Hospital Quality Reporting Program Updates:

An Overview of the CMS Final IPPS Rule for 2017

Presented by Vicky Mahn-DiNicola RN, MS, CPHQ

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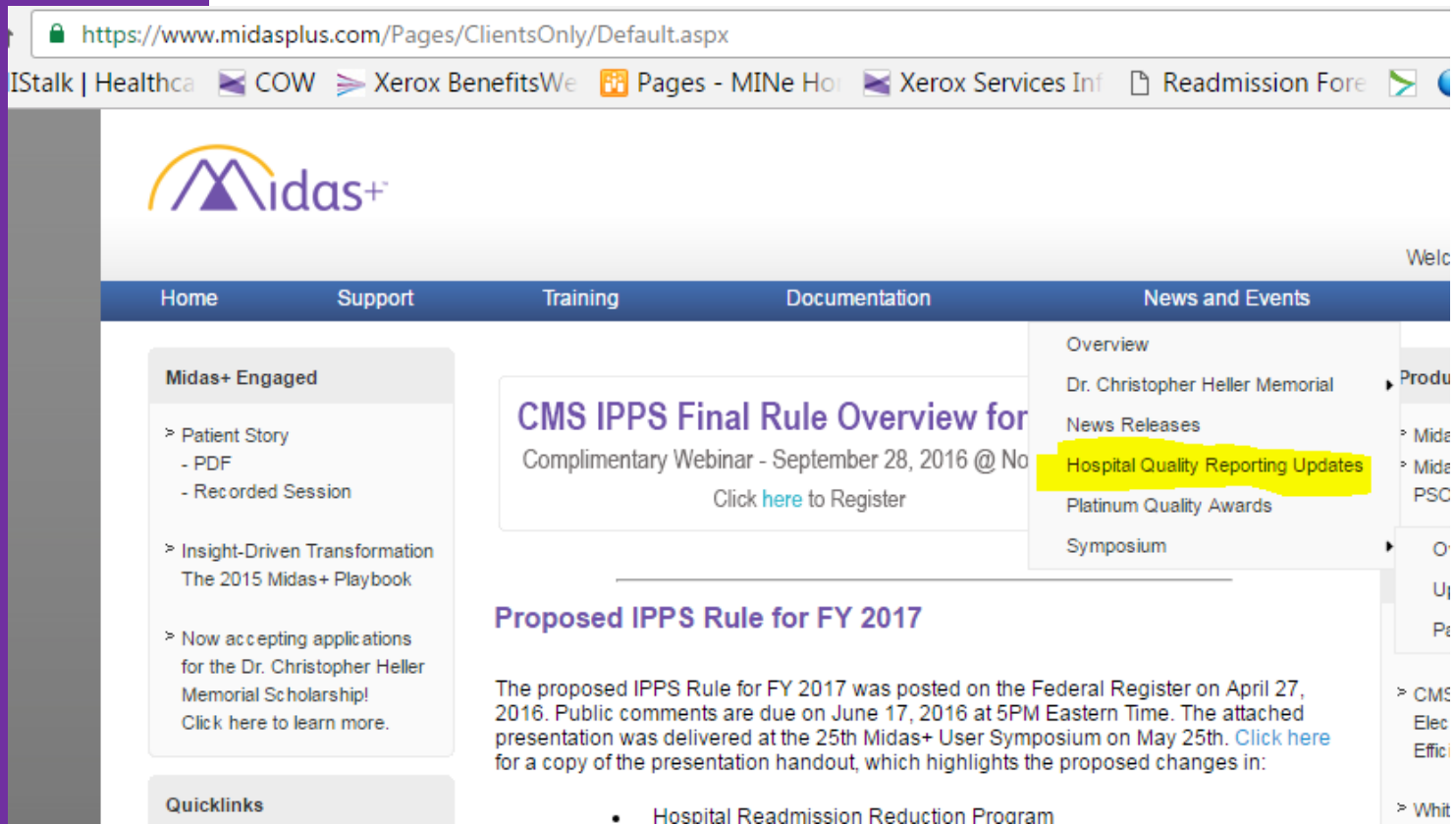
A. Go to the Midas Clients Only Website
B. Choose the “News and Events” tab
C. Choose “Hospital Quality Reporting Updates”



About Your Presenter

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- Currently serving on the Advanced Analytics Team at Midas+
- Measurement developer, product manager and analytics researcher at Midas+ since 1997
- Masters Degree in Nursing from University of Arizona
- Member of the National Quality Forum
- Member of the ACMA National Policy Committee

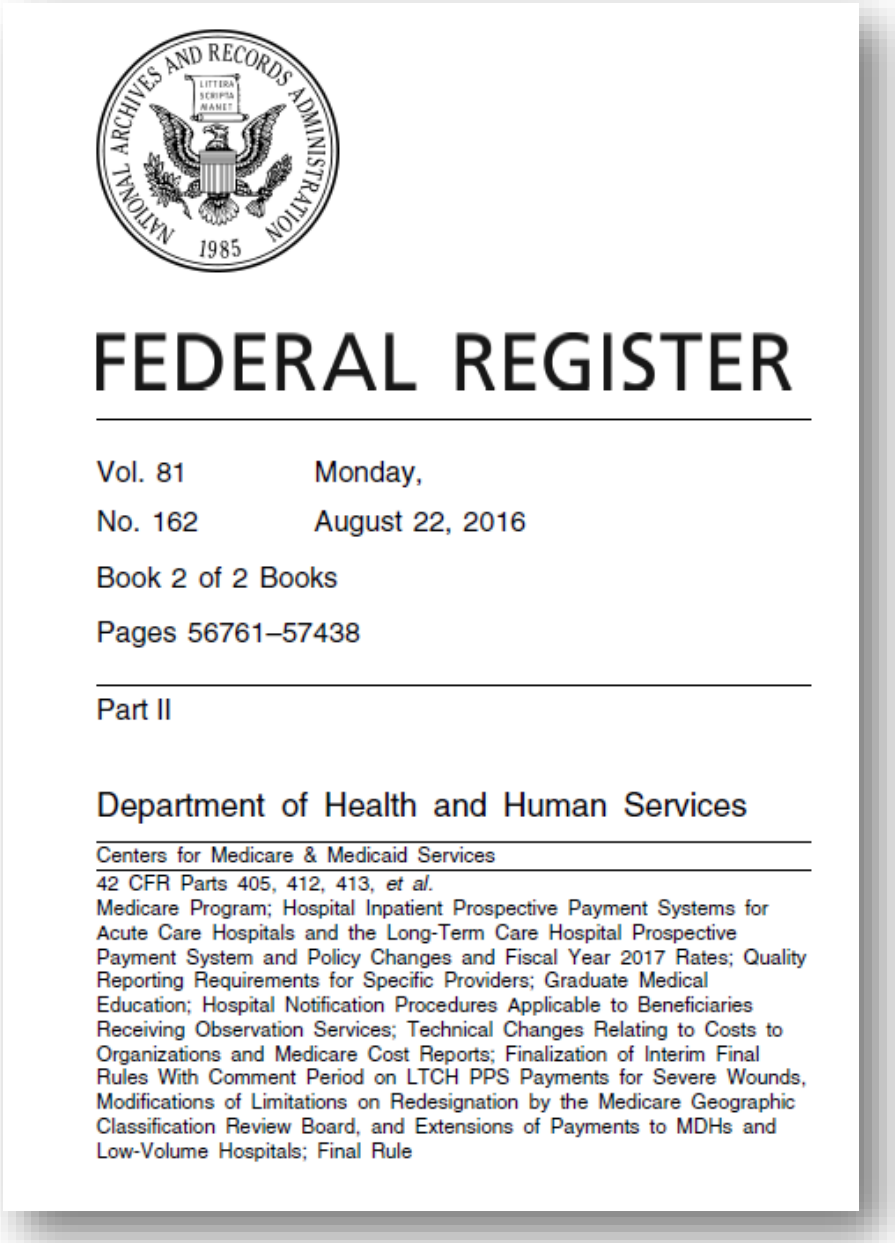
Session Objectives

- Describe the changes in the Hospital Readmission Reduction Program starting with discharges beginning October 1, 2016.
- Discuss how the Hospital Value Based Purchasing Program will be changing in FY 2018 and beyond.
- Explain the changes in the scoring methodology that will occur in the Hospital Acquired Conditions Reduction Program in FY 2018 and beyond.
- Discuss the way ways that the Hospital Inpatient Quality Reporting Program will be changing to align with the electronic quality reporting requirements associated with Meaningful Use.
- Describe the changes in the Hospital-based Inpatient Psychiatric Services Quality Reporting Program

Review of FINAL IPPS Rule for FY 2017 CMS-1655-F Vol. 81, No. 162

42 CFR Parts 405, 412, 413, and 485

Posted to Federal Registry August 22, 2016



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Vol. 81 Monday,

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Book 2 of 2 Books

Pages 56761–57438

Part II

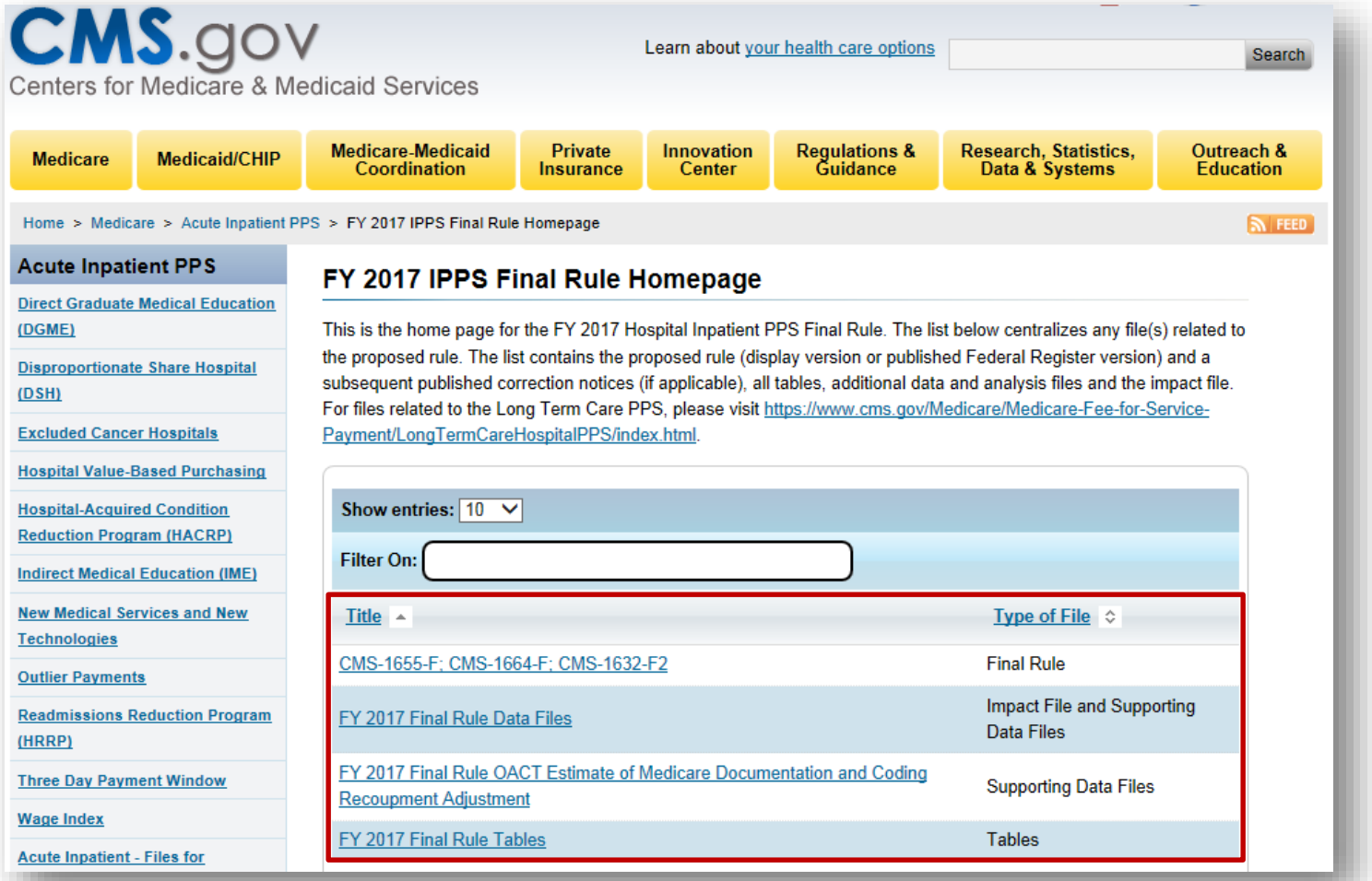
Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, 413, *et al.*

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; Technical Changes Relating to Costs to Organizations and Medicare Cost Reports; Finalization of Interim Final Rules With Comment Period on LTCH PPS Payments for Severe Wounds, Modifications of Limitations on Redesignation by the Medicare Geographic Classification Review Board, and Extensions of Payments to MDHs and Low-Volume Hospitals; Final Rule

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html



Dates to Remember

Applicable Discharges

Varies by Measure and Program

Example: Applicable discharges for Readmission Reduction Program in FY 2017 are July 1, 2012 to June 30, 2015

Payment Determination

October 1, 2016 is the first day of CMS Fiscal Year 2017

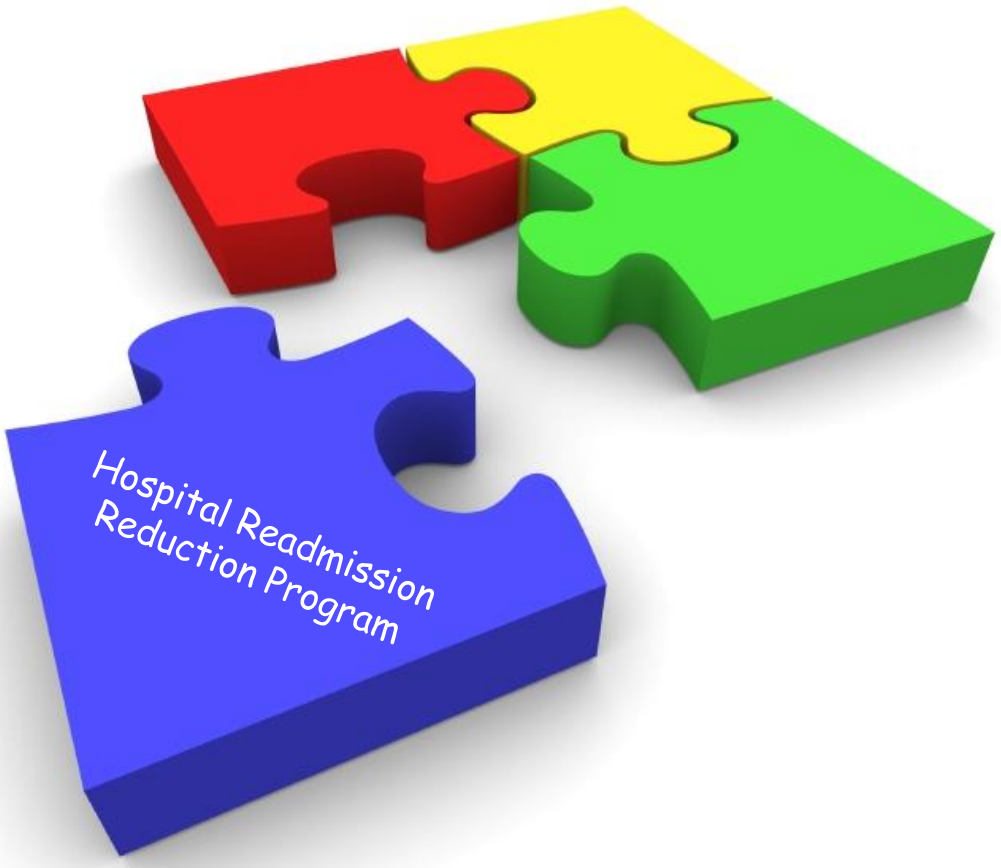
"Payment Determination"

Impacts payment for patients discharged October 1, 2016 through September 30, 2017

