MLN Connects®

National Provider Call

CMS Acute Care and Quality Reporting Programs

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Center for Clinical Standards and Quality

May 12, 2015

CMS

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Agenda and Learning Objectives

- This MLN Connects® National Provider Call will provide an overview of the quality reporting programs for CMS Acute Care Hospitals, including:
  - Hospital Inpatient Quality Reporting (IQR) Program
  - Electronic Health Record (EHR) Incentive Program
  - Hospital Value-Based Purchasing (VBP) Program
  - Hospital-Acquired Condition Reduction Program (HACRP)
  - Hospital Readmissions Reduction Program (HRRP)
  - Information regarding program alignment
- Participants will be able to:
  - Identify the purpose/objective of each of the programs
  - Understand basic program methodologies
  - Locate critical program-specific resources

Acronyms in this Presentation

- **ACA** — Affordable Care Act
- **AHRQ** — Agency for Healthcare Research and Quality
- **CAH** — Critical Access Hospital
- **CAUTI** — Catheter-Associated Urinary Tract Infection
- **CDC** — Centers for Disease Control and Prevention
- **CEHRT** — Certified Electronic Health Record Technology
- **CLABSI** — Central Line-Associated Blood Stream Infection
- **CMS** — Centers for Medicare & Medicaid Services
- **DACA** — Data Accuracy and Completeness Acknowledgement
- **DRG** — Diagnosis-Related Group
- **eCQM** — electronically Certified Quality Measures
- **EH** — Eligible Hospital
- **EHR** — Electronic Health Record
- **FFS** — fee-for-service
- **FY** — fiscal year
- **HAC** — Hospital-Acquired Condition

Acronyms in this Presentation

- **HAI** — Healthcare-Associated Infection
- **HCAHPS** — Hospital Consumer Assessment of Healthcare Providers and Systems
- **HIT** — Health Information Technology
- **HRRP** — Hospital Readmissions Reduction Program
- **HSR** — Hospital-Specific Report
- **IPPS** — Inpatient Prospective Payment System
- **IQR** — Inpatient Quality Reporting
- **LTCH PPS** — Long Term Care Hospital Prospective Payment System
- **MRSA** — Methicillin-resistant Staphylococcus aureus
- **NHSN** — National Healthcare Safety Network
- **PSI** — Patient Safety Indicators
- **P/E** — Ratio of Predicted to Expected Readmissions
- **QRDA** — Quality Reporting Document Architecture
- **SSI** — Surgical Site Infection
- **TBD** — to be determined
- **TPS** — Total Performance Score
- **VBP** — Value-Based Purchasing

Inpatient Quality Reporting

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IQR Program Purpose

The Hospital Inpatient Quality Reporting (IQR) program:

- Established to provide transparency about the quality and safety of America's hospitals
- Equips consumers with quality of care information to make more informed decisions about their health care and improves the quality of inpatient care provided to all patients
  - Data published on the Centers for Medicare & Medicaid Services' (CMS') Hospital Compare website
  - Financially incentivizes hospitals to report quality of care measure data

IQR Program Background

The Hospital IQR program was developed as a result of:

- Section 501(b) of the Medicare Modernization Prescription Drug, Improvement and Modernization Act (MMA) of 2003
  - Stipulated hospitals submit 10 quality measures during FY 2005 – 2007
  - Developed the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) initiative
  - Non-submission would result in a 0.4 percentage point reduction in APU
- Section 5001(a) of the Deficit Reduction Act of 2005, Pub. L. 109-171 (DRA) of 2005
  - Required the submission of additional measures
  - Non-submission would result in a 2.0 percentage point reduction in APU

