The Hospital Quality Reporting World in 2021

An Overview of the CMS Final IPPS Rule for FY 2021

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About Your Presenter

- Currently serving as the clinical lead on the Advanced Analytics Team at Medisolv
- Measurement developer, product manager and analytics researcher since 1997
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The Lucky Number 21

- The number of spots on a standard die
- The winning number for a hand in blackjack
- The winning number in slots
- The number of shillings in a guinea
- Currency of wagers and horse-racing
- Minimum age to enter a casino in the USA

Our Purpose for Today's Webinar

1) Provide participants with a comprehensive program update for four hospital quality reporting programs discussed in the final IPPS Rule for FY 2021:
   - Hospital Readmission Reduction Program
   - Hospital Acquired Conditions Reduction Program
   - Hospital Value-based Purchasing Program
   - Hospital Inpatient Quality Reporting Program

2) Provide participants ranging from novice to expert with resource materials that can be used as a reference throughout the year to educate stakeholders at your organization.

Review of FINAL IPPS Rule for FY 2021 CMS-1735-F Vol. 85, No. 182

42 CFR Parts 405, 412, 413, 417, 476, 480, 484 and 495

Posted to Federal Registry September 18, 2020

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, 413, 417, 476, 480, 484, and 495

[CMS–1735–F]

RIN 0938–AU11

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Final Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from our continuing experience with these systems for FY 2021 and to implement certain recent legislation. We are also making changes relating to Medicare graduate medical education (GME) for teaching hospitals. In addition, we are providing the market basket update that hospitals (CAHs) participating in the Medicare and Medicaid Promoting Interoperability Programs. We are also establishing performance standards for the Hospital Value-Based Purchasing (VBP) Program, and updating policies for the Hospital Readmissions Reduction Program and the Hospital-Acquired Condition (HAC) Reduction Program.

DATES:

Effective date: This final rule is effective October 1, 2020.

Applicability dates: The amendments at § 413.89(b)(1)(i), (c)(1), (e)(2)(i)(A)(*2*) are applicable to cost reporting periods before October 1, 2020. The amendments at § 413.89(e)(2)(i)(A)(*1*), (*4*) through (*6*), (i)(B), (iii), and (f) are applicable to cost reporting periods before, on, and after October 1, 2020. The amendments at § 413.89(b)(1)(ii), (c)(2), (e)(2)(i)(A)(*3*) and (e)(2)(ii) are applicable to cost reporting periods beginning on or after October 1, 2020.

FOR FURTHER INFORMATION CONTACT: Donald Thompson, (410) 786–4487, and Michele Hudson, (410) 786–4487, Operating Prospective Payment, MS–DRGs, Wage Index, New Medical Service and Technology Add-On Payments, Hospital Geographic Reclassifications, Graduate Medical Education, Capital Prospective Payment, Excluded Hospitals, Medicare Disproportionate Share Hospital (DSH) Payment Adjustment, Medicare-Dependent Small Rural Hospital (MDH) Program, Low-Volume Hospital

Julia Venanzi, (410) 786–1471, Hospital Inpatient Quality Reporting Program—Administration Issues Mihir Patel, (410) 786–2815 and Grace Snyder, (410) 786–0700, Hospital Quality Reporting Program Validation and Reconsideration Issues.

Julia Venanzi, (410) 786–1471and Pamela Brown (410) 786–3940, Hospital Value-Based Purchasing Program—Administration Issues

Katrina Hoadley, (410) 786–8490, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing—Measures Issues Except Hospital Consumer Assessment of Healthcare Providers and Systems Issues.

Elizabeth Goldstein, (410) 786–6665, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing—Hospital Consumer Assessment of Healthcare Providers and Systems Measures Issues.

Erin Patton, (410) 786–2437 and Katrina Hoadley, (410) 786–8490, PPS-Exempt Cancer Hospital Quality Reporting Issues.

Mary Pratt, (410) 786–6867, Long-Term Care Hospital Quality Data Reporting Issues.

Dylan Podson (410) 786–5031, Jessica Warren (410) 786–7519, and Elizabeth Holland, (410) 786–1309, Promoting Interoperability Programs.

Steve Rubio, (410) 786–1782, Reimbursement for Submission of Patient Records to Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC–QIOs) in Electronic Format

https://www.cms.gov/medicare/acute-inpatient-pps/fy-2021-ipps-final-rule-home-page#1735

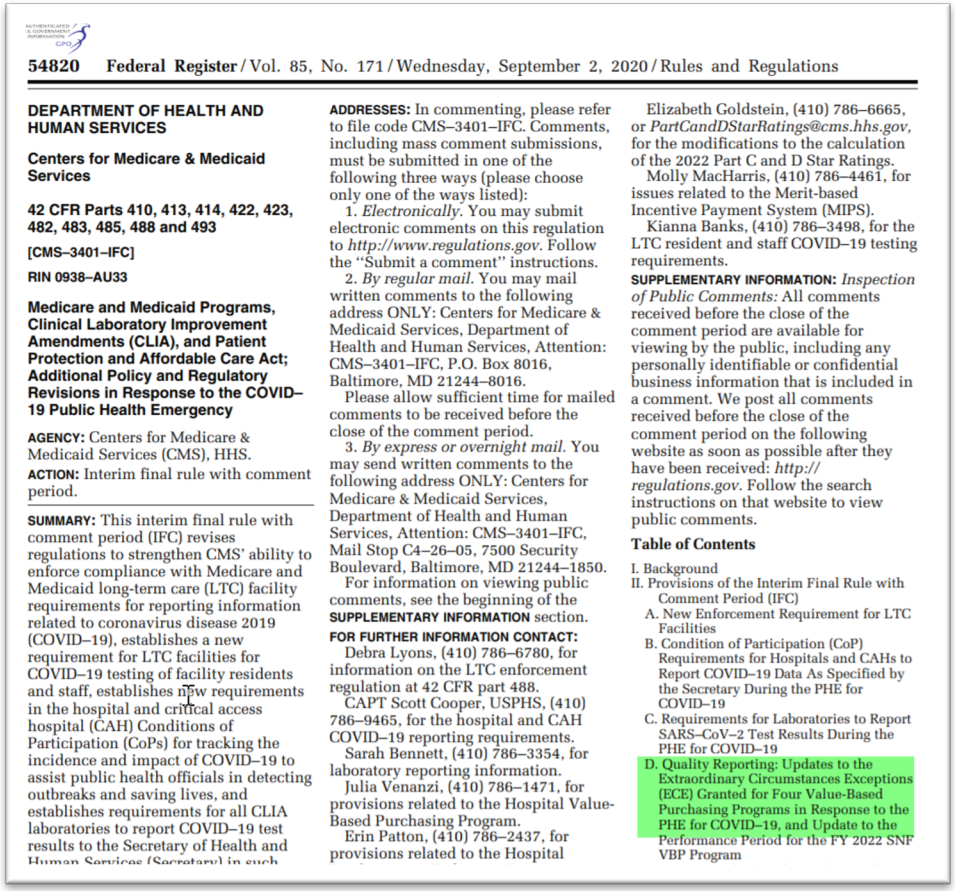
COVID-19 Impact on Quality Reporting

CMS 3401-IFC

42 CFR Parts 410, 413, 414, 422, 423, 483, 488 and 493

Posted September 2, 2020

https://www.govinfo.gov/content/pkg/FR-2020-09-02/pdf/2020-19150.pdf



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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 413, 414, 422, 423, 482, 483, 485, 488 and 493

[CMS–3401–IFC]

RIN 0938–AU33

Medicare and Medicaid Programs, Clinical Laboratory Improvement Amendments (CLIA), and Patient Protection and Affordable Care Act; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period (IFC) revises regulations to strengthen CMS' ability to enforce compliance with Medicare and Medicaid long-term care (LTC) facility requirements for reporting information related to coronavirus disease 2019 (COVID–19), establishes a new requirement for LTC facilities for COVID–19 testing of facility residents and staff, establishes new requirements in the hospital and critical access hospital (CAH) Conditions of Participation (CoPs) for tracking the incidence and impact of COVID–19 to assist public health officials in detecting outbreaks and saving lives, and establishes requirements for all CLIA laboratories to report COVID–19 test results to the Secretary of Health and Human Services (Secretary) in such

ADDRESSES: In commenting, please refer to file code CMS–3401–IFC. Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the "Submit a comment" instructions.
2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3401–IFC, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3401–IFC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Debra Lyons, (410) 786–6780, for information on the LTC enforcement regulation at 42 CFR part 488.

CAPT Scott Cooper, USPHS, (410) 786–9465, for the hospital and CAH COVID–19 reporting requirements.

Sarah Bennett, (410) 786–3354, for laboratory reporting information.

Julia Venanzi, (410) 786–1471, for provisions related to the Hospital Value-Based Purchasing Program.

Erin Patton, (410) 786–2437, for provisions related to the Hospital

Elizabeth Goldstein, (410) 786–6665, or *PartCandDStarRatings@cms.hhs.gov,* for the modifications to the calculation of the 2022 Part C and D Star Ratings.

Molly MacHarris, (410) 786–4461, for issues related to the Merit-based Incentive Payment System (MIPS).

Kianna Banks, (410) 786–3498, for the LTC resident and staff COVID–19 testing requirements.

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://regulations.gov.* Follow the search instructions on that website to view public comments.

Table of Contents

Interim Final Rule with Comment Contains Hints About Additional Changes to Come!

Key Concepts to Remember

Applicable Discharges

Discharge dates for patients that will determine your score for measures in each Quality Reporting Program

Dates may vary for different measures within the same program. Dates may also vary for the same measures that exist across programs!

Payment Determination

Discharge dates for which your penalties or incentive payments will apply to payment

October 1st is the first day of a CMS Fiscal Year for hospital inpatients. Payment determination FY 2021 impacts payment for patients discharged October 1, 2020 through September 30, 2021

Hospital Readmission Reduction Program

Begins on page 58,844

Brief History of the Hospital Readmission Reduction Program

Begins on page 42,380

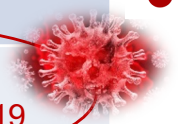
- Began in FY 2012 with a 1% Medicare payment reduction cap
- Payment Reduction cap increased to 2% in FY 2014
- Payment Reduction cap increased to 3% in FY 2015 *(holding steady)*
- Does not apply to hospitals excluded from the IPPS *(LTCHs, cancer hospitals, children's hospitals, IRFs, IPFs, Critical Access Hospitals, Veterans' Hospitals, Maryland Hospitals and hospitals in US Territories.*
- No new cohorts added since FY 2017 (no new measures added in FY 2021)
  - Acute MI 30-day Risk-Standardized Unplanned Readmissions
  - Heart Failure 30-day Risk-Standardized Unplanned Readmissions
  - Pneumonia 30-day Risk-Standardized Unplanned Readmissions (with expanded cohort)
  - COPD 30-day Risk-Standardized Unplanned Readmissions
  - Elective Total Knee or Hip Arthroplasty 30-day Risk-Standardized Unplanned Readmissions
  - Coronary Artery Bypass Graph 30-day Risk-Standardized Unplanned Readmissions

Hospital Readmission Reduction Program Measures

	Payments for FY 2015	Payments for FY 2016	Payments for FY 2017	Payments for FY 2018	Payments for FY 2019
Max Penalty	3%	3%	3%	3%	3% Stratified
Acute MI	✓	✓	✓	✓	✓
Pneumonia	✓	✓	✓ Expanded	✓ Expanded	✓ Expanded
Heart Failure	✓	✓	✓	✓	✓
COPD	✓	✓	✓	✓	✓
Total Joint	✓	✓	✓	✓	✓
CABG			✓	✓	✓
Based on Discharges	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	July 1, 2014 to June 30, 2017
Planned Readmit Logic	✓ Version 2.1	✓ Version 3.0	✓ Version 4.0	✓ Version 4.0	✓ Version 4.0

Three-Year Applicable Periods for FY 2022 Adjusted to Remove Discharges January 1 to June 30, 2020 due to COVID-19

	Payments for FY 2020	Payments for FY 2021	Payments for FY 2022
Max Penalty	3% Stratified	3% Stratified	3% Stratified
Acute MI	✓	✓	✓
Pneumonia	✓ Expanded	✓ Expanded	✓ Expanded
Heart Failure	✓	✓	✓
COPD	✓	✓	✓
Total Joint	✓	✓	✓
CABG	✓	✓	✓
Based on Discharges	July 1, 2015 to June 30, 2018	July 1, 2016 to June 30, 2019	July 1, 2017 to December 31, 2019
Planned Readmit Logic	Version 4.0 2000	Version 4.0 2000	pending
Note:	Hospital-Wide All-Cause Readmissions are included in Hospital Inpatient Quality Reporting Program but NOT in Hospital Readmission Reduction Program		



HRRP Updates in Interim Final Rule with Comments Found on pages 54,832 - 54,833

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comparison of hospitals. Alternatively, if we do not extend the ECE to cover Q3 and Q4 2020, it is possible that a majority of providers may still submit individual ECE requests for those quarters and it is possible that so many hospitals will submit individual ECE requests that we will not be able to produce a reliable national comparison. In both cases, we are concerned about using the measure calculated based on these data to score hospitals under the HAC Reduction Program and base payment adjustments on those scores. If circumstances warrant, we may propose to suspend prospective application of program penalties or payment adjustments through the annual IPPS/LTCH PPS proposed rule. However, in the interest of time and transparency, we may provide subregulatory advance notice of our intentions to suspend such penalties and adjustments through routine communication channels to hospitals, vendors, and Quality Improvement Organizations (QIOs). The communications could include memos, emails, and notices on the public QualityNet website (*https://www.qualitynet.org/*). We welcome public comments on our policy to exclude any data submitted regarding care provided during the first and second quarter of CY 2020 from our calculation of performance for the FY 2022 and FY 2023 program years.

3. Update to the HRRP ECE Granted in Response to the PHE for COVID–19

a. Background of the Hospital Readmissions Reduction Program ECE Policy

In the FY 2016 IPPS/LTCH PPS final rule (80 FR 49542 through 49543), we adopted an ECE policy for the Hospital Readmissions Reduction Program, which recognized that there may be periods of time during which a hospital is not able to submit all claims (from which readmission measures data are derived) in an accurate or timely fashion due to an extraordinary circumstance beyond its control. We noted that we considered the feasibility and implications of excluding data for certain measures for a limited period of time from the calculations for a hospital's excess readmissions ratios for the applicable performance period. We expressed that we hoped to minimize data excluded from the program to allow affected hospitals to continue to participate in the HRRP for a given year if these hospitals otherwise continue to meet applicable measure minimum threshold requirements. We further observed that section 1886(q)(5)(D) of the Act permits the Secretary to determine the applicable period for readmissions data collection, and we interpreted the statute to allow us to determine that the period not include times when hospitals may encounter extraordinary circumstances. This policy was similar to the ECE policy for the Hospital Inpatient Quality Reporting (IQR) Program, as initially adopted in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51651), and modified in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50836) and the FY 2015 IPPS/LTCH PPS final rule (79 FR 50277).

In the FY 2016 IPPS/LTCH PPS final rule (80 FR 49542), we also stated that this policy would not preclude CMS from granting ECEs to hospitals that do not request them if we determined at our discretion that a disaster or other extraordinary circumstance has affected an entire region or locale. We noted that if CMS made such a determination to grant an ECE to hospitals in an affected region or locale, we would convey this decision through routine communication channels to hospitals, vendors, and QIOs, including, but not limited to, issuing memos, emails, and notices on the QualityNet website.