Hospital Readmission Reduction Program

Review of the IPPS 2017 Final Rule

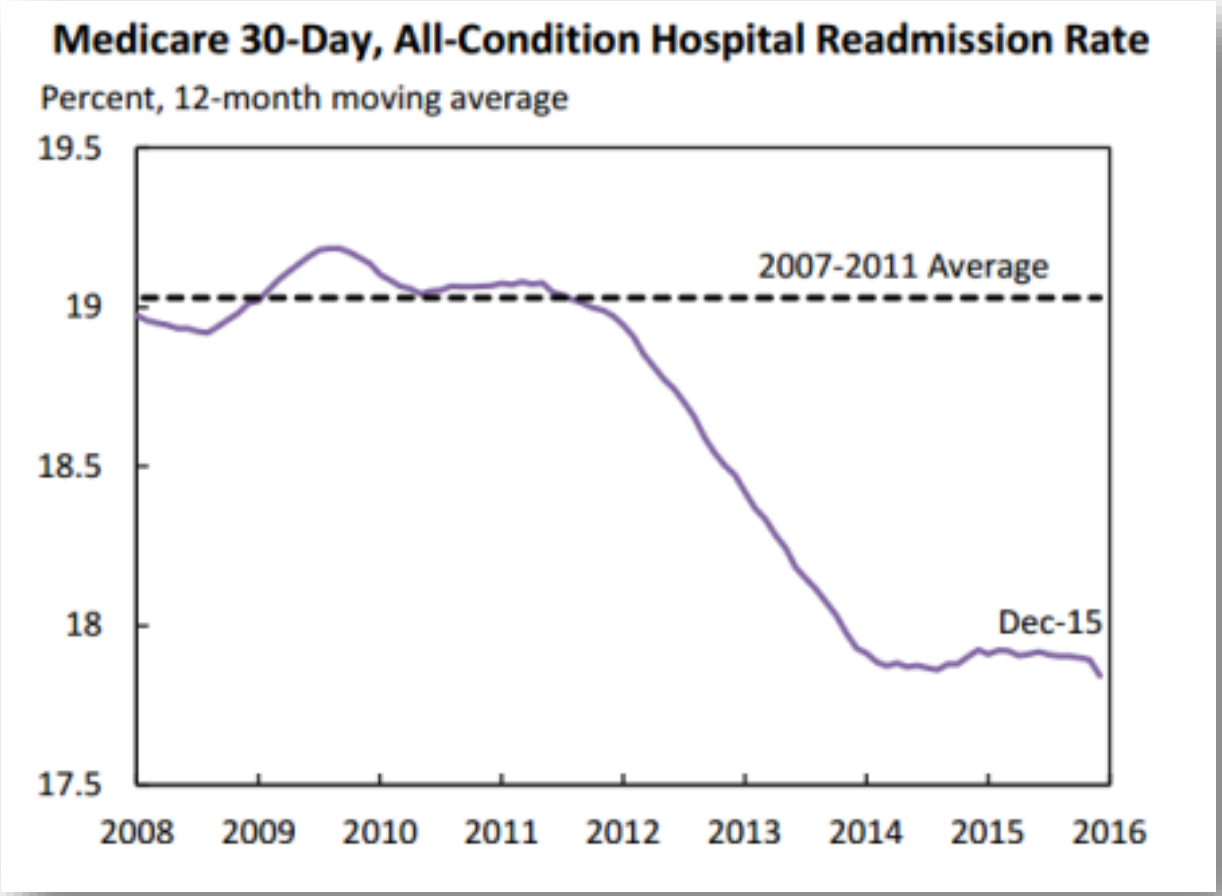
Starts on page 56,973



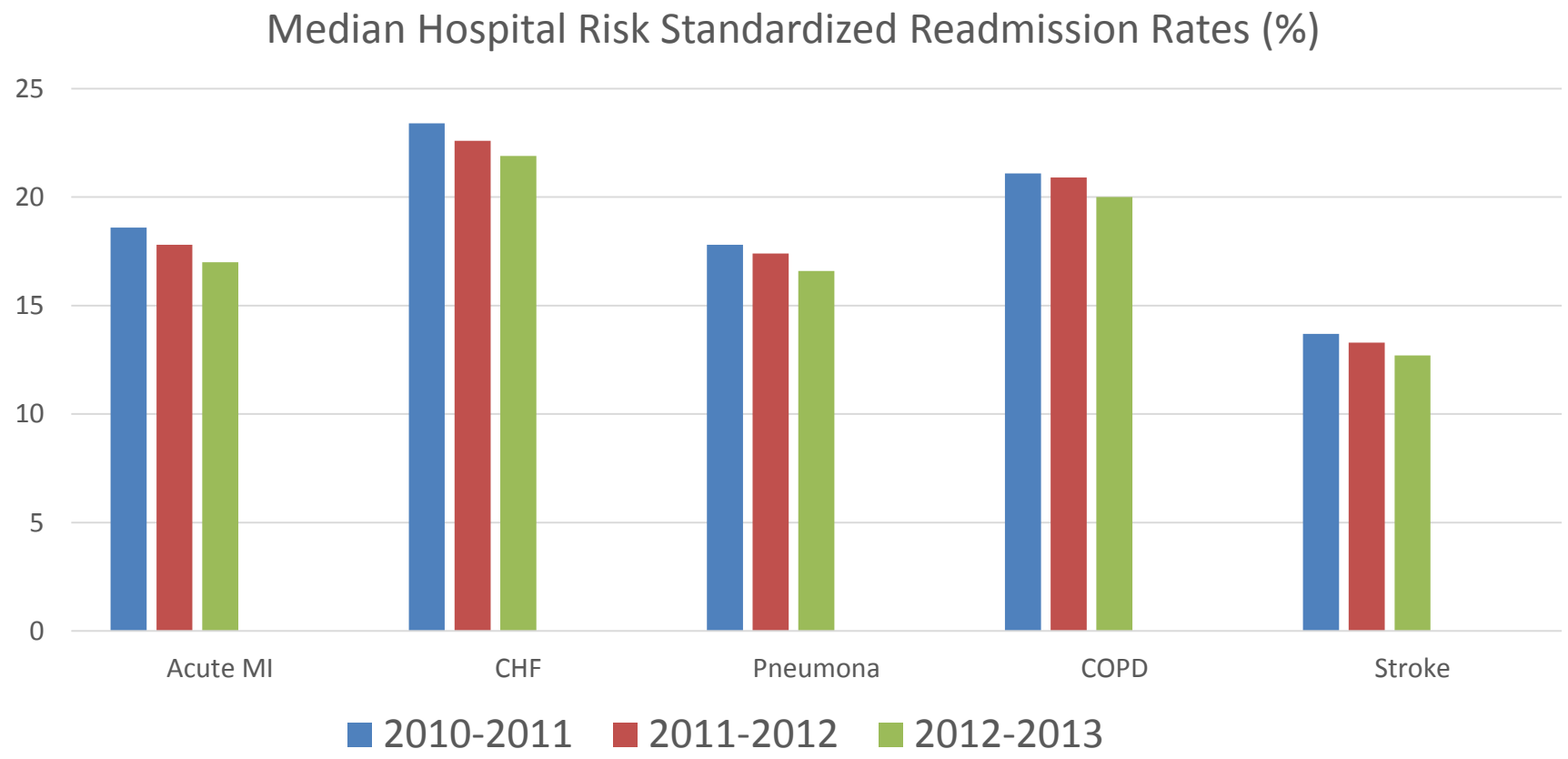
Readmission Rates Falling Nationally

https://blog.cms.gov/2016/09/13/new-data-49-states-plus-dc-reduce-avoidable-hospital-readmissions/

- All states but one have seen Medicare 30-day readmission rates fall.
- In 43 states, readmission rates fell by more than 5 percent.
- In 11 states, readmission rates fell by more than 10 percent.



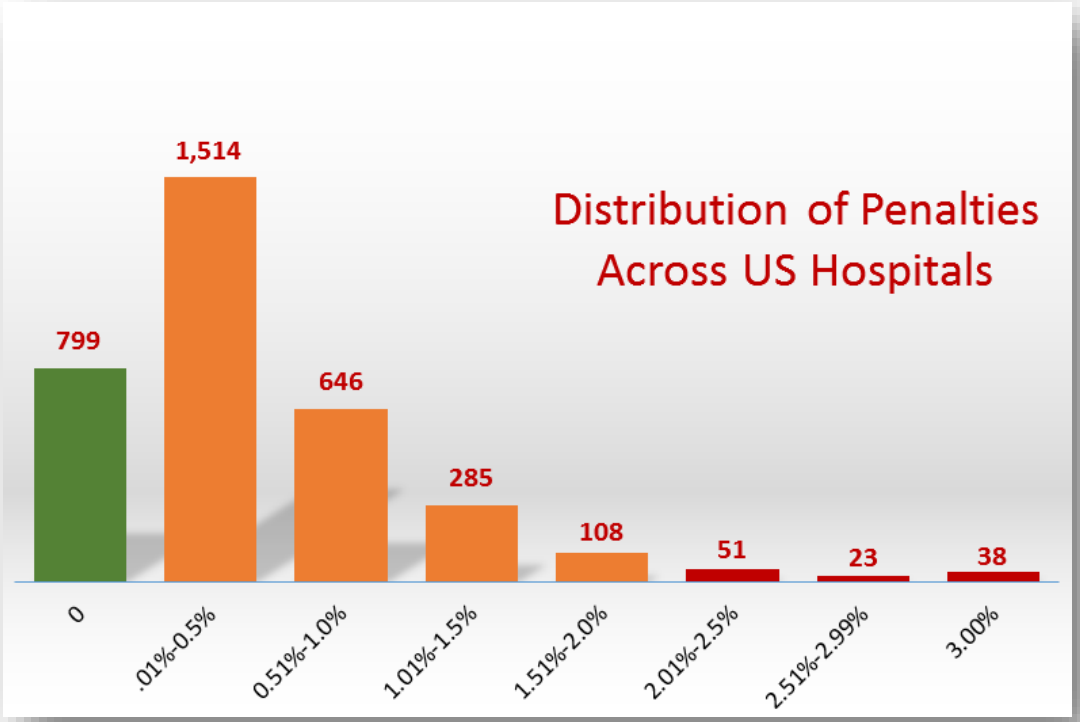
Incremental Progress Being Made to Reduce Readmissions Across All Groups



Impact on US Hospitals FY 2016 Readmission Penalty

FY 2016

- 3,464 hospitals in the program
- 2,665 hospitals penalized
- $420 Million in all US Penalties
- 799 (23%) had no penalty
- 38 had full 3% penalty
- Average penalty .61



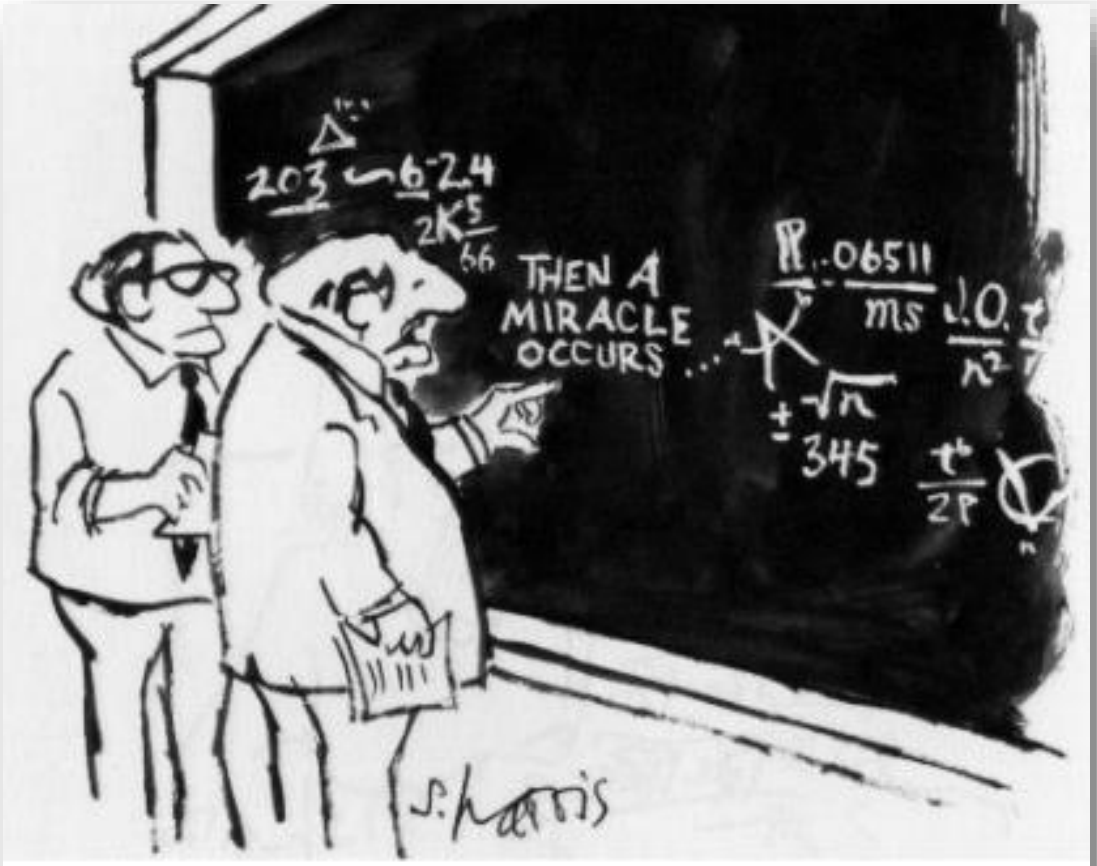
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page-Items/FY2016-IPPS-Final-Rule-Tables.html

Performance, Penalty and Payment

- An “excess readmission ratio” is calculated for each cohort
- Must have NO excess readmissions in ALL SEVEN cohorts to avoid penalty (no extra credit is given for better than expected performance)
- Your final hospital adjustment factor is multiplied by your hospital’s base DRG payment
  - An adjustment factor of .9800 means you will be penalized 2% of your payment from Medicare
  - .9700 (3%) is the maximum allowable adjustment factor for any hospital
  - Applies to ALL Medicare FFS claims, not just for claims in the program cohorts

Excess Readmission Ratio Calculation

Excess Readmission Ratio = Predicted/Expected



"I think you should be more explicit here in step two."

from *What's so Funny about Science?* by Sidney Harris (1977)

- Difficult for hospitals to "replicate" their excess readmission ratios because readmissions to non-same hospitals can apply and Medicare Part A and B claims and enrollment histories are used in risk adjustment methodology

A Primer on Predicted and Expected

Excess Readmission Ratio = Predicted /Expected

Predicted FY 2017 = [**Your patient's risk factors from Part A & B Claims** (July 1, 2011 – June 30, 2015) **x** **CMS Risk Coefficients** (July 1, 2012 – June 30, 2015)] + **Your hospital provider Intercept** (July 1, 2012 - June 30, 2015)

Expected FY 2017 = [**Your patient's risk factors from Part A & B Claims** (July 1, 2011 – June 30, 2015) **x** **CMS Risk Coefficients** (July 1, 2012-June 30, 2015)] + **Average hospital provider intercept for all Section(d) Hospitals in US** (July 1, 2012 – June 30, 2015)

Timelines for Reporting on Hospital Compare

- Preview files not available before late June
- Hospitals have 30 days to review and correct the "excess readmission" calculations (not permitted to change the data)
- Final "Hospital Specific Reports" available and posted on hospital compare as early as October *(although could occur later for a particular year in order to streamline reporting and align with other quality reporting programs)*

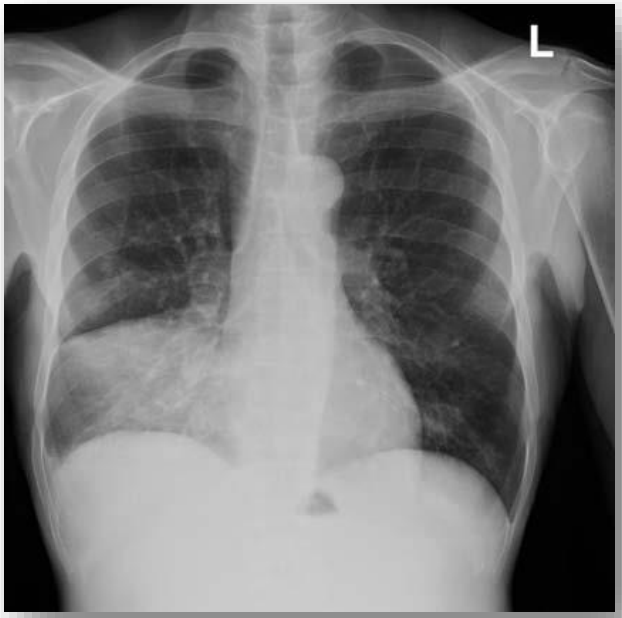
The History of the Hospital Readmission Reduction Program

	Payments for FY 2013	Payments for FY 2014	Payments for FY 2015	Payments for FY 2016	Payments for FY 2017	Payments for FY 2018
Max Penalty	1%	2%	3%	3%	3%	3%
Acute MI	✓	✓	✓	✓	✓	✓
Pneumonia	✓	✓	✓	✓	✓ *Expanded*	✓ *Expanded*
Heart Failure	✓	✓	✓	✓	✓	✓
COPD			✓	✓	✓	✓
Total Hip/Knee			✓	✓	✓	✓
CABG					✓ New!	✓
Stroke	*Included in Hospital Inpatient Quality Reporting Program but **NOT** in Hospital Readmission Reduction Program*					
Planned Readmits Excluded		✓ Version 2.1	✓ Version 2.1	✓ Version 3.0	✓ Version 4.0	*Pending*
Based on Discharges	July 1, 2008 to June 30, 2011	July 1, 2009 to June 30, 2012	July 1, 2010 to June 30, 2013	July 1, 2011 to June 30, 2014	July 1, 2012 to June 30, 2015	July 1, 2013 to June 30, 2016

Changes Made in Last Year's FY 2016 IPPS Rule
Impacting Payment Determination for FY 2017

- Heart Failure population exclusions added
  - Left ventricular assist device (LVAD) implantation or heart transplantation either during index admission or in the 12 months prior to the index admission
- Expansion of Pneumonia Cohort (index population)
  - 30-day, All-Cause, Risk-Standardized Readmission Rate following Pneumonia Hospitalization (NQF-0506)
  - Currently including only patients with a principle diagnosis of viral or bacterial pneumonia
  - ADDDING patients with a principle diagnosis (meaning present on admission) of aspiration pneumonia
  - ADDING patients with a principle diagnosis of sepsis or respiratory failure (meaning present on admission) with a secondary diagnosis of pneumonia
  - Begins with payment determination FY 2017 (applies to July 1, 2012 discharges forward)
- Adopted an Extraordinary Circumstance Exception policy *(implemented FY16)*

Expected Impact of Broader Pneumonia Cohort



- More hospitals will be eligible (hospitals with less than 25 cases in the three year reporting period are excluded from public reporting)
  - Change in population would add 634,519 patients (representing a 65% increase in national population size)
  - 42 additional hospitals will be eligible for public reporting
  - Overall increase of 0.9 estimated in absolute percentage points
  - Excess readmission ratios expected to change for some hospitals

See Additional Details About Impact of this change at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html

Exclusions to New CABG Population

- Patients < 65 years of age
- Patients who leave AMA
- Patients who expire during the initial hospitalization
- Patients who undergo repeat CABG procedures during the three year measurement period (only the first one will be included)
- Patients not enrolled in Medicare FFS Part A and B for 12 months prior to date of index admission
- Admissions for patients without at least 30-days post-discharge enrollment in Medicare FFS
- Patients enrolled in Medicare Advantage (Part C)
- Patients in a Federal VA hospital

- Isolated CABG Procedures (ICD-9 Codes 36.10 to 36.19) only Included in cohort. Patients with the following are excluded:
  - Valve procedures;
  - Atrial and/or ventricular septal defects;
  - Congenital anomalies;
  - Other open cardiac procedures;
  - Heart transplants;
  - Aorta or other non-cardiac arterial bypass procedures;
  - Head, neck, intracranial vascular procedures; or,
  - Other chest and thoracic procedures.

For codes that identify non-isolated CABG procedures not included in cohort or to see Risk Adjustment variables see *http://www.QualityNet.org* >Hospital-Inpatient > Claims-Based Measures > Readmission Measures > Measure Methodology (Version 4.0).

NQF Ongoing Pilot on Risk Adjustment by Sociodemographic Variables

No changes from CMS for FY 2017

- 2 year pilot *(began January 2015)*
- Evaluating multiple SDS methods for conceptual and empirical evidence
- Evaluating potential for organizations to make incorrect inferences on risk adjusted data
  - Disincentive to provide care to underserved or under privileged populations
- Evaluating potential data constraints and burden
- Anticipate that multiple criteria for application of SDS adjustment will evolve
  - Use for Performance Improvement Only
  - Use for P4P
  - Accountability measures

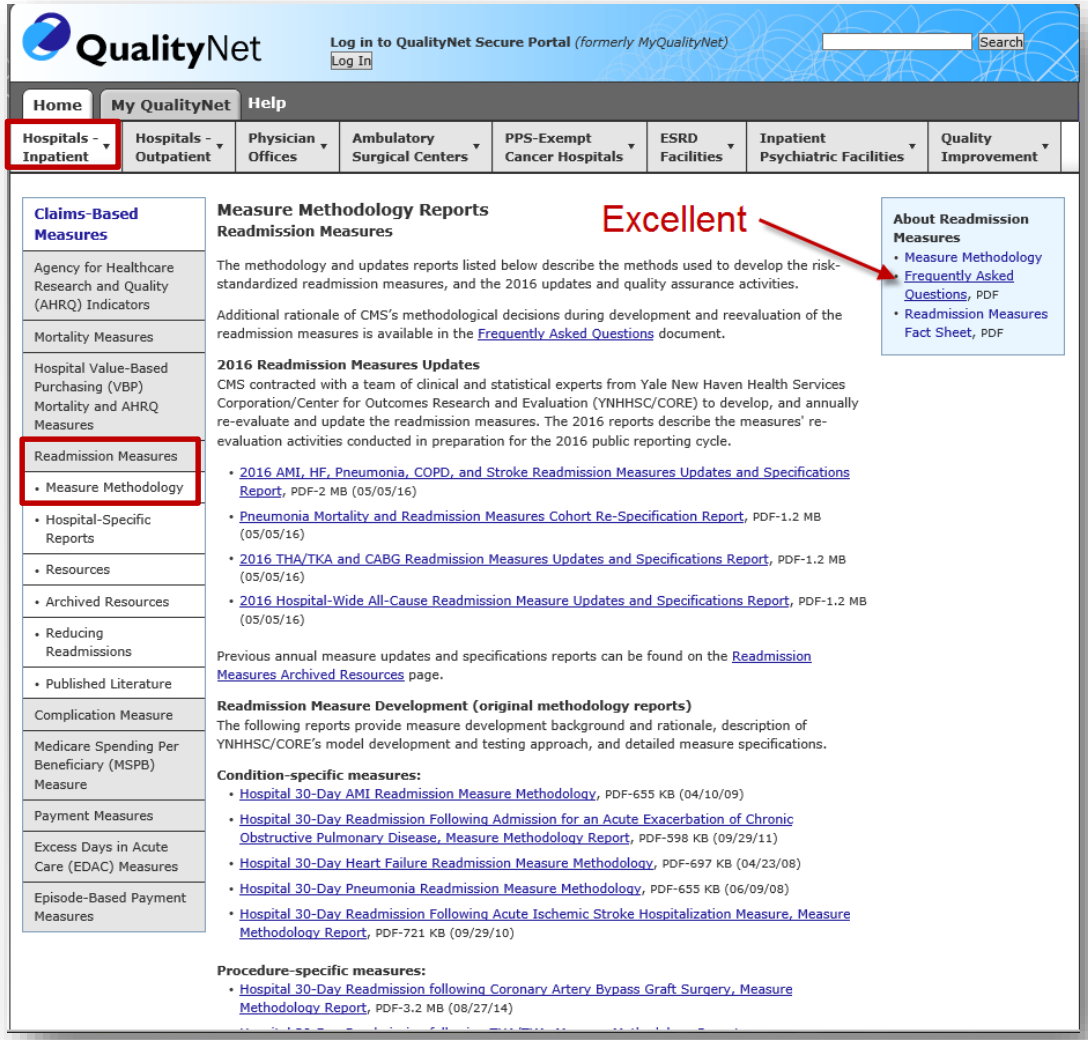
IMPACT ACT

Improving Medicare Post-Acute Care Transformation Act of 2014

- Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting research to examine the impact of sociodemographic status on quality measures, resource use, and other measures under the Medicare program
- Implement a standardize assessment and care planning tool, known as CARE (Continuity Assessment Record & Evaluation)
- Post Acute Care settings include skilled nursing facilities (SNF), home health agencies (HHA), inpatient rehabilitation facilities (IRF), and long-term care

Additional Resources

https://www.qualitynet.org/dcs/ContentServer?cid=1219069855841&pagename=QnetPublic%2FPage%2FQnetTier4&c=Page



- Scoring and Penalty Calculation Formulas
  https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html
- Send Questions about Risk Adjustment and Measure Methodology to:
  cmsreadmissionmeasures@yale.edu

Hospital Value Based Purchasing Program

Review of the IPPS 2017 Final Rule

Starts on page 56,979

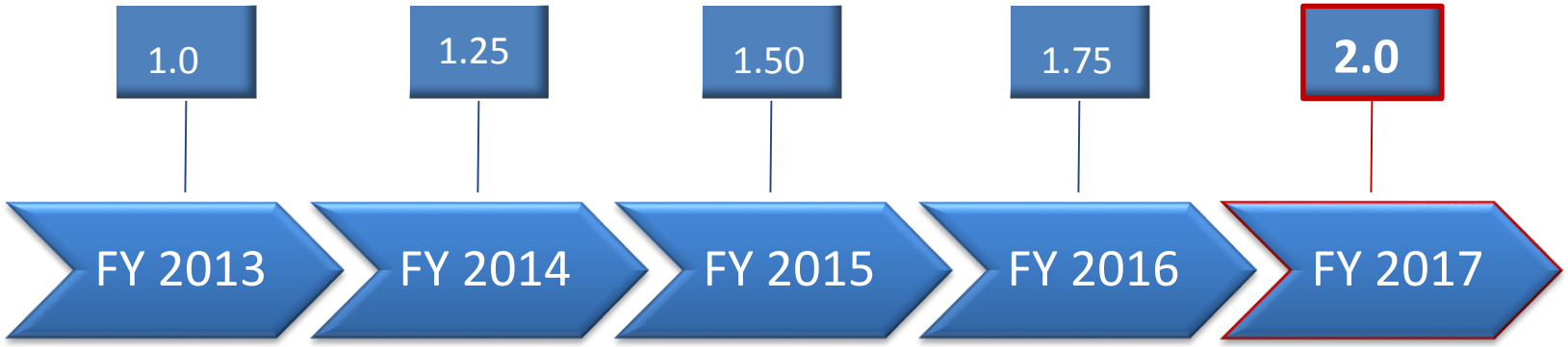
Hospital Value Based Purchasing FY 2018 and Beyond!

