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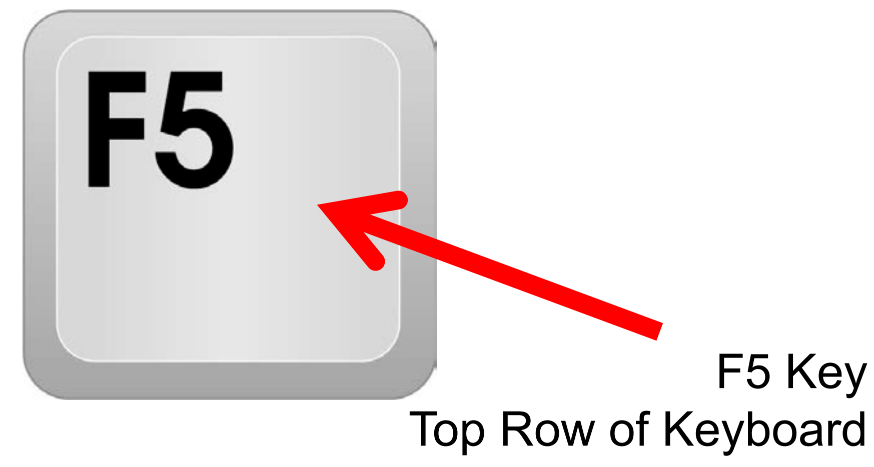

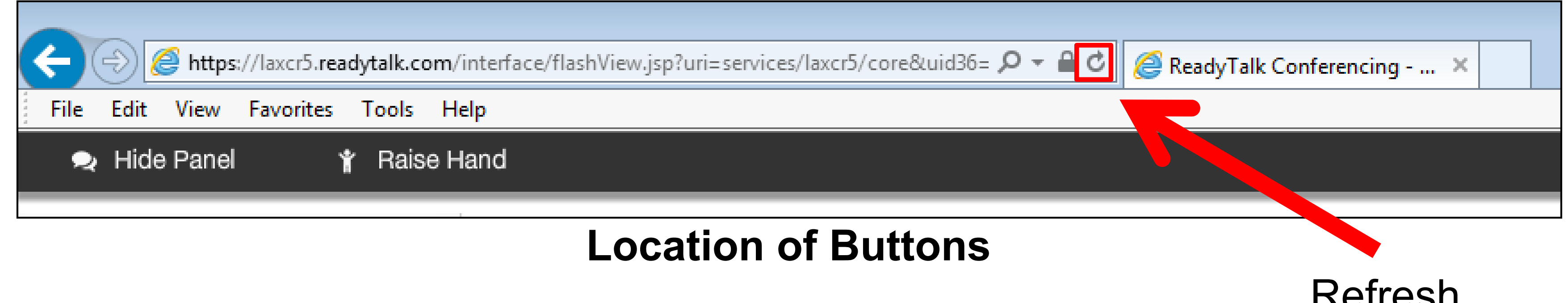

Location of Buttons

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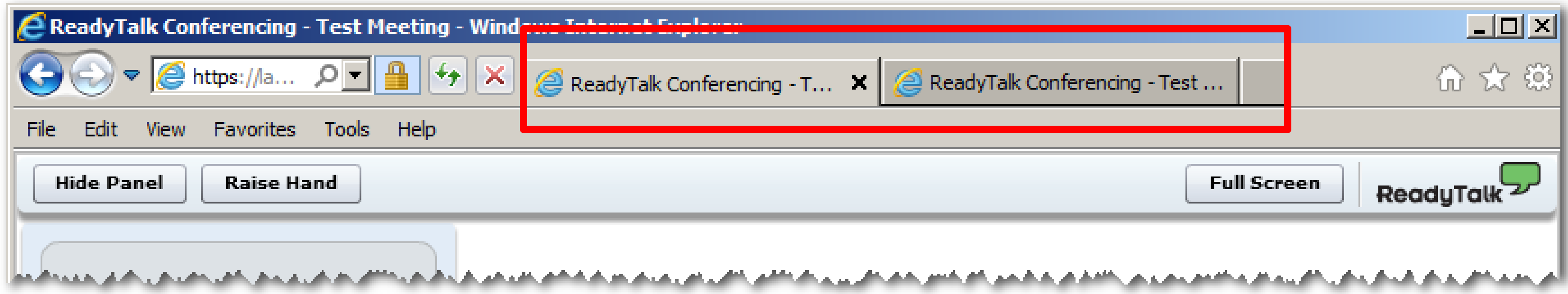
- Close all but one browser/tab and the echo will clear.