In the 2018 IPPS/LTCH PPS final rule (82 FR 38239), we modified the requirements for the HRRP ECE policy to further align with the processes used by other QRP and VBP programs for requesting an exception from program reporting due to an extraordinary circumstance not within a provider's control.

b. Background of the HRRP ECE Granted for the PHE for COVID–19

On March 22, 2020, in response to COVID–19, CMS announced relief for clinicians, providers, hospitals and facilities participating in Medicare QRPs and VBP programs.[20] Specifically, we announced that we were granting ECEs for certain data reporting requirements and submission deadlines for the first and second quarters of CY 2020. On March 27, 2020, we published a supplemental guidance memorandum that described the scope and duration of the ECEs we were granting under each Medicare QRP and VBP program.[21]

Under the ECE for the PHE for COVID–19 that we granted to all hospitals subject to the HRRP, qualifying claims from January 1, 2020 through March 31, 2020 (Q1 2020) and April 1, 2020 through June 30, 2020 (Q2 2020) will be excluded from the measure calculations for the readmission measures used in the program. We also advised that hospitals should be aware of the potential subsequent impact to the HRRP minimum case threshold counts for inclusion in this program.

c. Update to the HRRP ECE Granted in Response to the PHE for COVID–19

We continue to believe that the readmissions claims data we have excepted serve multiple purposes, including allowing us to understand the impact of the PHE for COVID–19 on the quality of care provided to Medicare beneficiaries. However, we are concerned that excess readmission ratios calculated using excepted claims data could affect the national comparability of these data due to the geographic differences of COVID–19 incidence rates and hospitalizations along with different impacts resulting from different state and local law and policy changes implemented in response to COVID–19. Thus, the excess readmission ratios and payment adjustments calculated from excepted data during the PHE for COVID–19 may not provide a nationally comparable assessment of performance in keeping with the program goal of national comparison.

i. CY 2019 Fourth Quarter Data

Data were not excepted from the fourth quarter of CY 2019 from the HRRP. The readmissions measures used to evaluate performance are claims-based measures and do not require hospitals to report data to CMS. Additionally, we believe that the quality measure data regarding care provided prior to the PHE would not be affected by the PHE for COVID–19.

ii. CY 2020 First and Second Quarter Data

In our application of the ECE policy for the PHE for COVID–19, we excepted the use of claims data from the first and second quarters of CY 2020 from the HRRP because of our concern that the data collected during this period may be greatly impacted by the response to COVID–19, and therefore, may not be reflective of a hospital's performance during this time due to concerns with national comparability, as described above. Therefore, we believe that it would be inappropriate to include claims data submitted regarding care provided during first and second quarter CY 2020 in our calculation of a hospital's performance that assesses their performance as compared to other

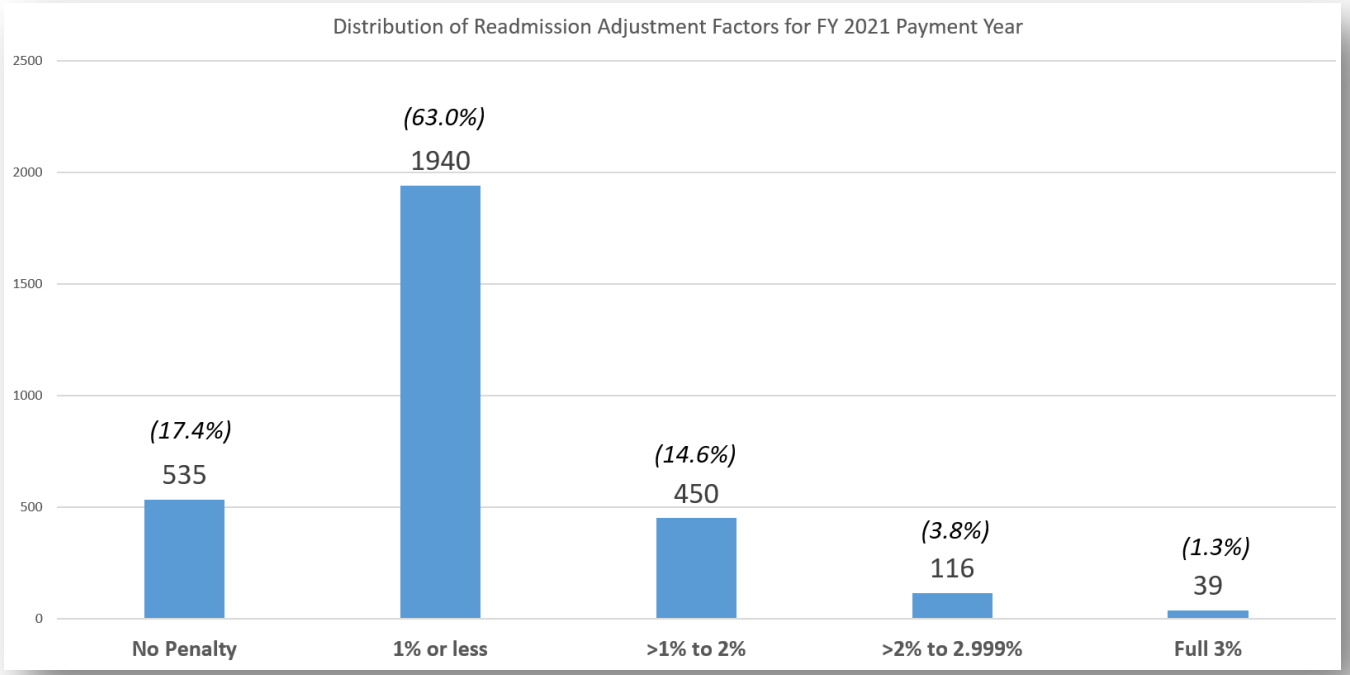
[20] CMS press release available at *https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting.*

[21] CMS memorandum available at *https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.*

- Original plan was to exclude readmissions data for Q1 and Q2 2020 and calculate hospital penalties based on remaining 30 months of data….
- …BUT there are concerns that there may not be enough data to reliably measure national performance in an equitable manner
- Smaller hospitals may not have sufficient cases to evaluate performance
- Additional Extraordinary Circumstances Exemptions (ECE) likely to be requested by some hospitals for Q3 and Q4 2020 due to COVID-19
- Decision not yet made to extend the exemption beyond Q1 and Q2 2020 for all hospitals, but if it is extended, penalties for the affected program year could be suspended
- Look for changes to HRRP Program in future proposed rules or memos from CMS

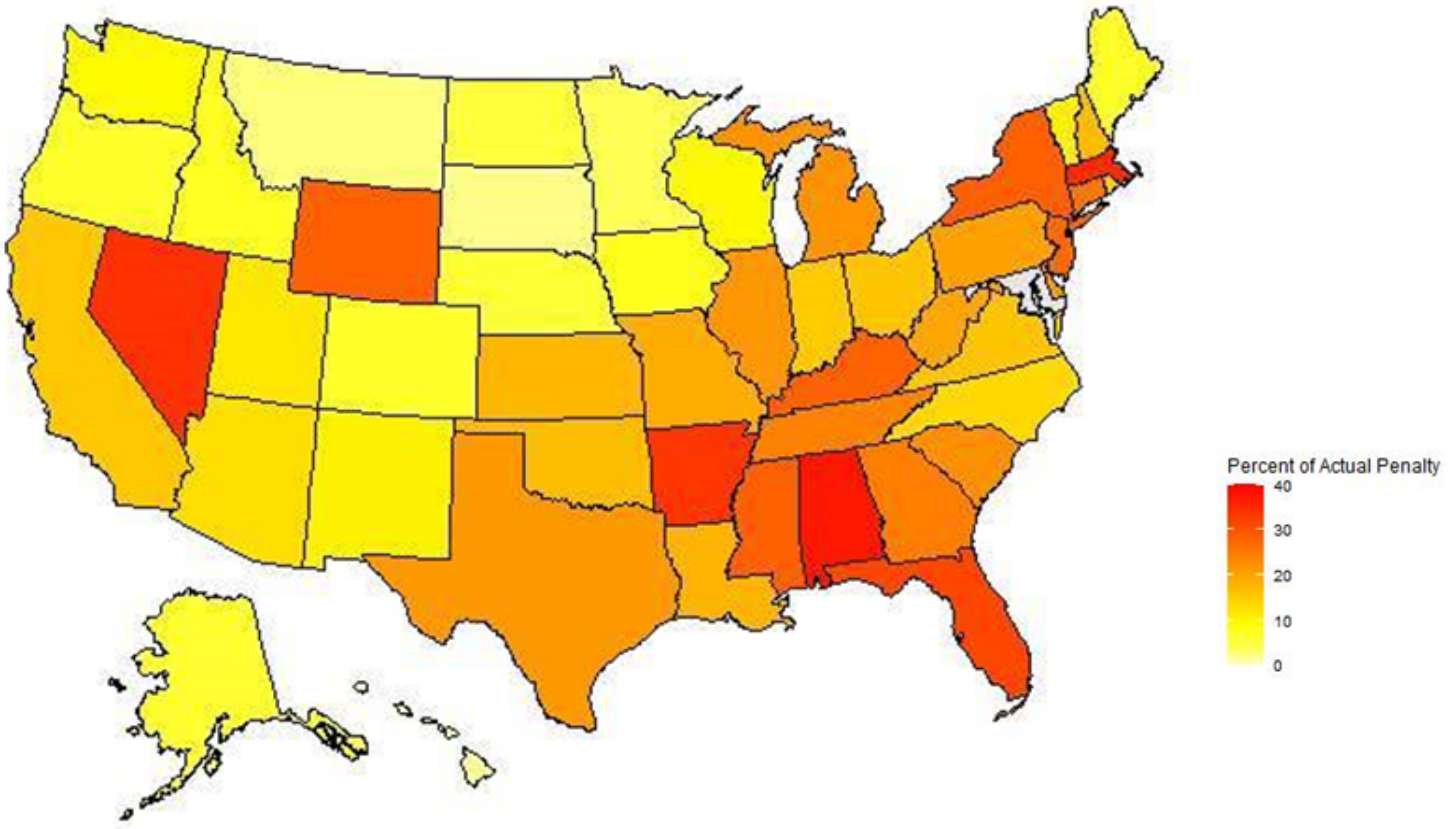
https://www.govinfo.gov/content/pkg/FR-2020-09-02/pdf/2020-19150.pdf

Distribution of Readmission Adjustment Factors Across all Strata for FY 2021 Payment Determination across 3,080 Hospitals



Hospitals are compared to their assigned peer group strata. Five stratification groups are established based on the dual proportion ratio (# of dually eligible stays/total Medicare stays

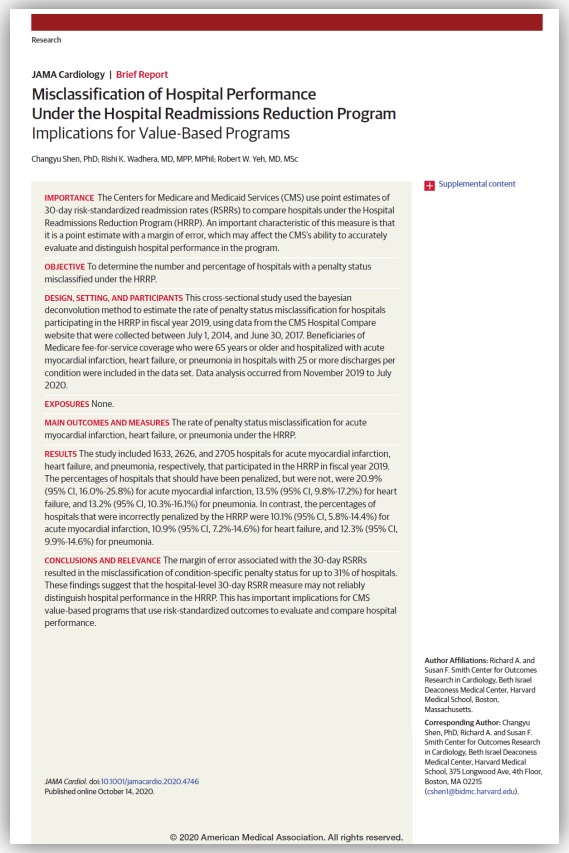
Average Percentage of Maximum Penalties for Readmission by State in FY 2020



Analysis performed by Medisolv

October 2020 Publication Suggesting Error in Penalty Calculation

- 82% of 3,080 US Hospitals Penalized in CMS Payment Year FY 2021
- Recent article in JAMA suggests miscalculation of penalty status in up to 31% of hospitals
- Their amount of error was causing a hospital to go from “no penalty” to “extreme penalty” (not likely to happen)
- Methodology does not recognize that there are varying degrees of penalty



Research

JAMA Cardiology | Brief Report

Misclassification of Hospital Performance Under the Hospital Readmissions Reduction Program
Implications for Value-Based Programs

Changyu Shen, PhD; Rishi K. Wadhera, MD, MPP, MPhil; Robert W. Yeh, MD, MSc

Supplemental content

IMPORTANCE The Centers for Medicare and Medicaid Services (CMS) use point estimates of 30-day risk-standardized readmission rates (RSRRs) to compare hospitals under the Hospital Readmissions Reduction Program (HRRP). An important characteristic of this measure is that it is a point estimate with a margin of error, which may affect the CMS's ability to accurately evaluate and distinguish hospital performance in the program.

OBJECTIVE To determine the number and percentage of hospitals with a penalty status misclassified under the HRRP.

DESIGN, SETTING, AND PARTICIPANTS This cross-sectional study used the bayesian deconvolution method to estimate the rate of penalty status misclassification for hospitals participating in the HRRP in fiscal year 2019, using data from the CMS Hospital Compare website that were collected between July 1, 2014, and June 30, 2017. Beneficiaries of Medicare fee-for-service coverage who were 65 years or older and hospitalized with acute myocardial infarction, heart failure, or pneumonia in hospitals with 25 or more discharges per condition were included in the data set. Data analysis occurred from November 2019 to July 2020.

EXPOSURES None.

MAIN OUTCOMES AND MEASURES The rate of penalty status misclassification for acute myocardial infarction, heart failure, or pneumonia under the HRRP.

RESULTS The study included 1633, 2626, and 2705 hospitals for acute myocardial infarction, heart failure, and pneumonia, respectively, that participated in the HRRP in fiscal year 2019. The percentages of hospitals that should have been penalized, but were not, were 20.9% (95% CI, 16.0%-25.8%) for acute myocardial infarction, 13.5% (95% CI, 9.8%-17.2%) for heart failure, and 13.2% (95% CI, 10.3%-16.1%) for pneumonia. In contrast, the percentages of hospitals that were incorrectly penalized by the HRRP were 10.1% (95% CI, 5.8%-14.4%) for acute myocardial infarction, 10.9% (95% CI, 7.2%-14.6%) for heart failure, and 12.3% (95% CI, 9.9%-14.6%) for pneumonia.

CONCLUSIONS AND RELEVANCE The margin of error associated with the 30-day RSRRs resulted in the misclassification of condition-specific penalty status for up to 31% of hospitals. These findings suggest that the hospital-level 30-day RSRR measure may not reliably distinguish hospital performance in the HRRP. This has important implications for CMS value-based programs that use risk-standardized outcomes to evaluate and compare hospital performance.

JAMA Cardiol. doi:10.1001/jamacardio.2020.4746
Published online October 14, 2020.

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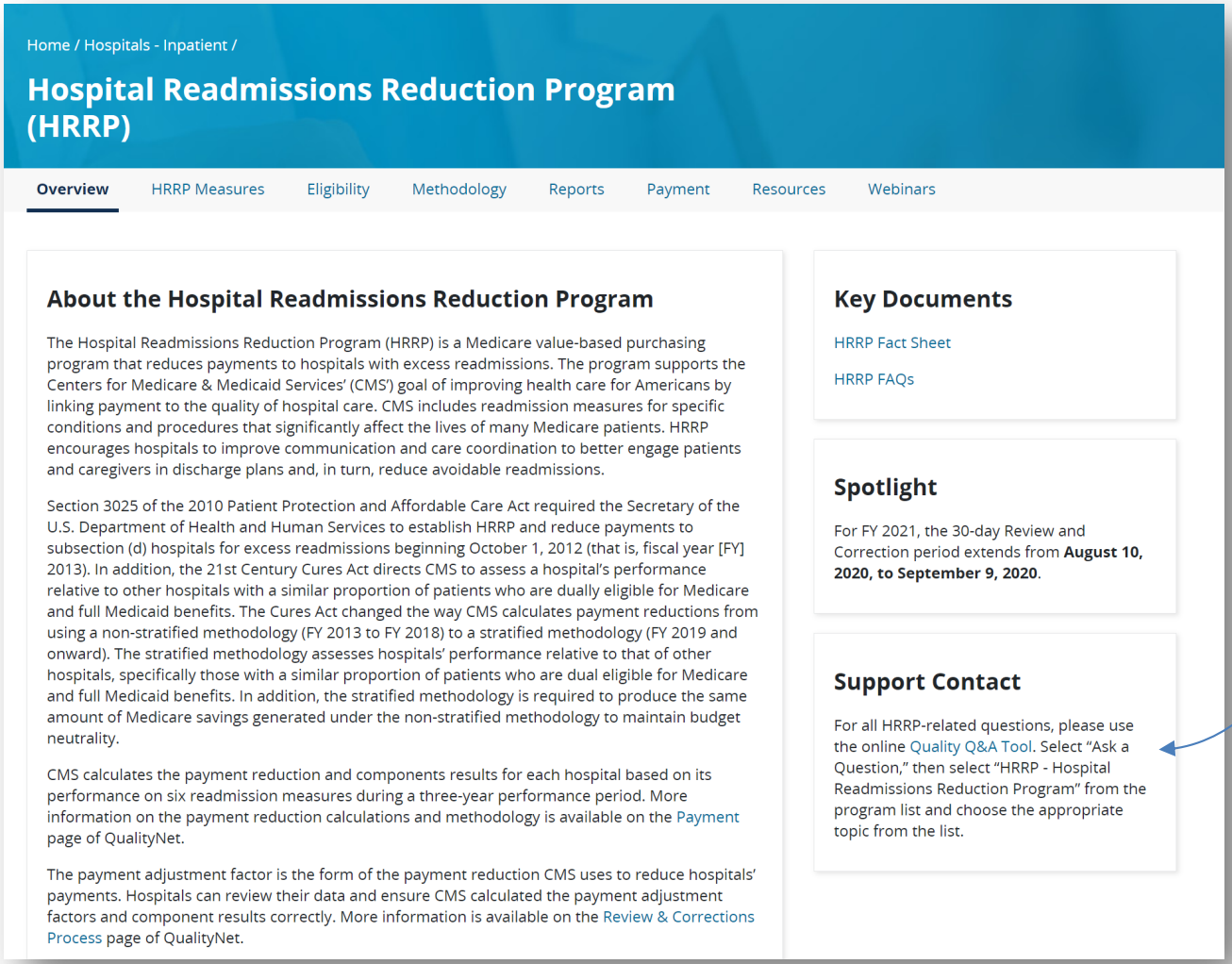
https://jamanetwork.com/journals/jamacardiology/article-abstract/2771672

Confidential Reporting of Stratified Data

- **In the spring of 2021**, hospitals will receive confidential hospital-specific reports (HSR) data stratified by patient dual eligible status for the six readmissions measures included in the Hospital Readmissions Reduction Program.
- These data will include two disparity methodologies designed to illuminate potential disparities within individual hospitals and across hospitals nationally and will supplement the measure data currently publicly reported on the Hospital Compare website.
- **Within-Hospital Disparity Method** highlights differences in outcomes for dual eligible versus non-dual eligible patients within an individual hospital.
- **Dual Eligible Outcome Method**, allows for a comparison of performance in care for dual-eligible patients across hospitals.
- These two methodologies will NOT be used to determine payment reduction in the HRRP Program.
- CMS is trying to account for social risk factors in quality measurement and hopes this information can help hospitals identify and reduce potential disparities in care.