Section 1886(b)(3)(B)(viii) of the Social Security Act

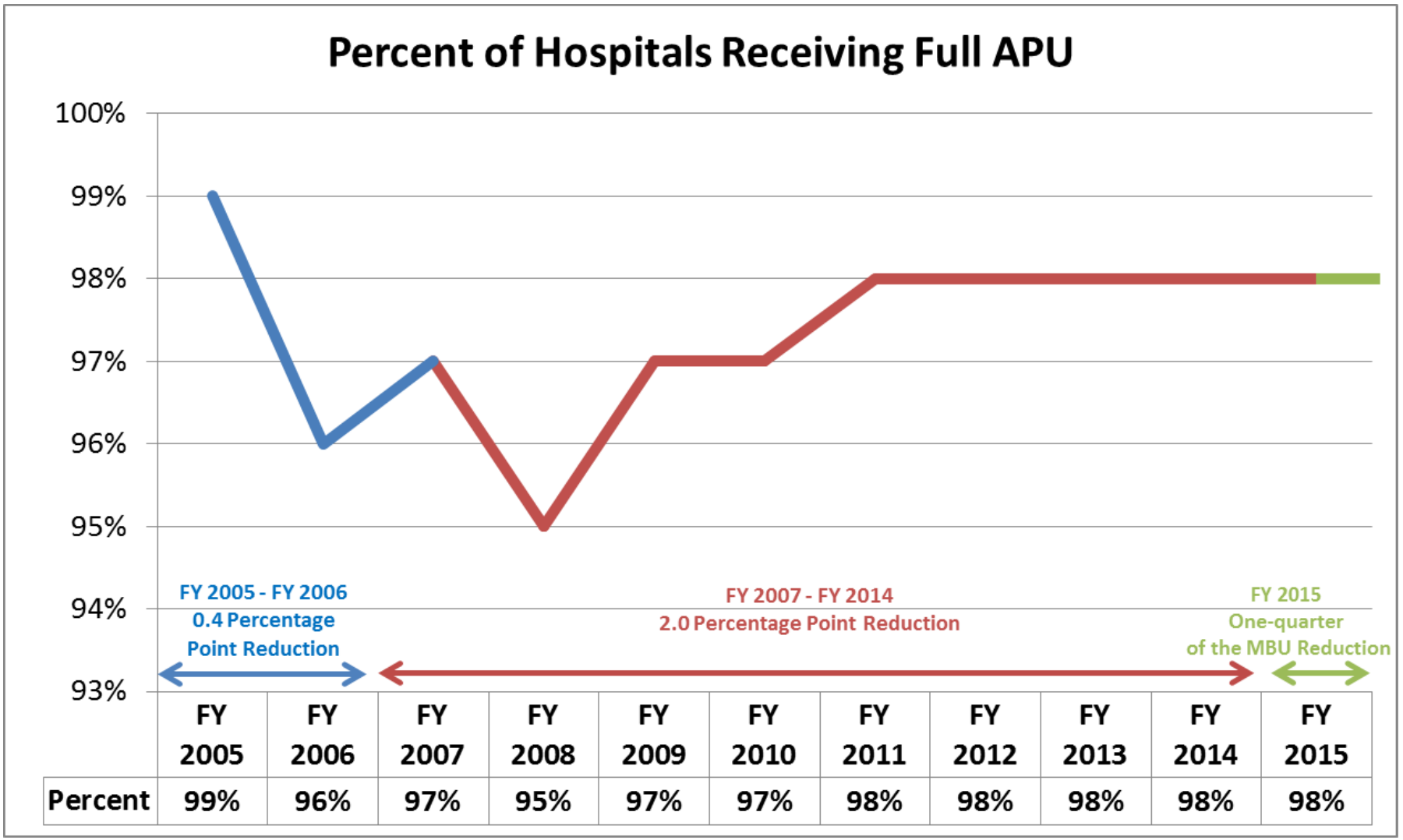
Under section 1886(b)(3)(B)(viii) of the Social Security Act (SSA), beginning with FY 2015, the reduction in the applicable percentage increase for hospitals that fail to submit quality information under rules established by the Secretary, is one quarter of the applicable percentage or **one quarter of the applicable market basket update**.

CMS Reporting Period	Fiscal Year	Inpatient Quality Reporting Reduction	Medicare EHR Incentive Program Reduction
2013	2015	1/4 MBU	33 1/3% of 3/4 MBU = 1/4 of MBU
2014	2016	1/4 MBU	66 2/3% of 3/4 MBU = 1/2 of MBU
2015	2017 (and subsequent fiscal years)	1/4 MBU	100% of 3/4 MBU = 3/4 of MBU

IQR FY 2017 Program Requirements

- Register with *QualityNet*
- Complete Notice of Participation (new hospitals only)
- Maintain a *QualityNet* Security Administrator
- Collect and report data as required in the Federal Register
  - Clinical data
  - HCAHPS data
  - HAI measures reported through NHSN
  - Structural measures
  - Data Accuracy and Completeness Acknowledgement (DACA)
- Submit complete data by the established deadlines
- Submit aggregate population and sample size counts
- Meet validation requirements
- Display quality data on *Hospital Compare*

IQR Program Participation Rates



	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Percent	99%	96%	97%	95%	97%	97%	98%	98%	98%	98%	98%

IQR Resources

- ***QualityNet***
  www.qualitynet.org
- ***Hospital Compare***
  www.medicare.gov/hospitalcompare
- **National Healthcare Safety Network (NHSN)**
  www.cdc.gov/nhsn/

EHR Incentive and Hospital IQR Program

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EHR Incentive Program Purpose

The Medicare EHR Incentive Programs

- Also known as “Meaningful Use”
- Provides Medicare and Medicaid incentive payments to qualifying physicians, healthcare professionals, and hospitals when they adopt and meaningfully use Certified Electronic Health Record Technology (CEHRT)
- CMS published Meaningful Use CEHRT regulations in final rules
  - Stage 1 Final Rule published July 2010
    - http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf
  - Stage 2 Final Rule published September 2012
    - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

What are eCQMs?

- Electronically specified versions of traditionally chart-abstracted Clinical Quality Measures
- Developed specifically so Certified Electronic Health Record Technology (CEHRT) can capture, calculate, export, and transmit the measure data

CMS' Vision

Simplify and streamline quality reporting by collecting and reporting data through health information technology (HIT).