Funding pool started in 2012 with 1.00 percent of the base-operating DRG

FY 2017 Funding Pool capped at 2.0 with estimated funds at 1.8 Billion (1.489 Billion in FY 2016)

Applies to subsection (d) hospitals

Maryland Hospitals no longer exempt because they are no longer paid under section 1814 (b)(3), however they remain Exempt due to new Agreement signed January 1, 2014 to Participate in a 5-year All Payer Model



Impacts Payment for Discharges October 1, 2016 to September 30, 2017

More Dates to Remember

Dates vary by measure and program
Not all measures have baseline periods

Discharge dates for *prior performance* periods that you will be evaluated against

Discharge dates for *current performance* periods that will determine your score

Discharge dates for which your penalties or incentives will apply to payment

Value Based Purchasing Line Up for Program Year 2017

Three new measures adopted in FY 2015 IPPS Rule for FY 2017 VBP Program and domain weighting changes

25%	**Clinical Care Outcome Domain** Baseline Period: Oct 1, 2010 – June 30, 2012 Performance Period: Oct 1, 2013 – June 30, 2015
Mort-30-AMI	AMI 30-day mortality rate
Mort-30-HF	Heart Failure 30-day mortality rate
Mort-30-PN	Pneumonia 30-day mortality rate
5% Previously was 10%	**Clinical Care Process Domain** Baseline Period: Jan-Dec 2013 Performance Period: Jan-Dec 2015
AMI–7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
IMM-2	Influenza Immunization
PC-01	Elective Delivery Prior to 39 Completed Weeks Gestation

25%	**Patient Experience Domain** Baseline Period: Jan-Dec 2013 Performance Period: Jan-Dec 2015
HCAHPS	Hospital Consumer Assessment of Healthcare providers & Systems Survey

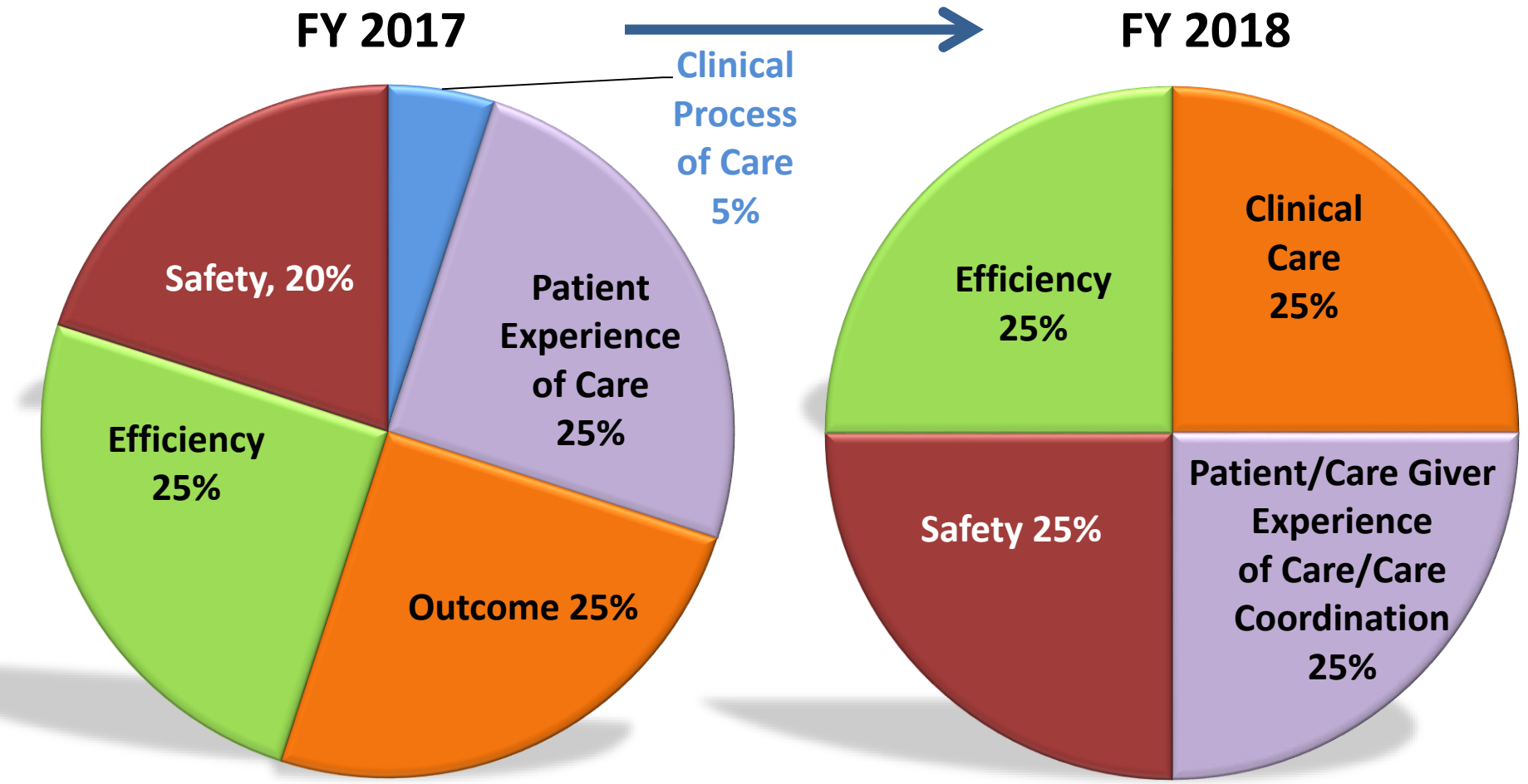
20% Previously was 15%	**Safety Domain** Baseline Period: Jan-Dec 2013 (excluding PSI-90) Performance Period: Jan-Dec 2015 (excluding PSI-90)
CAUTI	Catheter-Associated UTI
CLABSI	Central Line-Associated BSI SIR (non reliability adjusted)
PSI-90	Composite patient safety/complication • Baseline Period Oct 1, 2010 to June 30, 2012 • Performance Period Oct 1, 2013 to June 30, 2015
SSI	Surgical Site Infection • Colon • Abdominal Hysterectomy
C. Difficile	Clostridium difficile Infection SIR
MRSA	Methicillin-Resistant Staphylococcus aureus Bacteremia SIR

25%	**Efficiency Domain** Baseline Period: Jan-Dec 2013 Performance Period: Jan-Dec 2015
MSPB-1	Medicare Spending per Beneficiary

Hospitals must have sufficient data in at least three of four domains to calculate a total performance score

More Changing Domain Weighting

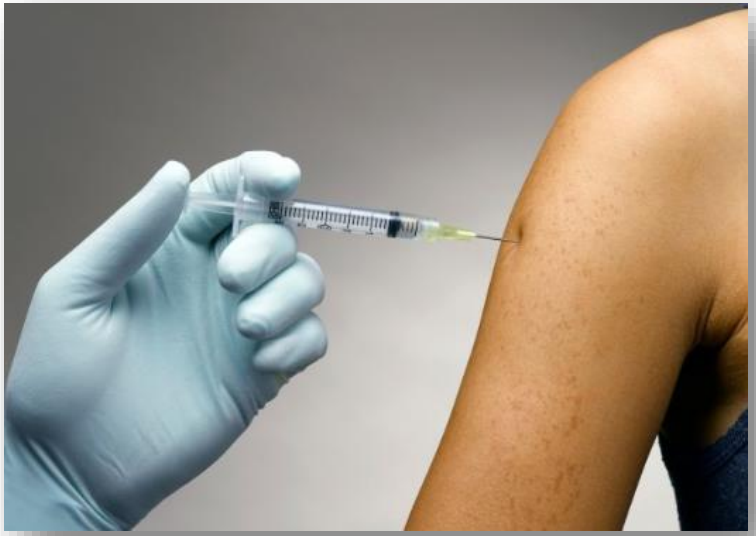
from previous rule making



Two Measures Finalized for Removal from Value Based Purchasing Program in FY 2018

In Final IPPS Rule 2016

- IMM-2 Influenza Immunization
  - Topped out statistically
  - Will continue in HIQR Program because it aligns with National Quality Strategy's Best Practice for Healthy Living Goal



Two Measures Finalized for Removal from Value Based Purchasing Program in FY 2018

In Final IPPS Rule 2016

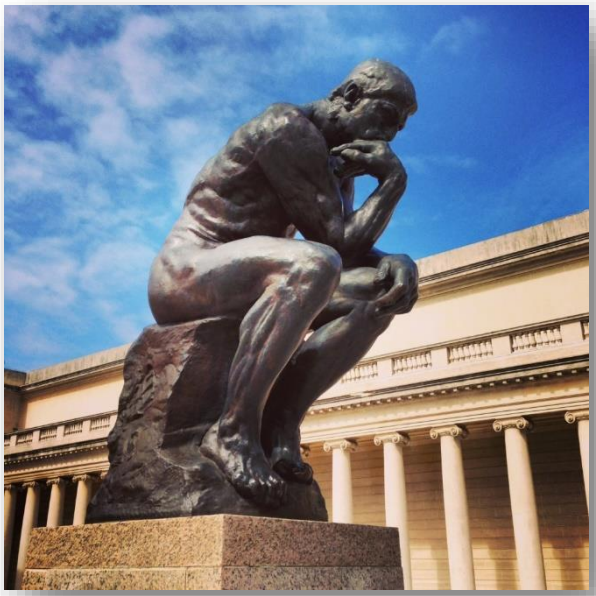
- AMI-7a Fibrinolytic Therapy Received within 30 minutes of hospital arrival
  - Rarely reported at most hospitals *(Most AMI patients get PCI)*
  - Also removed from Hospital IQR Program and EHR Incentive Program

Final Changes to AHRQ PSI 90: Patient Safety for Selected Indicators Composite for FY 2018 VBP

pages 56,979 -56,983

PREVIOUS PERFORMANCE PERIOD FOR FY 2018

- July 1, 2014 to June 30, 2016



Lots of thoughtful comments about weightings and inclusion variables for PSI-90 Composite

NEW PERFORMANCE PERIOD FOR FY 2018

- 15 month performance period: July 1, 2014 through September 30, 2015 for FY 2018 program
- Decision made not to combine ICD-9 and ICD-10 codes
- Proposing to remove the PSI-90 Composite Measure for FY 2019
- ICD-10 version of PSI 90 software not expected to be available from AHRQ until late CY 2017
- Intending to propose adoption of modified PSI 90 Measure in future rule making. FY 2018 will be using the older version of PSI-90

Current Value Based Purchasing Line Up for FY 2018 Program

25%	Safety Domain	Baseline Period	Performance Period
PC-1	Elective Delivery Prior to 39 Completed Weeks Gestation	Jan 1, 2014 – Dec 31, 2014	Jan 1, 2016 – Dec 31, 2016
CLABSI	Central Line-Associated Blood Stream Infection (non reliability adjusted)	Jan 1, 2014 – Dec 31, 2014	Jan 1, 2016 – Dec 31, 2016
CAUTI	Catheter-Associated UTI	Jan 1, 2014 – Dec 31, 2014	Jan 1, 2016 – Dec 31, 2016
SSI	Surgical Site Infection (Colon and Abdominal Hysterectomy)	Jan 1, 2014 – Dec 31, 2014	Jan 1, 2016 – Dec 31, 2016
C. Difficile	Clostridium difficile Infection SIR	Jan 1, 2014 – Dec 31, 2014	Jan 1, 2016 – Dec 31, 2016
MRSA	Methicillin-Resistant Staphylococcus aureus Bacteremia SIR	Jan 1, 2014 – Dec 31, 2014	Jan 1, 2016 – Dec 31, 2016
PSI-90	AHRQ Composite patient safety/complication **(non-modified version)**	July 1, 2010 – June 30, 2012	July 1, 2014 – **September 30, 2015****

25%	Patient Experience Domain Baseline Period: Jan-Dec 2014 Performance Period: Jan-Dec 2016
HCAHPS	Hospital Consumer Assessment of Healthcare providers & Systems Survey
CTM-3	Care Transition Measures (3)

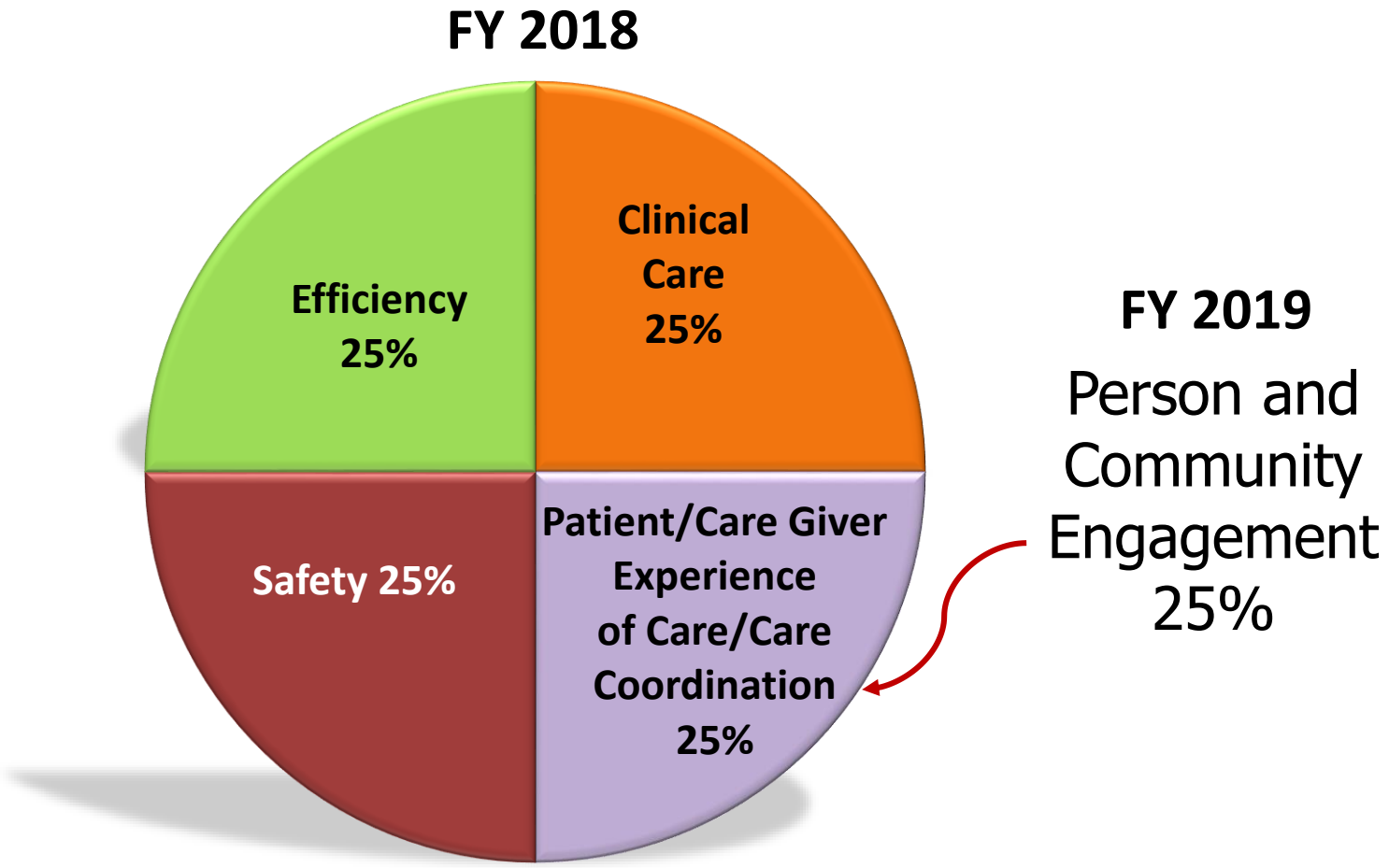
25%	Efficiency Domain Baseline Period: Jan 1, 2014 – Dec 31, 2014 Performance Period: Jan 1, 2016 – Dec 31, 2016
MSPB-1	Medicare Spending per Beneficiary

** Finalized in FY 2017 IPPS Rule

25%	Clinical Outcomes Domain Baseline Period: Oct 1, 2009 – June 30, 2012 Performance Period: Oct 1, 2013 – June 30, 2016
Mort-30-AMI	AMI 30-day mortality rate
Mort-30-HF	Heart Failure 30-day mortality rate
Mort-30-PN	Pneumonia 30-day mortality rate

Domain Name Change Finalized

Becomes effective for FY 2019



Final Changes in FY 2017 Rule for Safety Domain Effective in FY 2019

- ***Finalized*** *to add non-ICU patients to CAUTI and CLABSI*
- ***Proposing*** *to remove PSI-90 for FY 2019*

25%	Safety Measure	Baseline Period	Performance Period
PC-1	Elective Delivery Prior to 39 Completed Weeks Gestation	Jan 1, 2015 – Dec 31, 2015	Jan 1, 2017 – Dec 31, 2017
CLABSI	Central Line-Associated Blood Stream Infection (non reliability adjusted) - ICU and non-ICU locations	Jan 1, 2015 – Dec 31, 2015	Jan 1, 2017 – Dec 31, 2017
CAUTI	Catheter-Associated UTI - ICU and non-ICU locations	Jan 1, 2015 – Dec 31, 2015	Jan 1, 2017 – Dec 31, 2017
SSI	Surgical Site Infection (Colon and Abdominal Hysterectomy)	Jan 1, 2015 – Dec 31, 2015	Jan 1, 2017 – Dec 31, 2017
C. Difficile	Clostridium difficile Infection SIR	Jan 1, 2015 – Dec 31, 2015	Jan 1, 2017 – Dec 31, 2017
MRSA	Methicillin-Resistant Staphylococcus aureus Bacteremia SIR	Jan 1, 2015 – Dec 31, 2015	Jan 1, 2017 – Dec 31, 2017
~~PSI-90~~	~~AHRQ Composite patient safety/complication~~	~~July 1, 2011– June 30, 2013~~	~~July 1, 2015 – Jun 30, 2017~~