Additional Resources on QualityNet's New Website



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Hospital Readmissions Reduction Program (HRRP)

Overview | HRRP Measures | Eligibility | Methodology | Reports | Payment | Resources | Webinars

About the Hospital Readmissions Reduction Program

The Hospital Readmissions Reduction Program (HRRP) is a Medicare value-based purchasing program that reduces payments to hospitals with excess readmissions. The program supports the Centers for Medicare & Medicaid Services' (CMS') goal of improving health care for Americans by linking payment to the quality of hospital care. CMS includes readmission measures for specific conditions and procedures that significantly affect the lives of many Medicare patients. HRRP encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions.

Section 3025 of the 2010 Patient Protection and Affordable Care Act required the Secretary of the U.S. Department of Health and Human Services to establish HRRP and reduce payments to subsection (d) hospitals for excess readmissions beginning October 1, 2012 (that is, fiscal year [FY] 2013). In addition, the 21st Century Cures Act directs CMS to assess a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full Medicaid benefits. The Cures Act changed the way CMS calculates payment reductions from using a non-stratified methodology (FY 2013 to FY 2018) to a stratified methodology (FY 2019 and onward). The stratified methodology assesses hospitals' performance relative to that of other hospitals, specifically those with a similar proportion of patients who are dual eligible for Medicare and full Medicaid benefits. In addition, the stratified methodology is required to produce the same amount of Medicare savings generated under the non-stratified methodology to maintain budget neutrality.

CMS calculates the payment reduction and components results for each hospital based on its performance on six readmission measures during a three-year performance period. More information on the payment reduction calculations and methodology is available on the Payment page of QualityNet.

The payment adjustment factor is the form of the payment reduction CMS uses to reduce hospitals' payments. Hospitals can review their data and ensure CMS calculated the payment adjustment factors and component results correctly. More information is available on the Review & Corrections Process page of QualityNet.

Key Documents

HRRP Fact Sheet

HRRP FAQs

Spotlight

For FY 2021, the 30-day Review and Correction period extends from **August 10, 2020, to September 9, 2020**.

Support Contact

For all HRRP-related questions, please use the online Quality Q&A Tool. Select "Ask a Question," then select "HRRP - Hospital Readmissions Reduction Program" from the program list and choose the appropriate topic from the list.

Submit questions about readmission measures, risk adjustment and measure methodology to Quality Q&A Tool link found at https://www.qualitynet.org/inpatient/hrrp

Hospital Acquired Conditions Reduction Program

Begins on page 58,860

Brief History of the Hospital Acquired Conditions Reduction Program

- Began in FY 2015
- Mandatory for all IPPS Hospitals
- LTACHs, Cancer Hospitals, Children's Hospitals, Critical Access Hospitals, IRFs, IPFs, Veterans Hospitals, Maryland Hospitals** and Hospitals in the U.S. territories are exempt
- Payment penalty is a full 1% of base operating DRG for all hospitals in the worse performing quartile (roughly 25% of all US hospitals will therefore be penalized)
- CMS finalized and adopted the Winsorized z-score methodology for the FY 2018 HAC Reduction Program in the FY 2017 Final Rule (no more points!)
- CMS finalized the new Equal Weights Measure approach for the FY 2020 HAC Reduction Program in the FY 2019 Final Rule, thus discontinuing the concept of "domains" in the HAC Reduction Program.

*** Maryland hospitals are included in the calculation of the means and standard deviations but are not included in the selection of the top quartile for penalty*

Brief History of the Hospital Acquired Conditions Reduction Program

Fiscal Years Represent Payment Determination Years

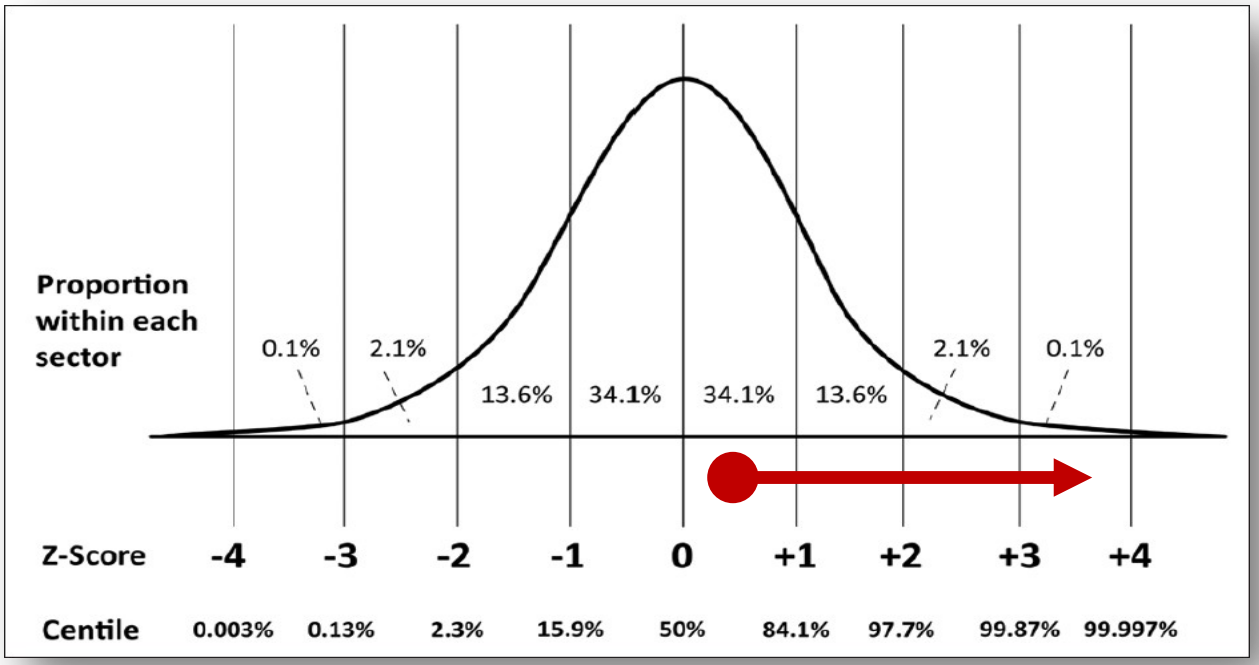
Measure	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
CMS PSI 90: Patient Safety for Selected Indicators	✓	✓	✓					
CMS PSI 90: Composite modified version				✓	✓	✓	✓	✓
CLABSI	✓	✓	✓	✓	✓	✓	✓	✓
CAUTI	✓	✓	✓	✓	✓	✓	✓	✓
SSI (Colon and Hysterectomy)		✓	✓	✓	✓	✓	✓	✓
MRSA			✓	✓	✓	✓	✓	✓
CDI			✓	✓	✓	✓	✓	✓

No Changes in Measures for FY 2021 and Beyond

HAC Scoring Methodology for FY 2021

Established in FY 2017 Final Rule

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



Hospitals in the top quartile (> 75th Centile) of all US Hospitals will have 1% Penalty

HAC Scoring Methodology for FY 2020 and Beyond

Established in FY 2019 Final Rule

Step 1

- Calculate Winsorized measure results for each measure.
  - Hospitals with a measure result below the 5th percentile will receive a Winsorized measure result equal to the 5th percentile value for the measure
  - Hospitals with a measure result above the 95th percentile will receive a Winsorized measure result equal to the 95th percentile value for the measure.
  - Hospitals with a measure result between the 5th and 95th percentile will receive a Winsorized measure result equal to their measure result.
- Calculate Winsorized z-scores (measure scores) based on Winsorized measure results, national mean and standard deviation

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

HAC Equal Weights Methodology for FY 2020 and Beyond

New Total HAC Score Calculation established in FY 2019 Final Rule

Step 2

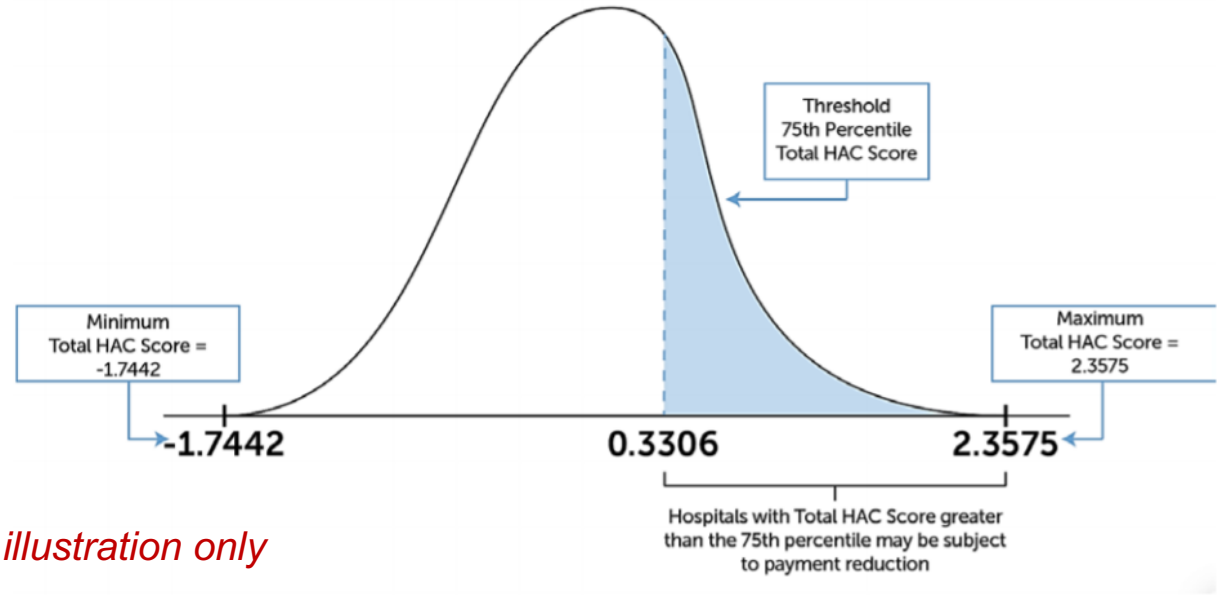
1. Apply an equal weight for each measure for which a hospital has a measure score.
2. Multiply the Winsorized measure score by the weight for each measure to obtain each measure's contribution to the Total HAC Score.
3. Sum the contributions of the weighted measure scores to obtain the Total HAC Score.

Number of Measures with a Z-Score	Weight Applied to each measure
0	N/A
1	100%
2	50%
3	33.3%
4	25%
5	20%
6	16.7%

Determining Hospitals with Penalties

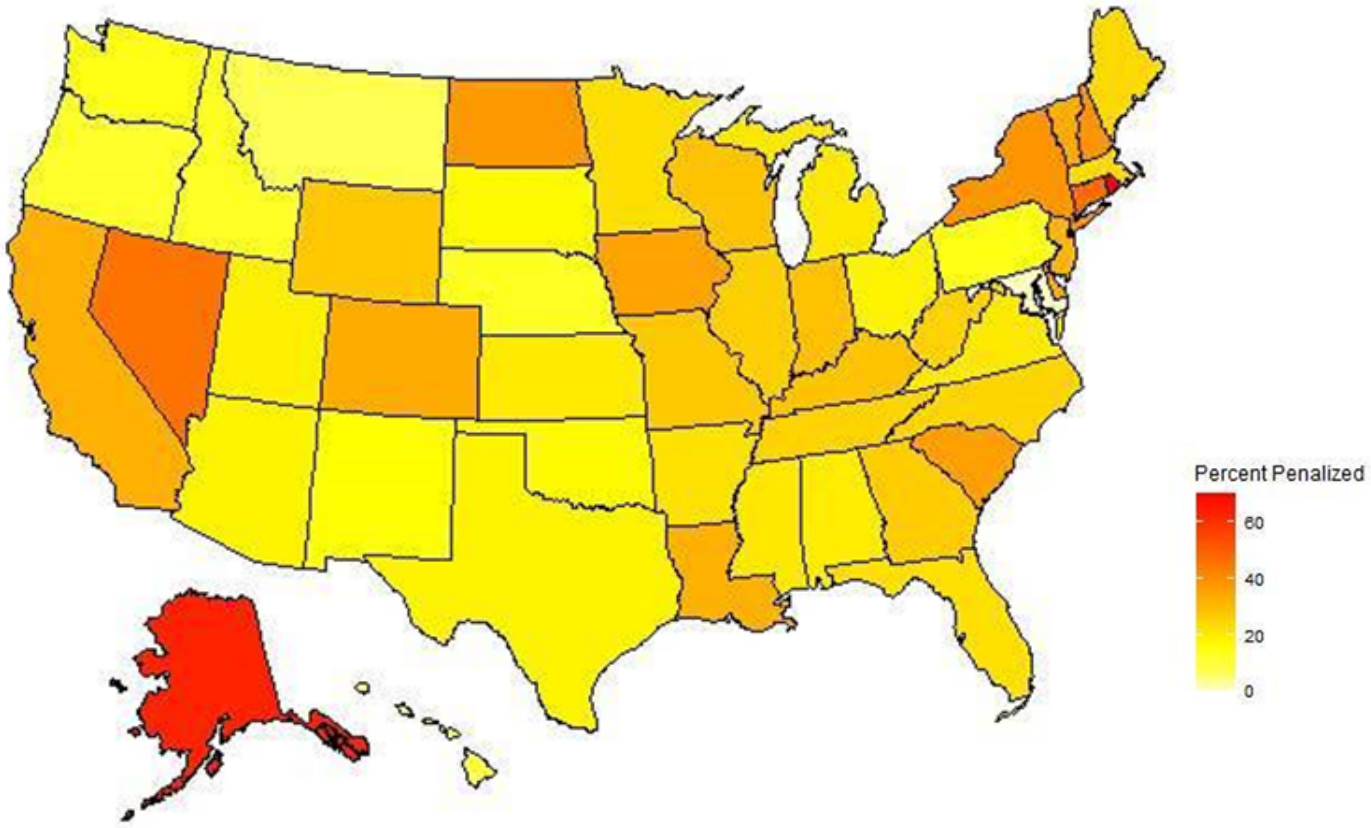
Step 3

1. Determine the percentile ranking of all subsection (d) hospitals
2. Negative Z-scores reflect more favorable performance
3. Z-scores in top quartile (> 75th percentile) penalized full 1% base operating DRG payments, applicable to all Medicare patients



Sample data for illustration only

Percent of Hospitals by State with HAC Penalties for FY 2020



Analysis performed by Medisolv

HAC Reduction Measures for Payment Determination FY 2021

Finalized in FY 2019 Final Rule

CMS Patient Safety Indicator (PSI) 90 FY 2021: Discharges July 1, 2017 - June 30, 2019	
PSI 03	Pressure Ulcer Rate
PSI 06	Iatrogenic Pneumothorax Rate
PSI 08	In-hospital fall with Hip Fracture Rate
PSI 09	Periop Hemorrhage or Hematoma Rate
PSI 10	Postop Acute Kidney Injury Dialysis Rate
PSI 11	Postop Respiratory Failure Rate
PSI 12	Periop Pulmonary Embolism or DVT Rate
PSI 13	Postop Sepsis Rate
PSI 14	Postop Would Dehiscence Rate
PSI 15	Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate

CDC NHSN Infection Measures FY 2021: Discharges Jan. 1, 2018 - Dec 31, 2019	
CAUTI	Catheter-Associated UTI (ICU and non-ICU)
CLABSI	Central Line-Associated BSI SIR (non reliability adjusted for ICU and non-ICU)
SSI	Surgical Site Infection (ICU and Non-ICU) • Colon • Abdominal Hysterectomy
CDI	Clostridium difficile Infection SIR
MRSA	Methicillin-Resistant Staphylococcus aureus Bacteremia SIR

HAC Reduction Measures Payment Determination FY 2022 and FY 2023

CMS Patient Safety Indicator (PSI) 90 FY 2022: Discharges July 1, 2018 - June 30, 2020 FY 2023: Discharges July 1, 2019 – June 30, 2021	
PSI 03	Pressure Ulcer Rate
PSI 06	Iatrogenic Pneumothorax Rate
PSI 08	In-hospital fall with Hip Fracture Rate
PSI 09	Periop Hemorrhage or Hematoma Rate
PSI 10	Postop Acute Kidney Injury Dialysis Rate
PSI 11	Postop Respiratory Failure Rate
PSI 12	Periop Pulmonary Embolism or DVT Rate
PSI 13	Postop Sepsis Rate
PSI 14	Postop Would Dehiscence Rate
PSI 15	Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate

CDC NHSN Infection Measures FY 2022: Discharges Jan. 1, 2019 - Dec 31, 2020 FY 2023: Discharges Jan. 1, 2020 - Dec 31, 2021	
CAUTI	Catheter-Associated UTI (ICU and non-ICU)
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SSI	Surgical Site Infection (ICU and Non-ICU) • Colon • Abdominal Hysterectomy
CDI	Clostridium difficile Infection SIR
MRSA	Methicillin-Resistant Staphylococcus aureus Bacteremia SIR

Current HAC Program Validation Process for FY 2022 and 2023

- Up to 600 hospitals may be selected for validation
  - 400 randomly selected hospitals
  - Up to 200 additional hospitals selected using targeting criteria

- Targeting criteria include:
  - Failure to meet validation requirements in previous fiscal year
  - Lower bound confidence interval (CI) less than or equal to 75 percent in previous fiscal year
  - Failure to report at least half of the HAI events detected during previous fiscal year to NHSN
  - Rapidly changing data patterns
  - Abnormal or conflicting data patterns
  - Submission of data to NHSN after the Hospital IQR Program submission deadline
  - Not having been validated in the previous three years.

