Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Fiscal Year (FY) 2018 Inpatient Prospective Payment System (IPPS) Final Rule: Acute Care Hospital Quality Reporting Programs Overview

Presentation Transcript

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Candace Jackson: Thank you, Matt. Hello, and welcome to the Hospital IQR Program Fiscal Year 2018 Inpatient Prospective Payment System (IPPS) Final Rule webinar. My name is Candace Jackson, and I am the Hospital Inpatient Quality Reporting Program Support Contractor Lead from the Hospital Inpatient Values, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be hosting today's event. Before we begin, I would like to make a few announcements. This program is being recorded. A transcript of the presentation and the questions and answers will be posted to the Inpatient website – www.qualityreportingcenter.com – in the future. If you have registered for this event, a reminder email and the slides were sent out to your email address about two hours ago. If you did not receive that email, you can download the slides at the Inpatient website. And, again, that's www.qualityreportingcenter.com. If you have a question as we move through the webinar, please type your question into the chat window with the slide number associated to your question at the beginning. As time allows, we will have a short question and answer session at the conclusion of the webinar. Applicable questions that are not answered during that question and answer session will be posted to the qualityreportingcenter.com website in the upcoming weeks. Next slide, please.

I would now like to welcome and introduce our guest speakers for today – Grace Snyder, Mihir Patel, Elizabeth Bainger, and Lauren Lowenstein. Grace Snyder, JD, MPH, is the Program Lead for the Hospital Inpatient Quality Reporting Program and Hospital Value-Based Purchasing Program, CMS, Center for Clinical Standards and Quality, Quality Measurements and Value-Based Incentives Group. Grace is responsible for all aspects of implementing these programs and works in collaboration with the Centers for Medicare, as well as other hospital quality programs and measure development for the acute care setting. Grace received her JD from the University of Virginia School of Law and MPH in Health Policy from the George Washington Milken Institute School of Public Health.

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Mihir Patel, MHA, is the Program Lead for the Hospital Inpatient and Outpatient Quality Reporting Program Data Validation, CMS, Center for Clinical Standards and Quality, Quality Measurement and Value-Based Incentives Group. Mihir is responsible for all aspects of implementing data validation for IQR and OQR and works in collaboration with the IQR and OQR programs. Mihir received his Master's in Health Administration from Mount St. Mary's University.

Dr. Elizabeth Bainger joined CMS in 2014 to become the Program Lead for the Hospital Outpatient Quality Reporting Program. This past February, she transitioned to Program Lead for the Hospital-Acquired Condition Reduction Program. Elizabeth has a broad clinical background, including behavioral health, ambulatory surgery, cardiac care, critical care, light nursing, and nursing education. She received her doctorate of nursing practice from the University of Maryland with an administrative focus on quality improvement. Her QI background includes positions as a Performance Improvement Coordinator and Senior Abstraction Specialist. She is a certified professional in Healthcare Quality and member of the National Association for Healthcare Quality.

Lauren Lowenstein, MPH, MSW, is responsible for the publication of the Hospital Readmissions Reduction Program Fiscal Year 2018 Final Rule. Lauren received her MPH from Johns Hopkins University's Bloomberg School of Public Health and her MSW from the University of Maryland School of Social Work. Next slide, please.

This presentation will provide participants with the fiscal year 2018 IPPS hospital quality program finalized proposals for the Hospital IQR Program, Hospital VBP Program, HAC Reduction Program, and HRRP. Next slide, please.

At the end of this presentation, you will be able to locate the fiscal year 2018 IPPS final rule text and identify changes within the fiscal year 2018 IPPS final rule. Next slide, please.

	I will now turn the presentation over to our first speaker. Grace, the floor is yours.
Grace Snyder:	All right. Thanks, Candace. Good afternoon, and thank you for joining us today. For the Hospital Inpatient Quality Reporting Program, we finalized several policies related to quality measure reporting. Next slide, please.