Value Based Purchasing Line Up for FY 2019 Program

FY 2017 Final IPPS Rule – page 56,985

25%	Clinical Care Domain Baseline Period: July 1, 2009 to June 30, 2012 Performance Period: July 1, 2014 to June 30, 2017
Mort-30-AMI	AMI 30-day mortality rate
Mort-30-HF	Heart Failure 30-day mortality rate
Mort-30-PN	Pneumonia 30-day mortality rate
RSCR-THA/TKA	Total Hip or Knee Arthroplasty Complication Rate Following Elective Surgery Baseline: July 1, 2010 to June 30, 2013 Performance: Jan 1, 2015 to June 30, 2017

25%	Person & Community Engagement Baseline Period: Jan-Dec 2015 Performance Period: Jan-Dec 2017
HCAHPS	Hospital Consumer Assessment of Healthcare providers & Systems Survey
CTM-3	Care Transition Measures (3)

25%	Efficiency and Cost Reduction Baseline Period: Jan-Dec 2015 Performance Period: Jan-Dec 2017
MSPB-1	Medicare Spending per Beneficiary

25%	Safety Domain Baseline Period: Jan-Dec 2015 Performance Period: Jan-Dec 2017
CAUTI	Catheter-Associated UTI (ICU and non-ICU)
CLABSI	Central Line-Associated Blood Stream Infection SIR (ICU and non-ICU)
PSI-90 ***	~~Composite patient safety/complication~~ • ~~Baseline Period July 1, 2011 to June 30, 2013~~ • ~~Performance Period: July 1, 2015 – Jun 30, 2017~~
SSI	Surgical Site Infection (ICU-only, signaling intent to propose inclusion of non-ICU for FY 2019) • Colon • Abdominal Hysterectomy
CDI	Clostridium difficile Infection SIR
MRSA	Methicillin-Resistant Staphylococcus aureus Bacteremia SIR
PC-01	Elective Delivery Prior to 39 Completed Weeks Gestation

**** **PSI-90 proposed for removal in FY 2017 Final IPPS Rule***

Value Based Purchasing Measures and Applicable Periods Proposed in Previous Rule Making

FY 2020 VBP Program (page 24504 of FY 2016 Proposed IPPS Rule)

25%	Clinical Care Domain Baseline Period: July 1, 2010 to June 30, 2013 Performance Period: July 1, 2015 to June 30, 2018
Mort-30-AMI	AMI 30-day mortality rate
Mort-30-HF	Heart Failure 30-day mortality rate
Mort-30-PN	Pneumonia 30-day mortality rate
RSCR-30-THA/TKA	Total Hip or Knee Arthroplasty Complication Rate (assumes same timelines as others)

25%	Person & Community Engagement Baseline Period: Jan-Dec 2016 Performance Period: Jan-Dec 2018
HCAHPS	Hospital Consumer Assessment of Healthcare providers & Systems Survey
CTM-3	Care Transition Measures (3)

25%	Efficiency Domain Baseline Period: Jan-Dec 2016 Performance Period: Jan-Dec 2018
MSPB-1	Medicare Spending per Beneficiary

25%	Safety Domain Baseline Period: Jan-Dec 2016 (excluding PSI-90) Performance Period: Jan-Dec 2018 (excluding PSI-90)
CAUTI	Catheter-Associated UTI (ICU and non-ICU)
CLABSI	Central Line-Associated BSI SIR (non reliability adjusted for ICU and non-ICU)
PSI-90	*Future rule making to add new modified PSI-90* *Dates not yet published*
SSI	Surgical Site Infection (ICU and Non-ICU) • Colon • Abdominal Hysterectomy
CDI	Clostridium difficile Infection SIR
MRSA	Methicillin-Resistant Staphylococcus aureus Bacteremia SIR
PC-01	Elective Delivery Prior to 39 Completed Weeks Gestation

No discussion in this year's proposed IPPS Rule about FY 2020. This discussion occurred in previous rule making.

Finalized Changes to Add Two New Efficiency Measures for FY 2021

- **Hospital-level, Risk-standardized Payment Associated with 30-day Episode-of-Care for Acute MI (NQF #2431)**
  - Wide variation exists in average payments to hospitals for Acute MI ($12,862 to $29,802 reported on Hospital Compare)
  - NQF MAP vote was 27% support, 15% conditional, 58% do NOT support
- **Hospital-level, Risk-standardized Payment Associated with 30-day Episode-of-Care for Heart Failure (NQF #2436)**
  - Wide variation exists in average payments to hospitals for Heart Failure ($11,086 to $21,867 reported on Hospital Compare)
  - NQF MAP vote was 27% support, 8% conditional, 65% do NOT support

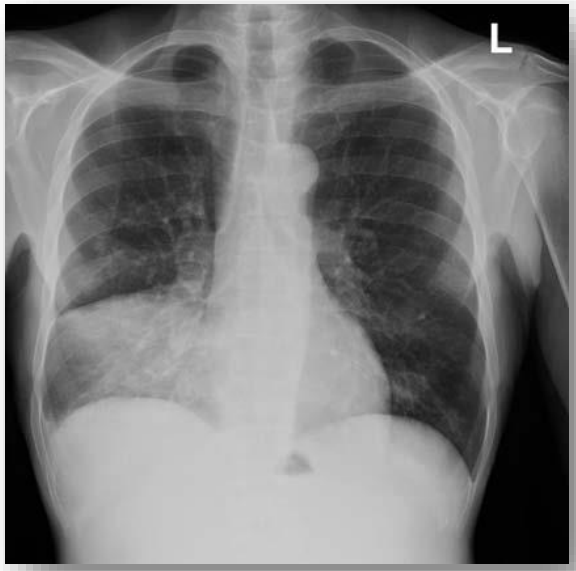
Concerns included lack of risk adjustment for SDS variables, variation caused by health professional shortage areas, potential that measure will overlap and double count services captured in the MSPB measure

Scoring for New Efficiency Measures for FY 2021

- Same scoring methodology as MSPB measure
  - Achievement points 1-10 based on the ratio of hospital spending compared to the national median spending during the performance period
  - Improvement benchmark is the mean of the lowest decile across all hospitals
- New “value scoring” methodologies are currently under consideration, which would create composite scores that include both quality and efficiency measures
  - Quality/Cost ratios being considered
  - May be separate measures within a domain or may become a new “Value” Domain

Finalized Changes to the Clinical Care Domain for FY 2021

- Adoption of the expanded pneumonia cohort for 30-day all cause, risk standardized mortality rate following pneumonia hospitalization. Includes:
  - Principal diagnosis of viral or bacterial pneumonia
  - Principal diagnosis of aspiration pneumonia
  - Principal diagnoses of respiratory failure or non-severe sepsis with a secondary diagnoses of pneumonia (bacterial, viral or aspiration pneumonia)
- Performance period initially to be 22 months instead of 36 months to accommodate the length of time this measure cohort has been on hospital compare



Final Rules on VBP Baseline and Performance Periods

Clinical Care Domain

Domain	Effective Year	Baseline Period	Performance Period
• Mort-30-HF • Mort-30-AMI • Mort-30-COPD • Mort-30-PN **	FY 2019 *and ongoing*	*36 month period starting ten years prior to program year* • July 1, 2009 to • June 30, 2012	*36 month period starting five years prior to program year* • July 1, 2014 to • June 30, 2017
• Mort-30-PN ** modified cohort begins FY 2021	FY 2021	*36 month period starting nine years prior to program year* • July 1, 2012 to • June 30, 2015	*22 month period starting five years prior to program year* • Sept 1, 2017 to • June 30, 2019
	FY 2022	*36 month period starting ten years prior to program year* • July 1, 2012 to • June 30, 2015	*34 month period starting five years prior to program year* • Sept 1, 2017 to • June 30, 2020
	FY 2023	*36 month period starting ten years prior to program year* • July 1, 2013 to • June 30, 2016	*36 month period starting five years prior to program year* • July 1, 2018 to • June 30, 2021

Final Rules on VBP Baseline and Performance Periods

Clinical Care Domain Continued

Domain	Effective Year	Baseline Period	Performance Period
• RSCR-THA/TKA Complication Rate	FY 2019	*36 month period starting nine years prior to program year* • July 1, 2010 to • June 30, 2013	*30 month period starting four years prior to program year* • Jan 1, 2015 to • June 30, 2017
	FY 2020	*36 month period (intentionally same as 2019)* • July 1, 2010 to • June 30, 2013	*36 month period starting five years prior to program year* • July 1, 2015 to • June 30, 2018
	FY 2021 *and ongoing*	*36 month period starting ten years prior to program year* • April 1, 2011 to • March 31, 2014	*36 month period starting five years prior to program year* • April 1, 2016 to • March 31, 2019
• Mort-30-CABG	FY 2022	*36 month period starting ten years prior to program year* • July 1, 2012 to • June 30, 2015	*36 month period starting five years prior to program year* • July 1, 2017 to • June 30, 2020

Final Rules on VBP Baseline and Performance Periods

Person & Community Engagement Domain
Efficiency & Cost Reduction Domain

Domain	Effective Year	Baseline Period	Performance Period
HCAHPS Survey	FY 2019 *and ongoing*	*One calendar year starting four years prior to the applicable program year* • January 1, 2015 to • December 31, 2015	*One calendar year starting two years prior to the applicable program year* • January 1, 2017 to • December 31, 2017
Medicare Spending per Beneficiary	FY 2019 *and ongoing*	*One calendar year starting four years prior to the applicable program year* • January 1, 2015 to • December 31, 2015	*One calendar year starting two years prior to the applicable program year* • January 1, 2017 to • December 31, 2017
AMI and HF 30-day Episode of Care Payment	FY 2021	*36 month period* • July 1, 2012 to • June 30, 2015	*24 month period* • July 1, 2017 to • June 30, 2019
	FY 2022	*36 month period (same as 2021)* • July 1, 2012 to • June 30, 2015	*36 month period* • July 1, 2017 to • June 30, 2020

Final Rules on VBP Baseline and Performance Periods
Safety Domain

Domain	Effective Year	Baseline Period	Performance Period
Safety Domain *(all except PSI-90 Composite measure)*	FY 2019 *and ongoing*	*One calendar year starting four years prior to program year* • January 1, 2015 to • December 31, 2015	*One calendar year starting two years prior to program year* • January 1, 2017 to • December 31, 2017
• PSI-90 Composite Measure *Proposing to retire in FY 2019*	FY 2018 *only*	*Two calendar years starting eight years prior to program year* • July 1, 2010 to • June 30, 2012	*Shortened period to avoid merging ICD 9 and 10 codes* • July 1, 2014 to • September 30, 2015

Value Based Purchasing Line Up Finalized in FY 2017 Rule for FY 2021 VBP Program

25%	Clinical Care Domain Baseline Period: July 1, 2011 to June 30, 2014 Performance Period: July 1, 2016 to June 30, 2019
Mort-30-AMI	AMI 30-day mortality rate
Mort-30-HF	Heart Failure 30-day mortality rate
Mort-30-COPD	COPD 30-day mortality Rate
Mort-30-PN	Pneumonia (expanded) 30-day mortality rate Baseline Period: July 1, 2012 – June 30, 2015 Performance Period: Sept 1, 2017 – June 30, 2019)
RSCR-THA/TKA	Total Hip or Knee Arthroplasty Complication Rate Baseline period: April 1, 2011 –Mar 31, 2014 Performance period: April 1, 2016 – Mar 31, 2019
25%	Person & Community Engagement Baseline Period: Jan-Dec 2017 Performance Period: Jan-Dec 2019
HCAHPS CTM-3	HCAHPS Survey & Care Transition Measures (3)

25%	Safety Domain Baseline Period: Jan-Dec 2017 (excluding PSI-90) Performance Period: Jan-Dec 2019 (excluding PSI-90)
CAUTI	Catheter-Associated UTI (ICU and non-ICU)
CLABSI	Central Line-Associated BSI SIR (non reliability adjusted for ICU and non-ICU)
PSI-90 ??	*Future rule making to add new modified PSI-90* *Dates not yet published*
SSI	Surgical Site Infection (ICU and Non-ICU) • Colon • Abdominal Hysterectomy
CDI	Clostridium difficile Infection SIR
MRSA	Methicillin-Resistant Staphylococcus aureus Bacteremia SIR
PC-01	Elective Delivery Prior to 39 Completed Weeks Gestation

25%	Efficiency Domain Baseline Period: Jan-Dec 2017 (** July 1, 2012-June 30, 2015) Performance Period: Jan-Dec 2019 (**July 1, 2017-June 30, 2019)
MSPB-1	Medicare Spending per Beneficiary
RSPA-30-AMI	Risk standardized payment associated with 30 day episode of care for Acute MI **
RSPA-30-HF	Risk standardized payment associated with 30 day episode of care for Heart Failure **

Value Based Purchasing Line Up Finalized in FY 2017 Rule for FY 2022 VBP Program

25%	Clinical Care Domain Baseline Period: July 1, 2012 to June 30, 2015 Performance Period: July 1, 2017 to June 30, 2020
Mort-30-AMI	AMI 30-day mortality rate
Mort-30-HF	Heart Failure 30-day mortality rate
Mort-30-COPD	COPD 30-day mortality Rate
Mort-30-CABG	CABG 30-day mortality rate
Mort-30-PN	Pneumonia 30-day mortality rate Baseline Period: July 1, 2012 – June 30, 2015 Performance Period: Sept 1, 2017 – June 30, 2020)
RSCR-TH/TKA	Total Hip or Knee Arthroplasty Complication Rate Baseline: Apr 1, 2012-Mar 31, 2015 Performance: April 1, 2017 – Mar 31, 2020

25%	Person & Community Engagement Baseline Period: Jan-Dec 2018 Performance Period: Jan-Dec 2020
HCAHPS CTM-3	HCAHPS Survey Care Transition Measures (3)

25%	Safety Domain Baseline Period: Jan-Dec 2018 (excluding PSI-90) Performance Period: Jan-Dec 2020 (excluding PSI-90)
CAUTI	Catheter-Associated UTI (ICU and non-ICU)
CLABSI	Central Line-Associated BSI SIR (non reliability adjusted for ICU and non-ICU)
PSI-90 ??	*Future rule making to add new modified PSI-90* *Dates not yet published*
SSI	Surgical Site Infection (ICU and Non-ICU) • Colon • Abdominal Hysterectomy
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PC-01	Elective Delivery Prior to 39 Completed Weeks Gestation

25%	Efficiency Domain Baseline Period: Jan-Dec 2018 (** July 1, 2012 – June 30, 2015) Performance Period: Jan-Dec 2020 (** July 1, 2017 – June 30, 2020)
MSPB-1	Medicare Spending per Beneficiary
RSPA-30-AMI	Risk standardized payment associated with 30 day episode of care for Acute MI **
RSPA-30-HF	Risk standardized payment associated with 30 day episode of care for Heart Failure **

Minimum Scoring Requirements for FY 2017 and Beyond

Page 57,010-57,011

- Must score in three of four domains
- 100 HCAHPS Surveys
- 25 cases each for MSPB and Acute MI and HF payment measures
- At least two measure scores in Clinical Care Domain
  - 25 cases for each mortality measure
- At least three measure scores within the Safety domain.
  - three cases for indicators in the AHRQ PSI 90 measure
  - At least one predicted infection for NHSN surveillance measures
  - At least 10 cases for the PC–01 measure

New Performance Standards Posted

- See pages 57,005 to 57,009 for proposed achievement thresholds, benchmarks and floor values for FY 2019 through FY 2022

Changes to VBP Participation for Hospitals Cited with Immediate Jeopardy

page 57,003 – 57,004

PREVIOUS RULE

- Any time during the performance period, hospitals cited for two deficiencies on CMS-2567 (Statement of Deficiencies and Plan of Correction), which pose immediate jeopardy to health and safety to patients under the Medicare Conditions of Participation (CoP) are **not** eligible for the VBP Program.

NEW RULE

- Changing the policy to exclude hospitals from the VBP Program from two to three deficiencies during an applicable period
- Survey end dates will be the default date for EMTALA-related and EMTALA-non-related immediate jeopardy citations for consideration for exclusion

EMTALA – Emergency Medical Treatment and Active Labor Act, that allows surveyors to immediately sanction facilities who have an immediate threat to patient safety

Hospital Acquired Conditions Reduction Program

Changes in Final FY 2017 Rule

Starts on page 57,011

FY 2015 HAC Reduction Measures

Mandatory for all IPPS Hospitals

LTCHs, cancer hospitals, children's hospitals, IRFs, IPFs, CAHs, and Puerto Rico hospitals are exempt

Domain 1: AHRQ PSI-90

35% of Total HAC Score

Complications/Patient Safety for Selected Conditions Composite (PSI 90)

- Pressure ulcer rate (PSI 3)
- Iatrogenic pneumothorax (PSI 6)
- Central venous catheter-related blood stream infection rate (PSI 7)
- Postop hip fracture rate (PSI 8)
- Post op pulmonary embolism or DVT (PSI 12)
- Postop sepsis rate (PSI 13)
- Wound dehiscence rate (PSI 14)
- Accidental puncture and laceration rate (PSI 15)

Domain 2: CDC HAIs

65% of Total HAC Score

- CLABSI SIR*(initially only ICU)*
- CAUTI SIR *(initially only ICU)*

Final Scoring Methodology for Domains 1 and 2 for HAC Reduction Program in FY 2016

Domain 1: AHRQ PSI-90

- 25% of Total HAC Score *(Was 35% in FY 2015)*

- Pressure ulcer rate (PSI 3)
- Iatrogenic pneumothorax (PSI 6)
- Central venous catheter-related blood stream infection rate (PSI 7)
- Postop hip fracture rate (PSI 8)
- Post op PE or DVT (PSI 12)
- Postop sepsis rate (PSI 13)
- Wound dehiscence rate (PSI 14)
- Accidental puncture/laceration (PSI 15)

Domain 2: CDC HAIs

- 75% of Total HAC Score
- *(Was 65% in FY 2015)*
-
- CLABSI SIR(initially only ICU)
- CAUTI SIR (initially only ICU)
- Surgical Site Infection
  - Colon Procedures)
  - Abdominal Hysterectomy

- *CMS averages the two SSI SIR scores and establishes a single "pooled" SSI score*
- *The final score for Domain 2 will be the average of the three scores: CLABSI, CAUTI and the pooled SSI score*

HAC Reduction Program in FY 2017

Finalized in the FY 2016 IPPS Rule

Domain 1: AHRQ PSI-90

- **15%** of Total HAC Score *(Was 25% in FY 2016)*
- Based on discharges July 1, 2013 through June 30, 2015.

Domain 2: CDC HAIs

- **85%** of Total HAC Score *(Was 75% in FY 2016)*
- Based on discharges CY 14 and 15
- CLABSI SIR(initially only ICU)
- CAUTI SIR (initially only ICU)
- Surgical Site Infections
  - SSI (Colon Procedures)
  - SSI (Abdominal Hysterectomy)
- MRSA
- CDI

Hospital Specific reports to calculate FY 2017 scores will be available on QualityNet Secure Portal late summer 2016

Changes to HAC Reduction Program FY 2018 *(from previous rule making)*

- Add non-ICU CAUTI and CLABSI SIR (data collection to begin with Jan 1, 2015 discharges)
  - Pediatric
  - Adult medical
  - Surgical
  - Medical/Surgical
- Update to CDC NHSN Standard Population Data (using CY 2015 as national baseline similar to the Value Based Purchasing Program)

Four New Changes to HAC Program in Final IPPS FY 2017 Rule

1) Revised definition of complete data
2) Clarification of participation for new hospitals
3) No additional measures added (domain weights unchanged)
   - New modified version of the PSI-90 Composite measure to be adopted in FY 2018
4) New scoring methodology to be adopted

Definition of Complete Data Requirements for FY 2017 and Beyond

pages 57,012

- Proposed change in definition of “Complete Data” for Domain 1
  - Must have at least three eligible cases in one component PSI indicator AND
  - Minimum of 12 months of data
  - Hospitals without complete data in Domain 1 will be scored using only Domain 2 data (assuming at least one eligible case in Domain 2)
  - Hospitals without complete data in Domain 2 will be scored using only Domain 1 data (assuming at least three eligible cases and 12 months of data)
  - Hospitals without complete data in either domain exempt from program

Clarification Finalized for New Hospitals

Remember HAC is Mandatory for all Subsection (d) hospitals
LTCH's, cancer hospitals, children's hospitals, IRFs, IPFs, Critical Access Hospitals and Puerto Rico hospitals exempt

- NHSN data is obtained from data submitted to CDC NHSN portal for the Hospital IQR Program (*which is voluntary)*
- Proposed change will require new hospitals that file a notice of participation (NOP) within 6 months of opening to submit data for CDC NHSN HAI measure no later than first day of the quarter following the NOP.
- Example: Opens and files NOP January 1, 2016, must begin reporting NHSN data October 1, 2016
- Hospitals that do NOT file a NOP with the Hospital IQR Program within 6 months of opening would be required to begin submitting data for the CDC NHSN HAI measures on the first day of the quarter following the end of the 6-month period after they opened
- Example: Opens January 1, 2016 and does NOT file NOP, must begin reporting NHSN data July 1, 2016.

