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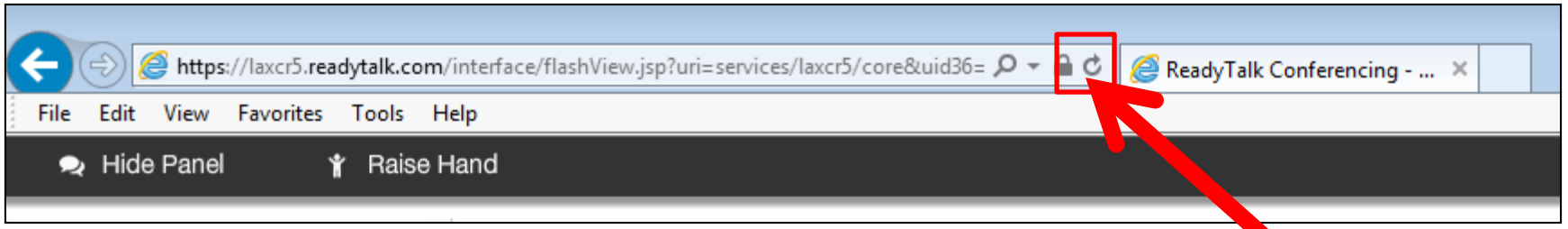

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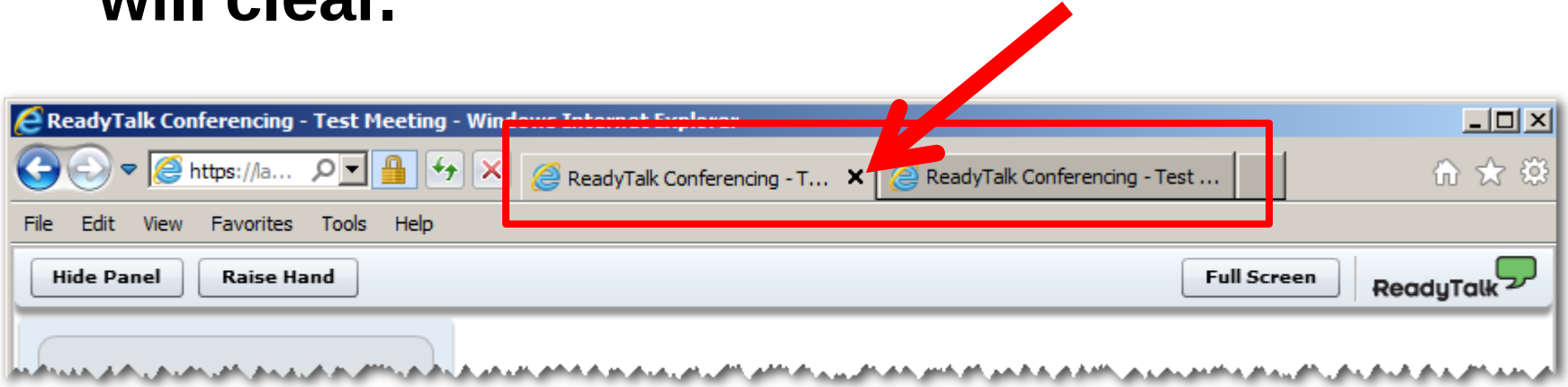

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Fiscal Year (FY) 2018 Inpatient Prospective Payment System (IPPS) Final Rule

Acute Care Hospital Quality Reporting Programs Overview

August 29, 2017

Speakers

Grace H. Snyder, JD, MPH

Program Lead, Hospital Inpatient Quality Reporting (IQR) Program and Hospital Value-Based Purchasing (VBP) Program Quality Measurement and Value-Based Incentives Group (QMVIG)
Center for Clinical Standards and Quality (CCSQ), CMS

Mihir P. Patel, MHA

Lead, Hospital IQR and Outpatient Quality Reporting (OQR) Program Data Validation
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Elizabeth Bainger, DNP, RN, CPHQ

Program Lead, Hospital-Acquired Condition (HAC) Reduction Program
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Lauren Lowenstein, MPH, MSW

Acting Program Lead, Hospital Readmissions Reduction Program (HRRP)
QMVIG, CCSQ, CMS

Moderator

Candace Jackson, RN

Project Lead, Hospital IQR Program
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)

Purpose

This presentation will provide participants with the FY 2018 IPPS hospital quality program finalized proposals. This discussion will address the final rule's impact on the following programs:

- Hospital Inpatient Quality Reporting (IQR) Program
- Hospital Value-Based Purchasing (VBP) Program
- Hospital-Acquired Condition (HAC) Reduction Program
- Hospital Readmissions Reduction Program (HRRP)

Objectives

Participants will be able to perform the following tasks:

- Locate the FY 2018 IPPS final rule text
- Identify changes within the FY 2018 IPPS final rule

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Program Lead, Hospital IQR Program and Hospital VBP Program, QMVIG, CCSQ, CMS

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Lead, Hospital IQR and OQR Program Data Validation, QMVIG, CCSQ, CMS

Hospital Inpatient Quality Reporting (IQR) Program

Refinements to Existing Measures

Refinements were finalized for the following measures:

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure
- Stroke 30-Day Mortality Rate (MORT-30-STK) measure

HCAHPS Survey

HCAHPS Survey Measure Refinements

- Refine the existing HCAHPS Survey questions (HCAHPS questions 12, 13, and 14) to focus more directly on communication with patients about their pain during the hospital stay
- Update the name of the composite measure from “Pain Management” to “Communication About Pain”
- Be effective for FY 2020 payment determination and subsequent years (beginning with CY 2018 reporting)
- Be publicly reported for the first time on *Hospital Compare* in October 2020, using CY 2019 data
- Will provide performance results, based on CY 2018 data, in confidential preview reports as early as July 2019

HCAHPS Survey

Previous Pain Questions	Newly Finalized Pain Questions
• During this hospital stay, did you need medicine for pain? ☐ Yes ☐ No	• During this hospital stay, did you have any pain? ☐ Yes ☐ No
• During this hospital stay, how often was your pain well controlled? ☐ Never ☐ Sometimes ☐ Usually ☐ Always	• During this hospital stay, how often did hospital staff talk with you about how much pain you had? ☐ Never ☐ Sometimes ☐ Usually ☐ Always
• During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? ☐ Never ☐ Sometimes ☐ Usually ☐ Always	• During this hospital stay, how often did hospital staff talk with you about how to treat your pain? ☐ Never ☐ Sometimes ☐ Usually ☐ Always

Stroke 30-Day Mortality Rate Measure

- Refinement of the risk-adjustment model to include stroke severity, based on the National Institutes of Health (NIH) Stroke Scale obtained from International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes in claims
- Confidential hospital-specific feedback reports in CY 2021, using claims data for discharges occurring from October 1, 2017 through June 30, 2020
- Public reporting, starting in CY 2022, using claims data for discharges occurring from July 1, 2018 through June 30, 2021; applicable for the FY 2023 payment determination

NOTE: Current stroke mortality measure (that does not use NIH stroke severity codes) will continue to be used in the Hospital IQR Program and publicly reported through CY 2021.

CY 2018 Voluntary Reporting on Hybrid Measure

Hybrid Hospital-Wide 30-Day Readmission (HWR) Measure

- Uses claims data and 13 core clinical data elements from electronic health records (EHRs) and six linking variables
- Measurement period: January 1 – June 30, 2018, on at least 50 percent of discharged Medicare fee-for-service (FFS) patients age 65 and older
- Submission period in fall 2018
- Confidential hospital-specific reports (HSRs)
- Will not impact a hospital's annual payment determination
- Will not be publicly displayed

CY 2018 Voluntary Reporting on Hybrid Measure

- EHR data should include the following elements:
  - Thirteen core clinical data elements
    - Six vital signs (heart rate, respiratory rate, temperature, systolic blood pressure, oxygen saturation, weight)
    - Seven laboratory test results (hematocrit, white blood cell count, sodium, potassium, bicarbonate, creatinine, glucose)
  - Six linking variables to match patient EHR data to CMS claims data (CMS Certification Number [CCN], Health Insurance Claim [HIC] Number or Medicare Beneficiary Identifier [MBI], date of birth, sex, admission date, discharge date)
- Report utilizing Quality Reporting Document Architecture (QRDA) Category I files via the *QualityNet Secure Portal*

Modifications to eCQM Reporting Requirements for the CY 2017 Reporting Period (FY 2019 Payment Determination)

For hospitals participating in the Hospital IQR Program:

- Report on **four** of the 15 available eCQMs
- Report **one** self-selected calendar quarter in CY 2017 (Quarter [Q] 1, Q2, Q3, or Q4)
- Submission deadline is February 28, 2018
- Technical requirements
  - Use EHR technology certified to the 2014 Edition, 2015 Edition, or combination (Office of the National Coordinator for Health Information Technology [ONC] standards) and certified to all available eCQMs
  - Use eCQM specifications published in the 2016 eCQM annual update for CY 2017 reporting and applicable addenda; available on the Electronic Clinical Quality Improvement (eCQI) Resource Center website at https://ecqi.healthit.gov/eh
  - Use 2017 CMS Implementation Guide for QRDA Category I; available at https://ecqi.healthit.gov/qrda

NOTE: Meeting the Hospital IQR Program eCQM requirement also satisfies the CQM electronic reporting requirement for the Medicare EHR Incentive Program for eligible hospitals (EHs) and critical access hospitals (CAHs).