First of all, one of the highlights that we've made is refinement to two of the existing quality measures in this program. The first measure we updated relates to the pain management questions in the Hospital Consumer Assessment of Healthcare Providers and System survey, or HCAHPS® survey. Secondly, we updated the risk adjustment model for the stroke 30-day mortality rate measure. In the next set of slides, I'll go into more detail about the specific changes to these measures. Next slide, please.

The HCAHPS® survey is a patient survey of the patient's experiences during the inpatient hospital stay. In this IPPS final rule, we have replaced – we are replacing the three questions related to pain management, and they are HCAHPS® questions 12, 13, and 14, to focus more directly on communication with patients about their pain during their hospital stay. And, as part of updating these questions, we're also updating the name of the question set from Pain Management to Communication about Pain. And, the three pain management questions will be replaced with another set of three questions. Again, these are really focused around the communication between the patients and the clinician at the hospital providing their care about their pain. These changes will be effective for the fiscal year 2020 payment determination for the Hospital Inpatient Quality Reporting Program, and that means that reporting using these new pain questions will begin with calendar year 2018 discharges, or January – beginning January 1, 2018. I would also like to note that in terms of public reporting of the data on the new pain questions, public reporting on the *Hospital Compare* website will begin in October of 2020 using calendar year 2019 data. With the calendar year 2018 data, which will be the first year that we're collecting data on the new pain questions, what we will do is provide hospitals with confidential preview reports, and this we

anticipate will be as early as the summer of 2019, and so this will allow time for hospitals to be able to see how they're performing on these questions and become more familiar with these results before we begin publicly reporting them. Next slide, please.

So, this slide just shows kind of a side-by-side comparison of the pain questions that we had in the HCAHPS® surveys before and the new pain questions, and really again, the main change is that in terms of the focus, the questions are really moving from pain management aspect to more of a communications between the patient and their caregivers of – at the hospital. Next slide, please.

The other Inpatient Quality Reporting Program measure that we have updated in this IPPS final rule is the stroke 30-day mortality rate measure. Specifically, we are updating the risk adjustment model to begin using NIH stroke severity scale information that we will obtain through ICD-10 codes on claims. And, as part of this plan, we will in calendar year 2021, actually provide confidential feedback reports to hospitals, using discharge data from October 1, 2017 through June 30, 2020. We will not be publicly reporting this information, but it will allow hospitals time to see the results from this measure and to become more familiar with the measure. And, then in the following year for 2022, we will begin publicly measuring information, and we will be using discharge data from July 1, 2018 through June 30, 2021. And, this will be applicable to the fiscal year 2023 payment determination for the Inpatient Quality Reporting Program. So, if your facility has not yet started using the ICD-10 stroke severity codes or is not using the codes consistently yet for your stroke patients, we strongly encourage you to begin working with your teams to begin using the ICD-10 stroke severity codes. We also, I want to note that until this updated measure using the stroke severity codes is implemented for public reporting beginning in 2022, that we will up until then use the current version of the stroke mortality rate measure, which does not use the stroke severity codes. But, we want to make sure that you're getting this information ahead of time so that you can plan accordingly. Next slide, please.

We have also adopted some voluntary reporting to the hospital Inpatient Quality Reporting Program: a, what we call a hybrid measure, and this is a hybrid hospital-wide 30-day readmission measure. We refer to it as hybrid because it uses data from both the EHR as well as claims data, which are merged together to be able to calculate the readmission rate. This is very similar to the claims-based hospital-wide readmission measure that we are already using in the Inpatient Quality Reporting Program. So, I think many of you will already be very familiar with this measure. The new – really, the new aspect of it is the part where there are patient-level data elements being submitted using QR – what we call Quality Reporting Document Architecture, or QRDA, 1 files that are submitted to us through the *QualityNet Secure Portal*. And, we call these Patientable data coming from the EHR as core clinical data elements, and the next slide will list what those are, but to just to finish up on this slide, for the purposes of voluntary reporting, the measuring period will be January 1 through June 30, 2018, and will be asking for data on patients for at least 50 percent of discharge Medicare fee-for-service patients who are age 65 or older. We will be opening up the *QualityNet Secure Portal* in the fall of 2018 for the submission of these data and using the data that are submitted through the EHRs. We'll combine that with claims data and provide hospitals with confidential feedback reports so the hospitals sending us data can become more familiar with the measure and be able to review their measure results. As this is a voluntary measure, there will be no impact to the hospital's annual payments determinations, and we will not be publicly reporting this data. Next slide, please.