HAC Program to Adopt Modified Version of PSI 90 Composite Measure Beginning FY 2018

See comments on pages 57,013 to 57,020

8 Current PSI 90 Measures:

Patient Safety for Selected Indicators Composite Measure

- ✓ PSI 3 Pressure ulcer rate
- ✓ PSI 6 Iatrogenic pneumothorax
- ✓ PSI 7 CLABSI infection rate
- ✓ PSI 8 Postop hip fracture rate
- ✓ PSI 12 Post op PE or DVT
- ✓ PSI 13 Postop sepsis rate
- ✓ PSI 14 Wound dehiscence rate
- ✓ PSI 15 Accidental puncture/laceration

10 Modified PSI 90 Measures

Patient Safety and Adverse Events Composite (NQF #0531)

- ✓ PSI 3 Pressure ulcer rate
- ✓ PSI 6 Iatrogenic pneumothorax
- ✓ PSI 8 Postop hip fracture rate
- ✓ PSI 9 Postop Hemorrhage or Hematoma
- ✓ PSI 10 Physiologic/Metabolic Derangement
- ✓ PSI 11 Postop Respiratory Failure
- ✓ PSI 12 Post op PE or DVT
- ✓ PSI 13 Postop sepsis rate
- ✓ PSI 14 Wound dehiscence rate
- ✓ PSI 15 Accidental puncture/laceration

PSI 7 CLABSI Infection discontinued

Additional Changes to Modified PSI 90 Composite Measure

Applies to FY 2018 and Beyond

PSI 12 Perioperative Pulmonary Embolism or DVT Rate

- Now excludes Extracorporeal membrane oxygenation (ECMO) procedures in the denominator
- Now excludes isolated deep vein thrombosis of the calf veins in the numerator

PSI 15 Accidental Puncture or Laceration Rate

- Now limited to discharges with an abdominal/pelvic operation, rather than including all medical and surgical discharges
- Requires BOTH
  - (1) A diagnosis of an accidental puncture and/or laceration; and
  - (2) an abdominal/pelvic reoperation one or more days after the index surgery

Changes in Risk Adjustment for PSI 90 Composite Measures
Applies to FY 2018 and Beyond

- In prior versions the weights of each component PSI were based solely on volume (numerator rates).
- In the modified PSI 90, rates are weighted based on
  - Volume
  - Excess clinical harm
  - Disutility (individual preference for a health state linked to a harm, such as death or disability).

- **Volume weights** are based on the number of safety events in an all-payer reference population
- **Harm weights** are calculated by multiplying empirical estimates of excess harms associated with the patient safety event by utility weights linked to each of the harms.
- **Excess harms** are estimated using statistical models comparing patients with a safety event to those without a safety event in a Medicare FFS sample.
- **The final weight** is the product of harm weights and volume weights (numerator weights).

Changes in Risk Adjustment for PSI 90 Composite Measures

Applies to FY 2018 and Beyond

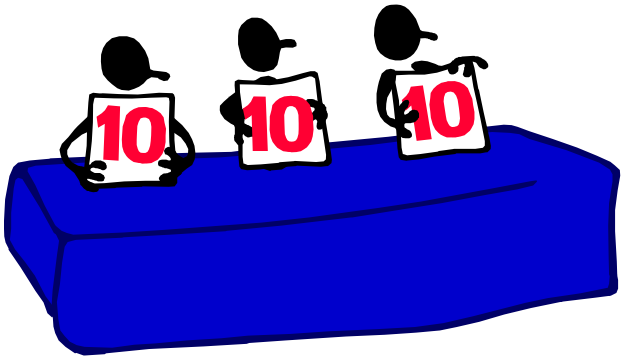
For more information See Quality Indicator Empirical Methods available online at: *www.qualityindicators.ahrq.gov*.

Finalized Changes to Applicable Periods for HAC Reduction Program

Fiscal Year Payment Determination	Domain	Applicable Period
FY 2017	Domain 1	July 1, 2013 - June 30, 2015 (24 month period)
	Domain 2	January 1, 2014 - December 31, 2015
FY 2018 *(ICD-9 claims)*	Domain 1	July 1, 2014 – September 30, 2015 (15 month period)
	Domain 2	January 1, 2015 – December 31, 2016
FY 2019 *(ICD-10 claims)*	Domain 1	October 1, 2015 – June 30, 2017 (21 month period)
	Domain 2	January 1, 2016 – December 31, 2017

Changes in red to accommodate risk adjusted ICD-10 version of the PSI-90 Composite Software expected late CY 2017

Current HAC Reduction Scoring Methodology

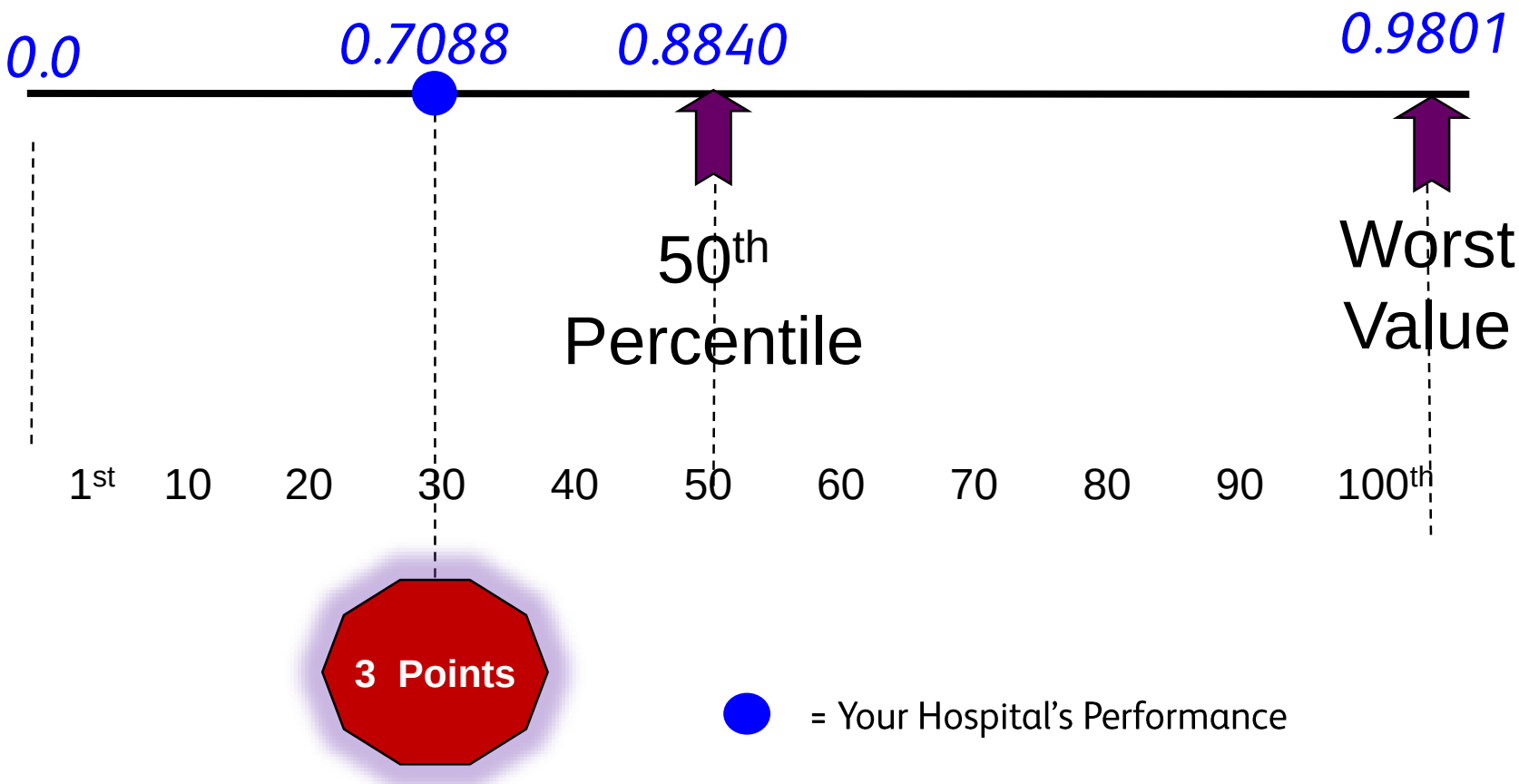


Percentile	Decile	Points
Min-20th *(zero)*	1	1
Min-20th *(not zero)*	2	2
21st-30th	3	3
31st-40th	4	4
41st-50th	5	5
51st-60th	6	6
61st-70th	7	7
71st-80th	8	8
81st-90th	9	9
91st-Max	10	10

Each Measure Worth 1 to10 Points

AHRQ PSI-90 Composite

Performance scores for all hospitals will be rank ordered into percentiles.
Rates of 0 are assigned one point. Non-zero rates < or = 20th assigned two points
Ten points are assigned to any value > 91st percentile.

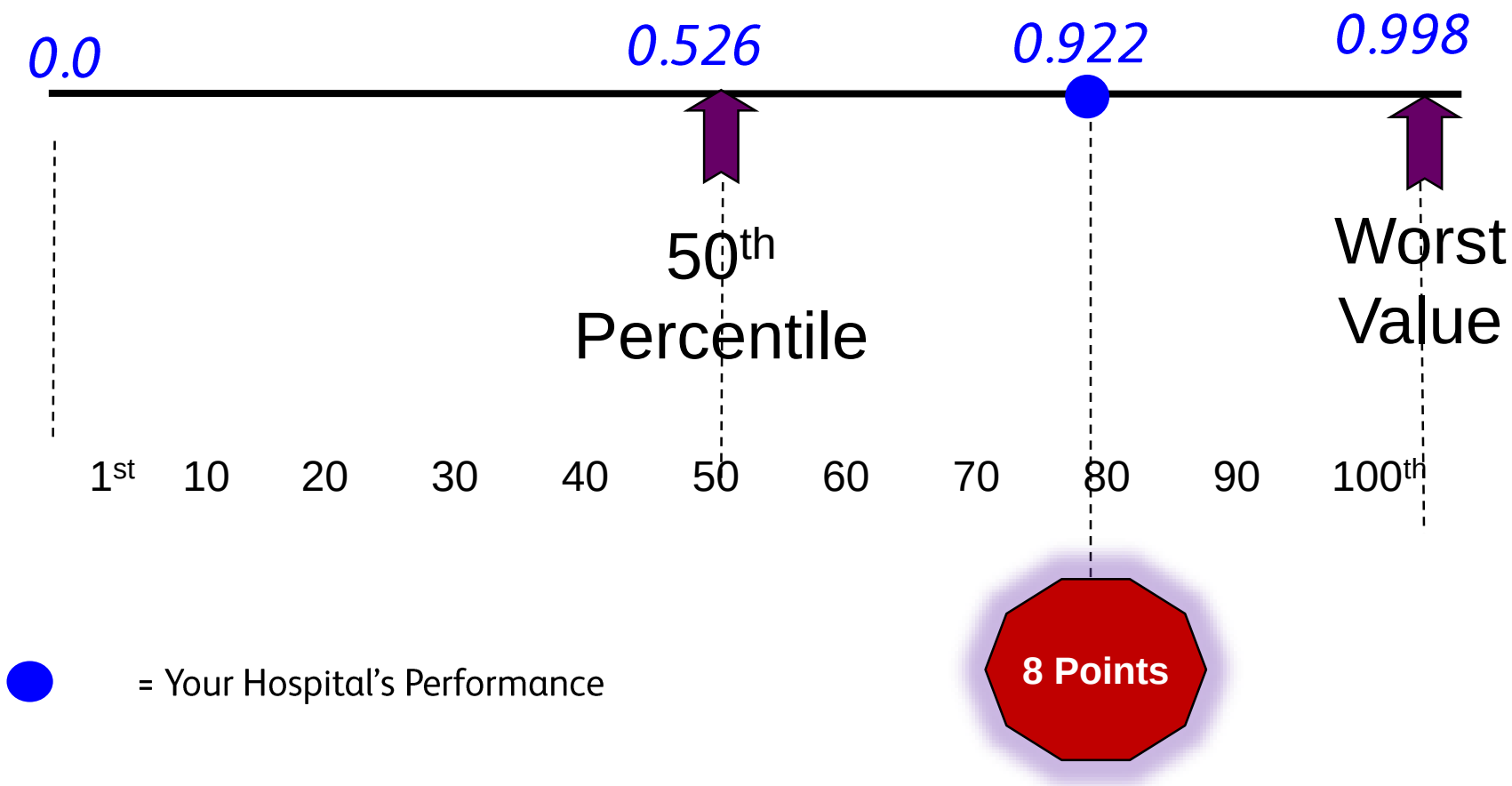


Note: Numbers in this illustration are fictitious and do not represent actual distribution

Each Measure Worth 1 to10 Points

CLABSI Standardized Infection Ratio

Performance scores for all hospitals will be rank ordered into percentiles.
Rates of 0 are assigned one point. Non-zero rates < or = *20th assigned two points*
Ten points are assigned to any value > 91st percentile.

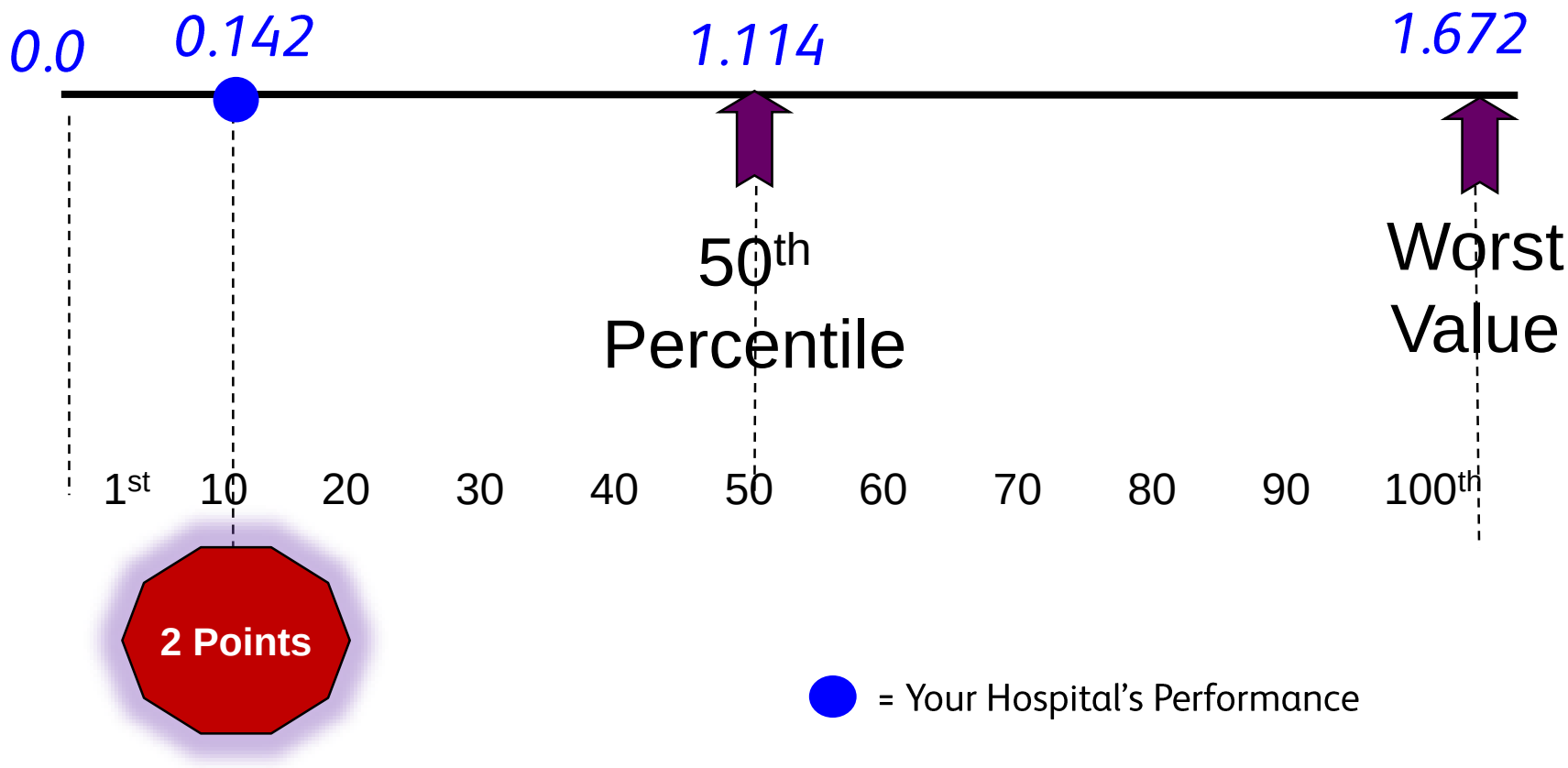


Note: Numbers in this illustration are fictitious and do not represent actual distribution

Each Measure Worth 1 to10 Points

CAUTI Standardized Infection Ratio

Performance scores for all hospitals will be rank ordered into percentiles.
Rates of 0 are assigned one point. Non-zero rates < or = 20th assigned two points
Ten points are assigned to any value > 91st percentile.