EHR Incentive Program Requirements

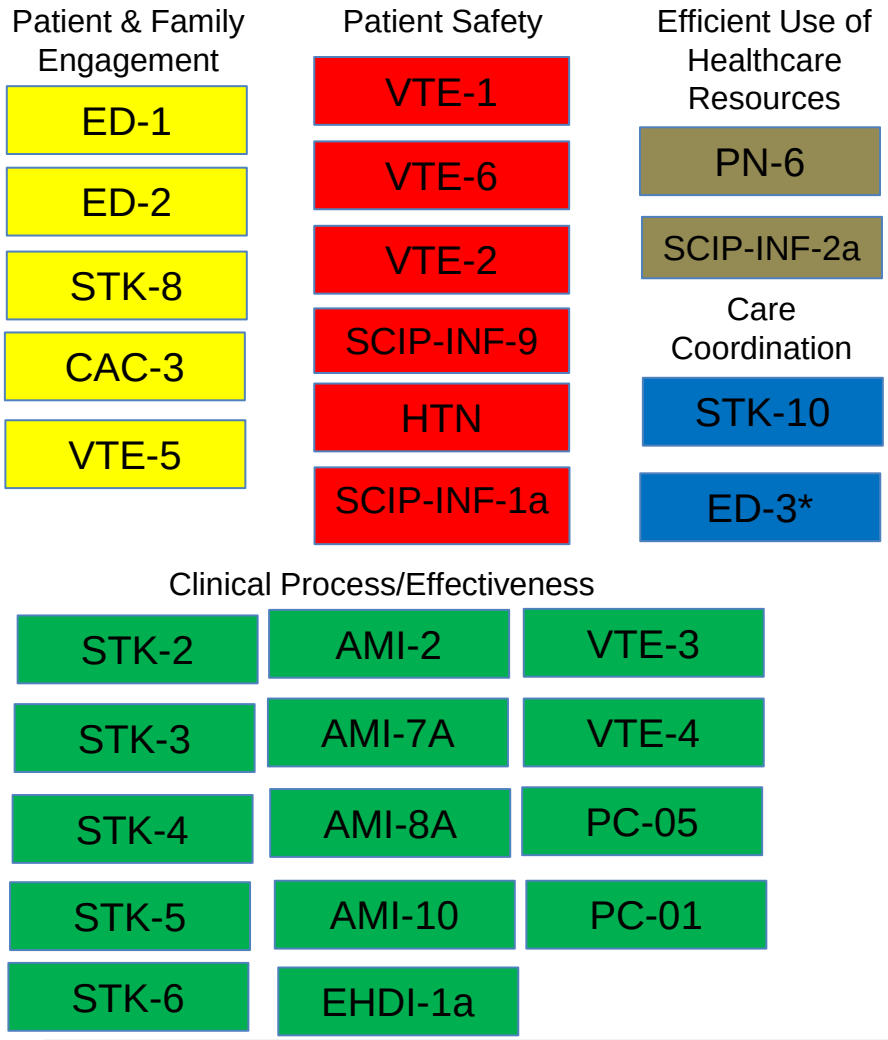
- Utilization of certified EHR technology
- Submission of structural objectives (Core and Menu measures) through the CMS Registration and Attestation System
- Submission of clinical quality measure data
  - Option 1: Aggregate reporting of numerators and denominators in the CMS Registration and Attestation system
  - Option 2: Submission of QRDA Cat I Release 2 files to the Hospital eCQM Receiving System

EHR Incentive Program eCQM Reporting for CY 2015

Eligible Hospitals and Critical Access Hospitals that seek to report CQMs *electronically* under the Medicare EHR Incentive or the Hospital IQR Program must use:

- The April 2014 version of the electronic specifications for the CQMs
- QRDA Category I Release 2 files that conform to the CMS QRDA Supplementary Implementation Guide for 2015 found at www.cms.gov/Regulations-andGuidance/Legislation/EHRIncentivePrograms/Downloads/QRDA_EP_HQR_Guide_2015.pdf

IQR and EHR Incentive Program Aligned eCQM Reporting for 2015



- There are 29 available eCQMs.
- Twenty-eight of the 29 eCQMs are eligible for the IQR Program*.
- A hospital can report data on any 16 of the eCQMs across three National Quality Strategy domains.
- A hospital must report data on at least 16 eCQMs to receive credit for either program.

*ED-3 is an Outpatient measure and therefore not applicable for IQR.

Zero Denominator Declaration/Case Threshold Exemption

- A Zero Denominator can be used when both:
  - A hospital's EHR system is certified for an eCQM
  - A hospital does not have patients that meet the denominator criteria of that eCQM
- A Case Threshold Exemption can be used when both:
  - A hospital's EHR system is certified for an eCQM
  - There are five or fewer discharges during the relevant EHR reporting period
- Both count as a successful submission for eCQM requirements for the EHR Incentive Program and/or the Hospital IQR Program

EHR Incentive Program and eCQM Reporting Periods

FY 2017 Electronic Reporting Periods and Submission Deadlines for EHs	
Discharge Reporting Period	**Submission Deadline**
January 1–March 31, 2015	November 30, 2015
April 1–June 30, 2015	November 30, 2015
July 1–September 30, 2015	November 30, 2015
October 1–December 31, 2015	Not Applicable

A hospital may voluntarily submit one calendar quarter (CY 2015 Q1, Q2, or Q3) as an eCQM by November 30, 2015.

Note: *The EHR Incentive Program and the Hospital IQR Program have deadlines that differ from eCQM submission deadlines.*

EHR Incentive Program and eCQM Resources

- **April 2014 eCQM Specifications**
  http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html
- **HL7 Implementation Guide for QRDA Cat I R2**
  http://www.hl7.org/implement/standards/product_brief.cfm?product_id=35
- **CMS Implementation Guide for QRDA Cat I and III; Eligible Professional Programs and Hospital Quality Reporting (HQR)**
  http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/QRDA_EP_HQR_Guide_2015.pdf
- **Most Common eCQM Submission Errors for Hospital QRDA Category-1 Files Presentation**
  https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228773852046

Hospital Value-Based Purchasing (VBP) Program

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CMS

Hospital VBP Program Purpose

- Hospital VBP is required by section 3001 of the Affordable Care Act and is designed to link Medicare payments to quality.
- The Centers for Medicare & Medicaid Services (CMS) views Value-Based Purchasing (VBP) as an important step in redesigning how healthcare and healthcare services are paid for, moving increasingly toward rewarding better value, outcomes, and innovations, instead of merely volume.
- The Hospital VBP Program is designed to promote better clinical outcomes for hospital patients, as well as improve their experience of care during hospital stays. Specifically, Hospital VBP seeks to encourage hospitals to improve the quality and safety of care that Medicare beneficiaries and all patients receive during acute care inpatient stays by:
  - Eliminating or reducing the occurrence of adverse events (healthcare errors resulting in patient harm);
  - Adopting evidence-based care standards and protocols that result in the best outcomes for the most patients; and
  - Re-engineering hospital processes that improve patients' experience of care.