Example of Two Browsers/Tabs open in Same Event

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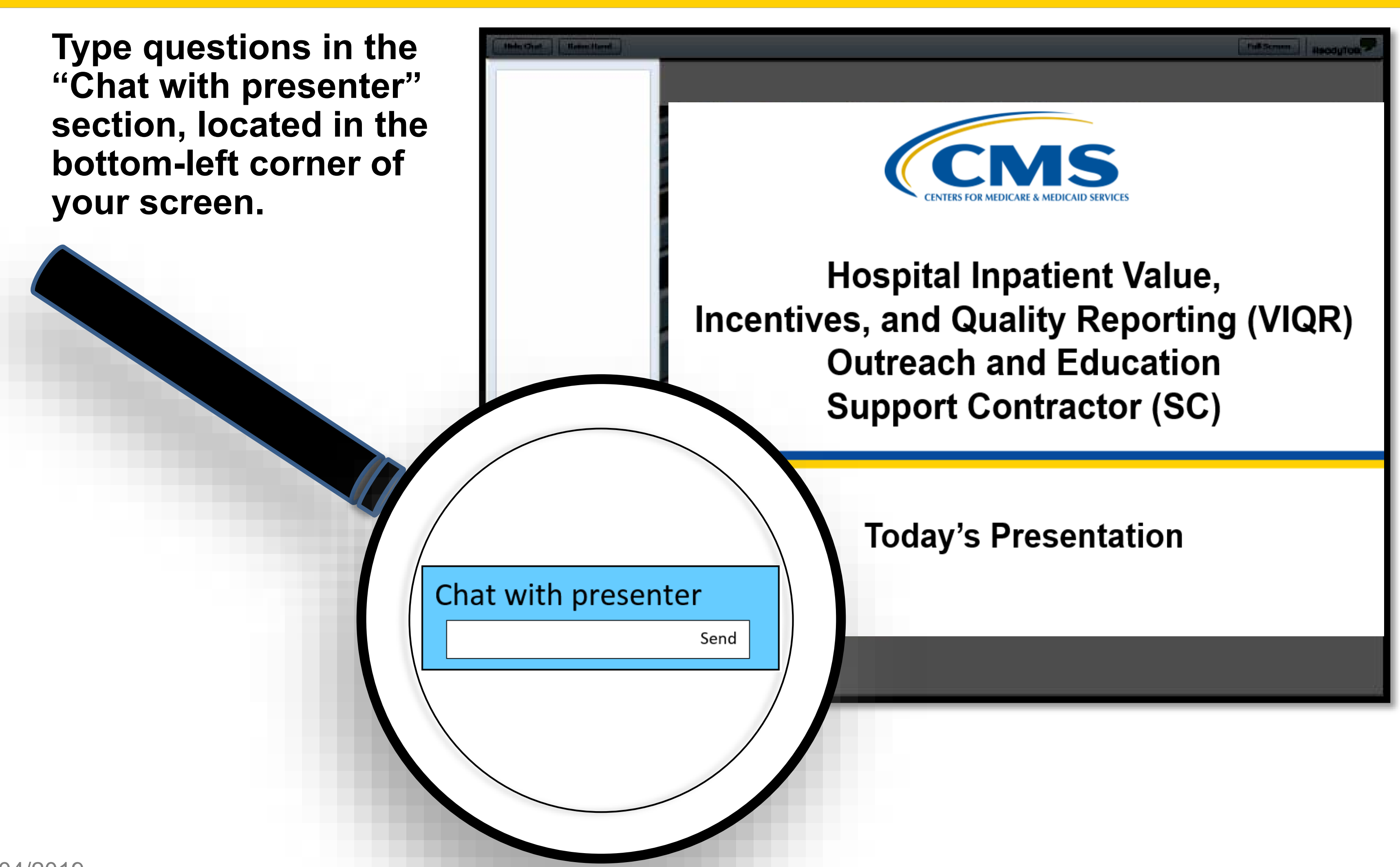


Traveling the Road to Success: Navigating the FY 2021 Hospital VBP Program

Bethany Bunch, MSHA
Hospital Value-Based Purchasing (VBP) Program Support Contract Lead
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)

Maria Gugliuzza, MBA
Outreach and Education Lead
Hospital Inpatient VIQR Outreach and Education SC

April 4, 2019
2 p.m. ET

Purpose

This event will provide an overview of the fiscal year (FY) 2021 Hospital VBP Program, including the following:

- Evaluation criteria for hospitals within each domain and measure
- Eligibility requirements
- Explanation of the scoring methodology

Objectives

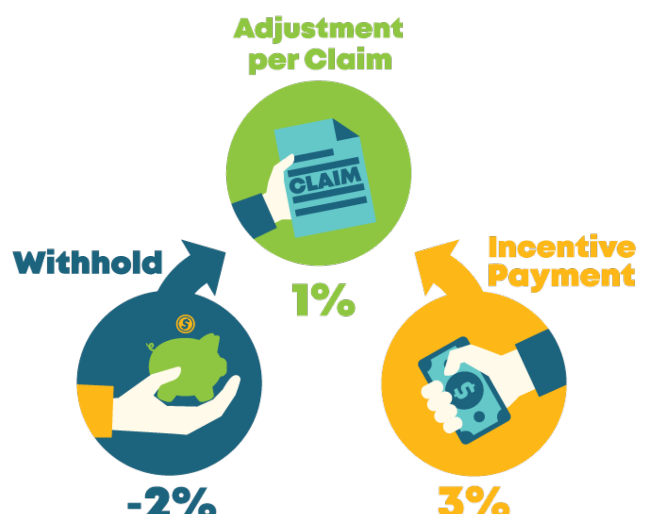
Participants will be able to:

- Identify how hospitals will be evaluated within each domain and measure.
- Recognize changes in the Hospital VBP Program based on the latest final rule.
- Explain the eligibility requirements for the Hospital VBP Program.
- Interpret the scoring methodology used in the Hospital VBP Program.