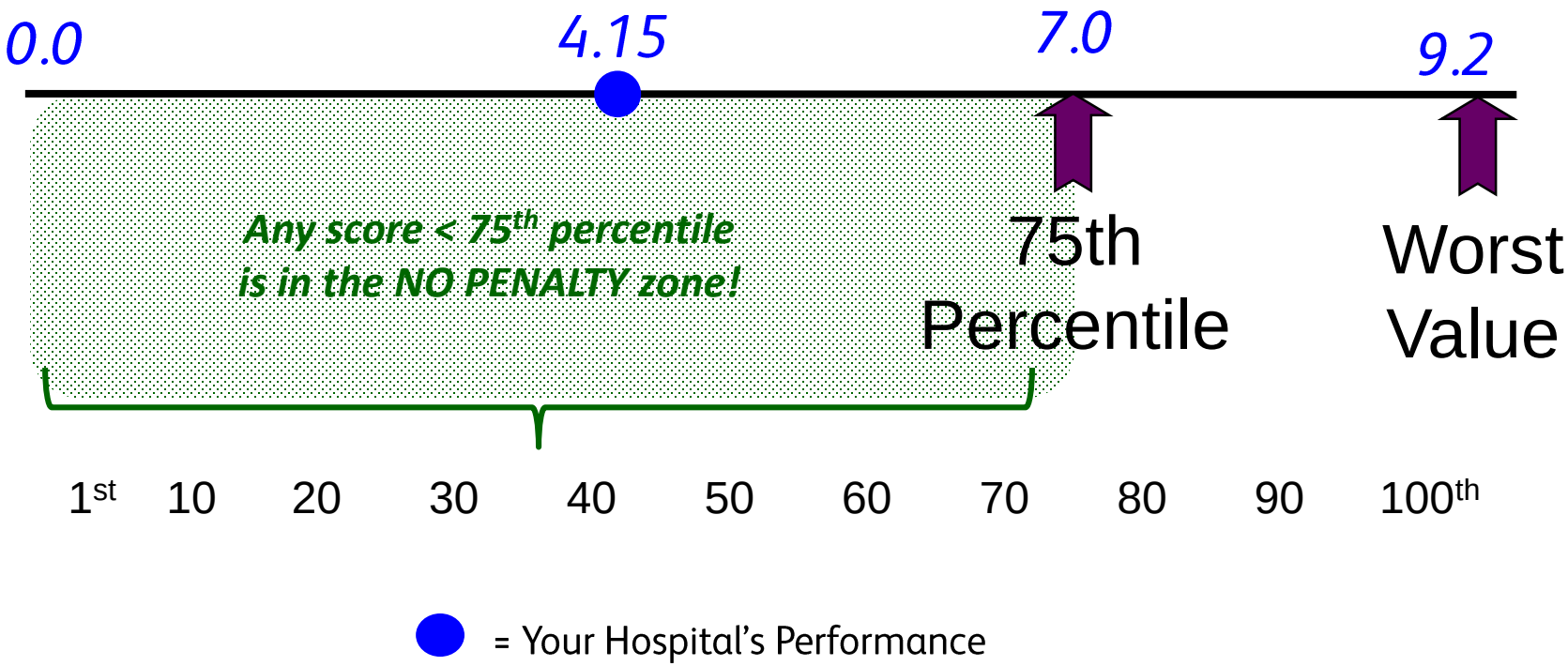
Note: Numbers in this illustration are fictitious and do not represent actual distribution

Total HAC Score Calculation for FY 2017

Measure	Decile Points	Domain Weight	Domain Score
Domain 1 Score ▪ PSI-90 Composite	3	**.15**	.75
▪ CLABSI	8		
▪ CAUTI	2		
▪ SSI Average	5		
▪ MRSA	3		
▪ CDI	2		
Domain 2 Score (Average)	**4**	**.85**	3.4
		Total HAC Score	**4.15**

Distribution of Total HAC Scores

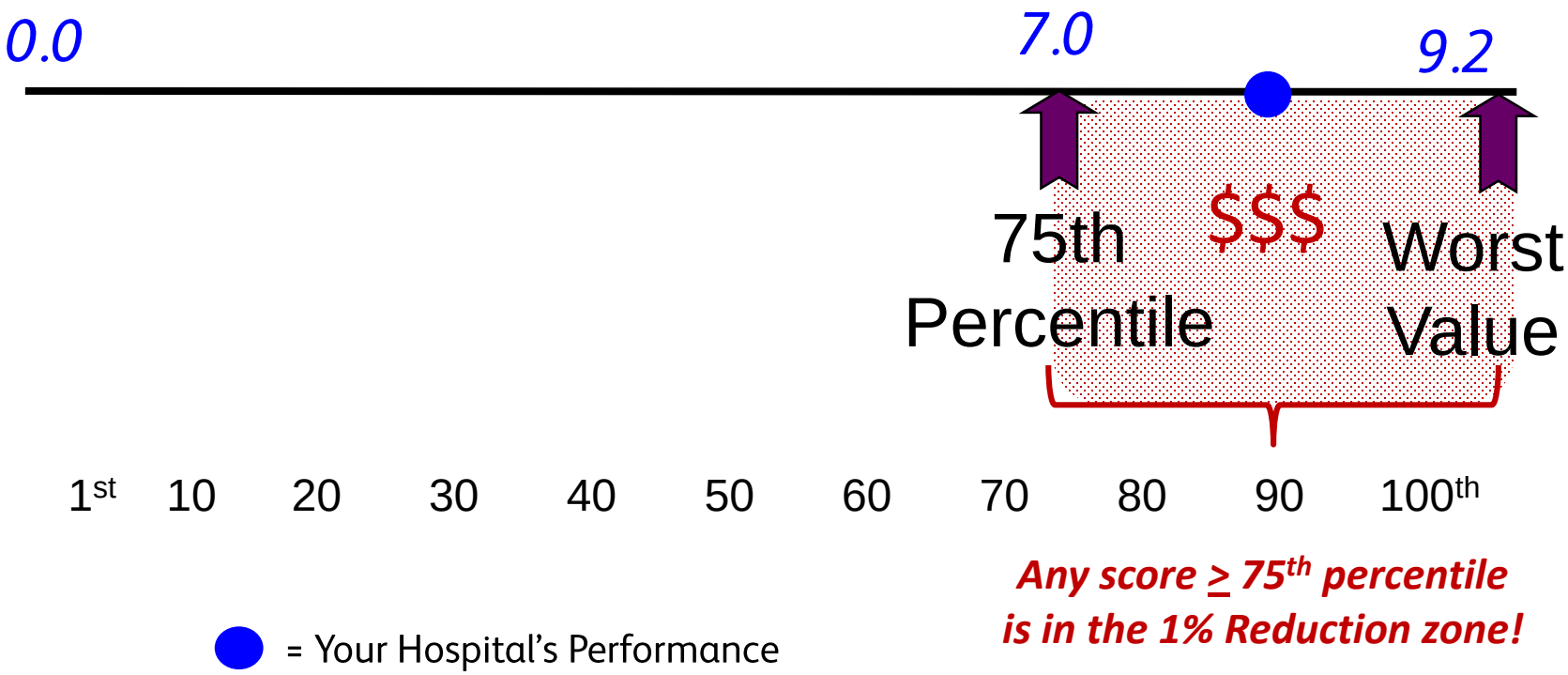
Performance scores for all hospitals will be rank ordered into percentiles. Hospitals that perform less than the 75th percentile will have NO Penalty



Note: Numbers in this illustration are fictitious and do not represent actual distribution

Distribution of Total HAC Scores

Performance scores for all hospitals will be rank ordered into percentiles.
Hospitals that perform less than the 75th percentile will have NO Penalty
Hospitals that perform at the 75th percentile or greater will have a 1% Reduction



Note: Numbers in this illustration are fictitious and do not represent actual distribution

Final Changes to HAC Scoring Methodology for FY 2018 Payment Determination

- Scoring by decile bins not achieving payment penalties for 25% of hospitals as designed by CMS
  - 21.9% in FY 2015
  - 23.7% in FY 2016

Three Concerns Identified by Technical Expert Panel:

- ✓ Ties at the penalty threshold reduced the number of hospitals at top quartile
- ✓ Hospitals with limited amount of data identified as poor performers
- ✓ Hospitals with only Domain 1 data and no Domain 2 data can receive higher total HAC scores than hospitals contributing data in both domains

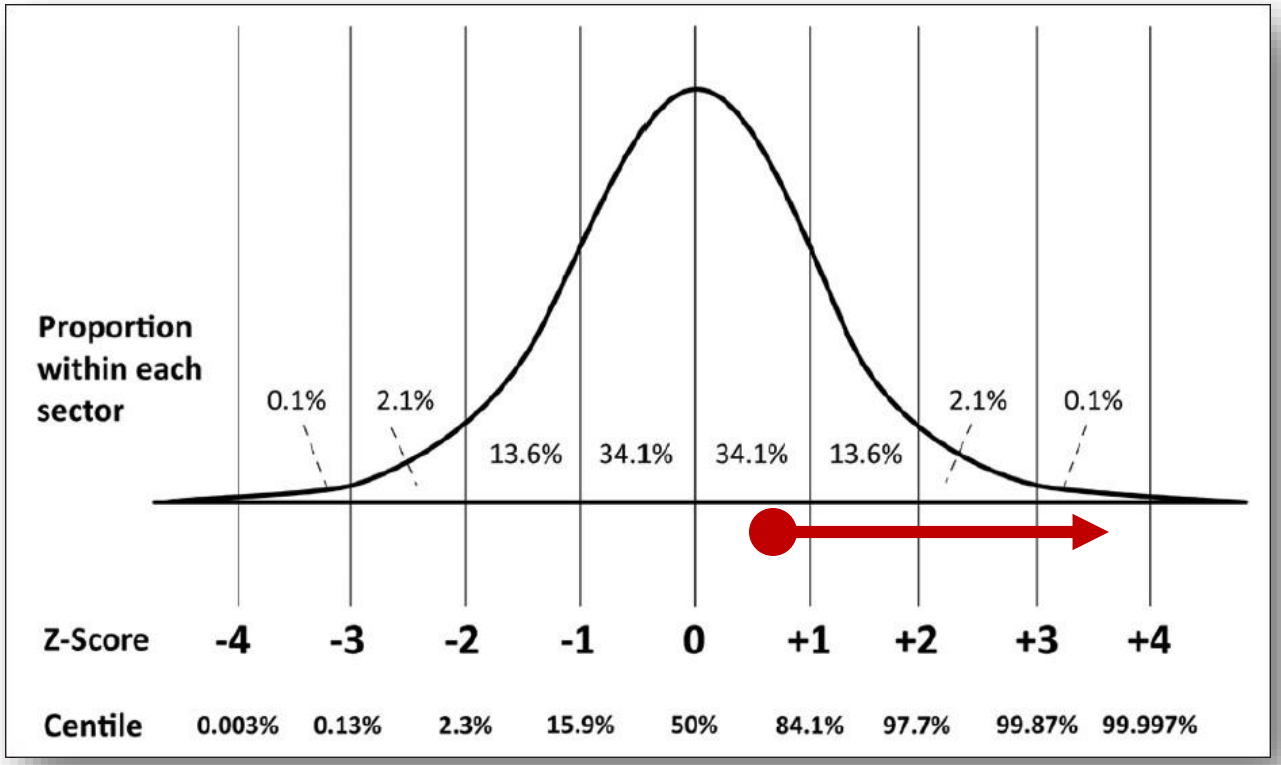
Changes to HAC Scoring Methodology for FY 2018 Payment Determination and Beyond

pages 57,022 to 57,025

- Winsoried Z-score Method
- Continuous measure of central tendency rather than forcing scores into decile bins
- Truncated at the 5th and 95th percentiles
  - Reduces penalties for small hospitals, low scores or those without adverse events
  - May slightly increase penalties for moderately high DSH Hospitals (Increase from 28% to 35% with penalties using this approach, which represents approximately 11 more hospitals)

New HAC Scoring Methodology Using Winsoried Z-Score

Z Score = (Hospital's Measure Performance - Mean Performance for All Hospitals)
Standard Deviation for All Hospitals



Hospitals scoring in the top quartile of all US Hospitals will have HAC Penalties

New HAC Scoring Methodology Using Winsoried Z-Score FY 2018 and Beyond

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

Measure	Z Score	Domain Weight	Domain Score
Domain 1 Score ▪ PSI-90 Composite	1.234	**.15**	0.1851
▪ CLABSI	- .823		
▪ CAUTI	- 1.22		
▪ SSI Average	-.510		
▪ MRSA	1.456		
▪ CDI	1.211		
Domain 2 Score (Average)	**0.0228**	**.85**	0.01938
		Total HAC Score	**0.20448**

Negative Z scores reflect better performance. Positive Z scores reflect worse performance

Technical Specifications Resources for HAC Reduction Program

- CMS is using a recalibrated version 5.0.1 of the AHRQ PSI software to calculate PSI 90 Composite results for the FY 2017 Hospital IQR and HAC Reduction Programs, but is using Version 4.5a of the AHRQ PSI software for the FY 2017 Hospital VBP Program performance period calculations.

- Technical specifications for AHRQ's PSI–90 measure in Domain 1 can be found at AHRQ's Web site at: *http://qualityindicators.ahrq.gov/Modules/PSI_TechSpec.aspx*

- Technical specifications for the CDC NHSN HAI measures in Domain 2 can be found at CDC's NHSN Web site at: *http://www.cdc.gov/nhsn/acute-care-hospital/index.html*

Hospital Inpatient Quality Reporting Program

Begins on page 57,111

Hospital Quality Inpatient Reporting Program
Final IPPS FY 2017 Changes At A Glance

Failure to Meet Requirements Results in 25% Reduction in Annual Payment Update

	CY 2015 for 2017 Payment	CY 2016 for 2018 Payment	CY 2017 for 2019 Payment
Chart Abstracted Measures	15 (11 with eCQM version)	8 (6 with eCQM version)	6 (3 with eCQM equivalent)
Electronic Measures (eCQM)	28 Voluntary submission option	28 Mandatory to submit 4 across any NQS Domain for Q3 or Q4 discharges	8 Mandatory to submit 8 of 15 eCQMs for entire calendar year
NHSN Hospital Acquired Infections	6	6	6
Mortality	6	6	6
Readmission	8	8	8
Complications & Safety	3	3	3
Structure of Care	3	4	2
HCAHPS Survey & CTM-3	1	1	1
Cost Efficiency	4	5	11
Excess Days	0	2	3

Acute MI Hospital IQR Program

Measures	CY 2016 FY 2018 Payment Determination	CY 2017 FY 2019 Payment Determination	CY 2017 TJC ORYX Flexible Options
AMI-2 Aspirin prescribed at discharge	Electronic option	✓ Removed (topped out)	N/A
AMI-7a Fibrinolytic Therapy Within 30 Minutes of Arrival	Electronic option	✓ Removed (does not result in better outcomes)	N/A
AMI-8a Timing of PCI Intervention	Electronic option	Electronic option	Electronic
AMI-10 Statin prescribed at discharge	Electronic option	✓ Removed (topped out)	N/A

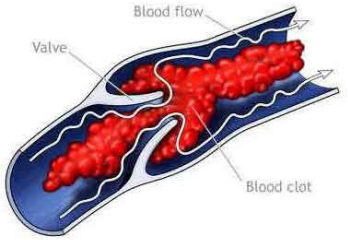
Pneumonia
Hospital IQR Program

Measures	CY 2016 FY 2018 Payment Determination	CY 2017 FY 2019 Payment Determination	CY 2017 TJC ORYX Flexible Option
PN-6 Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients	Electronic option	✓ Removed (not feasible to collect electronically)	N/A

SCIP
Hospital IQR Program

Measures	CY 2016 FY 2018 Payment Determination	CY 2017 FY 2019 Payment Determination	CY 2017 TJC ORYX Flexible Option
SCIP-Inf-1a Prophylactic Antibiotic Received Within One Hour Prior to Incision	Electronic option	✓Removed (Topped Out)	N/A
SCIP-Inf-2a Prophylactic Antibiotic Selection for Surgical Patients	Electronic option	✓Removed (Topped Out)	N/A
SCIP-Inf-9 Urinary Catheter Removed on Postop Day 1 (POD 1) or Postop Day 2 (POD 2) with Day of Surgery Being Day Zero	Electronic option	✓Removed (not feasible to collect electronically)	N/A

VTE
Hospital IQR Program

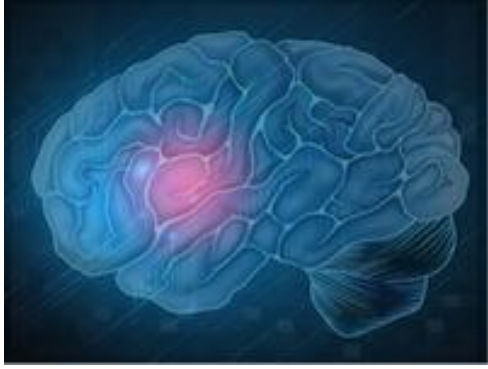


Measures	CY 2016 FY 2018 Payment Determination	CY 2017 FY 2019 Payment Determination	CY 2017 TJC ORYX Flexible Option
VTE-1 VTE Prophylaxis	Electronic Option	Electronic option	Electronic
VTE-2 ICU VTE Prophylaxis	Electronic Option	Electronic option	Electronic
VTE-3 VTE Patients with Anticoagulation Overlap Therapy	Electronic Option	✓ Removed (topped out and not feasible to collect electronically)	N/A
VTE-4 VTE Patients Receiving Heparin Monitor by Protocol or Nomogram	Electronic Option	✓ Removed (topped out and not feasible to collect electronically)	N/A
VTE-5 VTE Discharge Instructions	Required for HIQR Abstracted or electronic EHR Program option	✓ Removed (topped out and not feasible to collect electronically)	N/A
VTE-6 Incidence of Potentially Preventable VTE	Required for HIQR Abstracted or electronic EHR Program option	✓ Electronic Only Removed **Chart Abstracted Required** **	Chart Abstracted Only

** Removed electronically but still clinically important and not yet topped out statistically

Stroke
Hospital IQR Program

Certified stroke centers will still have to *chart abstract* the entire measure set



Measures	CY 2016 FY 2018 Payment Determination	CY2017 FY2019 Payment Determination	CY 2017 ORYX Flexible Option
STK-1 VTE Prophylaxis	Chart-abstracted removed, no eCQM option	N/A	N/A
STK-2 Discharged on Antithrombotic Therapy	Electronic option	Electronic option	Electronic
STK-3 Anticoagulation Tx for Atrial Fib/Flutter	Electronic option	Electronic option	Electronic
STK-4 Thrombolytic Therapy for Acute Ischemic Stroke	Required for HIQR Abstracted or electronic EHR Program option	✓ Electronic and Abstracted removed *(topped out)*	N/A
STK-5 Antithrombotic Therapy End of Hospital Day Two	Electronic option	Electronic option	Electronic
STK-6 Discharged on Statin	Electronic option	Electronic option	Electronic
STK-8 Stroke Education	Electronic option	Electronic option	N/A
STK-10 Assessed for Rehabilitation	Electronic option	Electronic option	N/A

Emergency
Hospital IQR Program

Measures	CY 2016 FY 2018 Payment Determination	CY 2017 FY 2019 Payment Determination	CY 2017 TJC ORYX Flexible Option
ED-1 Median Time from ED Arrival to ED Departure for patients Admitted ED	Required for HIQR • Abstracted or electronic EHR Program option	Electronic Option Abstracted	Electronic (1a) Abstracted (1a)
ED-2 Admit Decision Time to ED Departure Time for Admitted Patients	Required for HIQR • Abstracted or electronic EHR Program option	Electronic Option Abstracted	Electronic (2a) Abstracted (2a)

Must submit chart-abstracted version and may select to submit electronically to meet minimum requirements for minimum of eight eCQM measures in CY 2017.

Immunization
Hospital IQR Program

Measures	CY 2016 FY 2018 Payment Determination	CY 2017 FY 2019 Payment Determination	CY 2017 TJC ORYX Flexible Option
IMM-2 Influenza Immunization	Abstracted	Abstracted	Abstracted

Perinatal Care Hospital IQR Program

Measures	CY 2016 FY 2018 Payment Determination	CY 2017 FY 2019 Payment Determination	CY 2017 TJC ORYX Flexible Option
PC-01 Elective Delivery Prior to 39 Completed Weeks of Gestation (Collected in aggregate, submitted via Web-based tool or electronic clinical quality measure)	Required for HIQR • Abstracted or electronic EHR Program option	Required in BOTH Electronic and Abstracted Formats	Electronic or Abstracted **
PC-02 Cesarean Section	N/A	N/A	Abstracted **
PC-03 Antenatal Steroids	N/A	N/A	Abstracted **
PC-04 Health Care Associated Bloodstream Infection in Newborns	N/A	N/A	Abstracted **
PC-05 Exclusive Breast Milk Feeding	EHR Program option	Electronic	Electronic or Abstracted **

** PC-01, PC-02, PC-03, PC-04, PC-05) are required for health care organizations with at least 300 live births per year.

Sepsis Hospital IQR Program

Measures	CY 2016 FY 2018 Payment Determination	CY 2017 FY 2019 Payment Determination	CY 2017 TJC ORYX Flexible Option
Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	Abstracted	Abstracted	N/A

Children's Asthma Care Hospital IQR Program

Measures	CY 2016 FY 2018 Payment Determination	CY 2017 FY 2019 Payment Determination	CY 2017 TJC ORYX Flexible Option
CAC-3 Home Management Plan of Care Document Given to Patient/Caregiver	EHR Program option	Electronic Option	Electronic

Healthy Term Newborn Care Hospital IQR Program

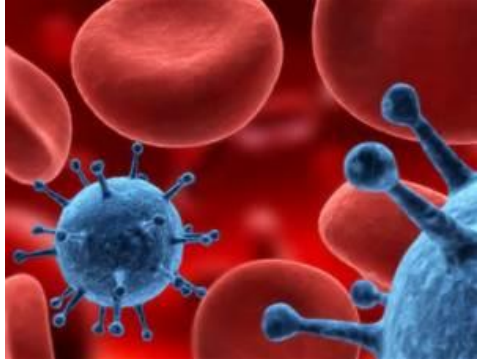
Measures	CY 2016 FY 2018 Payment Determination	CY 2017 FY 2019 Payment Determination	CY 2017 TJC ORYX Flexible Option
Healthy Term Newborn	EHR Program option	✓ Removed	N/A

Measure steward changed the measure to focus on unexpected complications in newborns, rather than on the healthy newborn. Measure is no longer feasible to collect electronically.