So, I mentioned that we will be collecting core clinical data elements from EHRs. The core clinical elements include six elements related to vital signs and seven elements for laboratory test results. We will also ask for six elements that are linking variables to be able to match the EHR data that are coming through QRDA files with the claims data that we already have. And by being able to link the data together, we can then calculate measure rate. Next slide, please.

In this most recent IPPS final rule, we have also finalized several policies that will modify electronic clinical quality measure reporting requirements for both calendar year 2017 reporting and also calendar year 2018 reporting. And, so to begin with calendar year 2017 reporting, we have reduced the requirements from requiring eight eCQMs to be reported to four eCQMs. We had proposed in the spring to reduce the number of eCQMs to six, and we actually ended up finalizing an even lower number. So now we will only be requiring reporting of four eCQMs, which is the same as this past calendar year 2016 reporting. So, I think most hospitals will be able to either report on the same four that they might have picked for 2016 or, you know, are welcome to pick a different set of four eCQMs. And, also, we will be asking for one quarter of data. So, hospitals can choose to report either first quarter, second quarter, third quarter, or fourth quarter data. But, whichever quarter is picked, the submission deadline for all eCQM data will be February 28 of 2018. And, we also want to note for you the technical requirements with respect to eCQM reporting. So, in terms of the – which edition of certified EHR technology should be used – it can be 2014 edition, the 2015 edition, or any combination of both. Also, please look to the eCQI Resource Center for the most updated eCQM measure specifications, as well as our Implementation Guide for the submission of the QRDA files. And, also, I wanted to note that meeting these eCQM requirements for the Inpatient Quality Reporting Program will also provide hospitals with credit for the electronic reporting of clinical quality measures for the Medicare EHR Incentive Program for eligible hospitals and critical access hospitals. Next slide, please.

For calendar year 2018 reporting of electronic clinical quality measures, it will be very similar to the calendar year 2017 requirements. So, again, we are asking hospitals to – for 2018 reporting, pick four eCQMs and report one calendar quarter of data. Again, hospitals may pick which quarter of data that they would like to report on, but all data will be due by February 28, 2019. And, then again, in terms of which edition of Certs – Certified EHR technology should be used, we will allow the use of the 2014 edition, the 2015 edition, or a combination of both. And, again, I'd like to point

the audience to our eCQI Resource Center for the most updated measure specifications and the Implementation Guide. Next slide, please.

And, then also, just want to note we will not yet be publicly reporting the eCQM data that are submitted to us. I know that's often this question is on people's minds, and so we wanted to let you know that we will not be publicly reporting the data yet. Now, I'd like to turn it over to my colleague, Mihir Patel, to discuss finalized policies regarding the Inpatient Quality Reporting Program's data validation process. Mihir?

Mihir Patel: Thank you, Grace. Good afternoon, everyone. Thank you for joining us today. I will be going over the updates we made to the Hospital Inpatient Quality Reporting Program data validation first. Next slide, please.

First, the electronic clinical quality measures data validation. CMS will be randomly selecting up to 200 hospitals for participating in the electronic clinical quality measures data validation. CMS will be requesting eight records, or cases, for one quarter of validation from each selected hospital for fiscal year 2020 payment determination. If the hospital is selected for chart-abstracted measures validation or has filed an ECE request and was approved by the program, those hospitals will not be selected for eCQM data validation. There are other additional exclusion criteria, which will be discussed later in the upcoming slides. Hospitals are required to submit at least 75 percent of the requested medical records before the deadline in order to meet eCQM validation requirements. Next slide, please.

Again, this slide shows CMS will be requesting eight cases for one quarter of eCQM data for both the fiscal year 2020 and 2021 payment determination. Next slide, please.