Hospital VBP Program Introduction

The Hospital VBP Program is a quality incentive program.

- Set forth under Section 1886(o) of the Social Security Act
- When selecting new measures for the Hospital VBP Program, the measure must have been originally specified under the Hospital IQR Program
- CMS will refrain from beginning the performance period for any new measure until the data on that measure have been posted on *Hospital Compare* for at least one year
- Ties hospital reimbursement based on the *quality* of care, not just the *quantity* of inpatient acute care services provided
- Funded by a **2.00%** reduction from participating hospitals' base operating Medicare Severity (MS) Diagnosis-Related Group (DRG) payments for FY 2021



Hospital VBP Program Eligibility

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. This excludes the following:

- Hospitals and hospital units excluded from the inpatient prospective payment system (IPPS)
- Hospitals subject to payment reductions under the Hospital 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

Note: Hospitals excluded from the Hospital VBP Program will **not** have 2.00% withheld from their base operating MS-DRG payments and will not be eligible to receive incentive payments in Fiscal Year 2021.

FY 2021 Domain Weights and Measures

Safety

1. **CDI**: *Clostridium difficile* Infection
2. **CAUTI**: Catheter-Associated Urinary Tract Infection
3. **CLABSI**: Central Line-Associated Bloodstream Infection
4. **MRSA**: Methicillin-Resistant *Staphylococcus aureus* Bacteremia
5. **SSI**: Surgical Site Infection Colon Surgery & Abdominal Hysterectomy

Clinical Outcomes

1. **MORT-30-AMI**: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
2. **MORT-30-HF**: Heart Failure (HF) 30-Day Mortality Rate
3. **MORT-30-COPD**: Chronic Obstructive Pulmonary Disease 30-Day Mortality Rate
4. **MORT-30-PN**: Pneumonia (PN) 30-Day Mortality Rate, Updated Cohort
5. **COMP-HIP-KNEE**: Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate

Domain Weights

25%
25%
25%
25%

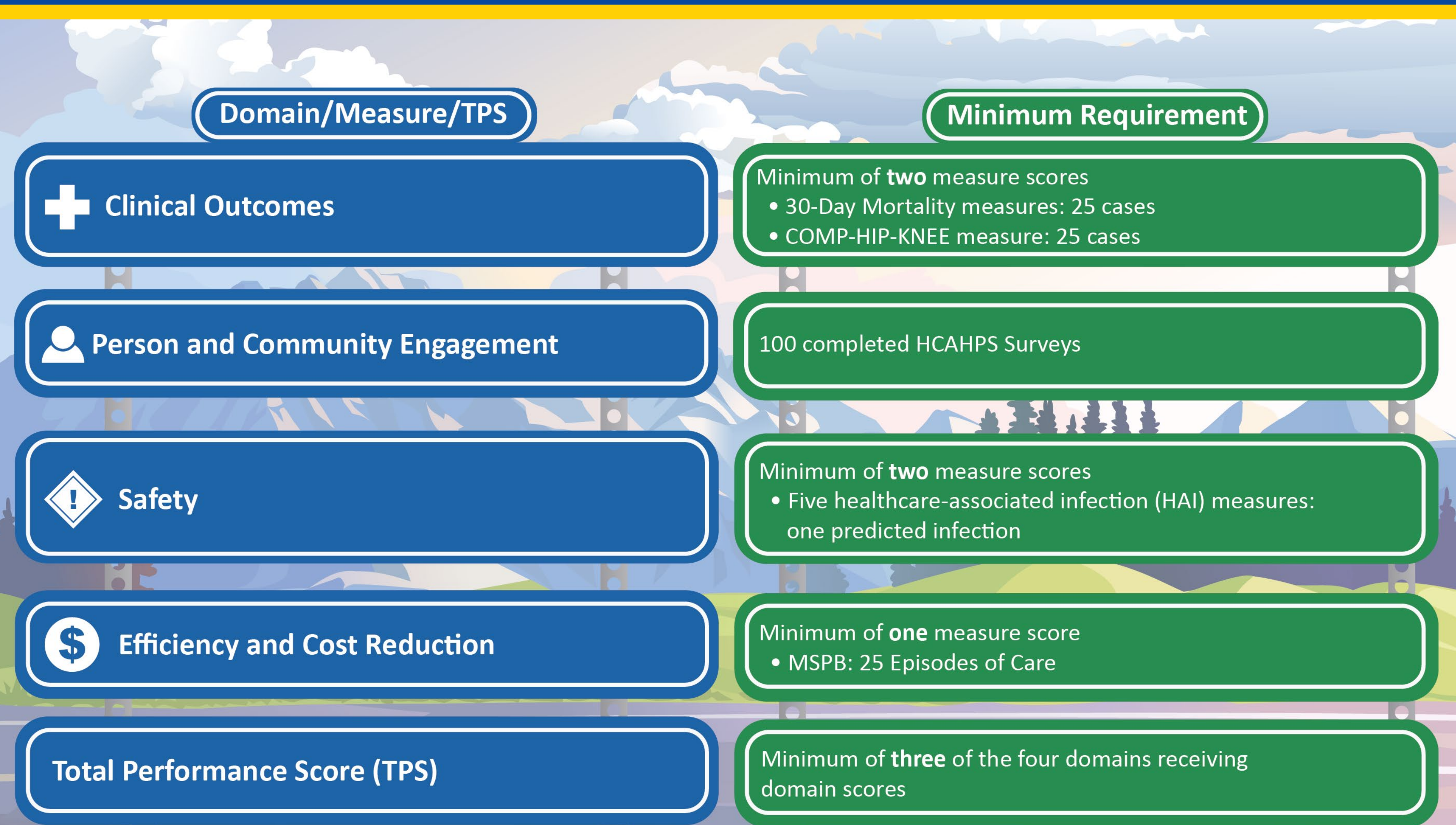
Efficiency and Cost Reduction

1. **MSPB**: Medicare Spending per Beneficiary

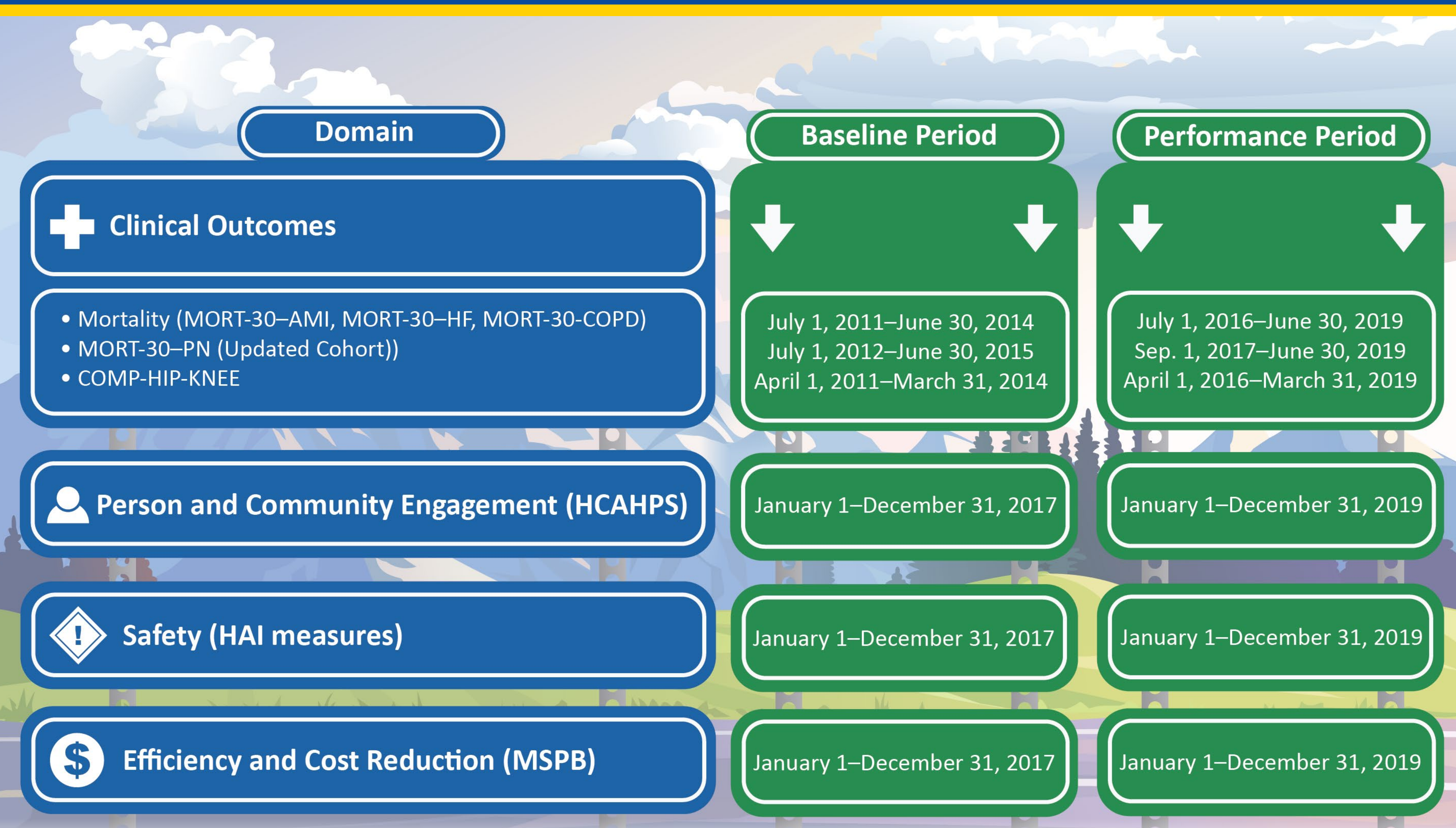
Person and Community Engagement

1. **Hospital Consumer Assessment of Healthcare Providers and Systems Survey Dimensions (HCAHPS)**
   - Communication with Nurses
   - Communication with Doctors
   - Responsiveness of Hospital Staff
   - Communication about Medicines
   - Cleanliness and Quietness of Hospital Environment
   - Discharge Information