Hearing Screening Care
Hospital IQR Program

Measures	CY 2016 FY 2018 Payment Determination	CY 2017 FY 2019 Payment Determination	CY 2017 TJC ORYX Flexible Option
EHDI-1a Hearing Screening Prior to Hospital Discharge	EHR Program option	Electronic Option	Electronic

NHSN Topics for Hospital IQR Program



* No Changes for FY2019 Payment Determination

Measures	CY 2016 for FY 2018 Payment Determination	CY 2017 for FY 2019 Payment Determination
CLABSI -Central Line-Associated Bloodstream Infection	NHSN tool	NHSN tool
CAUTI -Catheter-associated Urinary Tract Infection	NHSN tool	NHSN tool
Surgical Site Infections - Colon - Abdominal Hysterectomy	NHSN tool	NHSN tool
MRSA – Facility-wide inpatient hospital-onset Methicillin-resistant *Staphylococcus aureus*	NHSN tool	NHSN tool
CDI- Clostridium difficile Infection	NHSN tool	NHSN tool
HCP- Influenza Vaccination Coverage Among Healthcare Personnel	NHSN tool October 1, 2016 – March 31, 2017 flu season	NHSN tool October 1, 2017 – March 31, 2018 flu season

Mortality Claims-based Measures for Hospital IQR Program

No Changes for FY2019 Payment Determination

Measures	FY 2018 Payment Determination	FY 2019 Payment Determination
MORT-30-AMI Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction	Claims	Claims
MORT-30-HF Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure	Claims	Claims
MORT-30-PN Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia	Claims	Claims
MORT-30-COPD Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following COPD	Claims	Claims
MORT-30-STK Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke	Claims	Claims
CABG- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft Surgery	Claims	Claims

Readmissions Claims-based Measures for Hospital IQR Program

No Changes for FY2019 Payment Determination

Measures	FY 2018 Payment Determination	FY 2019 Payment Determination
READM-30-AMI Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Acute Myocardial Infarction	Claims	Claims
READM-30-HF Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Heart Failure	Claims	Claims
READM-30-PN Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Pneumonia	Claims	Claims
READM-30-THA/TKA - Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate Following Elective Total Hip or Knee Arthroplasty	Claims	Claims
READM-30-HWR Hospital-Wide All-Cause Unplanned Readmission	Claims	Claims
READ-30-COPD Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following COPD	Claims	Claims
READMIT-30-STK 30-Day Risk Standardized Readmission Rate Following Stroke	Claims	Claims
READMIT-30-CABG Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following CABG	Claims	Claims

Complications Measures for Hospital IQR Program

Measures	FY 2018 Payment Determination	FY 2019 Payment Determination
Hip/knee complications - Hospital-Level Risk-Standardized Complication Rate following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty	Claims	Claims
PSI 4 (PSI/NSI) - Death among Surgical Inpatients with Serious, Treatable Complications	Claims	Claims
PSI 90 - Patient Safety and Adverse Events Composite (Composite Measure)	Claims Adoption of modified PSI 90 using ICD-9 claims for FY 2018 July 1, 2014 – Sept 30, 2015 (15 month period)	Claims Adoption of modified PSI 90 using ICD-10 claims for FY 2019 Oct 1, 2015 – June 30, 2017 (21 month period)

Proposed timelines for the modified PSI 90 Composite are the same as those proposed in the HAC Reduction Program

Registry and Structure of Care Measures Hospital IQR Program

Measures	FY 2018 Payment Determination	FY 2019 Payment Determination
Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	Structural Web-based QNET	✓ Removed
Systematic Clinical Database Registry for General Surgery	Structural Web-based QNET	✓ Removed
Safe Surgery Checklist	Structural Web-based QNET	Structural Web-based QNET
Patient Safety Culture	Structural Web-based QNET	Structural Web-based QNET

The reporting of submission to a registry has no direct impact on improvement of patient outcomes for these measures.
CMS is exploring future topics.

Patient & Community Engagement Measures for Hospital IQR Program

No Changes for FY2019 Payment Determination

Measures	FY 2018 Payment Determination	FY 2019 Payment Determination
HCAHPS Survey • HCAHPS Patient Experience of Care • 3-Item Care Transition (CTM–3)	Survey	Survey

Claims-based Payment Measures for Hospital IQR Program

Measures	FY 2018 Payment Determination	FY 2019 Payment Determination
MSPB Payment-Standardized Medicare Spending Per Beneficiary	Claims	Claims
AMI Payment- Hospital-Level, Risk-Standardized Payment 30-Day Episode-of-Care	Claims	Claims
HF Payment- Hospital-Level, Risk Standardized Payment 30-Day Episode-of-Care	Claims	Claims
PN Payment- Hospital-Level, Risk-Standardized Payment 30-Day Episode-of-Care (includes aspiration pneumonia and sepsis with secondary diagnosis of pneumonia)	Claims Adopting Expanded Cohort	Claims
THA/TKA Payment- Hospital-Level, Risk-Standardized Payment with a 30-Day Episode-of-Care for Elective Total Hip or Knee Arthroplasty	Claims	Claims
Kidney/UTI Payment- Kidney/UTI Clinical Episode-Based Payment	N/A	Claims
Cellulitis Payment- Clinical Episode-based payment	N/A	Claims
GI Payment- Gastrointestinal Hemorrhage Clinical Episode-Based Payment	N/A	Claims
AA Payment- Aortic Aneurysm Procedure Clinical Episode-Based Payment	N/A	✓ New
Cholecystectomy and CDE Payment- Cholecystectomy/Common Duct Exploration Clinical Episode-Based Payment	N/A	✓ New
Spinal Fusion Payment- Spinal Fusion Clinical Episode-Based Payment	N/A	✓ New

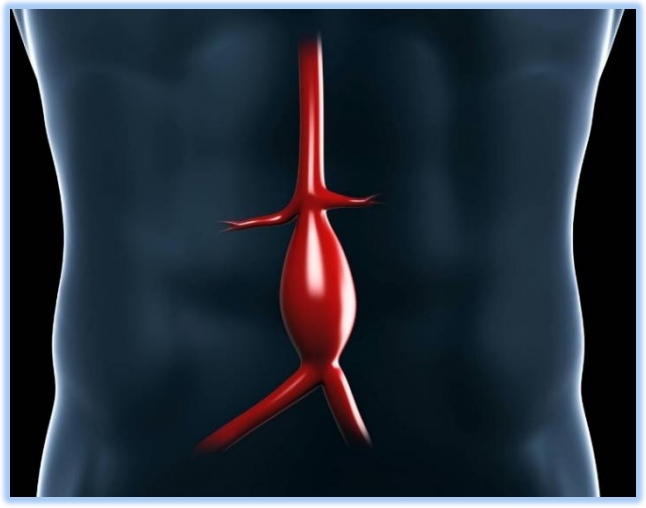
3 New Clinical Episode-Based Payment Measures

- Measures evaluate the difference between observed and expected episode cost at the episode level before comparing at the provider level
  - **Aortic Aneurysm**
  - **Cholecystectomy & Common Duct**
  - **Spine Fusion**
- Uses Medicare Part A and Part B services data
- Reporting period is a one-year timeframe (CY2017 for FY 2019 Payment Determination)
- Not yet NQF endorsed (will be submitted for endorsement)

- **Exemptions from Measure Inclusion:**
  - Lack of continuous enrollment in Medicare Parts A and B from 90 days prior to index admission through the end of the episode with Medicare as the primary payer.
  - Death date during episode window.
  - Enrollment in Medicare Advantage during the episode window
  - Claims with missing date of birth
  - Death dates preceding the date of the trigger event
  - Claims with payment ≤0.
  - Acute inpatient stays that involved a transfer
  - Claims from a non-IPPS or non-subsection (d) hospital

Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure

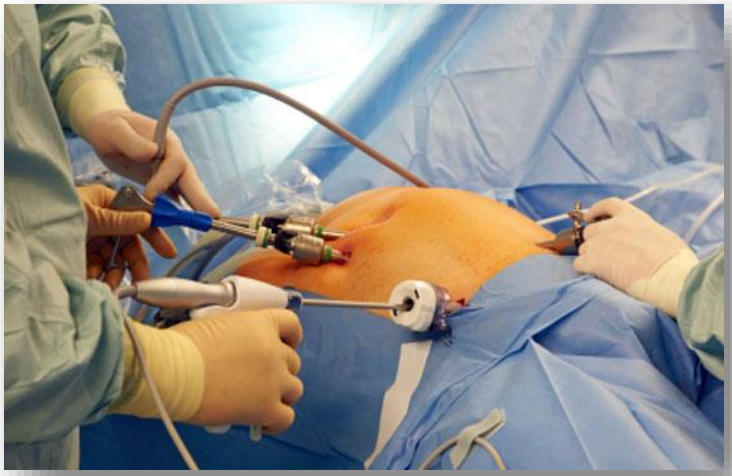
- Payments by Medicare in CY2014 for aortic aneurysm procedures during the episode window, approximately $760 million
- High payments with substantial variation across providers



- Similar to Medicare Spending per Medicare Beneficiary Measure but measures limited to abdominal aortic aneurysm and thoracic aneurysm procedures
- Risk adjusted separately for each clinical sub-type
- Attributed to the hospital at which the index stay occurred
- Episode window begins 3 days prior to the initial (index) admission and extends 30 days following discharge

Cholecystectomy and Common Duct Exploration (CDE) Clinical Episode-Based Payment Measure

- In CY2014, payments by Medicare for cholecystectomy and CDE procedures during the episode window, almost $690 million
- Approximately 48,000 procedures performed with high payments and substantial variation between providers



- Similar to Medicare Spending per Medicare Beneficiary Measure but measures limited to cholecystectomy and common duct exploration procedures
- Risk adjusted
- Attributed to the hospital at which the index stay occurred
- Episode window begins 3 days prior to the initial (index) admission and extends 30 days following discharge

Spinal Fusion Clinical Episode-Based Payment Measure

- In CY2014, payments by Medicare spinal fusion procedures during the episode window, over $2 billion
- Approximately 60,000 procedures performed with high payments with substantial variation across providers

- Similar to Medicare Spending per Medicare Beneficiary Measure but measures limited to 1) anterior fusion–single, 2) anterior fusion-2 levels, 3) posterior/posterior-lateral approach fusion-single, 4) posterior/posterior-lateral approach fusion -2 or 3 levels, OR 5) combined fusion procedures
- Risk adjusted separately for each clinical subtype
- Attributed to the hospital at which the index stay occurred
- Episode window begins 3 days prior to the initial (index) admission and extends 30 days following discharge

Methodology Clinical Episode-Based Payment Measures

$$Risk\ Adjusted\ Payments_{jk} = \left(\frac{1}{n_{jk}} \sum_{i \in \{I_{jk}\}} \frac{Y_{ijk}}{\hat{Y}_{ijk}}\right) * \left(\frac{1}{n_k} \sum_{i \in \{I_k\}} Y_{ik}\right)$$

$$\left[\frac{\text{Average of ratios for each episode observed cost}}{\text{Expected Costs}}\right] \times \text{National average observed Episode Cost}$$

Episode-weighted Median of all US Providers' Episode Amount

Measure Methodology available at: *http://www.qualitynet.org*

- *Hospital-Inpatient> Claims-Based Measures > Proposed episodic payment measures (located in call out box on top right)> Measure Methodology*

Claims-based Excess Days Measures for Hospital IQR Program

Measures	FY 2018 Payment Determination	FY 2019 Payment Determination
AMI Excess Days in Acute Care after hospitalization	Claims	Claims
HF Excess Days in Acute Care after hospitalization	Claims	Claims
PN Excess Days in Acute Care after Hospitalization	N/A	✓ New **

- 3rd most common principal discharge diagnosis with Medicare in 2011
- 7th most expensive condition billed to Medicare in 2011
- 9.5 percent of patients return to the ED within 30 days of discharge
- 12 percent are discharged from the ED and are not captured by the READM-30-PN
- Observation status admits are increasing and variable across US hospitals

Excess Days in Acute Care After Hospitalization for Pneumonia

Finalized for FY 2019 Payment Determination

- Measures includes all-cause acute care utilization 30 days post discharge and includes
  - Hospital readmissions
  - Observation stays
  - ED visits
- ED treat-and-release counted as one half day
- Observation stays calculated in hours and rounded up to nearest half days

- Using expanded clinical pneumonia cohort
- Uses same risk adjustment variables as READM-30-PN
- Planned readmissions excluded
- Uses 3 years of Medicare Part A and Part B data
- Initially applies to FY2019 Payment Determination using discharges July 2014 through June 2017
- Submitted to NQF for endorsement (original measure was NQF endorsed prior to improvements)

Methodology to Calculate Excess Days in Acute Care After Hospitalization for Pneumonia

Finalized for FY 2019 Payment Determination

- Excess Acute Care Day (EACD) are calculated as the difference between the average of the predicted number of days spent in acute care for patients discharged from the average number of days that would have been expected if those patients had been cared for at an average hospital
- The difference is multiplied by 100 so that EACD represents EACD per 100 discharges
- A negative EACD score reflects better quality

For more information on this calculation see the Pneumonia Excess Days in Acute Care zip file at:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html

Summary of 15 HIQR Measures Removed for FY 2019 Payment Determination

Reference slide 1 to summarize removed measures

Measure #	Measure Name	Version Removed
AMI-2	Aspirin prescribed at discharge (NQF #0142)	Electronic
AMI-7a	Fibrinolytic Therapy Within 30 Minutes of Arrival	Electronic
AMI-10	Statin prescribed at discharge	Electronic
HTN	Healthy Term Newborn (NQF #0716)	Electronic
PN-6	Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients (NQF #0147)	Electronic
SCIP-Inf-1a	Prophylactic Antibiotic Received Within One Hour Prior to Incision (NQF #0527)	Electronic
SCIP-Inf-2a	Prophylactic Antibiotic Selection for Surgical Patients (NQF #0528)	Electronic
SCIP-Inf-9	Urinary Catheter Removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with Day of Surgery Being Day Zero	Electronic
STK-4	Thrombolytic Therapy (NQF #0437)	Electronic Chart-abstracted

Summary of 15 HIQR Measures Removed for FY 2019 Payment Determination

Reference slide 2 to summarize removed measures

Measure #	Measure Name	Version Removed
VTE-3	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy (NQF #0373)	Electronic
VTE-4	Venous Thromboembolism Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram)	Electronic
VTE-5	Venous Thromboembolism Discharge Instructions	Electronic Chart-abstracted
VTE-6 ★	Incidence of Potentially Preventable VTE *Electronic version removed due to feasibility to collect. Chart-abstracted form retained.*	Electronic
	Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	Structural
	Participation in a Systematic Clinical Database Registry for General Surgery	Structural

Six Chart-Abstracted Measures Remain for FY 2019 Payment Determination

(data for discharges in CY 2017)

Existing Compliment of Chart-Abstracted Measures CY2016	CY 2017 FY 2019 Payment Determination	Retained as eCQM
ED-1 Median Time from ED Arrival to ED Departure for patients Admitted ED Patients	Retained **	Yes
ED-2 Admit Decision Time to ED Departure Time for Admitted Patients	Retained **	Yes
PC-01 Elective Delivery	Retained **	Yes
IMM-2 Influenza Immunization	Retained	No electronic version
SEP-1 Severe Sepsis and Septic Shock: Management Bundle	Retained	No electronic version
VTE-6 Incidence of Potentially Preventable VTE	Retained	No electronic version

** Must submit a full year of chart-abstracted data on a quarterly basis, regardless of whether data also are submitted electronically.

New Quality Measures and Measure Topics for Consideration in Future Years for Hospital IQR Program

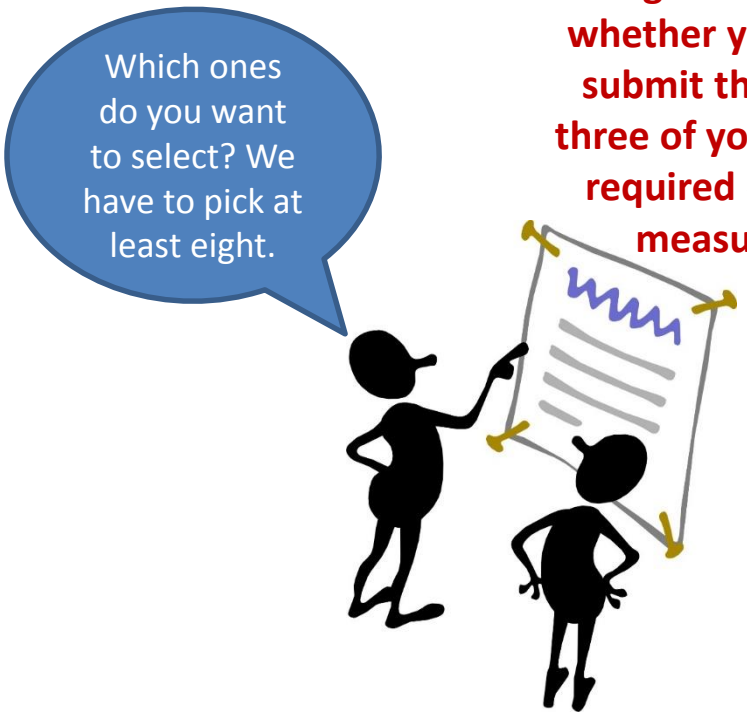
1. Refine MORT-30-STK Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke by changing the measure's risk adjustment to include stroke severity by incorporating the NIH Stroke Scale as an assessment of stroke severity as early as FY 2022 Payment
2. NHSN Antimicrobial Use Measure
   - Purpose is to advance national efforts to reduce the emergence of antibiotic resistance
   - Antibiotic use reported by hospital facility compared to predicted antibiotic use based on nationally aggregated data (observed/expected)
   - Includes both adult and pediatric populations in any medical and/or surgical wards and surgical ICU locations
3. Behavioral Health measures for patients in acute care hospital beds (not within distinct-part psychiatric units)
4. Stratify Hospital IQR data on Hospital Compare by race, ethnicity, sex, and disability.