Additional details on the exclusion criteria for selected hospitals for eCQM validation are as follows: Any hospital that does not at least five discharges for at least one reported eCQM will be excluded from the selected eCQM validation, as will episodes of care that are longer than 120 days, as well as cases with a zero denominator for each measure. Please note that criteria will be applied before the random selection of 200

hospitals for eCQM data validation, meaning the hospitals meeting any one of the criteria are not eligible for selection. Next slide, please.

The accuracy of the eCQM data submitted for validation does not affect hospitals' validation score. As long as hospitals send in at least 75 percent of the requested medical records within the deadline, they will meet the eCQM data validation requirements. Next slide, please.

For the chart-abstracted measures data validation, we have formalized the educational review process beginning with fiscal year 2020 payment determination and subsequent years. CMS will use the correct updated quarterly scores for computing the confidence interval if we find a discrepancy in favor of hospitals for any of the first three quarters of validation. Next slide, please.

Now, I will turn it back to my colleague, Grace Snyder. Grace?

Grace Snyder: Thanks, Mihir. Now for the Hospital Value-Based Purchasing Program, I'd like to share with you a summary of the policies that we finalized in this past IPPS final rule. Next slide, please.

For the fiscal year 2018 program, as required by statute, we are withholding 2 percent, and then we estimate that this 2 percent amounts to a total of approximately $1.9 billion, which will be available to redistribute to participating hospitals through this program. Next slide, please.

The final rule also contains tables related to the Hospital VBP, or Value-Based Purchasing, Program, as estimates of what we think the adjustment factors will be. So, the proposed rule back in the spring included Table 16, which – again, these are estimates based on the fiscal year 2017 total performance scores, since fiscal year 2018 total performance scores are not available yet. The final rule contained what we refer to as Table 16a. So, it's from updated estimates using more recent MedPAR data; however, it still uses fiscal year 2017 total performance scores since we just completed the review and corrections process for fiscal year 2018 total performance scores. So, I do want you to know that later this fall, we will

posting Table 16b on CMS.gov, which will have the actual payment adjustment factors, and these factors will be based on final fiscal year 2018 total performance scores for hospitals. Next slide, please.

In terms of the quality measures and payment measures used in the Hospital Value-Based Purchasing Program, we did finalize some changes. So, first of all, we finalized the removal of the composite Patient Safety Indicator (PSI) 90 measure, and we will – this measure will be removed from the program beginning next year for the fiscal year 2019 program year. The reason why we're having to remove this measure is, one, many of you may be familiar within our Inpatient Quality Reporting Program and the Hospital Acquired-Condition Reduction Program, last year, we had adopted a new version of this PSI 90 measure and also due to the inability to have an ICD-10 version of the older version – so the older version of this measure that we've been using in the Hospital VBP Program, it will no longer be available for use. So, we are removing this older version of the measure. Next slide, please.

So, also in this IPPS final rule, we've adopted for the Hospital Value-Based Purchasing Program the new version of the PSI 90 measure, and, as I just mentioned, we adopted this new version of the measure last year for the Inpatient Quality Reporting Program and the Hospital-Acquired Condition Reduction Program. And so, this way, now we will be able to have it in the Hospital Value-Based Purchasing Program, which will, I think, make use of this measure more aligned across our quality programs. So, for the Hospital Value-Based Purchasing Program, this new version of the PSI 90 measure will go into effect beginning with the fiscal year 2023 program year. And that's because by the nature of the program, we'll have to establish a baseline period, and then we will also have a performance period to be able to calculate improvement points for this program. Next slide, please.

So, to summarize here with respect to the new PSI 90 measure that we're adopting, as I mentioned, it will go into effect with the fiscal year 2023 program year, and this will correspond with a baseline period that goes

from October 1, 2015 through June 30, 2017, and a performance period that is from July 1, 2019 through June 30, 2021.

In terms of the measures used in the Hospital VBP Program, we have also adopted a new risk standardized payment measure associated with a 30-day episode of care for pneumonia, and many of you may already be familiar with this measure, as we use it in the Inpatient Quality Reporting Program and it is publicly reported on the *Hospital Compare* website. It is, in terms of the methodology of the measure, very similar to our AMI and heart failure payment measures, and in terms of the pneumonia patient cohort, it is defined in the same manner as our pneumonia 30-day mortality measure and our 30-day readmissions measure. And, the pneumonia payment measure, it will be effective with the fiscal year 2022 program year and will have a baseline period that goes from July 1, 2013 through June 30, 2016, and a performance period from August 1, 2018 through June 30, 2020. Next slide, please.