Previous Validation Schedule for HAC Reduction Program Data for FY 2023 Payment Determination

- In the 2019 and 2020 Final Rules, they finalized the schedule for FY 2023 HACRP Validation so that four quarters of data (discharges Q3 2020 through Q2 2021) would be used for validation

Discharge Quarters	NHSN Submission Deadline	NHSN Validation Templates	Estimated CDAC Record Request	Estimated Date Records Due to CDAC	Estimated Validation Completion
Q3 2020	2/15/2021	2/1/2021	2/28/2021	3/30/2021	6/15/2021
Q4 2020	5/15/2021	5/1/2021	5/30/2021	6/29/2021	9/15/2021
Q1 2021	8/15/2021	8/1/2021	8/30/2021	9/29/2021	12/15/2021
Q2 2021	11/15/2021	11/1/2021	11/29/2021	12/29/2021	3/15/2022

But this year's final rule modified this schedule in order to align with the Hospital IQR Validation Process

New Validation Schedule for HAC Reduction Program Data for FY 2023 Payment Determination

- FY 2021 Final Rule modified the schedule for FY 2023 HACRP Validation so that they could align with the Hospital IQR Program. Now two quarters of data (discharges Q3 2020 and Q4 2020) will be used for validation

Discharge Quarters	NHSN Submission Deadline	NHSN Validation Templates	Estimated CDAC Record Request	Estimated Date Records Due to CDAC	Estimated Validation Completion
Q3 2020	2/15/2021	2/1/2021	2/28/2021	3/30/2021	6/15/2021
Q4 2020	5/15/2021	5/1/2021	5/30/2021	6/29/2021	9/15/2021

Measure data from these two quarters will be used for both the random and targeted validation pools.
Note that dates above are subject to change!!

Changes to HAC Program Validation Process for FY 2024 and Beyond

(Aligned with Hospital IQR Program beginning in FY 2024)

- Up to 400 *(previously 600)* hospitals may be selected for validation
  - 200 *(previously 400)* **randomly selected** hospitals
  - Up to 200 additional hospitals selected using **targeting criteria**

- Targeting criteria include (no changes addressed in final rule):
  - Failure to meet validation requirements in previous fiscal year
  - Lower bound confidence interval (CI) less than or equal to 75 percent in previous fiscal year
  - Failure to report at least half of the HAI events detected during previous fiscal year to NHSN
  - Rapidly changing data patterns
  - Abnormal or conflicting data patterns
  - Submission of data to NHSN after the Hospital IQR Program submission deadline
  - Not having been validated in the previous three years.

Validation Schedule for HAC Reduction Program Data for FY 2024 Payment Determination

- FY 2021 Final Rule modified the schedule for FY 2024 HACRP Validation so that four quarters of data (Up to 10 cases quarter for discharges from Calendar Year 2021) will be used for validation
- New requirement for HACRP to submit electronic copies of medical records in PDF format beginning with submission of Q1 2021 discharge data

Discharge Quarters	NHSN Submission Deadline *	NHSN Validation Templates	Estimated CDAC Record Request	Estimated Date Records Due to CDAC	Estimated Validation Completion
Q1 2021	August 16, 2021				
Q2 2021	November 15, 2021				
Q3 2021	February 16, 2022				
Q4 2021	May 15, 2022				

* Exact dates have not yet been published for FY 2024 HAC Program Validation.

HACRP Updates in Interim Final Rule with Comments Found on pages 54,830 - 54,832

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not scoring or applying payment adjustments for the associated ESRD QIP payment year because data from the one non-excepted month may not be large enough to calculate reliable measure results for scoring purposes. Although the data themselves may be accurate, the measure(s) might not meet the reliability standards because of the small sample of the remaining non-excepted part of the performance period.[16] In addition, in the scenario we describe above, it is plausible that only larger facilities would be able to meet the required case minimums to be scored in the non-excepted part of the performance period. We may conclude that only scoring remaining facilities would not produce an accurate national comparison of dialysis facilities. Alternatively, if we do not extend the ECE to cover Q3 and Q4 2020, it is possible that a majority of facilities might still submit individual ECE requests for those quarters and it is possible that so many facilities will submit individual ECE requests that we will not be able to produce a reliable national comparison. In both cases, we are concerned about using the measures calculated based on these data to score facilities under the ESRD QIP and base payment adjustments on those scores. If circumstances warrant, we may propose to suspend prospective application of program penalties or payment adjustments through the annual ESRD PPS proposed rule. However, in the interest of time and transparency, we may provide subregulatory advance notice of our intentions to suspend such penalties and adjustments through routine communication channels to facilities, vendors, and Quality Improvement Organizations (QIOs). The communications could include memos, emails, and notices on the public QualityNet website (*https://www.qualitynet.org/*). We welcome public comments on the update to our regulations at § 413.178(d)(7) to consider a facility as having opted out of the ECE with respect to NHSN data reported for Q4 2019 if the facility actually reported the data by the submission deadline, without notifying CMS, and we will include these data when we calculate facility TPSs for PY 2021 and performance standards for PY 2023. We also welcome public comments on the exception we are finalizing to the ECE opt out policy for the ESRD QIP, and we will exclude any ESRD QIP data that facilities optionally reported during Q1 and Q2 2020 from our calculation of Payment Year 2022 TPSs and from the baseline for PY 2023.

[16] See *http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=86453* and choose the "Evaluation Guidance" link.

2. Updates to the Application of the HAC Reduction Program ECE Policy in Response to the PHE for COVID–19

a. Background of the HAC Reduction Program ECE Policy

The Hospital-Acquired Condition Reduction Program ("HAC Reduction Program") is authorized under section 1886(p) of the Act and it aims to heighten awareness of HACs and reduce the number of incidences that occur through implementing the payment adjustments authorized under such statute. The HAC Reduction Program began affecting hospitals' Medicare payments with FY 2015 discharges (that is, October 1, 2014). In the FY 2016 Inpatient Prospective Payment System (IPPS)/Long-term Care Hospitals (LTCH) PPS final rule (80 FR 49579 through 49581), we adopted an ECE policy for the HAC Reduction Program, which recognized that there may be periods of time during which a hospital is affected by an extraordinary circumstance beyond its control. We noted that we considered the feasibility and implications of excluding data for certain measures for a limited period of time from the calculations of the hospital's measure results or Total HAC Score for the applicable performance period. We expressed our aim to minimize data excluded from the program to allow affected hospitals to continue to participate in the HAC Reduction Program for a given year if these hospitals continue to meet applicable measure minimum threshold requirements. We further observed that section 1886(p)(4) of the Act permits the Secretary to determine the applicable period for HAC data collection, and we interpreted the statute to allow us to determine that the period not include times when hospitals may encounter extraordinary circumstances. This policy was similar to the ECE policy for the Hospital Inpatient QRP, as initially adopted in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51651), and modified in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50836) and the FY 2015 IPPS/LTCH PPS final rule (79 FR 50277).

In the FY 2016 IPPS/LTCH PPS final rule (80 FR 49580 through 49581), we also stated that this policy would not preclude CMS from granting ECEs to hospitals that do not request them if we determine at our discretion that a disaster or other extraordinary circumstance has affected an entire region or locale. We noted that if CMS makes such a determination to grant an ECE to hospitals in an affected region or locale, we will convey this decision through routine communication channels to hospitals, vendors, and QIOs, including, but not limited to, issuing memos, emails, and notices on the QualityNet website. When time permits we will also communicate such decisions through the annual IPPS/LTCH PPS proposed rule.

In the FY 2018 IPPS/LTCH PPS final rule (82 FR 38276 through 38277), we modified the requirements for the HAC Reduction Program ECE policy to further align with the process used by other QRP and VBP programs for requesting an exception from program reporting due to an extraordinary circumstance not within a provider's control.

b. Background of the HAC Reduction Program ECE Granted for the PHE for COVID–19

On March 22, 2020, in response to COVID–19, we announced relief for clinicians, providers, hospitals, and facilities participating in Medicare QRPs and VBP programs.[17] On March 27, 2020, we published a supplemental guidance memorandum that described in more detail the scope and duration of the ECEs we were granting under each Medicare QRP and VBP program.[18]

Under the ECE granted to all eligible hospitals under the HAC Reduction Program, we stated that qualifying claims would be excluded from the measure calculations for the CMS Patient Safety Indicators (PSI) 90 during the periods January 1, 2020–March 31, 2020 (Q1 2020) and April 1, 2020–June 30, 2020 (Q2 2020). We also provided an exception to reporting for all chart-abstracted HAC Reduction Program measures for the May, August, and November 2020 submission deadlines (for reporting Q4 2019, Q1 2020, and Q2 2020 data, respectively). This exception includes the following NHSN HAI Measures:

++ NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure, National Quality Forum (NQF) #0138.

++ NHSN Central Line-Associated Blood Stream Infection (CLABSI) Outcome Measure, NQF #0139.

++ NHSN Facility-wide Inpatient Hospital-onset *Clostridium difficile*

[17] CMS press release available at *https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting.*

[18] CMS memorandum available at *https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.*

- Original plan excluded PSI 90 Composite claims data for Q1 and Q2 2020 and to make NHSN HAI reporting optional for Q4 2019, Q1 2020 and Q2 2020, with intent to calculate scores based on remaining 18 months of data.
- 95.3% of all hospitals provided Q4 2019 data. CMS believes they will include optionally reported HAI data in the calculation of the HAC Score BUT…
- CMS now believes it would be inappropriate to include optionally submitted HAI data for Q1 and Q2 2020 due to potential reporting bias and impact on national comparability.
- CMS is still determining if sufficient data is available from CY 2019 data to continue program scoring as currently designed.
- Decision not yet made on continued blanket exemption for HAI reporting, scoring adjustments or program suspension.
- Look for changes to HACRP Program in future proposed rules or memos from CMS!

https://www.govinfo.gov/content/pkg/FR-2020-09-02/pdf/2020-19150.pdf

Hospital Value Based Purchasing Program

Begins on page 58,847

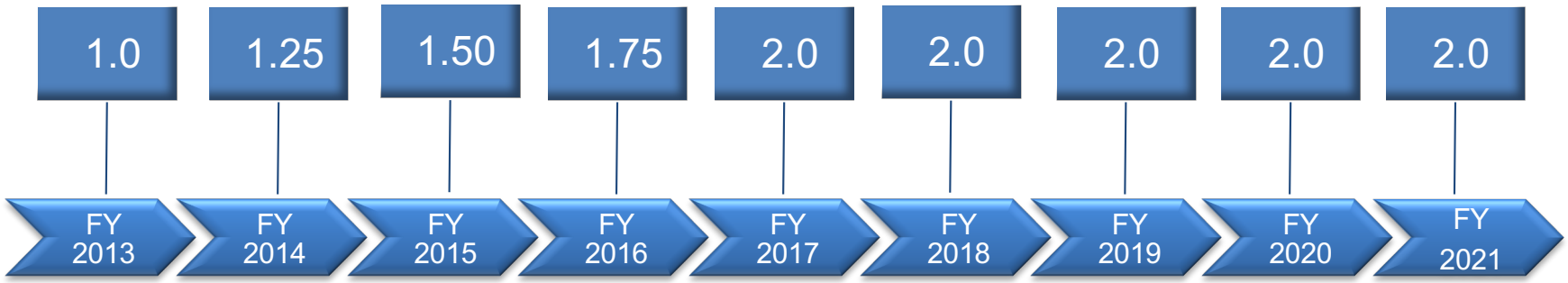
More Key Concepts to Remember

October 1, 2014 to June 30, 2016	October 1, 2017 to June 30, 2019	October 1, 2020 to September 30, 2021
Baseline Period	**Applicable Discharges**	**Payment Determination**
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 during the CMS Payment Year

The History of the Hospital VBP Program

Funding pool started in 2012 with 1.00 percent of the base-operating DRG
FY 2021 Funding Pool remains at 2.0 with estimated funds at 1.9 Billion
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



Maximum hospital penalties have been capped at 2% of their base operating DRG amount since 2017. No mention in this year's rule to increase cap.

Exclusions to Participation

- Hospitals that do not meet the minimum number of cases, measures or surveys required in a given fiscal year
- Hospitals who failed to meet their Hospital Inpatient Quality Reporting (HIQR) reporting requirements and were subject to a 25% reduction in their Annual Payment Update
- Psychiatric, rehab, long-term care, children's, critical access, cancer hospitals, and hospitals in Puerto Rico and other US Territories
- Hospitals in Maryland participating in the Maryland All-Payer Model
- Hospitals cited for deficiencies in care that pose an immediate jeopardy to patients' health or safety
- Hospitals with approved extraordinary circumstance exception

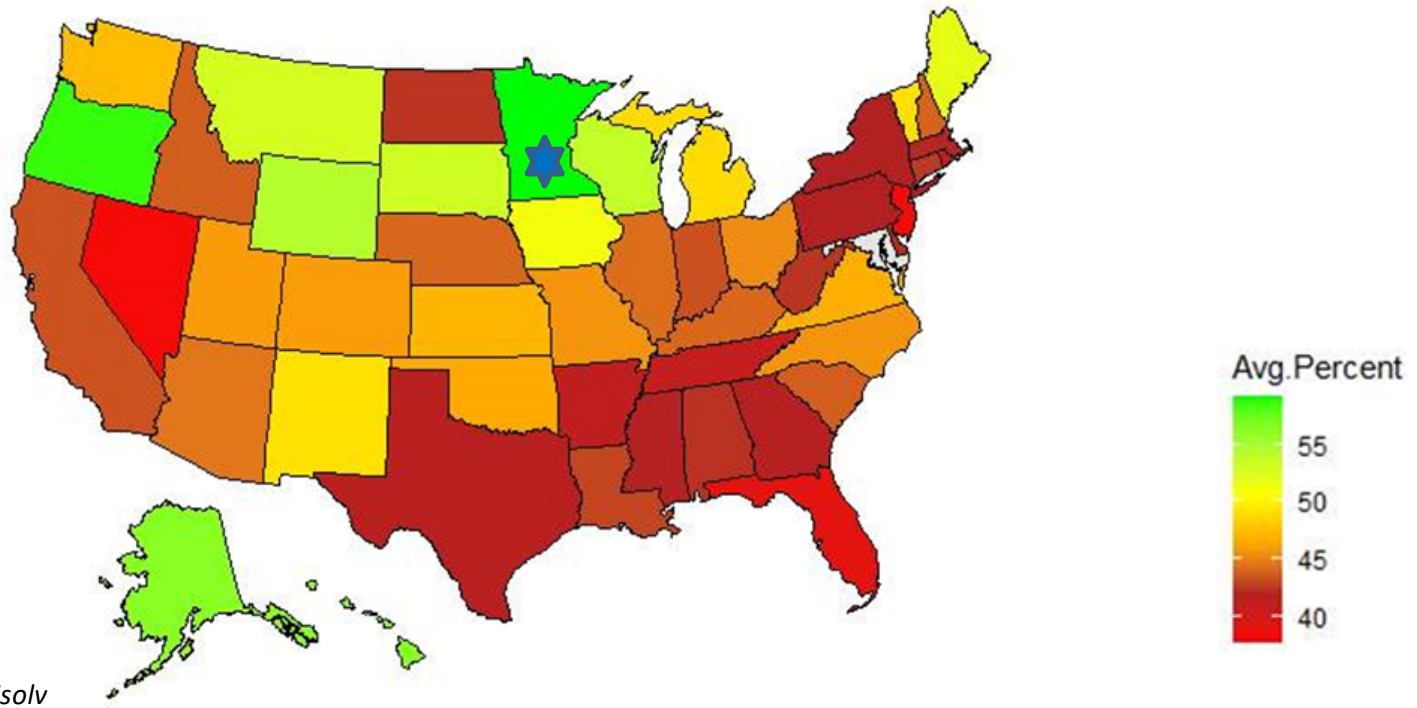
A Summary of FY 2020 Incentive Payments and Penalties

The Hospital VBP Program is the only quality reporting program where you have the potential to earn money!