Finalized Modifications to eCQM Reporting Requirements for the CY 2018 Reporting Period (FY 2020 Payment Determination)

For hospitals participating in the Hospital IQR Program:

- Report on **four** of the 15 available eCQMs
- Report **one** self-selected calendar quarter in CY 2018 (Q1, Q2, Q3 or Q4)
- Submission deadline is February 28, 2019
- Technical requirements
  - Use EHR technology certified to the 2014 Edition, 2015 Edition, or combination (ONC standards) and certified to all available eCQMs
  - Use eCQM specifications published in the 2017 eCQM annual update for CY 2018 reporting and applicable addenda; available on the eCQI Resource Center website at https://ecqi.healthit.gov/eh
  - Use 2018 CMS Implementation Guide for QRDA Category I; available at https://ecqi.healthit.gov/qrda

NOTE: Meeting the Hospital IQR Program eCQM requirement also satisfies the CQM electronic reporting requirement for the Medicare EHR Incentive Program for EHs and CAHs.

Public Reporting of eCQM Data

- Public display of eCQM data on *Hospital Compare* continues to be delayed in conjunction with the implementation of the eCQM data validation process.
- Public display of eCQM data will be addressed in a future CMS IPPS rule.

eCQM Data Validation of Hospital IQR Program

- Submit eight records (eight cases per quarter, over one quarter) for the FY 2020 payment determination and subsequent years
- Additional exclusion criteria for the FY 2020 payment determination and subsequent years
- Continuing previously finalized medical record submission requirements for the FY 2021 payment determination and subsequent years

eCQM Data Validation: Number of Cases

Hospitals selected for participation in eCQM data validation will be required to submit the following:

- 8 cases (8 cases x 1 quarter) from CY 2017 eCQM data (for the FY 2020 payment determination)
- 8 cases (8 cases x 1 quarter) from CY 2018 eCQM data (for the FY 2021 payment determination)

eCQM Data Validation: Selection of Hospitals and Cases

Expanded the types of hospitals excluded from selection for eCQM data validation FY 2020 and subsequent payment determinations.

- Any hospital that does not have at least five discharges for at least one reported eCQM
- Episodes of care that are longer than 120 days
- Cases with a zero denominator for each measure

NOTE: Criteria will be applied **before** the random selection of 200 hospitals for eCQM data validation, meaning the hospitals meeting any one of the aforementioned criteria are not eligible for selection.

eCQM Data Validation: Scoring

Continuing the policy that the accuracy of eCQM data submitted for validation will **not affect** a hospital's validation score for FY 2021 payment determination.

NOTE: Continue previously finalized medical record submission requirements in order to meet validation requirements for the FY 2021 payment determination and subsequent years.

Chart-Abstracted Data Validation

- Formalizing the educational review process for chart-abstracted measure data, beginning with validation for the FY 2020 payment determination and subsequent years.
- Use this process to correct quarterly scores for any of the first three quarters of validation in order to compute the final confidence interval.

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Hospital Value-Based Purchasing (VBP) Program

FY 2018 Estimated Funds

- Under section 1886(o)(7)(C)(iv) of the Social Security Act, the applicable percent withhold for FY 2018 is **2.00** percent.
- Estimated total amount available for value-based incentive payments for FY 2018 is approximately **$1.9 billion**.

FY 2018 Tables 16, 16A, and 16B

- Table 16 (Proxy Adjustment Factors)
  - Available in the FY 2018 IPPS proposed rule tables
  - Based on Total Performance Scores (TPSs) from FY 2017
- Table 16A (Updated Proxy Adjustment Factors)
  - CMS updated Table 16 as Table 16A in the FY 2018 IPPS final rule to reflect changes based on more updated MedPAR data and FY 2017 TPSs.
  - Available on CMS.gov at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending
- Table 16B (Actual Adjustment Factors)
  - After hospitals have been given an opportunity to review and correct their actual TPSs for FY 2018, CMS intends to display Table 16B in the fall of 2017.
    - Actual value-based incentive payment adjustment factors
    - Exchange function slope
    - Estimated amount available for the FY 2018 program year

Removal of Patient Safety Indicator (PSI) 90

- CMS is removing the current PSI 90 measure from the Hospital VBP Program, beginning with the FY 2019 program year.

- Background

  An ICD-10 version of the **current** PSI 90 measure is not being developed, nor will ICD-10 Agency for Healthcare Research and Quality (AHRQ) Quality Indicators (QI) software be available to calculate performance scores for the FY 2019 program year. As a result, CMS will not be able to calculate performance scores for the current PSI 90 measure for the FY 2019 through FY 2022 program years.