So, I think this next slide is very helpful in being able to see for these next upcoming two program years – fiscal year 2019 and fiscal year 2020. We have four domains in the program – safety, clinical care, person and community engagement, and efficiency and cost-reduction. Each of the four domains are weighted equally at 25 percent each of the total performance score, and hospitals must have domain scores for at least three of the domains to be able to calculate a total performance score. And, you'll also see on this slide each of the individual measures that are associated with each domain. You'll see that PSI 90 measure is no longer included in the safety domain, and also, you may note as we'd finalized in rule making last year under the Person and Community Engagement for the HCAHPS® survey dimension, the pain management dimension is no longer included there.

Also, I wanted to note under the clinical care domain, I think many of you may be familiar with the three mortality measures that we've been using for AMI, heart failure, and pneumonia. And we are also adding a total hip replacement to a knee replacement complications rate measure. Next slide, please.

So, this slide shows the measurement periods for both the baseline and performance periods for the measures that we'll be using in the fiscal year 2019 program year. Again, the PSI 90 measure has been removed. Next slide, please.

And for the fiscal year 2020 program year, these are the baseline and performance periods for the measures that are being used in the Hospital Value-Based Purchasing Program. Next slide, please.

This slide shows the minimum data requirements. So, I had previously mentioned that to be able to calculate a total performance score, we would need to be able to calculate domain scores for at least three of the four domains. Well, for each domain, we also have established data minimums to be able to calculate the domain score. So, for example, for the Person and Community Engagement domain, we would need at least 100 HCAHPS® surveys to be able to calculate that domain. Another example for the Efficiency and Cost Reduction domain, we would need at least 25 episodes of care to be able to calculate the Medicare Spending per Beneficiary measure, or MSPB measure. Next slide, please.

This slide shows the performance standards, which are the benchmarked and achievement thresholds for each of the measures for fiscal year 2020. And the benchmark and achievement thresholds for each measure have been calculated based on data from all hospitals during the baseline period for the respective measures. Next slide, please.

And this slide continues the fiscal year 2020 performance standards for the HCAHPS® dimensions. With HCAHPS® dimensions, we have also calculated the floor along with the benchmark and achievement thresholds. Next slide, please.

Also in this past IPPS final rule, we have finalized policy related to weighting of payment measures used in the efficiency and cost reduction domain. Beginning with the fiscal year 2021 program year, we'll be adding additional payment measures to this efficiency and cost reduction domain to join the Medicare Spending per Beneficiary measure. And, so

with more than one measure in this domain, if for any reason we're not – we don't have the case minimums to be able to calculate any one or more of the payment measures, then we would re-weight the remaining measures accordingly. So, the Medicare Spending per Beneficiary measure would be weighted at 50 percent, as would the other condition-specific payment measures. So, in fiscal year 2021, we would have the AMI and heart failure payment measures coming in to the program. They would be weighted with the remaining 50 percent of the domain score and weighted equally in that 50 percent, and then in the following year, when the pneumonia payment measure is also added to that domain, then those three condition-specific payment measures would be weighted at half of the domain score and weighted equally. But, again, this will really go into effect beginning with the fiscal year 2021 program year. Next slide, please.

So, now I'd to turn things over to my colleague, Elizabeth Bainger, to present on the Hospital-Acquired Condition Reduction Program. Thank you.

Elizabeth Bainger: Thank you, Grace, and I want to thank everyone for joining us today. I'm pleased to have this opportunity to talk with you about the recently published final rule as it relates to the Hospital-Acquired Condition, or HAC, Reduction Program. Next slide, please.