   - Care Transition
   - Overall Rating of Hospital

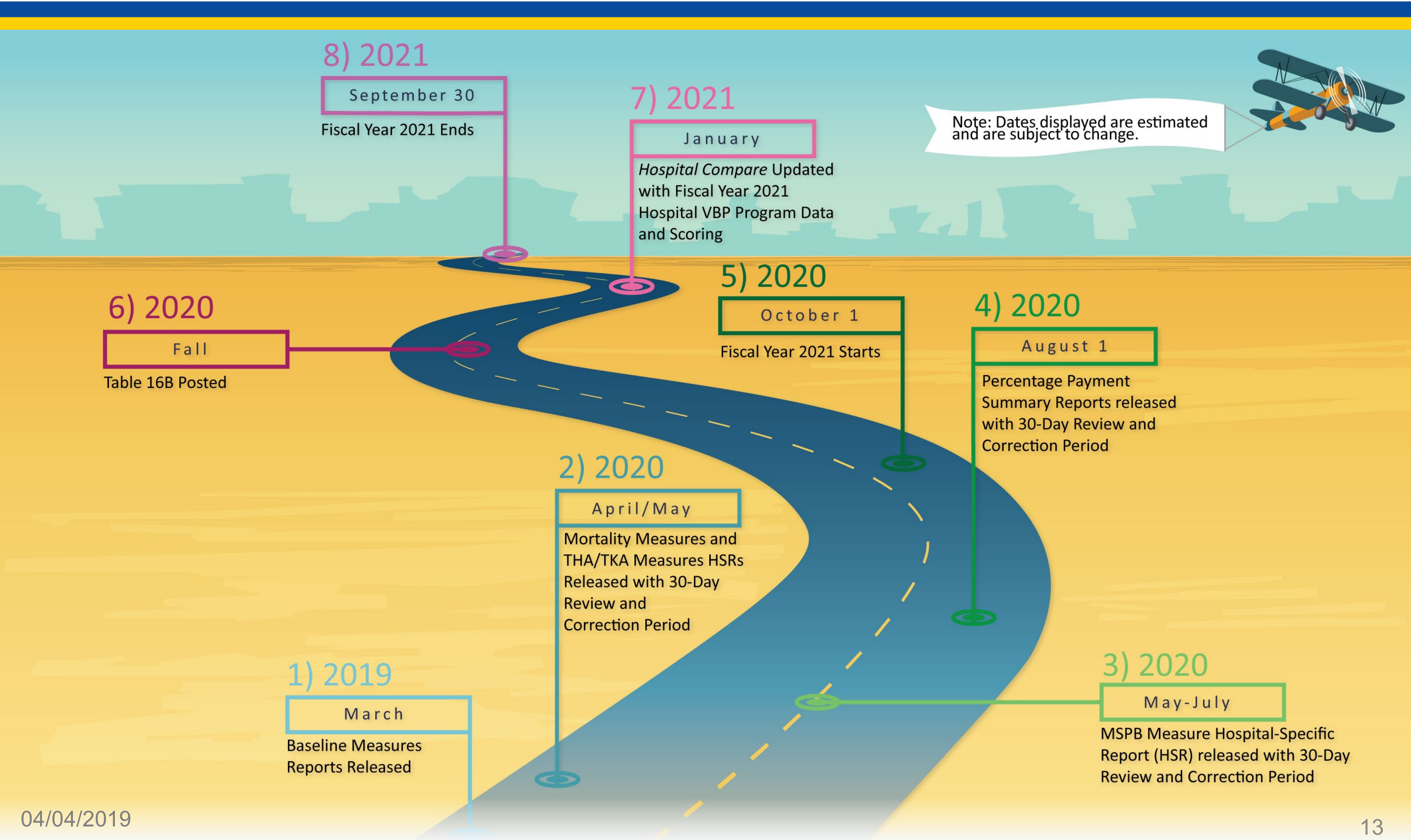
Summary of Minimum Data Requirements



Baseline and Performance Periods For FY 2021



FY 2021 Timeline



Evaluating Hospitals: Performance Standards

Benchmark: Average (mean) performance of the top 10% of hospitals

Achievement Threshold: Performance at the 50th percentile (median) of hospitals during the Baseline Period

Note: MSPB uses Performance Period data to calculate the benchmark and achievement threshold, not Baseline Period data like other measures.