Adoption of PSI 90 Modifications

Summary of PSI 90 modifications (beginning with FY 2023 program year):

- "Patient Safety Indicator" measure name changed to "Patient Safety and Adverse Events Composite"
- Addition of three indicators
  - PSI 09 - Perioperative Hemorrhage or Hematoma Rate
  - PSI 10 - Physiologic and Metabolic Derangement Rate
  - PSI 11 - Postoperative Respiratory Failure Rate
- Re-specification of two indicators
  - PSI 12 - Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
  - PSI 15 - Accidental Puncture or Laceration Rate
- Removal of PSI 07 Central Venous Catheter-Related Bloodstream Infection Rate
- Reweighting of component indicators in the modified PSI 90 measure is based not only on the volume of each of the patient safety and adverse events, but also the harms associated with the events.

Measure Additions

- Patient Safety and Adverse Events Composite (Modified PSI 90)
  - **Program Year:** FY 2023 and subsequent years
  - **Baseline Period:** October 1, 2015 – June 30, 2017
  - **Performance Period:** July 1, 2019 – June 30, 2021
  - **Domain:** Safety; aligns with CMS Quality Strategy goal of making care safer
- Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia (PN Payment)
  - **Program Year:** FY 2022 and subsequent years
  - **Baseline Period:** July 1, 2013 – June 30, 2016
  - **Performance Period:** August 1, 2018 – June 30, 2020
  - **Domain:** Efficiency and Cost Reduction; aligns with CMS Quality Strategy goal of making care affordable

FY 2019 and FY 2020 Domains and Measures

Safety

1. **CDI**: Clostridium difficile Infection
2. **CAUTI**: Catheter-Associated Urinary Tract Infection
3. **CLABSI**: Central Line-Associated Bloodstream Infection
4. **MRSA**: Methicillin-Resistant *Staphylococcus aureus* Bacteremia
5. **SSI**: Surgical Site Infection Colon Surgery & Abdominal Hysterectomy
6. **PC-01**: Elective Delivery Prior to 39 Completed Weeks Gestation

Efficiency and Cost Reduction

MSPB: Medicare Spending per Beneficiary

Domain Weights

Clinical Care

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

Person and Community Engagement

HCAHPS Survey Dimensions

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

FY 2019 Measurement Periods

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

*The current PSI 90 measure is being removed, beginning with the FY 2019 program year. As a result, the previously finalized performance and baseline periods for this measure are not included in this table.

FY 2020 Measurement Periods

Domain	Baseline Period	Performance Period
Clinical Care • Mortality (MORT-30-AMI, MORT-30-HF, MORT-30-PN) • THA/TKA	July 1, 2010–June 30, 2013 July 1, 2010–June 30, 2013	July 1, 2015–June 30, 2018 July 1, 2015–June 30, 2018
Person and Community Engagement (HCAHPS)	January 1–December 31, 2016	January 1–December 31, 2018
Safety • PC-01 • HAI Measures	January 1–December 31, 2016 January 1–December 31, 2016	January 1–December 31, 2018 January 1–December 31, 2018
Efficiency and Cost Reduction (MSPB)	January 1–December 31, 2016	January 1–December 31, 2018

FY 2019 and FY 2020 Minimum Data Requirements

Domain/TPS	Minimum Requirements
Person and Community Engagement Domain Score	100 HCAHPS Surveys
Efficiency and Cost Reduction Domain Score	Minimum of **one** measure score • MSPB: 25 Episodes of Care
Clinical Care Domain	Minimum of **two** measure scores • 30-Day Mortality measures: 25 cases • THA/TKA measure: 25 cases
Safety Domain	Minimum of **two** measure scores • HAI measures: one predicted infection • PC-01: 10 cases
Total Performance Score	Minimum of **three** of the four domains receiving domain scores

FY 2020 Performance Standards

Domain	Measure	Benchmark	Achievement Threshold
Safety	CAUTI	0.000	0.828
	CLABSI	0.000	0.784
	CDI	0.091	0.852
	MRSA Bacteremia	0.000	0.815
	SSI • Colon Surgery • Abdominal Hysterectomy	 0.000 0.000	 0.781 0.722
	PC-01	0.000000	0.000000
Clinical Care	MORT-30-AMI	0.875869	0.853715
	MORT-30-HF	0.906068	0.881090
	MORT-30-PN	0.909532	0.882266
	THA/TKA	0.023178	0.032229

FY 2020 Performance Standards

Domain	Dimension	Benchmark	Achievement Threshold	Floor
Person and Community Engagement	Communication with Nurses	87.12%	79.08%	51.80%
	Communication with Doctors	88.44%	80.41%	50.67%
	Responsiveness of Hospital Staff	80.14%	65.07%	35.74%
	Communication about Medicines	73.86%	63.30%	26.16%
	Cleanliness and Quietness of Hospital Environment	79.42%	65.72%	41.92%
	Discharge Information	92.11%	87.44%	66.72%
	Care Transition	62.50%	51.14%	20.33%
	Overall Rating of Hospital	85.12%	71.59%	32.47%

Weighting Measures Within the Efficiency and Cost Reduction Domain

Beginning with the FY 2021 program year, when additional payment measures join the MSPB measure in the Efficiency and Cost Reduction domain:

- MSPB measure will comprise 50 percent of a hospital's domain score.
- The other condition-specific payment measures, weighted equally, will comprise the remaining 50 percent of a hospital's domain score.