For the fiscal year 2020 program, we did not add or remove any measures to the HAC Reduction Program. We did finalize some policies. For the fiscal year 2020 program, we are returning to a two-year performance period. Domain 1 consists of this recalibrated PSI 90 patient safety and adverse events composite. For that measure, we will be using the 24-month period from July 1, 2016 through June 30, 2018. The claims for all Medicare fee-for-service beneficiaries discharged during this period will be included in the calculation of measure results. Domain 2 consists of five CDC NHSN measures. The measures include CLABSI, CAUTI, colon and abdominal hysterectomy SSI, MRSA, and C. diff. For these measures, CMS will use data from January 1, 2017 through December 31, 2018, in the calculation of measure results. Also, we modified the

Extraordinary Circumstances Exception policy for the HAC Reduction Program by allowing facilities to submit a form signed by the CEO or designated personnel. And, we specified that CMS will strive to provide our formal response within 90 days of receipt of a facility's request and that we may grant an ECE due to CMS data system issues that affect data submission. Next slide, please.

In the fiscal year 2018 final rule, we reminded leaders of the policy surrounding the HAC Reduction Program's review and correction period. These policies were first presented in the fiscal year 2014 IPPS final rule, and we have not changed them. During the review and correction period, CMS gives hospitals 30 days to review and submit questions about the calculation of their results and request corrections of calculation errors. So, this is an opportunity for hospitals to review and request recalculation of their recalibrated PSI 90 measure results, their CDC NHSN measure scores, and their total HAC score. So, that's what the review and corrections period is for. Now, let me clarify what it's not for. The review and corrections period does not allow hospitals to submit additional corrections related to the underlying data. So, the review and corrections period is not the time to submit corrections to claims data for the recalibrated PSI 90 composite or to add new claims to the data abstract that's used for – used to calculate the results. Nor does the review and corrections period allow hospitals to submit additional corrections related to the underlying NHSN data. I want to stress that hospitals do have the opportunity prior to the review and correction period to correct their underlying data. Hospitals are encouraged to review and correct their claims data in compliance with the time limits in the Medicare Claims Processing Manual. And, also under the Hospital Inpatient Quality Reporting Program, hospitals can submit, review, and correct their NHSN data for four and a half months after the end of the reporting quarter. So, you can think of it as a two-stage approach. First, hospitals have a chance to review and correct their underlying data before the specified deadline, and second, hospitals have an opportunity to review and correct their measure calculations during the HAC Reduction Program's review and correction period. Again, this was initially presented in the fiscal year

2014 IPPS final rule. We repeated it in this final rule, and we made no changes. Next slide, please.

As part of our ongoing efforts to evaluate and strengthen the HAC Reduction Program, we requested public comments and suggestions in three areas. First, we sought input for additional outcome patient safety measures that will help achieve the program goals. Second, we sought input on whether we should account for social risk factors and what method or combination of methods would be most appropriate, and we asked which social risk factors might be most appropriate. Third, we sought public comment about risk adjusting the NHSN measures for disability or medical complexity.

I want to thank everyone who commented and offered suggestions. CMS does read every comment, and we review them, and in September, the HAC Reduction Program will engage in strategic planning for the coming years. Your comments will help to build a stronger program, and I very much appreciate everyone's input. Next slide, please.

This slide provides links to additional resources related to program methodology and general information, program results, the PSI 90 composite, and HAIs. You can copy and paste these links into your browser, or if you download the slides, you'll find that the links are clickable. Thank you for your time and attention, and with that, I'd like to pass the presentation along to Lauren Lowenstein who will be discussing the Hospital Readmissions Reduction Program.

Lauren Lowenstein: Thank you. This slide summarizes the changes finalized in the fiscal year 2018 final rule. The fiscal year 2018 changes include changes to the applicable time period, calculation of the aggregate payments for excess readmissions, updates to the Extraordinary Circumstances Exception policy, and effective in fiscal year 2019, changes to the payment adjustment factor in accordance with the 21st Century Cures Act.

Fiscal year 2018 included the following readmissions measures: Acute myocardial infarction, heart failure, pneumonia, chronic obstructive

pulmonary disease, elective primary total hip arthroplasty and/or total knee arthroplasty, and coronary artery bypass graft surgery. The reporting period for these measures covered July 1, 2013 through June 30, 2016. The reporting period includes both ICD-9 and ICD-10 coding, and each condition is based on a specific list of codes as defined within the method specification.