Hospital VBP Program Eligibility

Who is eligible for the program?

- As defined in Social Security Act Section 1886(d)(1)(B), the program applies to subsection (d) hospitals located in the 50 states and the District of Columbia.

Who is excluded from the Hospital VBP Program?

- Hospitals and hospital units excluded from the Inpatient Prospective Payment System (IPPS)
- Hospitals subject to payment reductions under the Hospital Inpatient Quality Reporting (IQR) Program
- Hospitals cited for deficiencies during the performance period that pose immediate jeopardy to the health or safety of patients
- Hospitals with less than the minimum number of domains calculated
- Hospitals with an approved Disaster/Extraordinary Circumstance Exception specific to the Hospital VBP Program
- Short-term acute care hospitals in Maryland

Hospitals excluded from the Hospital VBP Program will not have 2.00% withheld from their base operating DRG payments in FY 2017.

Hospital VBP Scoring and Future Policy

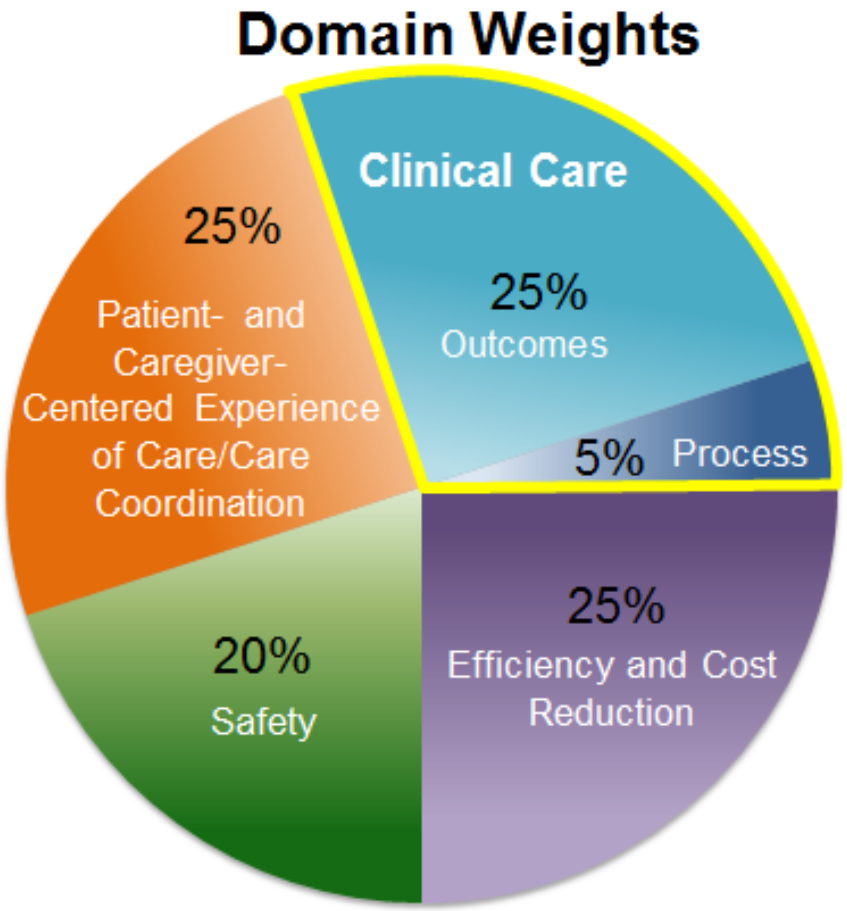
- The Hospital VBP Program uses performance on Clinical Processes of Care, Outcome, Patient Experience, and Cost Efficiency measures collected through the Hospital IQR Program to determine hospital payments.
- The Hospital VBP Program uses IQR Program measures that address heart attack, pneumonia, heart failure, surgical care, healthcare-associated infections, patient experience of care, outcome, and efficiency.
- Quality measures are scored on the greater of improvement or achievement for each measure.
- Total Performance Scores (TPS) are a compilation of the summed measure scores in a quality domain, multiplied by the weighting outlined in the IPPS Final Rules.
- Future program policies include:
  - Additional healthcare-associated infection measures in Fiscal Year (FY) 2016, including catheter-associated urinary tract infections (CAUTI) and surgical site infections (SSI);
  - Additional healthcare-associated infection measures in FY 2017 Methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* infection (CDI); and
  - Further alignment of the Hospital VBP domains with the National Quality Strategy domain structure beginning in FY 2017.

Hospital VBP Funding

- The Hospital VBP Program is an estimated budget neutral program.
- The program is funded by reductions from participating hospitals' base-operating Diagnosis-Related Group (DRG) payments.
- Resulting funds are redistributed to hospitals based on their TPS.
  - The actual amount earned by hospitals will depend on the range and distribution of all eligible/participating hospitals' TPS scores for a fiscal year.
  - A hospital may earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that program year.