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Hospital-Acquired Condition (HAC) Reduction Program

Finalized Policies

- FY 2020 performance periods
  - Domain 1: July 1, 2016 – June 30, 2018
  - Domain 2: January 1, 2017 – December 31, 2018
- ECE policies (beginning with events that occur on or after October 1, 2017)
  - Signed by CEO or designated personnel
  - Strive to notify the facility of CMS decision within 90 days of receiving request
  - CMS may grant ECEs due to CMS data system issues that affect data submission.

Clarification

- Hospitals have an opportunity to review and correct underlying claims and HAI data.
  (78 FR 50725 through 50728)
- HAC Reduction Program 30-day review and corrections period allows hospitals an opportunity to perform the following:
  - Review the scores, which are calculated from the underlying data
  - Submit questions about the calculations of their results
  - Request corrections of their scores
- HAC Reduction Program 30-day review and corrections period does not allow hospitals to correct underlying data.
- In the FY 2018 final rule, the HAC Reduction Program made no changes to its review and corrections policies.

Received Comments

- Additional measures for potential future adoption
- Accounting for social risk factors
- Accounting for disability and medical complexity in the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) measures in Domain 2

Thank you for your comments!

HAC Reduction Program Additional Resources

HAC Reduction Program Methodology and General Information

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

HAC Reduction Program Results

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

Recalibrated PSI 90 Composite

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

CLABSI, CAUTI, SSI, MRSA, and CDI

- HAIs: www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228760487021
- NHSN: nhsn@cdc.gov

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Acting Program Lead, HRRP, QMVIG, CCSQ, CMS

Hospital Readmissions Reduction Program (HRRP)

Summary of Finalized Changes

- **FY 2018**
  - Applicable time period
  - Calculation of the aggregate payments for excess readmission
  - Updates to the extraordinary circumstance exception (ECE)
- **Effective FY 2019**
  Changes to the payment adjustment factor in accordance with the 21st Century Cures Act

FY 2018 Updates

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

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

NOTE: PCS = Procedure Coding System

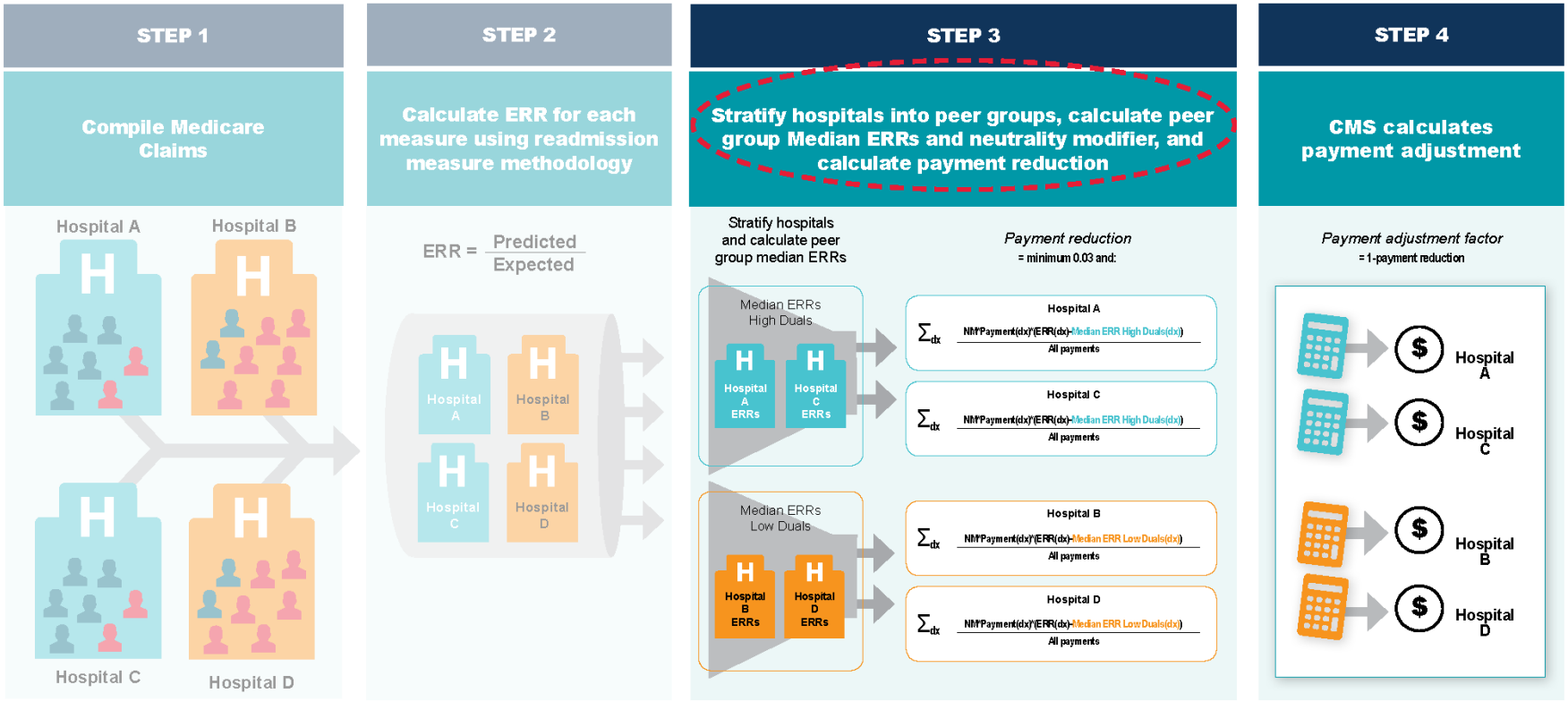
Extraordinary Circumstance Exception (ECE) Policy