The final rule includes an update to the Extraordinary Circumstances Exception policy. The first of the finalized updates permits the facility to submit a form signed by the facility's CEO or designated personnel. The second update clarifies that CMS will strive to provide our formal response notifying the facility of our decision within 90 days of receipt of the facility's request. The final ECE policy update allows CMS to have the authority to grant ECEs due to CMS data system issues that affect data submission.

In December 2016, the 21st Century Cures Act was signed into law. The legislation requires that CMS assess penalties based on a hospital's performance relative to that of other hospitals with a similar proportion of patients who are duly eligible for Medicare and full-benefit Medicaid. The legislation further requires that estimated payments under the new methodology equal payments under the original design, also known as budget neutrality.

This figure shows how the Cures Act changes the HRRP payment adjustment factor methodology to account for hospitals' proportion of dual-eligible patients. While Step 1 and Step 2 of this graphic are grayed out to show that these steps are not changing under the new methodology, in these steps, hospitals submit claims to Medicare, and CMS calculates excess readmission ratios for the six measures included in the program. However, as shown in Step 3, under the new stratified methodology, hospitals are stratified into peer groups based on their proportion of dual-eligible patients, and CMS calculates median excess readmission ratios (ERR) for each peer group. For each measure, hospital performance is assessed relative to the peer group median ERR when calculating the payment adjustment factor.

The rule finalized the use of a three-year period to account for the influence of social risk factors on the excess readmissions ratio. So, the proportion of dual-eligible patients is measured over the full period when they influence the likelihood of excess readmissions. The rule also finalized the definition of dual proportion. The numerator, full-benefit duals, was defined as the full-benefit dual eligibles, and the denominator, total number of Medicare patients, was defined as all Medicare fee-for-service and Medicare Advantage stays.

CMS finalized stratification of hospitals into five peer groups, or quintiles, because it creates the peer groups that accurately reflect the relationship between the proportion of duals in the hospital's population without the disadvantage of holding similar hospitals to different standards that result from establishing a larger number of peer groups.

In developing policy options to achieve the budget neutrality requirement, we analyzed four alternative methodologies for calculating the payment adjustment factors. All four of these considered methodologies satisfy the requirement of budget neutrality. We finalized the approach of using the median excess readmission ratio, ERR, plus neutrality modifier because it substantially reduced this final impact of the program on safety net hospitals. The median ERR was selected as the threshold to assess performance since it represents a consistent standard for the hospital's rank within its peer group. The neutrality modifier was developed to achieve the budget neutrality requirement.

On this slide, you can see how CMS calculates the budget neutrality modifier. The neutrality modifier is calculated by estimating the total Medicare savings across all hospitals under the original method and using the median ERR method in the absence of a modifier. Then it is calculated using a multiplicative factor that when applied to each hospital's payment adjustment under the median ERR method, it equates a total Medicare savings from that method to total Medicare savings under the original method.

This figure shows how the payment adjustment factors will be calculated starting in fiscal year 2019 under the stratified methodology. Starting in fiscal year 2019, hospital performance will be assessed relative to other hospitals with a similar proportion of dual-eligible patients. As shown in the first two steps of this graphic, CMS stratified hospitals into five peer groups based on their proportion of Medicare fee-for-service and managed care patients who are dually eligible for Medicare and full-benefit Medicaid. Hospital ERRs are calculated based on Medicare fee-for-service claims submitted by the hospital. In Step 3, once hospitals are stratified into peer groups, CMS determines the peer group median ERRs for each of the six measures included in the program. Then in Step 4, hospital performance is assessed relative to the peer group median ERR. An ERR greater than the hospital's peer group median ERR and at least 25 eligible discharges will enter the payment adjustment factor formula for that hospital.