Evaluating Hospitals: FY 2021 Performance Standards

Safety (25%)

Measures (Healthcare-Associated Infections)	Threshold	Benchmark
↓CLABSI	0.687	0.000
↓CAUTI	0.774	0.000
↓SSI: Colon	0.754	0.000
↓SSI: Abdominal Hysterectomy	0.726	0.000
↓MRSA	0.763	0.000
↓CDI	0.748	0.067

Clinical Outcomes (25%)

Measures	Threshold	Benchmark
MORT-30-AMI	0.860355	0.879714
MORT-30-HF	0.883803	0.906144
MORT-30-COPD	0.923253	0.938664
MORT-30-PN Updated Cohort	0.836122	0.870506
↓COMP-HIP-KNEE	0.031157	0.022418

Efficiency and Cost Reduction (25%)

Measures	Threshold	Benchmark
↓MSPB	Median Medicare Spending per Beneficiary ratio across all hospitals during the performance period	Mean of lowest decile of Medicare Spending per Beneficiary ratios across all hospitals during the performance period

Person and Community Engagement (25%)

	HCAHPS Performance Standards		
HCAHPS Survey Dimensions	Floor (%)	Threshold (%)	Benchmark(%)
Communication with Nurses	42.06	79.06	87.36
Communication with Doctors	41.99	79.91	88.10
Responsiveness of Hospital Staff	33.89	65.77	81.00
Communication about Medicines	33.19	63.83	74.75
Hospital Cleanliness and Quietness	30.60	65.61	79.58
Discharge Information	66.94	87.38	92.17
Care Transition	6.53	51.87	63.32
Overall Rating of Hospital	34.70	71.80	85.67

Evaluating Hospitals: Higher Performance Rates

A higher rate is better for the following domains/measures/dimensions:

- Clinical Outcomes
  (30-Day Mortality measures)*
- Person and Community Engagement

Benchmark
(Average of the Best 10%)

Achievement Threshold
(50th Percentile)

* The 30-Day Mortality measures are reported as survival rates; therefore, higher values represent a better outcome.

Evaluating Hospitals: Lower Performance Rates

A <u>lower</u> rate is better for the following domains/measures:

- Clinical Outcomes
  - COMP-HIP-KNEE
- Safety
  - HAI measures
- Efficiency and Cost Reduction
  - MSPB

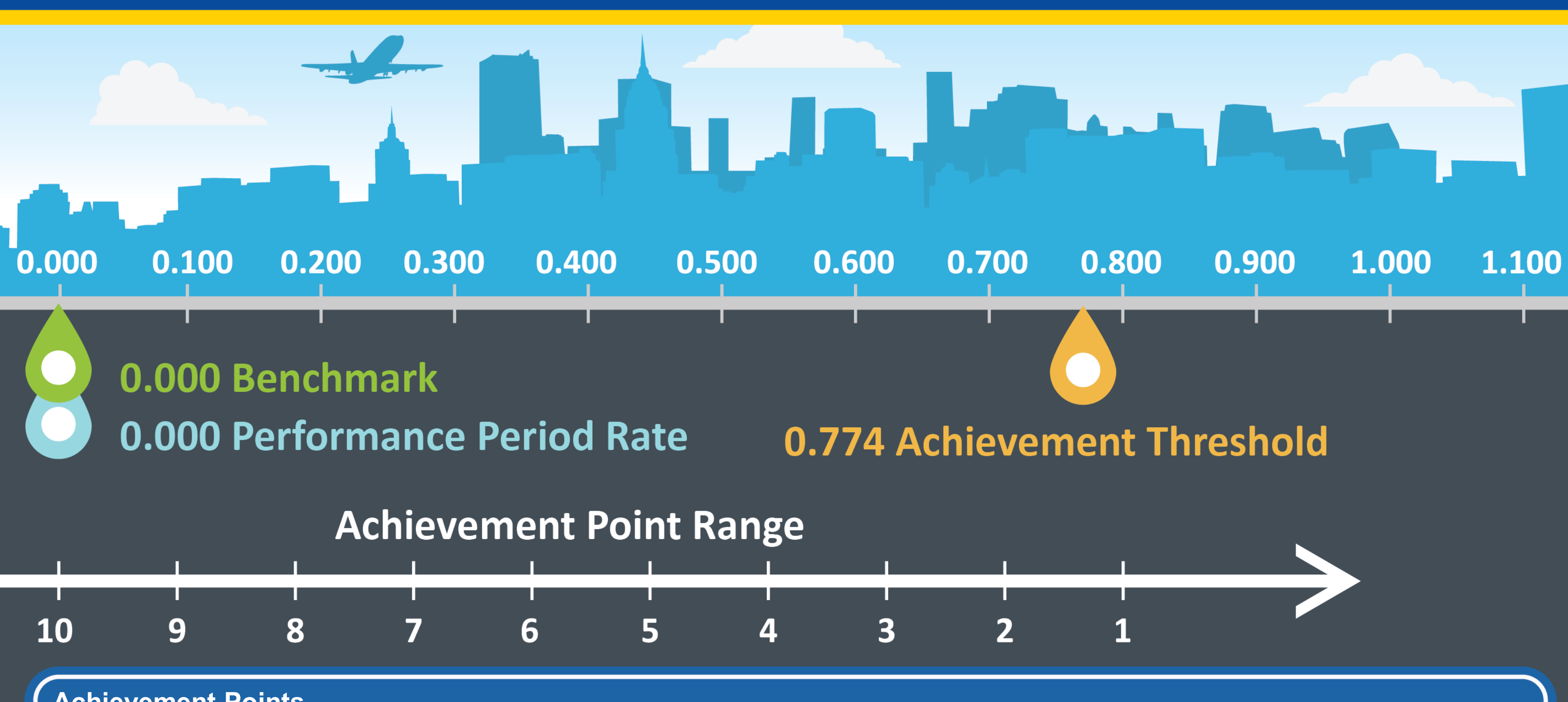
Note: MSPB uses Performance Period data to calculate the benchmark and achievement threshold, not Baseline Period data like other measures.