- The facility can submit a form signed by the CEO or designated personnel.
- Formal response notifying the facility of ECE decision within 90 days of receipt of the facility's request.
- CMS can grant ECEs due to CMS data system issues that affect data submission.

FY 2019: 21st Century Cures Act

- Requires CMS to assess penalties, based on a hospital's performance relative to other hospitals with a similar proportion of full-benefit dual-eligible patients
- Requires budget neutrality—estimated payments under the new methodology must equal estimated payments under the original methodology

Illustrative Example of the Stratified Methodology Using Two Peer Groups



NOTE: Blue = high proportion of dual-eligible beneficiaries; orange = low proportion of dual-eligible beneficiaries; blue person = dual-eligible beneficiary; red person = Medicare-only beneficiary; ERR = excess readmission ratio. An ERR is calculated for each of the six HRRP readmission measures: AMI, HF, pneumonia, COPD, THA/TKA, and CABG. This figure includes two peer groups for illustrative purposes; however, in the FY 2018 IPPS final rule, CMS finalized a policy to stratify hospitals into five peer groups.

FY 2019: Determining Proportion of Dually Eligible Patients

- **Dual Proportion Definition**
  - Numerator (full-benefit duals): Identified as full-benefit dual, based on data sourced from the State Medicare Modernization Act (MMA) file
  - Denominator (total number of Medicare patients):
    - All Medicare FFS and Medicare Advantage stays.
      - This will accurately represent the proportion of dually eligible patients the hospital served, particularly for hospitals in states with high managed care penetration rates.
- **Data Period**

  The three-year performance period will be used to account for the influence of social risk on excess readmissions.

Assigning Hospitals to Peer Groups

Quintile peer groups (five groups) will be used to accurately account for the proportion of dual-eligible patients the hospital serves without the disadvantages from establishing a large number of small peer groups.