- There were 2,731 hospitals in the HVBPP in FY 2020
- 1,533 (56.1%) of hospitals earned a net increase in IPPS Payments
  - The highest performing hospital received a net increase in IPPS payments of 2.93 percent
- 1,161 (42.5%) of hospitals had a net decrease in payment adjustments less than 1%
- 37 (1.4%) of hospitals had a net decrease in payment adjustments between 1.0 to 1.7%
  - The lowest performing hospital received a net decrease in IPPS payments of 1.7 percent

Average Percentage of Potential VBP Incentive Payments Earned by Hospitals by State in FY 2020

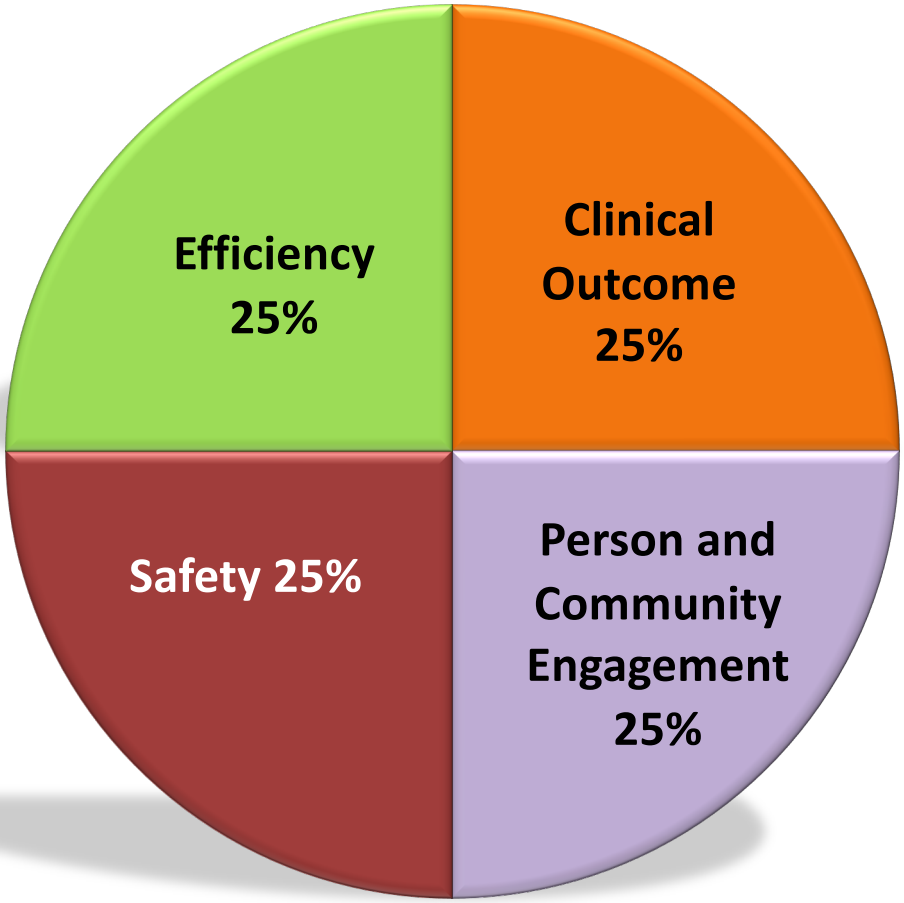
The Hospital that earned 100% of their maximum potential incentive payment was Olmsted Medical Center in Rochester, Minnesota



Analysis performed by Medisolv

Four Measure Domains in FY 2021 and Beyond

No Changes in the IPPS 2021 Final Rule



- Hospitals must receive domain scores on at least three of four quality domains in order to receive a Total Performance Score for the program

Clinical Outcome Domain FY 2021 to 2023

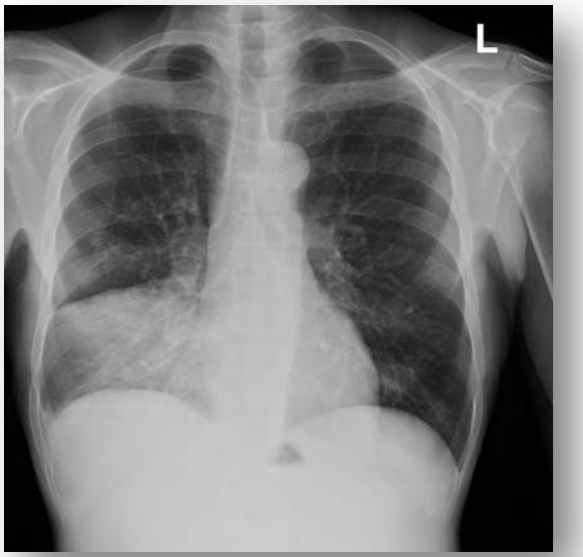
New Changes in Red are from Prior Rule Making

Hospitals must have at least 25 cases in at least 2 measures for this domain to receive a Clinical Outcome Domain Score

CMS Measure Name		FY 2021 Payment Determination	FY 2022 Payment Determination	FY 2023 Payment Determination
Mort-30-AMI	Acute MI 30-day Mortality Rate	Baseline: July 1, 2011 to June 30, 2014 Performance: July 1, 2016 to June 30, 2019	Baseline: July 1, 2012 to June 30, 2015 Performance: July 1, 2017 to June 30, 2020	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to June 30, 2021
Mort-30-HF	Heart Failure 30-day Mortality Rate	Baseline: July 1, 2011 to June 30, 2014 Performance: July 1, 2016 to June 30, 2019	Baseline: July 1, 2012 to June 30, 2015 Performance: July 1, 2017 to June 30, 2020	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to June 30, 2021
Mort-30-PN	Pneumonia 30-day Mortality Rate (expanded cohort)	Baseline: July 1, 2012 to June 30, 2015 Performance: Sept 1, 2017 to June 30, 2019	Baseline: July 1, 2012 to June 30, 2015 Performance: Sept 1, 2017 to June 30, 2020	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to June 30, 2021
Comp-Hip-Knee (Comp-Hip-Knee)**	Total Hip or Knee Arthroplasty Complication Rate	Baseline: April 1, 2011 to March 31, 2014 Performance: April 1, 2016 to March 31, 2019	** Baseline: April1, 2012 to March 31, 2015 Performance: April 1, 2017 to March 31, 2020	Baseline: April 1, 2013 to March 31, 2016 Performance: April 1, 2018 to March 31, 2021
Mort-30-COPD	COPD 30-day Mortality Rate	Baseline: July 1, 2011 to June 30, 2014 Performance: July 1, 2016 to June 30, 2019	Baseline: July 1, 2012 to June 30, 2015 Performance: July 1, 2017 to June 30, 2020	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to June 30, 2021
Mort-30-CABG	CABG 30-day Mortality Rate	———	Baseline: July 1, 2012 to June 30, 2015 Performance: July 1, 2017 to June 30, 2020	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to June 30, 2021

Expanded Pneumonia Cohort in FY 2021

- 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
- 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 and mortality rates expected to change for some hospitals



Clinical Outcome Domain FY 2021 to 2023

Changes in red are from previous rule making

Hospitals must have at least 25 cases in at least 2 measures for this domain to receive a Clinical Outcome Domain Score

CMS Me		FY 2021 nt Determination	FY 2022 Payment Determination	FY 2023 Payment Determination
Mort-30-AMI		July 1, 2011 to 30, 2014 e: July 1, 2016 to ne 30, 2019	Baseline: July 1, 2012 to June 30, 2015 Performance: July 1, 2017 to **June 30, 2020**	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to June 30, 2021
Mort-30-HF		aseline: July 1, 2011 to June 30, 2014 Perform e: July 1, 2016 to June 30, 2019	Baseline: July 1, 2012 to June 30, 2015 Performance: July 1, 2017 to **June 30, 2020**	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to June 30, 2021
Mort-30-PN	Pneumonia 30-day Mortality Rate (expanded cohort)	Baseline: July 1, 2012 to June 30, 2015 Perform	Baseline: July 1, 2012 to June 30, 2015 Performance: Sept 1, 2017 to **June 30, 2020**	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to June 30, 2021
RSCR-30-THA/TKA (Comp-Hip-Knee)**	Total Hip or Knee Arthroplasty Complication Rate	Baseli M Perform M	** Baseline: April1, 2012 to March 31, 2015 Performance: April 1, 2017 to **March 31, 2020**	Baseline: April 1, 2013 to March 31, 2016 Performance: April 1, 2018 to March 31, 2021
Mort-30-COPD	COPD 30-day Mortality Rate	Basel Perform	Baseline: July 1, 2012 to June 30, 2015 Performance: July 1, 2017 to **June 30, 2020**	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to June 30, 2021
Mort-30-CABG	CABG 30-day Mortality Rate		Baseline: July 1, 2012 to June 30, 2015 Performance: July 1, 2017 to **June 30, 2020**	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to June 30, 2021

Too late to Impact Performance for FY 2022!

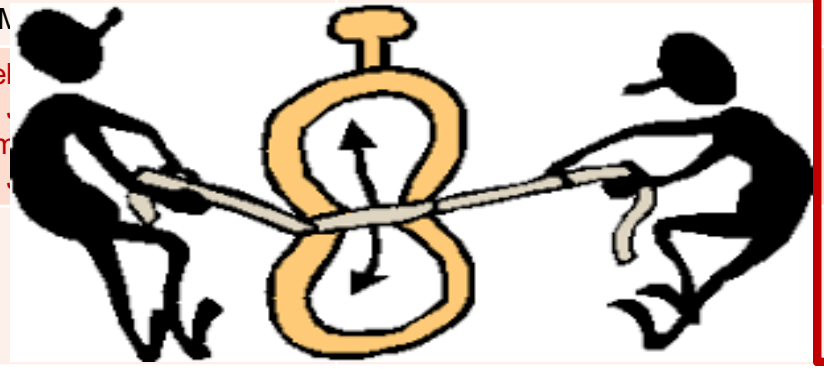
Clinical Outcome Domain FY 2021 to 2023

Changes in red are from previous rule making

Hospitals must have at least 25 cases in at least 2 measures for this domain to receive a Clinical Outcome Domain Score

CMS Measure Name		FY 2021 Payment Determination	FY 2022 Payment Determination	FY 2023 Payment Determination
Mort-30-AMI	Acute MI 30-day Mortality Rate	Baseline: July 1, 2011 to June 30, 2014 Perform…	Baseline: July 1, 2012 to June 30, 2015 Performance: July 1, 2017 to June 30, 2020	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to **June 30, 2021**
Mort-30-HF	Heart Failure 30-day Mortality …		…eline: July 1, 2012 to June 30, 2015 …nance: July 1, 2017 to June 30, 2020	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to **June 30, 2021**
Mort-30-PN	Pneumonia 30-day Mortality Rate (expanded cohort)	…17 to June 30, 2019	Baseline: July 1, 2012 to Ju…0, 2015 Performa… Sept 1, 2017 to June 30, 202…	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to **June 30, 2021**
RSCR-30-THA/TKA (Comp-Hip-Knee)**	Total Hip or Knee Arthroplasty Complication Rate	Baseline: April 1, 2011 to March 31, 2014 Performance: April 1, 2016 to M…	** Baseline: April1, 2012 to March 31, 2015 Performance: April 1, 2017 to	Baseline: April 1, 2013 to March 31, 2016 Performance: April 1, 2018 to **March 31, 2021**
Mort-30-COPD	COPD 30-day Mortality Rate	Basel… Perform…		Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to **June 30, 2021**
Mort-30-CABG	CABG 30-day Mortality Rate			Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to **June 30, 2021**

Only 203 Days Left to Impact Performance!

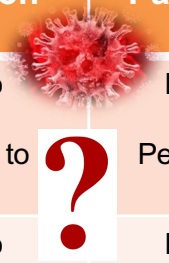


Clinical Outcome Domain FY 2021 to 2023

Q1 and Q2 2020 Claims Data Not to be Included in Calculation of Total Performance Score

Hospitals must have at least 25 cases in at least 2 measures for this domain to receive a Clinical Outcome Domain Score

CMS Measure Name		FY 2021 Payment Determination	FY 2022 Payment Determination	FY 2023 Payment Determination
Mort-30-AMI	Acute MI 30-day Mortality Rate	Baseline: July 1, 2011 to June 30, 2014 Performance: July 1, 2016 to June 30, 2019	Baseline: July 1, 2012 to June 30, 2015 Performance: July 1, 2017 to June 30, 2020	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to June 30, 2021
Mort-30-HF	Heart Failure 30-day Mortality Rate	Baseline: July 1, 2011 to June 30, 2014 Performance: July 1, 2016 to June 30, 2019	Baseline: July 1, 2012 to June 30, 2015 Performance: July 1, 2017 to June 30, 2020	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to June 30, 2021
Mort-30-PN	Pneumonia 30-day Mortality Rate (expanded cohort)	Baseline: July 1, 2012 to June 30, 2015 Performance: Sept 1, 2017 to June 30, 2019	Baseline: July 1, 2012 to June 30, 2015 Performance: Sept 1, 2017 to June 30, 2020	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to June 30, 2021
RSCR-30-THA/TKA (Comp-Hip-Knee)**	Total Hip or Knee Arthroplasty Complication Rate	Baseline: April 1, 2011 to March 31, 2014 Performance: April 1, 2016 to March 31, 2019	** Baseline: April1, 2012 to March 31, 2015 Performance: April 1, 2017 to March 31, 2020	Baseline: April 1, 2013 to March 31, 2016 Performance: April 1, 2018 to March 31, 2021
Mort-30-COPD	COPD 30-day Mortality Rate	Baseline: July 1, 2011 to June 30, 2014 Performance: July 1, 2016 to June 30, 2019	Baseline: July 1, 2012 to June 30, 2015 Performance: July 1, 2017 to June 30, 2020	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to June 30, 2021
Mort-30-CABG	CABG 30-day Mortality Rate	———	Baseline: July 1, 2012 to June 30, 2015 Performance: July 1, 2017 to June 30, 2020	Baseline: July 1, 2013 to June 30, 2016 Performance: July 1, 2018 to June 30, 2021



Clinical Outcome Domain FY 2024 to 2026

No Proposed Changes to Measures for FY 2024 to 2026 but performance periods may change and the HVBPP Program could be suspended in the future due to COVID-19

Hospitals must still have at least 25 cases in at least 2 measures for this domain to receive a Clinical Outcome Domain Score

CMS Measure Name		FY 2024 Payment Determination	FY 2025 Payment Determination	FY 2026 Payment Determination
Mort-30-AMI	Acute MI 30-day Mortality Rate	Baseline: July 1, 2014 to June 30, 2017 Performance: July 1, 2019 to June 30, 2022	Baseline: July 1, 2015 to June 30, 2018 Performance: July 1, 2020 to June 30, 2023	Baseline: July 1, 2016 to June 30, 2019 Performance: July 1, 2021 to June 30, 2024
Mort-30-HF	Heart Failure 30-day Mortality Rate	Baseline: July 1, 2014 to June 30, 2017 Performance: July 1, 2019 to June 30, 2022	Baseline: July 1, 2015 to June 30, 2018 Performance: July 1, 2020 to June 30, 2023	Baseline: July 1, 2016 to June 30, 2019 Performance: July 1, 2021 to June 30, 2024
Mort-30-PN	Pneumonia 30-day Mortality Rate (expanded cohort)	Baseline: July 1, 2014 to June 30, 2017 Performance: July 1, 2019 to June 30, 2022	Baseline: July 1, 2015 to June 30, 2018 Performance: July 1, 2020 to June 30, 2023	Baseline: July 1, 2016 to June 30, 2019 Performance: July 1, 2021 to June 30, 2024
Comp-Hip-Knee	Total Hip or Knee Arthroplasty Complication Rate	Baseline: April 1, 2014 to March 31, 2017 Performance: April 1, 2019 to March 31, 2022	Baseline: April 1, 2015 to March 31, 2018 Performance: April 1, 2020 to March 31, 2023	Baseline: April 1, 2016 to March 31, 2019 Performance: April 1, 2021 to March 31, 2024
Mort-30-COPD	COPD 30-day Mortality Rate	Baseline: July 1, 2014 to June 30, 2017 Performance: July 1, 2019 to June 30, 2022	Baseline: July 1, 2015 to June 30, 2018 Performance: July 1, 2020 to June 30, 2023	Baseline: July 1, 2016 to June 30, 2019 Performance: July 1, 2021 to June 30, 2024
Mort-30-CABG	CABG 30-day Mortality Rate	Baseline: July 1, 2014 to June 30, 2017 Performance: July 1, 2019 to June 30, 2022	Baseline: July 1, 2015 to June 30, 2018 Performance: July 1, 2020 to June 30, 2023	Baseline: July 1, 2016 to June 30, 2019 Performance: July 1, 2021 to June 30, 2024

HVBPP Updates in Interim Final Rule with Comments Found on pages 54,833 - 54,835

Federal Register / Vol. 85, No. 171 / Wednesday, September 2, 2020 / Rules and Regulations 54833

hospitals in the nation to determine penalties for excess readmissions.