To satisfy the budget neutrality requirement included in the Cures Act, in Step 5, CMS calculates a neutrality modifier to ensure that total Medicare savings under the original methodology is equivalent to total Medicare savings under the stratified methodology. Step 6 shows how CMS calculated the payment reductions under the new stratified methodology. Similar to the original methodology, ERRs enter the payment adjustment factor formula additively. Next, as show in Step 7 for fiscal year 2019, the maximum payment reduction is set at 3 percent, which corresponds to a minimum payment adjustment factor of .97. Finally, in Step 8, the payment adjustment factors are applied to the base operating payment for all Medicare fee-for-service claims hospitals submit for the fiscal year.

On this screen, you can see the payment adjustments formula methodology. The first formula that's shown here is the original fiscal year 2018 methodology used by the program to calculate payment adjustment factors. The second formula shows how the finalized approach will change the original formula for calculating payment adjustment factors. This method uses the median ERR plus neutrality modifier approach and uses the median ERR for the hospital's peer group in place

of 1.0 in the payment adjustment formula and applies a uniform modifier to maintain budget neutrality.

The table shows the financial impact on hospitals under the original methodology and the financial impact of the finalized changes to the payment adjustment formula. It shows the share of payment adjustments as a percentage of total payments under the original program methodology and the methodology finalized in the IPPS rule beginning fiscal year 2019. Since there are fewer safety net than non-safety net hospitals, as safety net is defined as hospitals in the top quintile of DSH patient percentage, the total Medicare savings for non-safety net hospitals are inherently much larger than for safety net hospitals. Therefore, to compare the financial impact of the program on hospitals in each group, we calculated the payment adjustment of the proportion of DRG payments. Using this metric allows comparison across the different methodologies, where the total base operating DRG payments are different between different groups of hospitals, and is a more accurate indication of the financial impact on the group. For example, under the original methodology using the fiscal year 2017 performance period, the payment adjustment as a proportion of all DRG payments amongst safety net hospitals is .64 percent. As shown in this table, the median ERR plus neutrality modifier substantially reduces the penalty of the share of total payments when calculated among discharges from both the fiscal year 2017 and fiscal year 2018 performance periods. Under the fiscal year 2017 performance period, the median ERR plus neutrality modifier reduces the penalty from .64 percent to .55 percent with quintile peer groups for safety net hospitals while not disproportionately increasing the payment reduction amount for non-safety net hospitals (from .61percent to .63 percent as a share of total payments). For the fiscal year 2018 period, the median plus neutrality modified approach reduces the penalty for safety net hospitals from .63 percent to .54 percent while the increase for non-safety net hospitals is from .63 percent to .65 percent.

In order to provide hospitals with additional information, CMS will distribute hospital-specific reports to hospitals via secure file transfer

during the first quarter of 2018. The fiscal year 2018 reporting period data will be used along with the new methodology to simulate hospital results. The reports will include the hospital's peer group assignment, payment adjustment factor, and ERR results. This report will not reflect actual payment adjustments for fiscal year 2019. The goal of these reports is to provide hospitals with an early look at what impact the methodology changes could have on their hospital in fiscal year 2019.

And on this slide, we can see additional resources on reducing hospital readmissions. And now, I will turn things over to [Bethany Wheeler].

Bethany Wheeler: Thank you. I want to thank everyone for joining today's presentation. I also want to thank you for being such a great interactive audience. We always receive such good questions from you all. Although we don't have time for questions today, we will still answer all of your applicable questions and post them to a Question and Answer transcript on the qualityreportingcenter.com website. Again, that's qualityreportingcenter.com.

Before we adjourn today, I would like you to know of an upcoming webinar that may be of interest. On September 12, CMS will be providing a webinar regarding the finalized policies from the fiscal year 2018 IPPS final rule specific to the eCQMs included in the Hospital IQR Program and the EHR Incentive Program. The webinar will start 2:00 p.m. Eastern Time. Please visit the qualityreportingcenter.com website for additional registration information. I would also like to announce that participants in today's webinar will be eligible to receive one Continuing Education Credit. For more information on obtaining that credit, please see the last few slides in this slide deck. I want to thank you all again for joining today, and I want to thank the presenters for all the valuable information that they presented today. Thank you all, and have a great rest of your day.