candace. Can we navigate back to that slide that shows the required chart-abstracted measures?

So, we had proposed to give the hospitals a choice between submitting in either the electronic or the chart-abstracted measure mode. However, based on public comments and the desire to have continuity in public reporting, we have finalized that all of the chart-abstracted measures listed on the slide that Candace is navigating to will actually be required for all four quarters for the program year.

Candace Jackson: And just a second, it was at the very beginning.

Cindy Tourison: It was, yes.

Candace Jackson: There we go.

Cindy Tourison: Yes, so all of these measures are required in their chart-abstracted form for the entire year. You may also choose those which have overlapping eCQM, you can choose to do those in the electronic version as part of the four required for FY 2018 reporting and that's – you only have to report a quarter of data and it can be quarter three or quarter four and the deadline for the eCQM data is February 28 of 2017.

Candace Jackson: Thank you, Cindy.

We have several questions in relation to the Structural Measure, the Patient Safety Culture Measure. "How will that measure be reported and is there anywhere that it defines what a standardized tool is?" And, I will address that to Cindy.

Cindy Tourison: Oh, I'm sorry, I'm getting some feedback.

So, we do – so it will be a Structural Measure that is entered through our *QualityNet* website. And, there – and actually the questions themselves are included in the Final Rule. And so, you can actually go into the Final Rule and see, I think there's four, maybe five questions, that will be asked and there are a couple of standard surveys that we believe are used by hospitals that are named on that. So, we'll be surveying to assess which hospitals are using which survey, if any survey.

Candace Jackson: Thank you, Cindy.

Couple more questions that we received – "Are any of the removed measures going to be considered voluntary for IQR?"

Cindy Tourison: No, they are not going to be considered voluntary for IQR.

Candace Jackson: Thank you.

And then we had a couple of questions in regards to, again, "If fourth quarter eCQM is submitted, is manual abstraction required for first, second and third quarters?" And I believe, maybe, that you covered that already, Cindy.

Cindy Tourison: Yes, I think maybe if you want to go back to that chart-abstracted screen again, slide 11, those measures are required to be chart-abstracted regardless of the eCQM selected for submission to satisfy the eCQM requirement.

Candace Jackson: And, if they submit the four eCQM measures, will they have to submit the same measures as manually abstracted?

Cindy Tourison: All of the measures listed on the screen are required for manual abstraction.

Candace Jackson: And I have a question for Grace. We received a couple of questions. "When will the Fiscal Year 2016 HAC preview reports be released?"

Grace Im: Thank you, Candace.

So, those preview reports, we actually refer to them as Hospital-Specific Reports, have already been made available on the *QualityNet Secure Portal*, and that's for the FY 2016 program.

Candace Jackson: And another question we received – a couple from the HAC program. "Is the HAC POA program going away or is there an update on it?"

Grace Im: So, I think that is referring to the Deficit Reduction Act HAC payment provision, and it's actually a completely separate payment provision than the HAC Reduction Program. So, I know that sometimes there is some

confusion. And, so with respect to the, what we call the DRA HACs, we did publicly report four measure rates that are used under that payment provision. And, unfortunately, I don't have any updates on that. Again, just to clarify, it is a separate program from the HAC Reduction Program.

Candace Jackson: Thank you.

And we have time for one last question, and that's in regard to the new hardship policy and extraordinary circumstance for eCQM, and – "Where can we find the hardship policy and would [it] be available for application for the four IQR eCQM reporting requirements?"

Cindy Tourison: Thank you, Candace.

As I mentioned during the slide, we will be issuing an FAQ and further education on this form. We've received several questions, including what would the deadline look like for something like this. So, we will be issuing further guidance in the coming months.

Candace Jackson: Thank you.

And again, that is the time for our presentation today. We thank everyone for joining us today, and I hope the information that was provided to you was beneficial and will be helping you as you proceed with the IQR and other program requirements. And we hope that you have a great rest of the afternoon. Thank you.

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