Achievement Points

Achievement points are awarded by comparing a hospital's rates during the Performance Period with all hospitals' rates from the Baseline Period.

- Rate at or better than the benchmark (10 points)
- Rate worse than the achievement threshold (0 points)
- Rate somewhere at or better than the threshold but worse than the benchmark (1–9 points)

Achievement Points Example



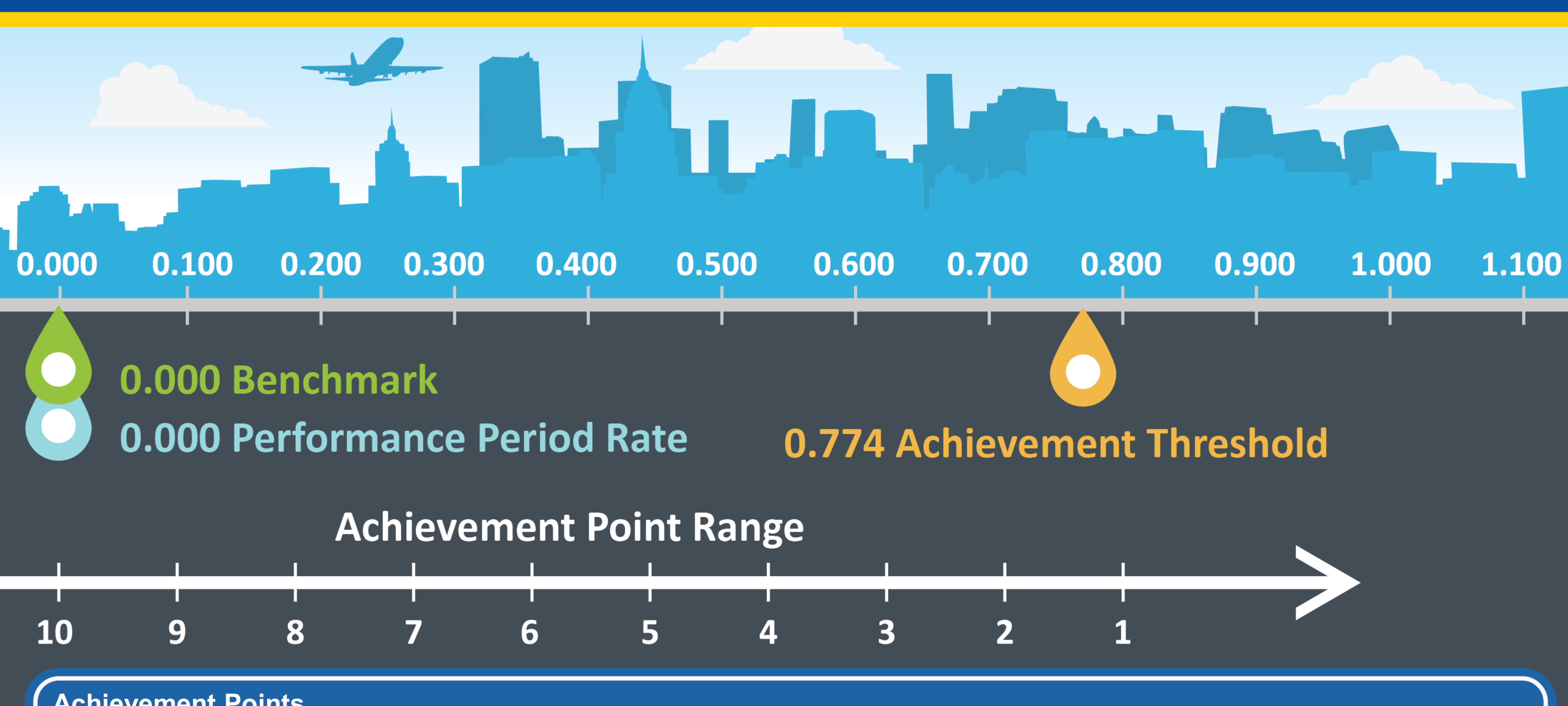
Achievement Points

Awarded by comparing a hospital's rates during the Performance Period with all hospitals' rates from the Baseline Period