Fiscal Year	Percentage Withhold	Total Value-Based Incentive Payments
FY 2013	1.00%	$963 million (est.)
FY 2014	1.25%	$1.1 billion (est.)
FY 2015	1.50%	$1.4 billion (est.)
FY 2016	1.75%	TBD
FY 2017 and future fiscal years	2.00%	TBD

Hospital VBP
FY 2017 Domains and Measures



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

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

Clinical Care

Outcomes	Process
MORT-30-AMI	AMI-7a
MORT-30-HF	IMM-2
MORT-30-PN	PC-01*

Efficiency and Cost Reduction

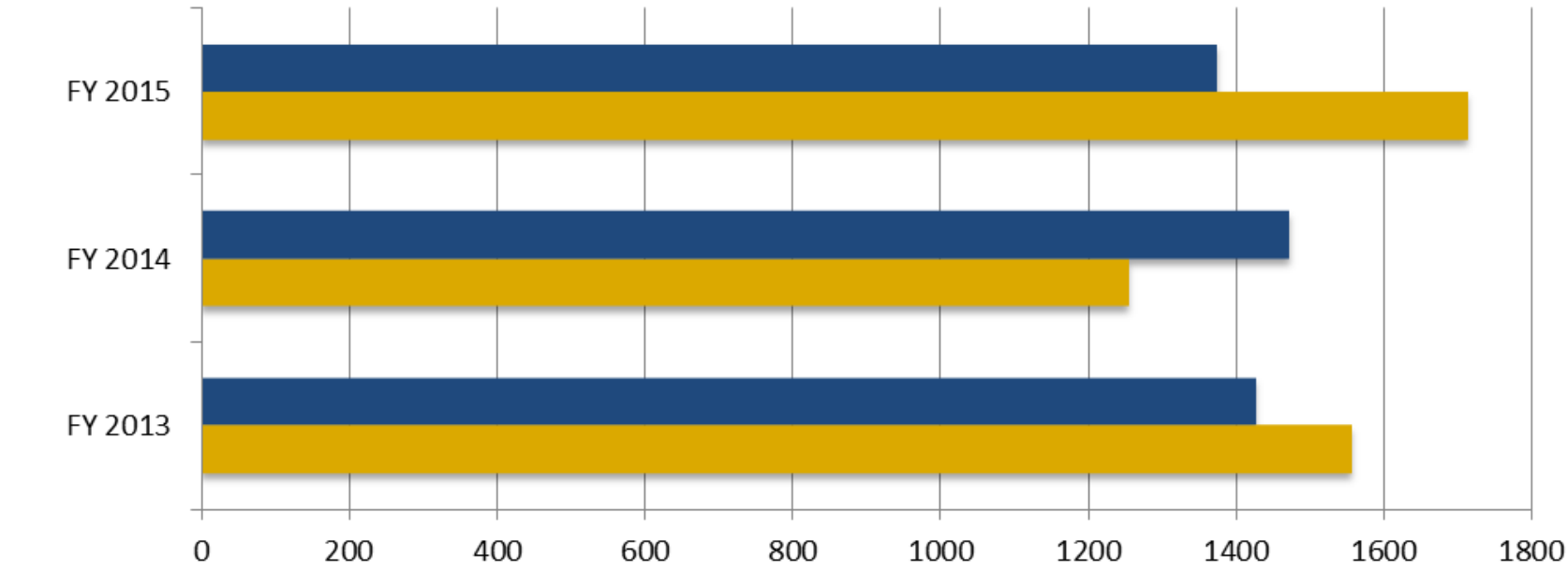
MSPB-1

Safety

CLABSI
CAUTI
SSI: Colon & Abdominal Hysterectomy
MRSA Infections*
C-difficile* Infections
AHRQ PSI-90

An asterisk (*) indicates a newly adopted measure for the Hospital VBP Program.

Hospital VBP
Historical Payment Distributions



	FY 2013	FY 2014	FY 2015
Reductions	1427	1473	1375
Increases	1557	1255	1714

Hospital VBP Resources

- **Hospital VBP Program section of CMS website:**

  http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/Hospital-Value-Based-Purchasing/

- **Hospital VBP Program Payment Adjustment Factor Table:**

  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page-Items/FY2015-Final-Rule-Tables.html

- **Section 1886 of the Social Security Act:**

  http://www.ssa.gov/OP_Home/ssact/title18/1886.htm

- **Hospital VBP Program pages of *QualityNet*:**
  https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937

- **Hospital VBP Program Scoring on *Hospital Compare*:**
  http://www.medicare.gov/hospitalcompare/data/hospital-vbp.html

- **Hospital VBP Program Aggregate Payments on *Hospital Compare*:**
  http://www.medicare.gov/hospitalcompare/data/payment-adjustments.html

Hospital IQR Program General Resources

Q & A Tool
https://cms-ip.custhelp.com

Email Support
InpatientSupport@viqrc1.HCQIS.org

Phone Support
844.472.4477 or
866.800.8765

Inpatient Live Chat
www.qualityreportingcenter.com/inpatient

Monthly Web Conferences
www.QualityReportingCenter.com

Secure Fax
877.789.4443

ListServes
Sign up on
www.QualityNet.org

Website
www.QualityReportingCenter.com

Hospital Readmissions Reduction Program

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Quality Measurement and Health Assessment Group
Center for Clinical Standards and Quality