Finally, although the ECE we granted for HRRP has ended, with data collection and reporting requirements having resumed July 1, 2020, we understand that geographic differences in COVID–19 incidence continue to change during the PHE for COVID–19. To maintain flexibility for addressing the impact of COVID–19 on HRRP and determine how best to implement the program equitably, we are announcing in this IFC that if, as a result of the extension of the ECE for the whole country that we grant without a request or the submission of individual ECE requests, we do not have enough data to reliably measure national performance, we may propose to not score hospitals based on such limited data or make the associated payment adjustments to hospitals under the IPPS for the affected program year. If we grant another ECE in the future, we would not require that hospitals report the excepted data for the duration of the ECE. Although a hospital may report data during the ECE, we may determine that such data will not be used for scoring purposes. We would still require that hospitals report the non-excepted data. However, we may determine that it would be inappropriate to score such data or base payment adjustments on it because of reliability concerns. For illustrative purposes only, if a PHE excepted enough quarters from the HRRP 36-month performance period to lead to unreliable measure calculations, we might consider not scoring for the entire year because the sample may not be large enough to calculate reliable measure results for scoring purposes. Although the data itself may be accurate, the measure(s) may not meet the reliability standards because of the small sample of the remaining non-excepted part of the performance period. In addition, in the scenario we describe above, it is likely that only larger hospitals would be able to meet the required case minimums to be scored in the non-excepted part of the performance period. We may conclude that only scoring those remaining large hospitals will produce an accurate national comparison of hospitals. Alternatively, if we do not extend the ECE to cover Q3 and Q4 2020, it is possible that a majority of providers may still submit individual ECE requests for those quarters and it is possible that so many hospitals will submit individual ECE requests that we will not be able to produce a reliable national comparison. In both cases, we are concerned about using the measures calculated based on these data to score hospitals under the HRRP and base payment adjustments on those scores. If circumstances warrant, we may propose to suspend prospective application of program penalties or payment adjustments through the annual IPPS/LTCH PPS proposed rule. However, in the interest of time and transparency, we may provide subregulatory advance notice of our intentions to suspend such penalties and adjustments through routine communication channels to facilities, vendors, and QIOs). The communications could include memos, emails, and notices on the public QualityNet website (*https://www.qualitynet.org/*).

We welcome public comments on our policy to exclude any data submitted regarding care provided during first and second quarter of CY 2020 from our calculation of performance for FY 2022, FY 2023, and FY 2024.

4. Update to the Hospital VBP Program ECE Granted in Response to the PHE for COVID–19

a. Background of the Hospital VBP ECE Policy

In the FY 2014 IPPS/LTCH final rule (78 FR 50704 through 50707), we finalized a disaster/ECE policy for the Hospital VBP Program. We stated that, upon a hospital's request, we will consider providing an exception from the Hospital VBP Program requirements to hospitals affected by natural disasters or other extraordinary circumstances (78 FR 50704 through 50706). Specifically, we stated that we interpreted the minimum number of cases and measures requirement in sections 1886(o)(1)(C)(ii)(III) and (IV) of the Act to not include any measures or cases for which a hospital has submitted data during a performance period for which the hospital has been granted a Hospital VBP Program ECE.

In the May 8th COVID–19 IFC (85 FR 27550), we modified the Hospital VBP Program's ECE policy to allow us to grant ECE exceptions to hospitals which have not requested them when we determine that an extraordinary circumstance that is out of their control, such as an act of nature (for example, a hurricane) or PHE (for example, the COVID–19 pandemic), affects an entire region or locale, in addition to retaining the individual ECE request policy (85 FR 27597 through 27598). We stated that if we grant an ECE to hospitals located in an entire region or locale under this revised policy and, as a result of granting that ECE, one or more hospitals located in that region or locale does not report the minimum number of cases and measures required to enable us to calculate a TPS for that hospital for the applicable program year, the hospital will be excluded from the Hospital VBP Program for the applicable program year. We also stated that a hospital that does not report the minimum number of cases or measures for a program year will not receive a 2 percent reduction to its base operating diagnosis-related group (DRG) payment amount for each discharge in the applicable program year, and will also not be eligible to receive any value-based incentive payments for the applicable program year. We referred readers to the FY 2020 IPPS/LTCH PPS final rule (84 FR 42399 through 42400) for the minimum number of measures and cases that we currently require hospitals to report in order to receive a TPS for a program year under the Hospital VBP Program.

b. Background of the Hospital VBP Program ECE Granted in Response to the PHE for COVID–19

On March 22, 2020, in response to COVID–19, CMS announced relief for clinicians, providers, hospitals, and facilities participating in Medicare QRPs and VBP programs.[22] On March 27, 2020, CMS published a supplemental guidance memorandum that described in more detail the scope and duration of the ECEs we were granting under each Medicare QRP and VBP program.[23]

Specifically, we granted an ECE for the PHE for COVID–19 to all hospitals participating in the Hospital VBP Program for the following reporting requirements:

- Hospitals will not be required to report data for the NHSN HAI measures and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey for the following quarters: October 1, 2019 through December 31, 2019 (Q4 2019), January 1, 2020 through March 31, 2020 (Q1 2020), and April 1, 2020 through June 30, 2020 (Q2 2020). However, hospitals can optionally submit part or all of these data by the posted submission deadlines on the Hospital VBP Program QualityNet site (available at *https://www.qualitynet.org/inpatient/iqr/participation*). This includes the following specific measures:
  - ++ HCAHPS, NQF #0166.

[22] CMS press release available at *https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting.*

[23] CMS memorandum available at *https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.*

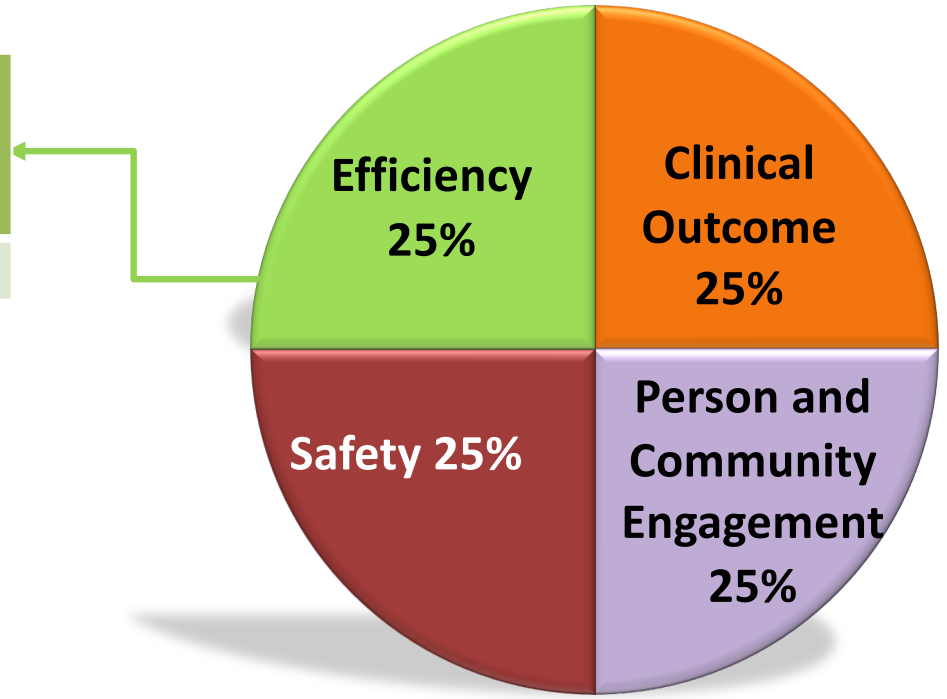
- Q4 2019 HVBPP claims data **will be included** in the Total Performance Score.
- **Q1 and 2 2020 claims data will not be**, but more changes could come!
- Look for changes to HVBP Program in future proposed rules or memos from CMS. Applicable periods for FY 2022 could be shortened, and HVBP Program Penalties in FY 2023 and beyond could be suspended!
- Look for changes to HVBP Program in future proposed rules or memos from CMS!

https://www.govinfo.gov/content/pkg/FR-2020-09-02/pdf/2020-19150.pdf

Efficiency Domain in FY 2021

Unchanged from FY 2020

25%	Efficiency and Cost Reduction Baseline Period: Jan-Dec 2017 Performance Period: Jan-Dec 2019
MSPB-1	Medicare Spending per Beneficiary



Hospitals must have at least 25 episodes of care for this domain to be included in the Total Performance Score

Finalized in FY 2017 Final Rule

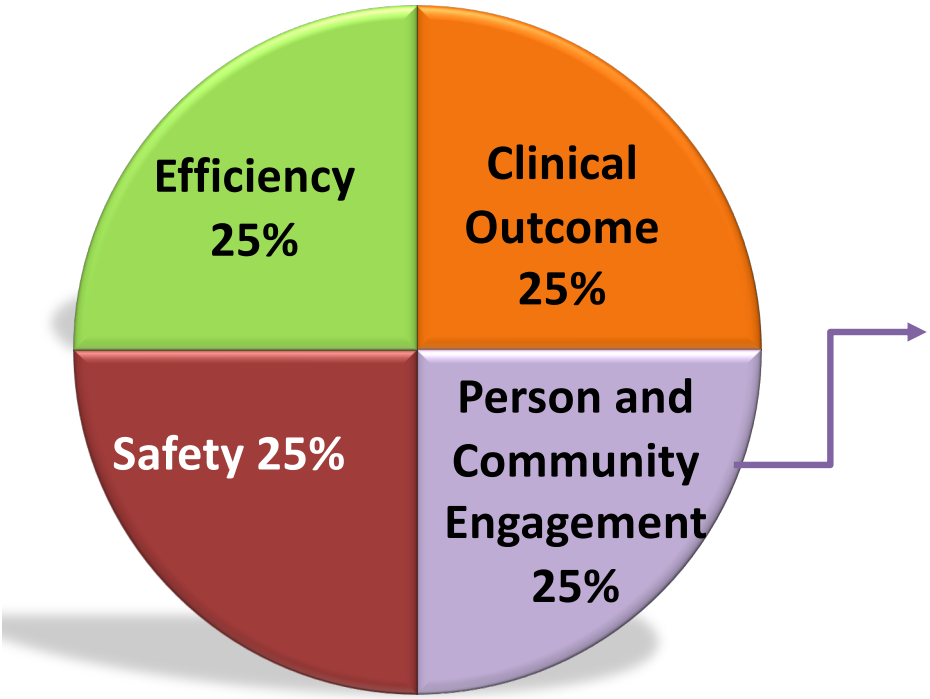
Efficiency Domain in FY 2022 to 2026

Claims for Q1 and 2, 2020 to be excluded from calculation of Total Performance Score

CMS Measure Name		FY 2022 Payment Determination	FY 2023 Payment Determination	FY 2024 Payment Determination	FY 2025 Payment Determination	FY 2026 Payment Determination
MSPB-1	Medicare Spending per Beneficiary	Baseline: CY 2018 Performance: CY 2020 	Baseline: CY 2019 Performance: CY 2021	Baseline: CY 2020 Performance: CY 2022 	Baseline: CY 2021 Performance: CY 2023	Baseline: CY 2022 Performance: CY 2024

Person and Community Engagement Domain in FY 2021

All Voluntarily Submitted Data from Q4 2019 will be Included in Total Performance Score for FY 2022 Payment Determination



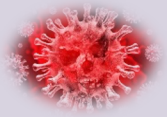
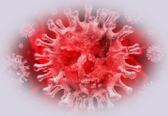
Hospitals must have at least 100 completed surveys for this domain to be included in the Total Performance Score

25%	Person & Community Engagement Baseline Period: Jan-Dec 2017 Performance Period: Jan-Dec 2019
HCAHPS	Communication with Nurses
HCAHPS	Communication with Doctors
HCAHPS	Responsiveness of Hospital Staff
HCAHPS	Communication about Medicines
HCAHPS	Cleanliness and Quietness of Hospital Environment
HCAHPS	Discharge Information
HCAHPS	Overall Rating of Hospital
CTM-3	3-Item Care Transition Questionnaire

Person and Community Engagement Domain in FY 2022 and Beyond

Measures Unchanged from FY 2021 – Timelines Uncertain for FY 2022 and 2024

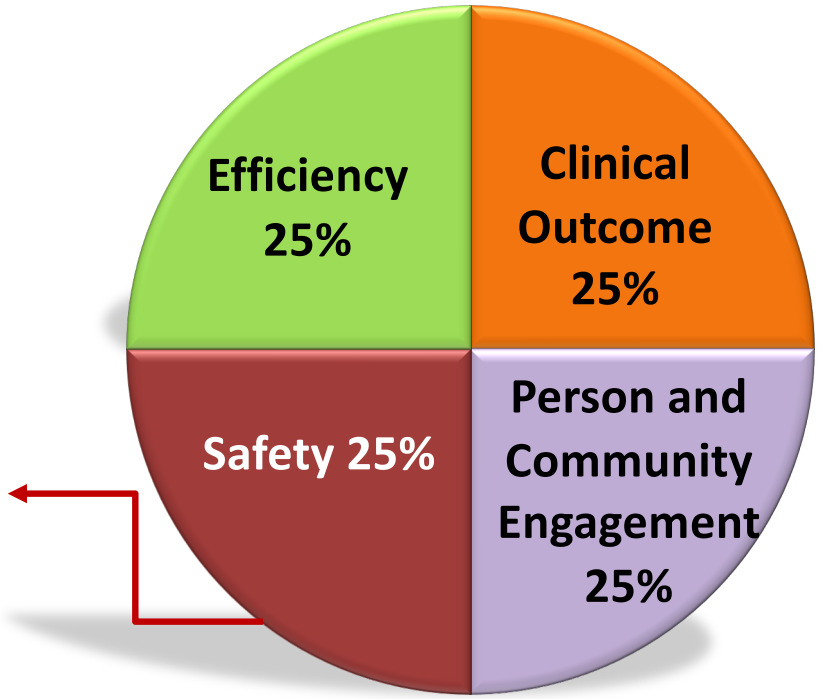
Minimum of 100 Completed Survey's Still Apply

CMS Measure Name	FY 2022 Payment Determination	FY 2023 Payment Determination	FY 2024 Payment Determination	FY 2025 Payment Determination	FY 2026 Payment Determination
Communication with Nurses Communication with Doctors Responsiveness of Hospital Staff Communication about Medicines Cleanliness and Quietness of Hospital Environment Discharge Information Overall Rating of Hospital 3-Item Care Transition Questionnaire	 Baseline: CY 2018 Performance: CY 2020 	Baseline: CY 2019 Performance: CY 2021	 Baseline: CY 2020 Performance: CY 2022 	Baseline: CY 2021 Performance: CY 2023	Baseline: CY 2022 Performance: CY 2024

Safety Domain in FY 2021

95.3% Hospitals Reported HAI Data to NHSN in Q4 2019
All Voluntarily Submitted Data for Q4 2019 will be Included in Total Performance Score

25%	Safety Domain Baseline Period: Jan-Dec 2017 Performance Period: Jan-Dec 2019
CAUTI	Catheter-Associated UTI (ICU and non-ICU)
CLABSI	Central Line-Associated BSI SIR (non reliability adjusted for ICU and non-ICU)
SSI	Surgical Site Infection (ICU and Non-ICU) • Colon • Abdominal Hysterectomy
CDI	Clostridium difficile Infection SIR
MRSA	Methicillin-Resistant Staphylococcus aureus Bacteremia SIR

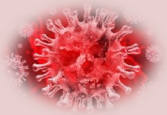
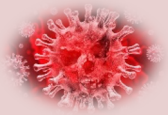
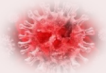
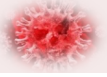


Hospitals must have a minimum of 1.000 predicted cases in at least 2 of the measures for this domain to be included in the Total Performance Score

Finalized in FY 2017 Final Rule

Safety Domain in FY 2022 to 2026

New Measures in Red – Minimum of 1.0 Predicted Cases Still Apply to HAI Measures, Minimum of 3 cases in any one underlying indicator in PSI-90 Composite

CMS Measure Name		FY 2022 Payment Determination	FY 2023 Payment Determination	FY 2024 Payment Determination	FY 2025 Payment Determination	FY 2026 Payment Determination
CAUTI	Catheter-Associated UTI (ICU and non-ICU)	 Baseline: CY 2018 Performance: CY 2020 ?	Baseline: CY 2019 Performance: CY 2021	? Baseline: CY 2020 Performance: CY 2022 	Baseline: CY 2021 Performance: CY 2023	Baseline: CY 2022 Performance: CY 2024
CLABSI	Central Line-Associated BSI SIR (non reliability adjusted for ICU and non-ICU)					
SSI	Surgical Site Infection (ICU and Non-ICU) • Colon • Abdominal Hysterectomy					
CDI	Clostridium difficile Infection SIR					
MRSA	Methicillin-Resistant Staphylococcus aureus Bacteremia SIR					
PSI-90	CMS Patient Safety and Adverse Events Composite	———	Baseline: October 1, 2015 to June 30, 2017 Performance: Jul 1, 2019 to June 30, 2021 ? 	Baseline: July 1, 2016 to June 30, 2018 Performance: Jul 1, 2020 to June 30, 2022	Baseline: July 1, 2017 to June 30, 2019 Performance: Jul 1, 2021 to June 30, 2023	Baseline: July 1, 2018 to June 30, 2020 Performance: Jul 1, 2022 to June 30, 2024 ? 