FY 2017 Rule Changes to align EHR Incentive and HIQR Programs for FY2019 Payment Determination

- Removed 13 eCQMs (15 remain)
- Proposed FY 2017 Rule to submit ***all*** 15 eCQM measures electronically for both HIQR and EMR Incentive Program did NOT pass
- Final FYI 2017 Rule: Must submit **8 of 15** eCQM measures for both HIQR and EMR Incentive Program
- eCQM Data will not be used for payment adjustments
- eCQM Data will not be publically reported *(until it is validated at some point in the future)*

- 3 eCQMs will have a chart-abstracted version
  - **ED-1, ED-2**
  - **PC-01**

Must submit a full year of chart-abstracted data for HIQR regardless of whether you also submit these as three of your eight required eCQM measures



FY 2019 and 2020 Payment Determination

13 Electronic Measures (eCQM) Removed in FY 2017 Rule

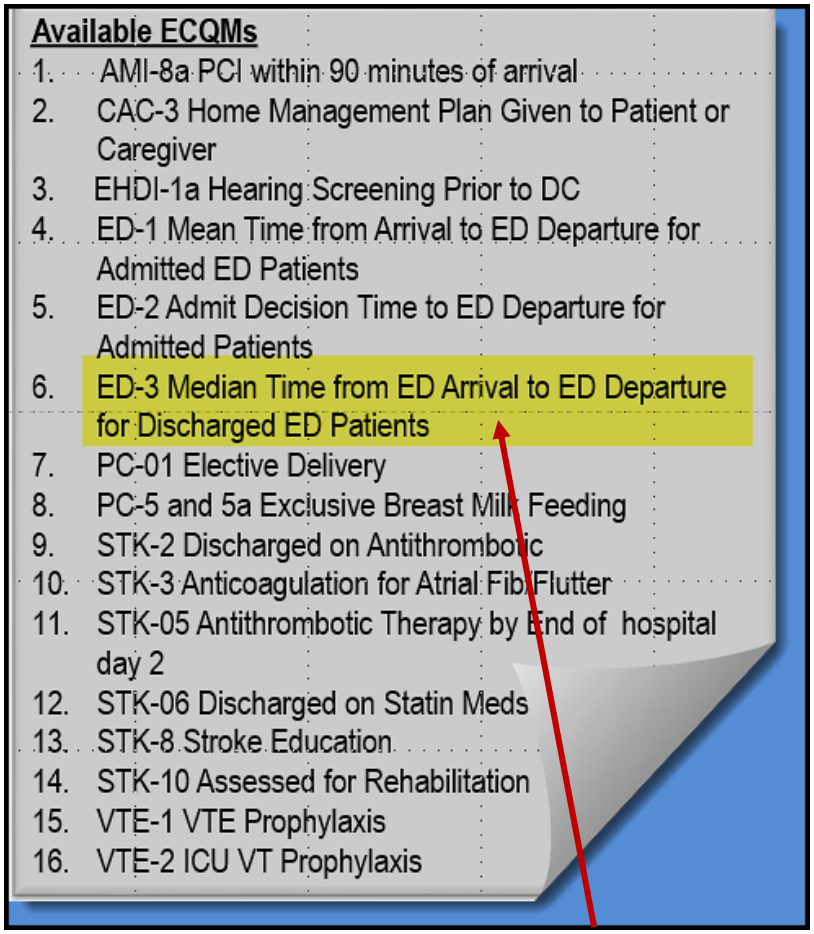
1. AMI-2 Aspirin Prescribed at Discharge
2. AMI-7a Fibrinolytic Therapy within 30 minutes of arrival
3. AMI-10 Statin Prescribed at Discharge
4. STK-4 Thrombolytic Therapy
5. HTN- Health Term Newborn
6. PN-6 Initial Antibiotic Selection for CAP Immunocompetent Patients
7. SCIP-Inf-1a Prophylactic Antibiotics within one hour of incision
8. SCIP-Inf-2a Prophylactic Antibiotic Selection
9. SCIP-Inf-9 Urinary Catheter Removed Post-op Day 2
10. VTE-3 VT Patients with Anticoagulation Overlap Therapy
11. VTE-4 VT Patients Receiving Unfractionated Heparin with Dosages Platelet Count Monitoring
12. VTE-5 VT Discharge Instructions
13. VTE-6 Incidence of Potentially Preventable Venous Thromboembolism

Must Pick at Least Eight from this List

1. AMI-8a PCI within 90 minutes of arrival
2. STK-2 Discharged on Antithrombotic
3. STK-3 Anticoagulation for Atrial Fib/Flutter
4. STK-05 Antithrombotic Therapy by End of hospital day 2
5. STK-06 Discharged on Statin Meds
6. STK-8 Stroke Education
7. STK-10 Assessed for Rehabilitation
8. VTE-1 VTE Prophylaxis
9. VTE-2 ICU VT Prophylaxis
10. CAC-3 Home Management Plan Given to Patient or Caregiver
11. EHDI-1a Hearing Screening Prior to DC
12. ED-1 Mean Time from Arrival to ED Departure for Admitted ED Patients
13. ED-2 Admit Decision Time to ED Departure for Admitted Patients
14. PC-01 Elective Delivery
15. PC-5 and 5a Exclusive Breast Milk Feeding

Eligible Hospitals and Critical Access Hospitals(CAHs) Participating in the EHR Incentive Programs in CY 2017 Through Attestation

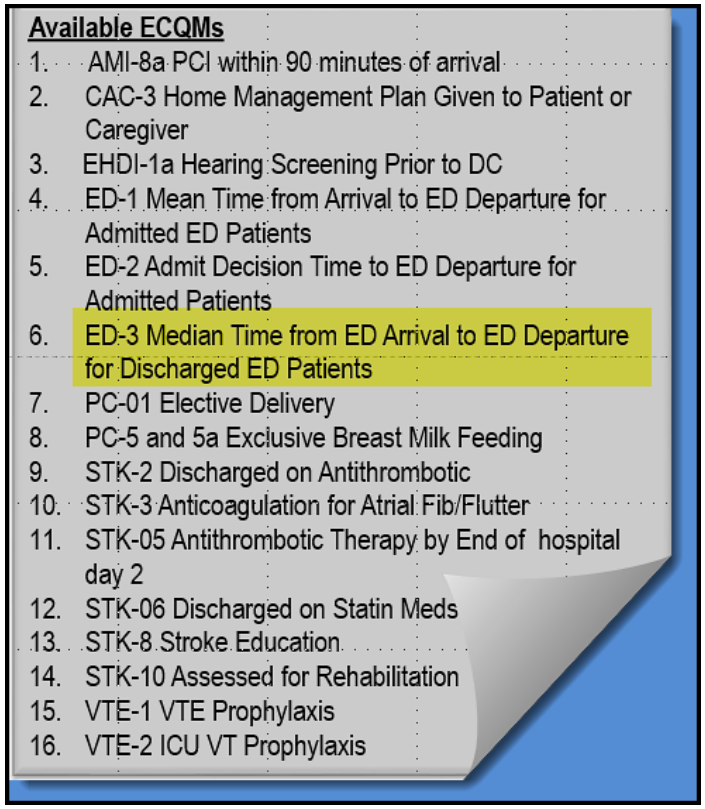
Reporting by Attestation	Requirements
If ONLY participating in EHR program (CAHs)	Report on **ALL 16 measures if Attesting**
Demonstrating MU 1st time in CY2017 AND NOT participating in Hospital IQR	**Reporting period:** Any continuous 90-day period within CY2017. **Submission:** Due 2 months following the end of the calendar year, ending February 28, 2018
Ongoing Demonstrated MU by attestation in any year prior to CY2017 AND NOT participating in Hospital IQR	**Reporting period:** Entire year (all 4 quarters of 2017) **Submission:** Due 2 months following the end of the calendar year, ending February 28, 2018



Outpatient Measure not included in Hospital Inpatient Quality Reporting Program

Eligible Hospitals and Critical Access Hospitals(CAHs) Participating in the EHR Incentive Programs in CY 2017 Through Electronic Reporting

Reporting Electronically	Requirements
If ONLY participating in EHR program (critical access hospitals) OR Participating in BOTH EHR and Hospital IQR	Report on **8 of 16 measures** *(different than attestation requirements)*
Demonstrating MU 1st time in 2017 – OR- demonstrated MU in any prior year	**Reporting period:** Entire year (all 4 quarters of 2017) **Submission:** Due 2 months following the end of the calendar year, ending February 28, 2018



Submission Requirements for eCQMs

- Data for discharges in **full year** of CY 2017 required for FY 2019 Payment Determination
- Data for discharges in **full year** of CY 2018 required for FY 2020 Payment Determination
- Submission due 2 months after the close of the calendar year
  - CY 2017 data to be submitted no later than February 28, 2018
- CMS encourages hospitals OR THEIR VENDOR to submit files early and to use pre-submission testing tools (checks for file formatting errors, not accuracy!)
  - CMS Pre-submission Validation Application (PSVA) downloaded from Quality Net at https://cportal.qualitynet.org/QNet/pgm_select.jsp
- May submit using the 2014 OR the 2015 Edition of the (ONC's) certified electronic health record technology (CEHRT) for CY2017 (FY 2019 Payment Determination)
- 2015 Edition required for submission of CY 2018 (FY 2020 Payment Determination)
- May use 3rd party to submit QRDA 1 files and can use abstraction or pull data from non-certified sources in order to input these data into CEHRT for capture and reporting QRDA1

Finalized Changes in HIQR Data Validation Plan for eCQM Measures for FY 2020 Payment Determination

- HIQR validation of eCQM data begins Spring CY 2018 (validating data from the CY 2017 reporting period)
- Validation scores will not impact payment in FY 2020
- Validations scores will not be publically reported *(will be shared with the hospitals)*
  - Hospital is excluded if already selected for chart-abstracted measure validation or if they have been granted a Hospital IQR Program "Extraordinary Circumstances Exemption"
  - A total of 800 hospitals to be selected for validation in CY 2018 (timelines for notification not yet specified)
    - 200 Hospitals Randomly selected for eCQM validation (new)
    - 400 Hospitals Randomly selected for Chart- Abstracted (no change)
    - 200 Targeted Hospitals randomly selected for Chart-Abstracted (no change)

Targeted Hospitals

Criteria outlined in Final Rule 78 FR pages 50833-50834

- Abnormal or conflicting data patterns
- Rapidly changing data patterns
- Data submission to NHSN after the Hospital IQR data submission deadline has passed

Finalized Criteria for Validation of Electronic Measures
for FY 2020 Payment Determination

- Required to submit 32 randomly selected cases by CMS (individual patient-level reports) from the QRDA I file per hospital selected for eCQM validation
  - Eight cases per quarter from CY 2017 discharges will be randomly selected
  - Each record contains data elements for one or more eCQM measure sets.
  - Hospitals will need to copy the medical record in pdf format for these 32 cases similar to chart abstracted measures
  - Must be submitted within 30 days of request to obtain full payment updates for FY 2020 payment determination
  - Hospitals will be reimbursed $3 per chart (same as chart abstracted)

More Proposed Changes in Hospital IQR Data Validation Plan

- For FY 2020 Payment Determination in order to receive full annual payment update hospitals must:
  - Attain at least 75% percent validation score for chart-abstracted data [Score matters]
  - Submit at least 75% (24 of the required 32) sampled eCQM measure medical records to CMS within 30 days of record request. [Timely submission and number of records submitted matters, not the score]

Extraordinary Circumstance Waivers

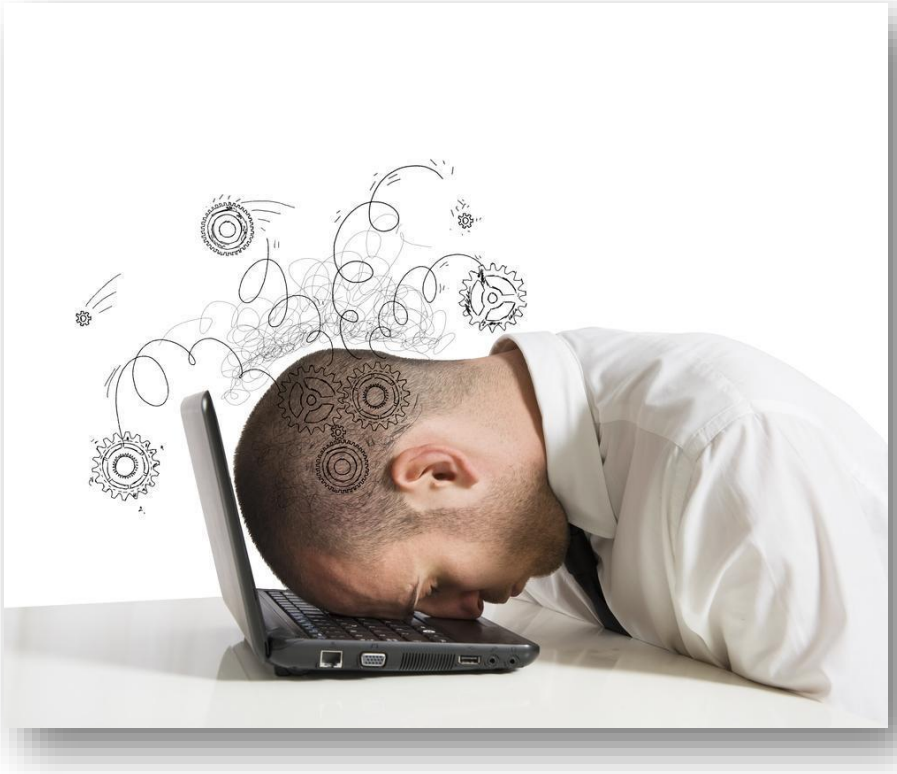
for non eCQM Circumstances

- Extending the deadline to request an extension or exemption from 30 days to 90 days following the extraordinary event
- Applies to events that occur October 1, 2016 forward

Extraordinary Circumstance Waivers

for eCQM Related Circumstances

- Significant and insurmountable IT infrastructure challenges
- Vendor issues outside of the hospital's control
- Considered on a case by case basis
- Deadline to apply is April 1st following the end of the reporting year



Hospital-based Inpatient Psychiatric Services Quality Reporting Program

Begins on page 57,236

Inpatient Psychiatric Facility Program Summary of Final FY 2017 Changes

Failure for Psychiatric Hospitals and Psychiatric Units within Acute Care and Critical Access Hospitals to Meet Requirements Results in 2.0 Percentage Point Reduction in Annual Payment Update

- Retain the previously finalized 15 measures from FY2016 IPF PPS Rule
- Update denominator criteria for Screening for Metabolic Disorder measure
- Adopt one new chart-abstracted measure
- Adopt one new claims-based measure
- Change timeframes for public display of data and the associated preview period

No change to submission procedures

Hospital-based Inpatient Psychiatric Topic for Inpatient Psychiatric Facility Reporting Program

Measures	CY 2016 FY 2018 Payment Determination	CY 2017 FY 2019 Payment Determination	CY 2017 TJC ORYX Flexible Options
HBIPS-1	N/A	N/A	Abstracted
HBIPS-2 Hours of Physical Restraint Use	Abstracted	Abstracted	Abstracted
HBIPS-3 Hours of Seclusion Use	Abstracted	Abstracted	Abstracted
HBIPS-5 Patients Discharged on Multiple Antipsychotic Meds with Appropriate Justification	Abstracted	Abstracted	Abstracted
TOB-1 Tobacco Use Screening	Abstracted	Abstracted	Abstracted
TOB-2 Tobacco Use Treatment Provided or Offered and TOB-2a Tobacco Use Treatment	Abstracted	Abstracted	Abstracted
TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge	Abstracted	Abstracted	Abstracted
FUH: F/U After Hospitalization for Mental Illness	Claims	Claims	N/A
IMM-2 Influenza Immunization	Abstracted	Abstracted	Abstracted
HCP Influenza vaccination coverage among healthcare personnel	NHSN tool	NHSN tool	N/A

Hospital-based Inpatient Psychiatric Topic for Inpatient Psychiatric Facility Reporting Program

Measures	CY 2016 FY 2018 Payment Determination	CY 2017 FY 2019 Payment Determination	CY 2017 TJC ORYX Options
Use of an Electronic Health Record	Structural Web-based	Structural Web-based	N/A
APEC Assessment Patient Experience Care	Structural Web-based	Structural Web-based	N/A
SUB-1 Alcohol Use Screening	Abstracted	Abstracted	N/A
SUB-2 and SUB-2a Alcohol Use Brief Intervention Provided or Offered at DC	Abstracted	Abstracted	N/A
SUB-3 and SUB-3a Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge	N/A	✓ New	N/A
Screening for Metabolic Disorders	N/A	Abstracted ✓ New	N/A
Transition Record with Specified Elements Received by Discharged Patients	N/A	Abstracted ✓ New	N/A
Timely Transmission of Transition Record	N/A	Abstracted ✓ New	N/A
30-Day All-Cause Unplanned Readmission Following Hospitalization in an IPF	N/A	✓ New	N/A

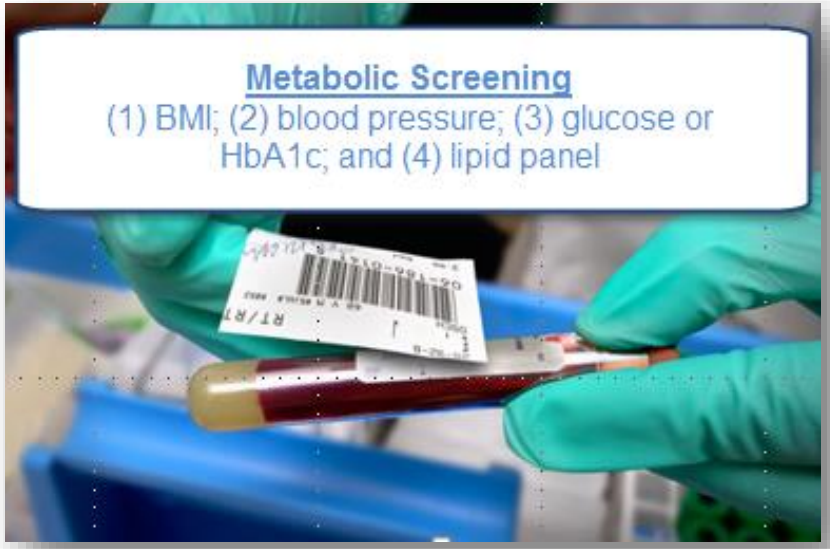
Two New Measures Controversial

- NQF #0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self or Any Other Site of Care
- NQF #0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care

- Originally planned to begin with discharges July 1, 2016 to December 31, 2016 for FY 2018 payment determination
- Concerns expressed about how to collect data
- Pushed back to begin January 1, 2017 for FY 2019 Payment
- Technical specifications updated June 8, 2016 see http://www.qualityreportingcenter.com/wp-content/uploads/2016/06/IPF_CY2016_IPRQRManual_Guide_20160607_FINAL.pdf1_.pdf

Finalized Update to Chart-Abstracted Measure, Screening for Metabolic Disorder

- Updated technical specifications and data collection tools posted June 8, 2016
- Finalized measure in FY2016 IPF PPS Rule, abstracted for July 2016 discharges forward changed to begin with discharged January 1, 2017 for FY 2019 Payment Determination
- IPF patients discharged on one or more antipsychotic medications who received metabolic screening either prior to, or during, the index IPF stay
- Specified to use same global population & sample as SUB, TOB, IMM, but denominator exclusions for Screening for Metabolic Disorders are different
- CMS modified the length of stay denominator exclusion to align with other global measures
  - FROM: LOS less than 3 days
  - TO: LOS less than or equal to 3 days or greater than 365 days



Finalized Chart-Abstracted Measures for CY 2017

SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge/SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge

- Individuals with mental illness experience substance use disorders at a much higher rate than the general population
- Nearly 18% of the 43.6 million adults 18 years and older who had a mental illness in 2013 met the criteria for a substance use disorder (SUD)
- Individuals with co-occurring mental illness and SUD are more likely to experience homelessness, incarceration, suicide, other medical illnesses and early death
- Due to prevalence of substance abuse among patients with mental illness, CMS believes it is important for Inpatient Psychiatric Facilities (IPF) to offer treatment options for patients who screen positive for drug and alcohol use
- The SUB-3 numerator includes patients who received or refused a prescription for medication for treatment of alcohol or drug use disorder at discharge
- The SUB-3a numerator includes patients who received a prescription for medication for treatment of alcohol or drug use disorder at discharge or received a referral for addictions treatment at discharge

New Claims-based Measure for HBIPS

30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF

- All-cause readmission rate was selected because it promotes a holistic approach to the treatment of patients with psychiatric disorders who often have co-morbid conditions
- In 2012-2013 more than 20% IPF admissions resulted in readmission to an IPF or short-stay hospital
- Uses Medicare Part A and B claims and enrollment data over a 24-month measurement period
- Risk-adjusted using variables specific to the IPF patient population
- NQF 2-year trial will review measures for risk-adjustment using sociodemographic variables
- Submitted to NQF for endorsement

30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF

(CY 2017 Discharges for FY 2019 Payment Determination)

- **Denominator:** Medicare FFS beneficiaries, age 18 and older, admitted and discharged from an IPF, with principal diagnosis of psychiatric disorder

- **Numerator:** any admission to an IPF or acute care hospital on or between day 3-30 post-discharge except those considered planned by CMS Planned Readmission Algorithm

- **Exemptions from Measure Inclusion:**
  - Lack of continuous enrollment in Medicare Parts A and B for 12 months prior to the index admission, the month of admission, or for 30 days post-discharge
  - Subsequent admission on day of discharge (Day 0) or within 2 days post discharge (Day 1-Day 2) due to transfer to another inpatient facility on Day 0 or 1; OR billing procedures for interrupted stays which do not allow for identification of readmissions to the same IPF within 3 days
  - Patients who leave AMA
  - Claims with coding errors (e.g. death date with admission date afterwards

No Changes in….

- Submission process
- Reporting periods
- Data Accuracy and completeness
- Global sampling (except to include SUB-3 and 3a in global sample)

You Have Survived the CMS FINAL Rule Overview!

Send Questions To:

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