May 12, 2015

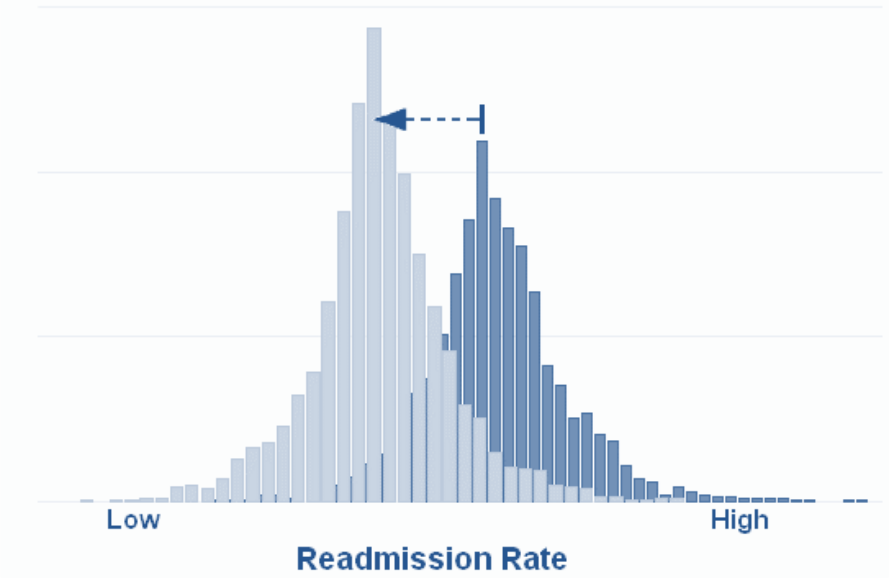
HRRP Program Purpose and Objectives

- Section 3025 of the Patient Protection and Affordable Care Act (ACA) added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program (HRRP).
- Hospital Readmissions Reduction Program:
  - Requires the Centers for Medicare & Medicaid Services to adjust payments to hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS) (*i.e.*, subsection (d) hospitals) with excess unplanned readmissions for certain applicable conditions.
  - Aims to improve the quality of care, especially by improving communication and care coordination, while reducing the costs.

Impact of the HRRP

Goal of ACA section 3025: Shift and narrow the curve

- Improve performance of all hospitals, not just those that perform poorly.
- Reduce variation of hospital performance by reducing the gap between the good performers and the poor performers.



HRRP Program Measures

Readmission Measures	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Acute myocardial infarction	✓	✓	✓	✓	✓
Heart failure	✓	✓	✓	✓	✓
Pneumonia	✓	✓	✓	✓	✓
Chronic obstructive pulmonary disease			✓	✓	✓
Total hip arthroplasty/ Total knee arthroplasty			✓	✓	✓
Coronary artery bypass graft surgery					✓

HRRP Risk Adjustment of Measures

- Goal of risk adjustment:
  - Accounts for patient characteristics that are clinically relevant
  - Illuminates important quality differences between hospitals
- Measures adjust for:
  - Age
  - Sex
  - Diagnoses present 12 months prior to admission date and during index admission
  - History of procedures
- Measures currently do not adjust for:
  - Complications of care
  - Socioeconomic status, gender, race, ethnicity
  - Hospital characteristics
  - Admission source

HRRP Calculation of Excess Readmission Rates

- Measure of relative performance.
- Ratio of Predicted to Expected Readmissions:
  - Predicted Readmission Rate = the number of readmissions within 30 days predicted based on the hospital performance with its observed case mix (also referred to as “adjusted actual” readmission)
  - Expected Readmission Rate = the number of readmissions expected based on average hospital performance with a given hospital’s case mix

HRRP Review & Corrections; Public Reporting

- Review & Correction period prior to public reporting (currently 30 days):
  - Hospital-specific reports (HSRs) made available to each hospital via *QualityNet* secure portal
  - HSRs include patient level discharge data
- Public reporting of hospital readmissions data:
  - Hospital-level results first made public in October 2012
  - Posted annually on CMS' *Hospital Compare* website

HRRP Application of Payment Adjustment

- Payment adjustment became effective with discharges beginning on October 1, 2012.
- Payment adjustment factor for each hospital is updated annually through the IPPS Final Rule and published on the CMS website as a *Supplemental Data File* at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.
- Payment adjustment is applied on each Medicare inpatient claim with the amount of the adjustment reported on the claim.
- Payment adjustment also reported on the Medicare Hospital Cost Report.

HRRP Payment Provisions

- Hospitals with a readmissions performance worse than the national average for any one of the conditions are subject to a payment adjustment.
- Payment adjustment applies to all Medicare discharges for that year, not just a hospital's readmissions.
- Payment adjustment is applied to a portion of a hospital's payments.

Fiscal Year (FY)	Number of Hospitals Subject to Adjustment	Estimated Savings for Medicare
FY 2013	2,214	$280 million (0.2% of payments)
FY 2014	2,225	$227 million (0.2% of payments)
FY 2015*	2,638	$428 million (0.4% of payments)
FY 2016	TBD	TBD

* Two additional readmission measures were added in FY 2015.

HRRP Resources

- **General Program Information**
  https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458
- **More Program and Payment Adjustment Information**
  http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html/
- **Readmission Measures**
  https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1219069855273
- **IPPS/LTCH PPS Final Rule (FY 2015)**
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html
- **Initiatives to Reduce Readmissions**
  https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228766331358

Hospital-Acquired Condition Reduction Program

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Center for Clinical Standards and Quality

May 12, 2015

HAC Reduction Program Purpose

- Section 3008 of the Patient Protection and Affordable Care Act (ACA) established the HAC Reduction Program to incentivize hospitals to reduce hospital-acquired conditions (HACs).
- The program began last year with payment adjustments to discharges beginning October 1, 2014 (FY 2015).
- Payment adjustments occur for hospitals that rank in the lowest performing quartile with respect to HACs.
- Estimated Medicare savings under the FY 2015 HAC Reduction Program were over $350 million.