How are the Infection Measures used in Hospital VBP Different than the ones used in HAC Reduction Program?

- The Hospital VBP Program uses a one-year reporting or performance period for CDC NHSN HAI measures.
- The HAC Reduction Program uses a two-year performance period.
- Note that Hospital IQR program also uses a one-year period but these measures are being discontinued from the Hospital IQR Program. They will still be reported in the Hospital VBP Program and posted on Hospital Compare.

Hospital Inpatient Quality Reporting Program

Begins on page 58,926

A Brief History of the Hospital IQR Program

- Began in FY 2010 to promote public transparency of quality
- Considered “voluntary” but hospitals are incentivized to “volunteer” if they want to receive their full annual payment update (APU) from Medicare (our nation’s first “P4P” program)
  - 3,131 Hospitals participated in CY 2019 (for FY 2021 Payment)
  - 25 Hospitals actively elected not to participate in 2019
  - 3,042 Hospitals received full APU update for FY 2021 Payment
  - 89 (2.8%) US IPPS hospitals failed to get their full APU (either by failure to meet requirements or failure to file a notice of participation)
- Hospitals who do not participate, or who participate but fail to meet program requirements are subject to a 25% reduction of their APU and are excluded from participation in the Hospital VBP Program (but are still required to participate in the HAC Reduction Program)

Eligible Hospitals

- All acute care hospitals that are paid for providing services to Medicare Beneficiaries (including Veterans Hospitals) may participate except:
  - Psychiatric, Rehab, Children's, Cancer and Long-Term Care Hospitals
  - Critical Access Hospitals are exempt but are permitted and encouraged to participate because they are also required to participate in the Medicare Promoting Interoperability Program
  - Maryland Hospitals do not participate in the Hospital IQR Program

Participation Requirements in a Nutshell

- These mandatory requirements are due quarterly:
  - HCAHPS Survey data
  - Population and Sampling (for chart-abstracted process measures only)
  - Clinical Process of Care measures (chart-abstracted measures)
  - Elective Delivery (PC-01) measure (submitted using the QualityNet web-based submission page)
  - Healthcare-Associated Infection (HAI) measures
- These mandatory requirements are due annually:
  - Data Accuracy and Completeness Acknowledgement (DACA)
  - Influenza Vaccination Coverage Among Healthcare Personnel
  - Electronic Clinical Quality Measures (eCQMs)
- Maintain an active QualityNet Security Administrator (SA)
- Meet validation requirements (if selected for validation)

Chart-Abstracted Clinical Process of Care Measures for Payment Determination in Hospital IQR Program

Short Name	Measure Name	Measurement Period for FY 2021 Payment	Measurement Period for FY 2022 Payment	Measurement Period for FY 2023 Payment	Measurement Period for FY 2024 Payment
ED-2 *	Admit Decision Time to ED Departure Time for Admitted Patients	Jan 1, 2019 to Dec 31, 2019	* ED-2 retained only as an electronic measure		
PC-01	Elective Delivery (Web-based Measure)	Jan 1, 2019 to Dec 31, 2019	Jan 1, 2020 to Dec 31, 2020	Jan 1, 2021 to Dec 31, 2021	Jan 1, 2022 to Dec 31, 2022
Sepsis	Severe Sepsis and Septic Shock: Management Bundle (Composite)	Jan 1, 2019 to Dec 31, 2019	Jan 1, 2020 to Dec 31, 2020	Jan 1, 2021 to Dec 31, 2021	Jan 1, 2020 to Dec 31, 2022

Note: The Interim Final Rule with Comments does not address COVID related reporting adjustments or potential program changes specific to Hospital IQR Program. Prior notice on March 27, 2020 provided voluntary blanket exemption for reporting during Q4 2019, Q1 2020 and Q2 2020. Impact to national reporting and program requirements unknown at this time.

Chart-Abstracted Clinical Process of Care Measures in CY 2021 for FY 2023 Payment Determinatior

Data is submitted through the QualityNet Secure Portal
(third party vendor authorization is required)

Short Name	Measure Name	Discharge Dates for Data Collection	Data Submission Deadlines
PC-01 *	Elective Delivery (Web-based Measure)	CY 2021	Q1 2021 due Aug 16, 2021** Q2 2021 due Nov 15, 2021** Q3 2021 due Feb 16, 2022** Q4 2021 due May 16, 2022**
Sepsis	Severe Sepsis and Septic Shock: Management Bundle (Composite)	CY 2021	

* PC-01 is reported quarterly via manual entered data in CMS Web-based Tool. If you do not delivery babies at your hospital, you must enter zeros for the PC-01 measure each quarter or submit an IPPS Measure Exception form.

** Data Accuracy and Completeness (DACA), Population and sample size numbers for both chart-abstracted measures are due on the first business day of August, November, February and May.

National Healthcare Safety Network Measures for Payment Determination in Hospital IQR Program

Removed measures will continue to be reported on Hospital Compare and are included in both the Hospital VBP and HAC Reduction Programs (FY 2019 Final IPPS Rule)

Short Name	Measure Name	FY 2020 Payment	FY 2021 Payment	FY 2022 Payment	FY 2023 Payment	FY 2024 Payment
CAUTI	Catheter Associated Urinary Track Infections	✓	✓			
CLABSI	Central line Associated Blood Stream Infections	✓	✓			
SSI	Surgical Site Infection: Colon and Abdominal Hysterectomy	✓	✓			
MRSA	Methicillin-Resistant Staphylococcus Aureus Bacteremia	✓	✓			
CDI	Clostridium difficile	✓	✓			
HCP	Influenza Vaccination Coverage Among Healthcare Personnel (due to NHSN May 15)	✓	✓	✓	✓	✓

National Healthcare Safety Network in 2021 for FY 2023 Payment Determination

Short Name	Measure Name	Discharge Dates for Data Collection	Data Submission Deadlines
HCP	Influenza Vaccination Coverage Among Healthcare Personnel (due to NHSN May 15)	Oct 1, 2020 to Mar 31, 2021	May 17, 2021

Reminder, you will still have to submit your Healthcare Associated Infection data for CY 2021 discharges to CDC NHSN to meet requirements for HAC Reduction Program and Hospital VBP Program

Claims Based Patient Safety Measures for Payment Determination in Hospital IQR Program

Hip/Knee Complications will continue to be reported on Hospital Compare once removed and are included in the Hospital VBP Programs (FY 2019 Final IPPS Rule)

Short Name	Measure Name	FY 2020 Payment	FY 2021 Payment	FY 2022 Payment	FY 2023 Payment	FY 2024 Payment
Comp-Hip-Knee	Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty	✓	✓	✓		
PSI-04	Death Rate among Surgical Inpatients with Serious Treatable Complications	✓	✓	✓	✓	✓

Claims Based Patient Safety Measures in 2021 for FY 2023 Payment Determination

Short Name	Measure Name	Discharge Dates for Data Collection	Data Submission Deadlines
PSI-04	Death Rate among Surgical Inpatients with Serious Treatable Complications	July 1, 2019 through June 30, 2021	N/A

Note: Neither the 2021 Final IPPS Rule or the Interim Final Rule with Comments address COVID related reporting adjustments or potential program changes specific to Hospital IQR Program data. Prior notice on March 27, 2020 provided blanket exemption to all US Hospitals and will not consider claims data during Q1 2020 and Q2 2020 for calculating performance. Impact to national reporting and program requirements unknown at this time.

Claims Based Mortality Measures for Payment Determination in Hospital IQR Program

Removed measures will continue to be reported on Hospital Compare and are included in the Hospital VBP Programs (FY 2019 Final IPPS Rule)

Short Name	Measure Name	FY 2020 Payment	FY 2021 Payment	FY 2022 Payment	FY 2023 Payment	FY 2024 Payment
MORT-30-COPD	Hospital 30-Day, All-Cause, Risk Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	✓				
MORT-30-PN	Hospital 30-Day, All-Cause, Risk Standardized Mortality Rate Following Pneumonia Hospitalization	✓				
MORT-30-CABG	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery	✓	✓			
MORT-30-STK	Hospital 30-Day, All-Cause, Risk Standardized Mortality Rate Following Acute Ischemic Stroke	✓	✓	✓	✓	✓

Claims Based Mortality Measures in 2021 for FY 2023 Payment Determination

Note that 30-day Mortality for Acute MI, Heart Failure, Pneumonia, COPD and CABG will continue to be compiled by CMS for HVBP Program

Short Name	Measure Name	Discharge Dates for Data Collection	Data Submission Deadlines
MORT-30-STK	Hospital 30-Day, All-Cause, Risk Standardized Mortality Rate Following Acute Ischemic Stroke	July 1, 2018 through June 30, 2021	N/A

Note: Neither the 2021 Final IPPS Rule or the Interim Final Rule with Comments address COVID related reporting adjustments or potential program changes specific to Hospital IQR Program data. Prior notice on March 27, 2020 provided blanket exemption to all US Hospitals and will not consider claims data during Q1 2020 and Q2 2020 for calculating performance. Impact to national reporting and program requirements unknown at this time.

Claims Based Coordination of Care Measures for Payment Determination in Hospital IQR Program

** FY 2020 Final Rule decision to remove Hospital-Wide All-Cause Unplanned Readmission and replacing it with Hybrid Hospital-Wide Readmission measure beginning with FY 2026 Payment

Short Name	Measure Name	FY 2020 Payment	FY 2021 Payment	FY 2022 Payment	FY 2023 Payment	FY 2024 Payment
READM-30-HWR	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) **	✓	✓	✓	✓	✓
AMI Excess Days	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	✓	✓	✓	✓	✓
HF Excess Days	Excess Days in Acute Care after Hospitalization for Heart Failure	✓	✓	✓	✓	✓
PN Excess Days	Excess Days in Acute Care after Hospitalization for Pneumonia	✓	✓	✓	✓	✓

Claims Based Coordination of Care Measures in 2021 for FY 2023 Payment Determination

Short Name	Measure Name	Discharge Dates for Data Collection	Data Submission Deadlines
READM-30-HWR **	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	July 1, 2020 to June 30, 2021	N/A
AMI Excess Days	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	July 1, 2018 to June 30, 2021	N/A
HF Excess Days	Excess Days in Acute Care after Hospitalization for Heart Failure	July 1, 2018 to June 30, 2021	N/A
PN Excess Days	Excess Days in Acute Care after Hospitalization for Pneumonia	July 1, 2018 to June 30, 2021	N/A

** FY 2020 Final Rule decision to remove Hospital-Wide All-Cause Unplanned Readmission and replacing it with NQF #2879 Hybrid Hospital-Wide Readmission measure beginning with FY 2026 Payment however voluntary submission starts in CY 2021

New Hybrid Hospital Wide Readmission Measure Coming in 2024 for FY 2026 Payment Determination

Details from FY 2020 Final IPPS Rule

- First mandatory reporting period applies to discharges July 1, 2023 through June 30, 2024 for FY 2026 payment determination
- The first voluntary submission of the new Hybrid Hospital Wide Readmission measure begins for discharges July 1, 2021 through June 30, 2022.
- The second voluntary submission begins for discharges July 1, 2022 through June 30, 2023.
- Submissions would be required no later than the first business day 3 months following the end of the reporting period
- First set of Hospital Specific Reports to be available in the spring of 2023
- Validation processes not yet established (expected in future rulemaking)
- Results for first mandatory submission will be posted on Hospital Compare July 2025

Claims Based Payment Measures for Payment Determination in Hospital IQR Program

Medicare Spending per Beneficiary measure was removed from Hospital IQR beginning with FY 2020 but is being maintained in the Hospital VBP Program (FY 2019 Final IPPS Rule)

Short Name	Measure Name	FY 2020 Payment	FY 2021 Payment	FY 2022 Payment	FY 2023 Payment	FY 2024 Payment
AMI Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI)	✓	✓	✓	✓	✓
HF Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF)	✓	✓	✓	✓	✓
PN Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia	✓	✓	✓	✓	✓
THA/TKA Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Primary Elective Total Hip and/or Knee Arthroplasty	✓	✓	✓	✓	✓

Claims Based Payment Measures for Hospital IQR and Public Reporting in 2021 for FY 2023 Payment Determination

Short Name	Measure Name	Discharge Dates for Data Collection	Data Submission Deadlines
AMI Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI)	July 1, 2017 to June 30, 2020**	N/A
HF Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF)	July 1, 2017 to June 30, 2020**	N/A
PN Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia	July 1, 2017 to June 30, 2020**	N/A
THA/TKA Payment	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Primary Elective Total Hip and/or Knee Arthroplasty	April 1, 2018 to March 31, 2021	N/A

** Note that dates for public reporting are July 1, 2018 to June 30, 2021

Patient Experience of Care Measures for Payment Determination in Hospital IQR Program

Short Name	Measure Name	FY 2020 Payment	FY 2021 Payment	FY 2022 Payment	FY 2023 Payment	FY 2024 Payment
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey (including Care Transition Measure).	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022

Note: The Interim Final Rule with Comments does not address COVID related reporting adjustments or potential program changes specific to Hospital IQR Program. Prior notice on March 27, 2020 provided voluntary blanket exemption for reporting during Q4 2019, Q1 2020 and Q2 2020. Impact to national reporting and program requirements unknown at this time.

Patient Experience of Care Measures in 2021 for FY 2023 Payment Determination

Short Name	Measure Name	Discharge Dates for Data Collection	Data Submission Deadlines
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey (including Care Transition Measure).	Jan 1, 2021 to Dec 31, 2021	Q1 2021 due July 1, 2021 Q2 2021 due Oct 1, 2021 Q3 2021 due Jan 3, 2022 Q4 2021 due Apr 1, 2022

Electronic Clinical Quality Measures Discontinued FY 2022 Forward for Payment Determination in Hospital IQR Program

(Update from FY 2019 Final IPPS Rule)

Short Name	Measure Name	FY 2020 Payment	FY 2021 Payment	FY 2022 Payment	FY 2023 Payment	FY 2024 Payment
AMI-8a	Primary PCI Received within 90 Minutes of Arrival	✓	✓			
CAC-3	Home Management Plan of Care Given to Patient/Caregiver	✓	✓			
EHDI-1a	Hearing Screening Prior to Hospital Discharge	✓	✓			
PC-01	Elective Delivery	✓	✓			
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients	✓	✓			
STK-08	Stroke Education	✓	✓			
STK-10	Assessed for Rehabilitation	✓	✓			

Retained and New Electronic Clinical Quality Measures for Payment Determination in Hospital IQR Program

Short Name	Measure Name	FY 2020 Payment	FY 2021 Payment	FY 2022 Payment	FY 2023 Payment	FY 2024 Payment
CMS506	Safe Use of Opioids – Concurrent Prescribing (NEW)				✓ optional	✓ mandatory
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients	✓	✓	✓	✓	✓
PC-05	Exclusive Breast Milk Feeding	✓	✓	✓	✓	✓
STK-02	Discharged on Antithrombotic Therapy	✓	✓	✓	✓	✓
STK-03	Anticoagulation Therapy for Atrial Fibrillation/Flutter	✓	✓	✓	✓	✓
STK-05	Antithrombotic Therapy by End of Hospital Day Two	✓	✓	✓	✓	✓
STK-06	Discharged on Statin Medication	✓	✓	✓	✓	✓
VTE-1	Venous Thromboembolism Prophylaxis	✓	✓	✓	✓	✓
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	✓	✓	✓	✓	✓

Safe Use of Opioids Electronic Measure Mandatory in 2022 for FY 2024 Payment Determination

Finalized in FY 2020 Final IPPS Rule

- Safe Use of Opioids: Concurrent Prescribing (electronic measure)
  - Hospitals **may** select this measure for CY 2021 discharges as one of their four eCQM measures for FY 2023 Payment Determination
  - **Required** for CY 2022 reporting period for FY 2024 Payment Determination
  - **Must** be submitted along with three additional self selected eCQM measures for FY 2024 payment determination

This measure is currently available for all Medisolv clients with Encor EH

New Data Submission Requirements for eCQM Measures

Finalized in FY 2021 IPPS Final Rule

Previous Requirements

- Hospitals required to report **four** self-selected eCQMS for only **one**, self-selected calendar quarter of data
- Starting with CY 2022 Reporting Period for FY 2024 Payment Determination, hospitals must submit **Safe Use of Opioids** PLUS **three** self-selected eCQMs

New Requirements

- **CY 2021 reporting (FY 2023 payment)**
  - Hospitals required to report **four** self-selected eCQMS for **two** self-selected calendar quarters
- **CY 2022 reporting (FY 2024 payment)**
  - Hospitals required to report **three** self-selected eCQMS PLUS **Safe Use of Opioids** for **three** self-selected calendar quarters
- **CY 2023 reporting (FY 2025 payment)**
  - Hospitals required to report **three** self-selected eCQMS PLUS **Safe Use of Opioids** for **four** self-selected calendar quarters

Self-selected quarters may be either consecutive or non-consecutive

Electronic Clinical Quality Measures in 2021 for FY 2023 Payment Determination

Hospitals must submit their eCQM data no later than 2 months following the close of the calendar year, regardless of how many self-selected calendar year quarters are submitted.