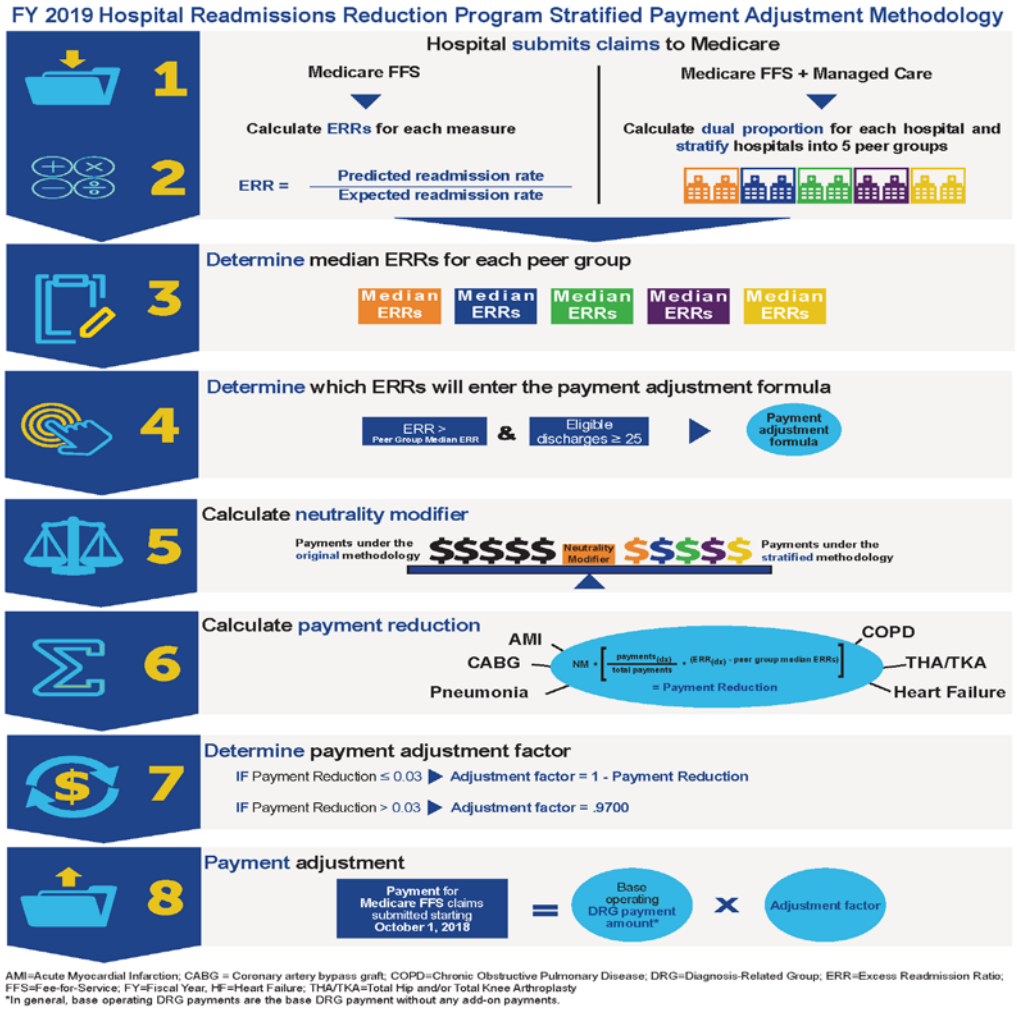
Payment Adjustment Formula Methodology

- Median excess readmission ratio (ERR) plus a neutrality modifier will be used to calculate a hospital's payment adjustment factor.
- This approach creates a standard where a hospital's ERR is subject to payment reduction if a hospital's performance, as measured by the ERR, is worse than half of other hospitals in its peer group.

Budget Neutrality Modifier

- CMS will apply a neutrality modifier to ensure budget neutrality.
- Calculating the neutrality modifier
  - Estimate total Medicare savings across all hospitals under the original method and using the Median ERR method (in the absence of a modifier).
  - Calculate a multiplicative factor that, when applied to each hospital's payment adjustment under the Median ERR method, equates total Medicare savings from that method to total Medicare savings under the original method.

New Payment
2019 Payment Methodology



AMI=Acute Myocardial Infarction; CABG = Coronary artery bypass graft; COPD=Chronic Obstructive Pulmonary Disease; DRG=Diagnosis-Related Group; ERR=Excess Readmission Ratio; FFS=Fee-for-Service; FY=Fiscal Year, HF=Heart Failure; THA/TKA=Total Hip and/or Total Knee Arthroplasty
*In general, base operating DRG payments are the base DRG payment without any add-on payments.

Payment Adjustment Formula Methodology

Original Methodology

$$P = 1 - \min\left\{.03, \sum_{dx} \frac{Payment\,(dx) * \max\{(\mathrm{ERR}\,(\mathrm{dx}) - 1.0), 0\}}{All\ payments}\right\}$$

FY 2019 Finalized Methodology

Median ERR plus a neutrality modifier

$$\mathrm{P} = 1 - \min\left\{.03, \sum_{\mathrm{dx}} \frac{NM_M\,\mathrm{Payment}\,(\mathrm{dx}) * \max\{(\mathrm{ERR}\,(\mathrm{dx}) - \boxed{\mathrm{Median}}\ \mathrm{peer\ \ group\ \ ERR}\,(\mathrm{dx})), 0\}}{\mathrm{All\ \ payments}}\right\}$$

Estimated Impact of the Finalized Methodology for the FY 2019 Compared to the Original Methodology

Table. Penalty as a share of payments for safety-net and non-safety-net hospitals for FY 2017 and FY 2018 performance periods

Performance Period	Methodology	Original Methodology	Finalized Methodology (median plus neutrality modifier)
FY 2017 Performance Period (proposed rule)	Safety-net hospitals	0.64%	0.55%
	Non-safety-net hospitals	0.61%	0.63%
FY 2018 Performance Period (final rule)	Safety-net hospitals	0.63%	0.54%
	Non-safety-net hospitals	0.63%	0.65%

NOTE: FY 17 NM = 0.9546; FY 18 NM = 0.9481

Early Look at Stratified HRRP Payment Methodology

CMS will distribute HSRs to hospitals in the first quarter of 2018.