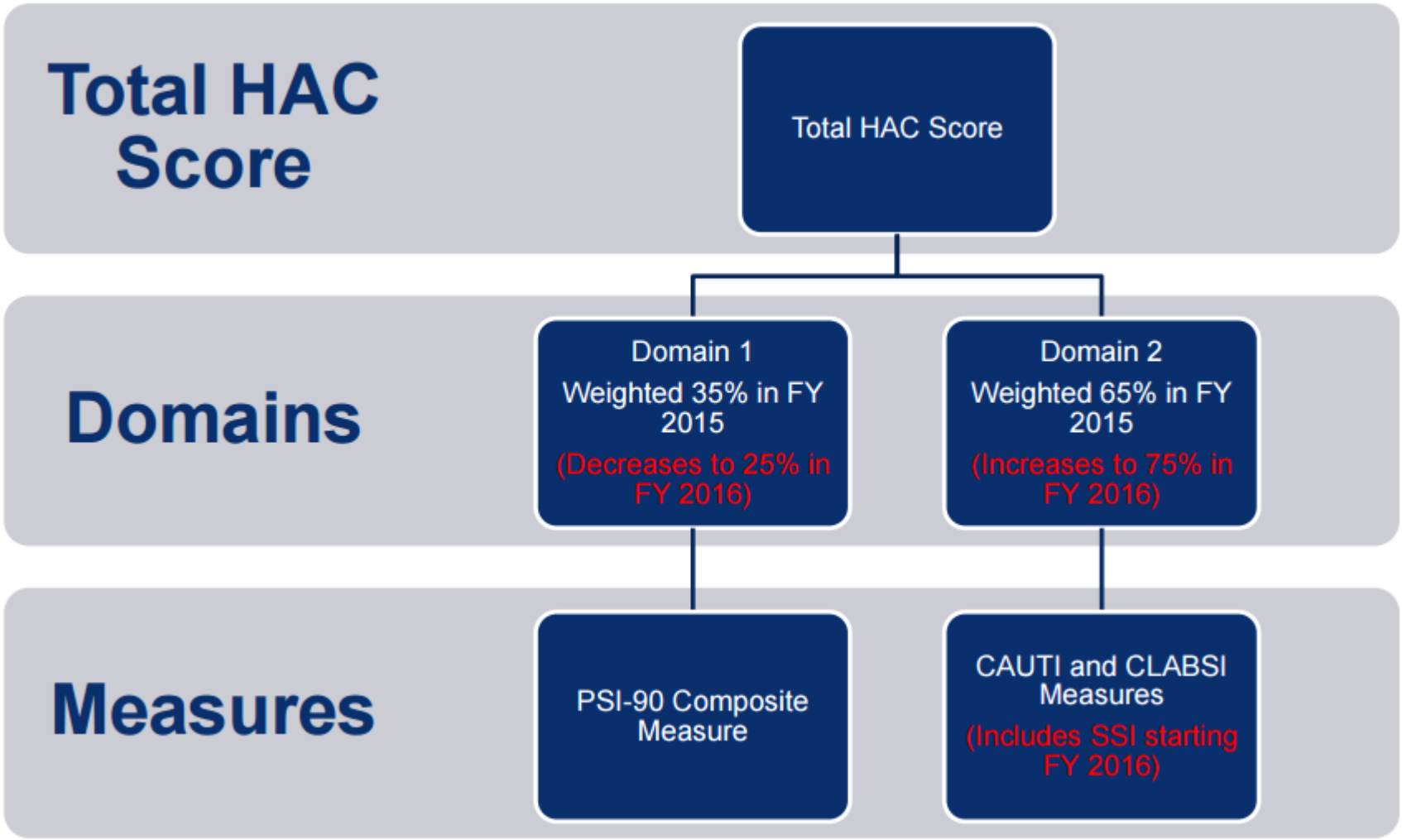
HAC Reduction Program Eligibility

- Applies to hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS) (i.e., subsection (d) hospitals)
- Program does not affect:
  - Long-term acute care hospitals
  - Cancer hospitals
  - Children's hospitals
  - Inpatient rehab facilities
  - Inpatient psychiatric facilities
  - Critical access hospitals

HAC Reduction Program Measures

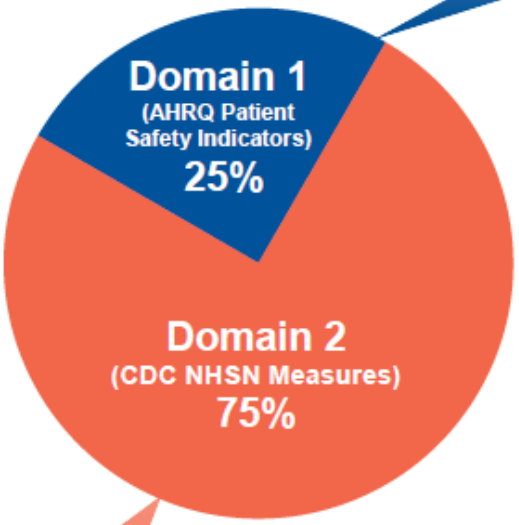
Measure	FY 2015	FY 2016	FY 2017
Patient Safety Indicator (PSI) 90 Composite	X	X	X
Central line-associated bloodstream infection (CLABSI)	X	X	X
Catheter associated urinary tract infection (CAUTI)	X	X	X
Surgical site infection (SSI) (colon and hysterectomy)		X	X
Methicillin-resistant Staphylococcus (MRSA) bacteremia			X
Clostridium difficile			X