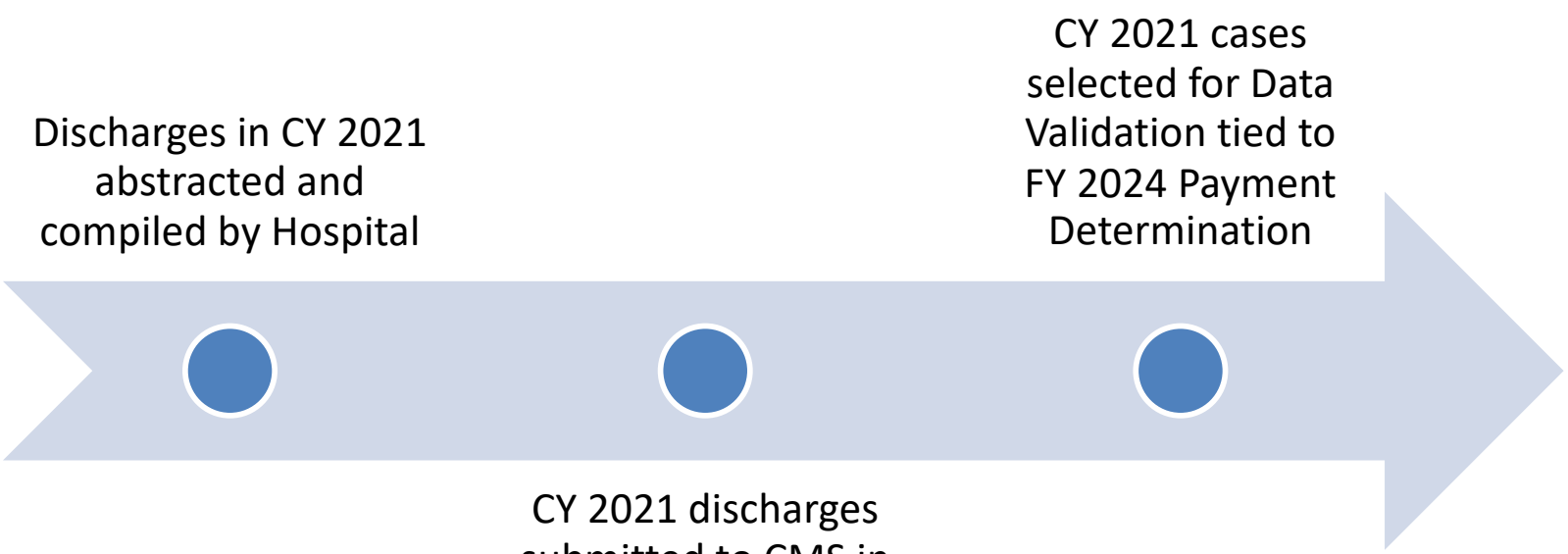
Short Name	Measure Name (Select at least four of nine measures)	Discharge Dates for Data Collection	Data Submission Deadlines
CMS506	Safe Use of Opioids – Concurrent Prescribing *(optional only in 2021)*	*Q 1 2021* *Q2 2021* *Q3 2021* *Q3 2021* *(select two quarters)*	**2 Self Selected Calendar Year Quarters in 2021 submitted by February 28, 2022** *If you do not have at least five cases in the Initial Population field, you must submit a Case Threshold Exemption.* *If your measure has a zero denominator, you must submit a Zero Denominator Declaration* May use third party vendors to submit
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients		
PC-05	Exclusive Breast Milk Feeding		
STK-02	Discharged on Antithrombotic Therapy		
STK-03	Anticoagulation Therapy for Atrial Fibrillation/Flutter		
STK-05	Antithrombotic Therapy by End of Hospital Day Two		
STK-06	Discharged on Statin Medication		
VTE-1	Venous Thromboembolism Prophylaxis		
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis		

Additional eCQM Facts and Resources

- eCQM submission to the IQR program also successfully meets your eCQM requirement for the Promoting Interoperability (Meaningful Use) program.
- EHR must be certified to the 2015 Edition of Certified EHR Technology (CEHRT) for reporting in 2020 or 2015 Technology certified to the 2015 Edition Cures Update standards.
- EHR technology must be certified to submit all nine eCQMs regardless of which measures you select for submission.
- All data must be submitted using QRDA (Quality Reporting Document Architecture) Category 1 file format. File submission must include one QRDA 1 file per patient, per quarter that contains all episodes of care and the measures associated with the patient file.
- Hospitals must use the most recent version of the eCQM specifications.
- The Annual Update and implementation guidance documents are available on the Electronic Clinical Quality Improvement (eCQI) Resource Center website at: *https://ecqi.healthit.gov/* .

Current Validation Requirements Used for Chart Abstracted and eCQM Measures

A Reminder about Timelines for Validation



Current Validation Requirements Used for Chart Abstracted and eCQM Measures

Established in previous rule making

- **Chart Abstracted Measures**
  - For CY 2021 Reporting (FY 2023 Payment Determination) and subsequent years, only one measure (SEP-1) remains in the program for chart abstracted validation
  - Eight records per quarter from discharges Q3 and Q4 2020 and Q1 and Q2 2021 are included for selection in validation for FY 2023 Payment Determination
  - Applies to 400 randomly selected hospitals and 200 targeted hospitals
- **Electronic Clinical Quality Measures** (eCQMs)
  - Validation for FY 2023 Payment Determination includes eight records from the four self-selected measures for the one self-selected quarter of data collected during CY 2020
- Depending on whether the hospital is selected as a random or targeted hospital, CMS requests data between 1 and 5 months following the data submission deadline for a given reporting quarter.
- Hospitals have 30 days from date of request for records to submit their data to the Clinical Data Abstraction Center (CDAC)
- Applies to 200 randomly selected hospitals

New Data Validation Requirements for FY 2023 Payment Determination

FY 2021 Final Rule – pages 58,942 to 58,959

- CMS is transitioning to a combined data validation process for both chart abstracted and eCQM Measures. FY 2023 will be the transition year.

- **Chart Abstracted Measure Validation for FY 2023 Payment Determination**
  - Only records from discharges from Q3 and Q4 of CY 2020 are required for validation (2 quarters instead of 4, which previously included records from Q1 and 2 2021)
  - Eight records for each quarter are required (no change)
  - 400 random hospitals plus 200 targeted hospitals will be selected for validation

- **Electronic Measure Validation for FY 2023 Payment Determination**
  - Submit eight records for the four self selected measures for the one self-selected quarter submitted for CY 2020
  - 200 random hospitals will be selected

New Data Validation Requirements for FY 2024 Payment Determination

(Record Selection Process Aligned with HAC Reduction Program beginning in FY 2024)

- **Chart Abstracted Measure Validation for FY 2024 Payment Determination**
  - Records from discharges from Q1 through Q4 of CY 2021 are required for validation (back to 4 quarters but now aligned with quarters for eCQM Validation
  - Eight records for each quarter (32 records per year) are still required for HIQR
  - Records must be submitted in a PDF file using a secure file transmission process available on the QualityNet Secure Portal (also called the Hospital Quality Reporting System). Paper copies no submission of CD, DVD or flash drive no longer allowed.
- **Electronic Measure Validation for FY 2024 Payment Determination**
  - Submit eight records for the four self selected measures for each of the TWO self-selected quarters submitted in CY 2021 (16 records total)
  - Former exclusion criteria for eCQM measure validation removed
    - Hospitals selected for Chart Abstracted Measure validation
    - Hospitals granted an Extraordinary Circumstance Exception (ECE)
    - Hospitals without at least five discharges for at least one reported eCQM

New Number of Hospitals for Data Validation Beginning with FY 2024 Payment Determination

(Aligned with HAC Reduction Program beginning in FY 2024)

- Two Hospital Pools for Data Validation Across 400 Total Hospitals (formerly 800)
  - **Random Selection**: Up to 200 hospitals (previously 400)
  - **Targeted Selection**: Up to 200 hospitals (no change, see criteria on slide 31)
- Hospitals selected in each pool would submit records for BOTH chart-abstracted and eCQM Measures
  - **Chart abstracted measures**: 8 records per quarter (32 records per year for four quarters)
  - **eCQM measures:**
    - FY 2024 Payment Determination: 8 records per quarter (16 records per year for two quarters in CY 2021)
    - FY 2025 Payment Determination: 8 records per quarter (24 records per year for three quarters in CY 2022)
    - FY 2026 Payment Determination: 8 records per quarter (32 records per year for four quarters in CY 2023)

Note: Since the selection process for chart validation for the HAC Reduction Program and the Hospital IQR Program has been aligned *(validation and scoring processes for each program remain distinct),* selected hospitals will also report an additional **10 cases per quarter (40 records per year for four quarters) for the HAI measures in HACRP**

CMS will continue reimbursing hospitals at $3 per chart for electronic submission of charts

Current Scoring Process for Data Validation

Chart Abstracted Measures

- 8 random records submitted quarterly
- CDAC re-abstracts records and calculates percentage of matching measure numerators and denominators for each measure
- Each quarter and clinical topic is treated as a stratum for variance estimation
- At the end of the year, the validation score is calculated by combining data from all four quarters into one agreement rate for each hospital to calculate a confidence interval around the agreement rate for each hospital
- The upper bound confidence level is the final validation score for the hospital
- Hospitals that score less than 75% receive a 25% reduction of their annual payment update

Electronic Measures

- 8 random records submitted annually for the one self- selected quarter
- Hospitals receive their full annual payment update if they submit at least 75% of the requested eCQM records in a timely and complete manner
- Accuracy is not currently impact annual payment update

New Weighted Scoring Process for Data Validation

Beginning with CY 2021 Data Collection for FY 2024 Payment Determination

- One combined total annual validation score that includes scores for both chart abstracted and eCQM measures
- Chart abstracted agreement rate weighted at 100%
  - Numerator and denominator agreement rates still being evaluated with 75% agreement rate or higher required for successful validation
- eCQM measures agreement rate weighted at zero percent
  - 75% or more of requested records received for requested eCQM records still a requirement to meet validation requirements (still no scoring based on accuracy)
- The validation score associated with the combined agreement rates would be the upper bound of the calculated confidence interval.
- Applies to 200 randomly selected hospitals and 200 targeted hospitals

Additional Comments about New Data Validation Process Moving Forward

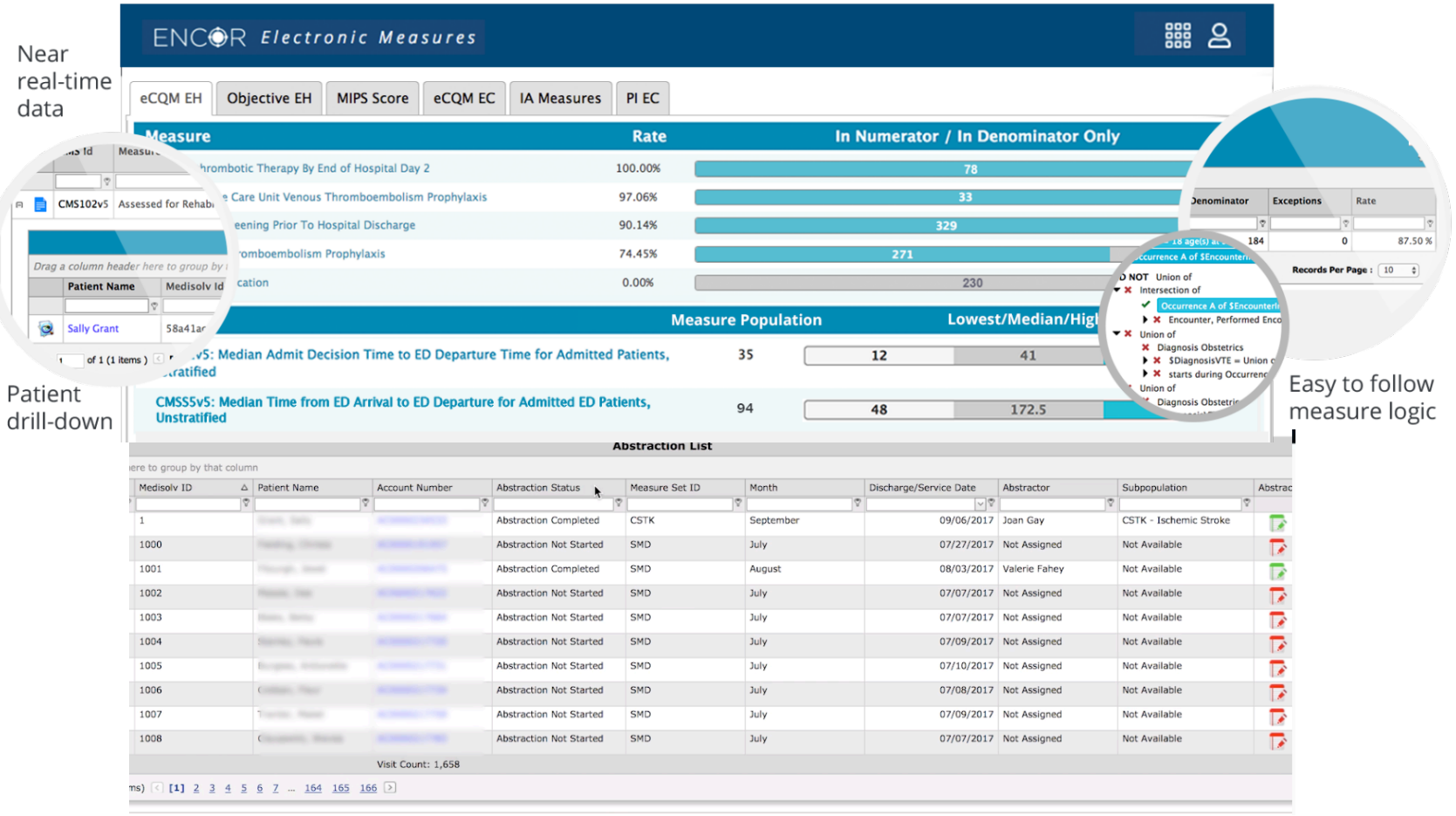
- Educational review process remains unchanged although it will be expanded to include eCQM measures beginning with validation of CY 2020 data affecting FY 2023 payment determination
- Hospitals have 30 calendar days following the data validation results (for first three quarters of validation results) to contact the Validation Support Contractor (VSC) to request an educational review
- If an educational review yields incorrect CMS validation results for chart abstracted measures, the corrected quarterly score will be used if it is higher than the original score
- Data Accuracy and Completeness Acknowledgements (DACA) are unchanged

Public Reporting of eCQM Measure Performance

- Based on five years of eCQM data submission and a voluntary review of accuracy of eCQM measure results for CY 2017 and 2018 (agreement rates of 80% or higher for over 1200 encounters across 190 hospitals) CMS believes eCQM data are accurate enough for public reporting
- Public reporting of eCQM data on Hospital Compare (or successor websites) to begin in fall of CY 2022 using two quarters of data reported for the CY 2021 reporting period and will progressively increase as the number of quarters increases for eCQM reporting
- State and national rates for each eCQM that has a sufficient level of hospital reporting to reliably calculate will be displayed
- eCQM measures reported through Hospital IQR will be used in the overall Hospital Quality Star Rating
- Hospitals with less than 25 cases for the combined reporting periods would be exempt from public reporting (footnote that there are too few cases to report)

ENCOR

Hospital Abstracted Measures Hospital Electronic Measures



Questions and Comments

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