- The FY 2018 reporting period data will be used along with the new methodology to simulate hospital results.
- The reports will include the hospital's peer group assignment, ERR results, and simulated payment adjustment factor.

Resources on Reducing Hospital Readmissions

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

HRRP General Inquiries
qnetsupport@hcqis.org

HRRP Measure Methodology Inquiries
cmsreadmissionmeasures@yale.edu

More Program and Payment Adjustment Information
https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html

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

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

FY 2018 IPPS Final Rule Page Directory

Download the FY 2018 IPPS final rule from the *Federal Register* at https://www.gpo.gov/fdsys/pkg/FR-2017-08-14/pdf/2017-16434.pdf.

Details regarding various quality programs can be found on the pages listed below.

- Hospital Readmissions Reduction Program pp. 38221 – 38240
- Hospital Value-Based Purchasing (VBP) Program pp. 38240 – 38269
- Hospital-Acquired Condition (HAC) Reduction Program pp. 38269 – 38278
- Hospital Inpatient Quality Reporting (IQR) Program pp. 38323 – 38411
- PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program pp. 38411 – 38425
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP) pp. 38425 – 38461
- Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program pp. 38461 – 38474
- Clinical Quality Measurement for Eligible Hospitals and Critical Access Hospitals (CAHs) Participating in the Electronic Health Record (EHR) Incentive Programs pp. 38474 – 38485
- Clinical Quality Measurement for Eligible Professionals (EPs) Participating in the Medicaid EHR Incentive Program in 2017 pp. 38485 – 38487
- Changes to the Medicare and Medicaid EHR Incentive Programs pp. 38487 – 38493

Questions

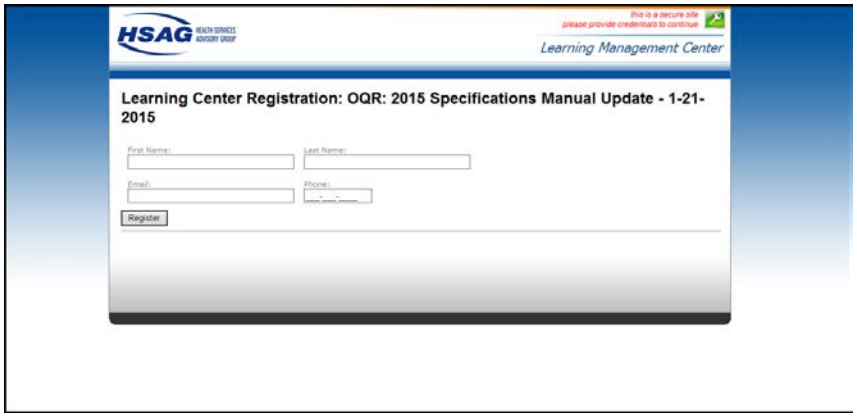
Continuing Education

- This event has been approved for 1.0 continuing education (CE) unit by the national Board of Registered Nursing (Provider #16578).

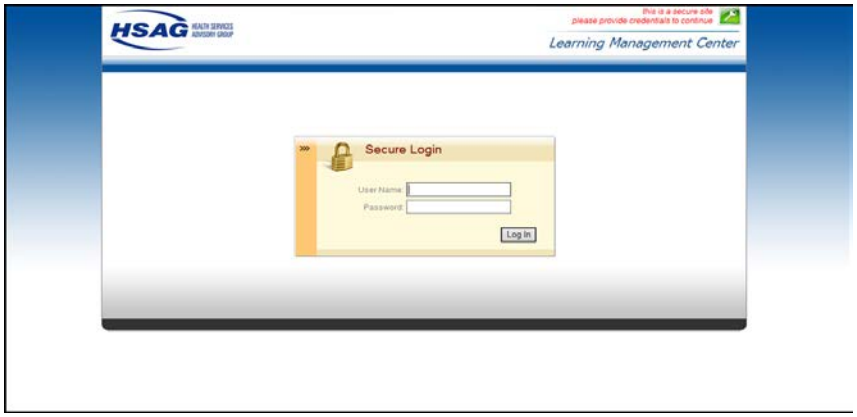
  Please Note: To verify CE approval for any other license or certification, please check with your licensing or certification board.
- Report your credit to your own board.
- Complete the survey and register for credit.
- Registration is automatic and instantaneous.

Register for Credit

- New User
- Use personal email and phone.
- Go to email address; finish process.



- Existing User
- Entire email is your user name.
- You can reset your password.



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