HAC Reduction Program Framework



HAC Reduction Program
FY 2016 Domain Weighting and Measures

(Payment adjustment effective for discharges from October 1, 2015 –September 30, 2016)



DOMAIN 1	
	Performance Period July 1, 2012 – June 30, 2014
AHRQ* PSI 90 Measure	**Score 1-10**
PSI 3 Pressure ulcer rate	
PSI 6 Iatrogenic pneumothorax rate	
PSI 7 Central venous catheter-related blood stream infection rate	
PSI 8 Postoperative hip fracture rate	
PSI 12 Postoperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT)	
PSI 13 Postoperative sepsis rate	
PSI 14 Wound dehiscence rate	
PSI 15 Accidental puncture and laceration rate	

*The Agency for Healthcare Research and Quality

DOMAIN 2	
	Performance Period January 1, 2013 – December 31, 2014
CDC NHSN* Measures	**Average Score 1-10**
CLABSI SIR rate	1-10
CAUTI SIR rate	1-10
SSI Colon Abdominal Hysterectomy	1-10†

Centers for Disease Control and Prevention
National Healthcare Safety Network

†There will be one SSI measure score that will be a weighted average based on predicted infections for both procedures.

FY 2016 HAC Reduction Program Domain Weighting and Measures
(Payment adjustment effective for discharges from October 1, 2015 –September 30, 2016)

HAC Reduction Program Measure Scoring

Percentile	Points
1st – 10th	1
11th – 20th	2
21st – 30th	3
31st – 40th	4
41st – 50th	5
51st – 60th	6
61st – 70th	7
71st – 80th	8
81st – 90th	9
91st – 100th	10

- For FY 2015, points were assigned according to a hospital's performance on three measures:
  - Domain 1
    - PSI-90 Composite
  - Domain 2
    - CLABSI
    - CAUTI
- Performance range for each measure divided into 10 equal groups
- All hospital received between 1 and 10 points per measure
- Points assigned for each measure in deciles between the score of the *best* performing hospital and the *worst* performing hospital

Higher Score = Worse Performance

HAC Reduction Program Public Reporting

HAC Reduction Program-related information for each hospital is available publicly on:

- *Hospital Compare* at www.medicare.gov/hospitalcompare/HAC-reduction-program.html
  - Measure scores
  - Domain scores
  - Total HAC score
- *CMS.gov* at cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html
  - Total HAC score
  - Payment adjustment category (Y/N)

HAC Reduction Program Additional Resources

HAC Reduction Program Methodology & General Information

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

Scores

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

Patient Safety Indicators 90

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

CLABSI, CAUTI, SSI, MRSA and *C. difficile*

- Healthcare-Associated Infections: www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228760487021
- National Health Safety Network: nhsn@cdc.gov

Program Alignment

Cindy Tourison, MSHI
Lead, Hospital Inpatient Quality Reporting and
Hospital Value-Based Purchasing
CMS

CMS Quality Strategy
Goals and Foundational Principles

Hospital Quality Reporting Programs Reduced Burden

- Alignment of measures across programs will minimize the reporting burden imposed on hospitals
- Alignment of measurement periods and deadlines where feasible
- Consistency in hospital specific reports
- Simplifying Public Reporting
- Alignment of Policies across programs
- Consolidated forms available across programs

Hospital Quality Reporting Programs Payment Impacts

Fiscal Year	Hospital IQR Program	EHR Incentive Program	Hospital VBP Program	HAC Reduction Program	HRRP
2013	2.0 Percentage Point Reduction to Market Basket Update (MBU)	N/A	1.00% withhold to base-operating DRG Payment Amount	N/A	1.00% maximum reduction to base-operating DRG Payment Amount
2014	2.0 Percentage Point Reduction to MBU	N/A	1.25% withhold to base-operating DRG Payment Amount	N/A	2.00% maximum reduction to base-operating DRG Payment Amount
2015	¼ reduction to the applicable MBU	¼ reduction to the applicable MBU	1.50% withhold to base-operating DRG Payment Amount	1.00% reduction to base operating DRG payment amount and add-on payments	3.00% maximum reduction to base-operating DRG Payment Amount
2016	¼ reduction to the applicable MBU	½ reduction to the applicable MBU	1.75% withhold to base-operating DRG Payment Amount	1.00% reduction to base operating DRG payment amount and add-on payments	3.00% maximum reduction to base-operating DRG Payment Amount
2017	¼ reduction to the applicable MBU	¾ reduction to the applicable MBU	2.00% withhold to base-operating DRG Payment Amount	1.00% reduction to base operating DRG payment amount and add-on payments	3.00% maximum reduction to base-operating DRG Payment Amount

Question & Answer Session

Evaluate Your Experience

- Please help us continue to improve the MLN Connects® National Provider Call Program by providing your feedback about today's call.
- To complete the evaluation, visit http://npc.blhtech.com and select the title for today's call.

CME and CEU

- This MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit (CE). For more information about continuing education credit, Review review the *CE Activity Information & Instructions* document available at the link below for specific details:

  http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/TC-L05122015-Marketing-Materials.pdf

Thank You

- For more information about the MLN Connects® National Provider Call Program, please visit http://cms.gov/Outreach-and-Education/Outreach/NPC/index.html.

- For more information about the Medicare Learning Network®, please visit http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html.