- Rate at or better than the Benchmark (10 points)
- Rate worse than the Achievement Threshold (0 points)
- Rate somewhere at or better than the Threshold but worse than the Benchmark (1–9 points)

CAUTI Achievement Point Example

Achievement Points Example



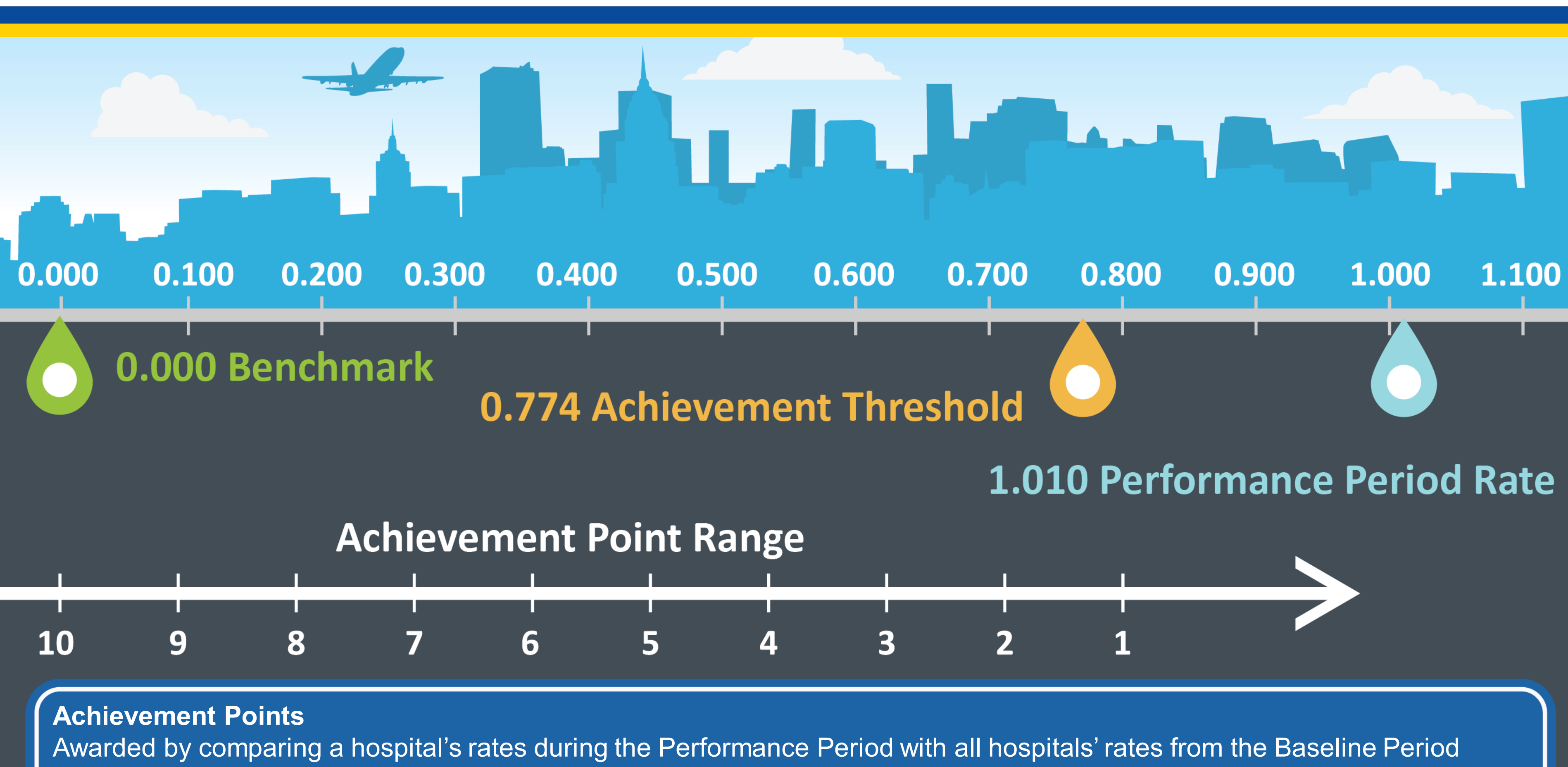
Achievement Points
Awarded by comparing a hospital's rates during the Performance Period with all hospitals' rates from the Baseline Period

- **Rate at or better than the Benchmark (10 points)**
- Rate worse than the Achievement Threshold (0 points)
- Rate somewhere at or better than the Threshold but worse than the Benchmark (1–9 points)

Achievement Points = 10

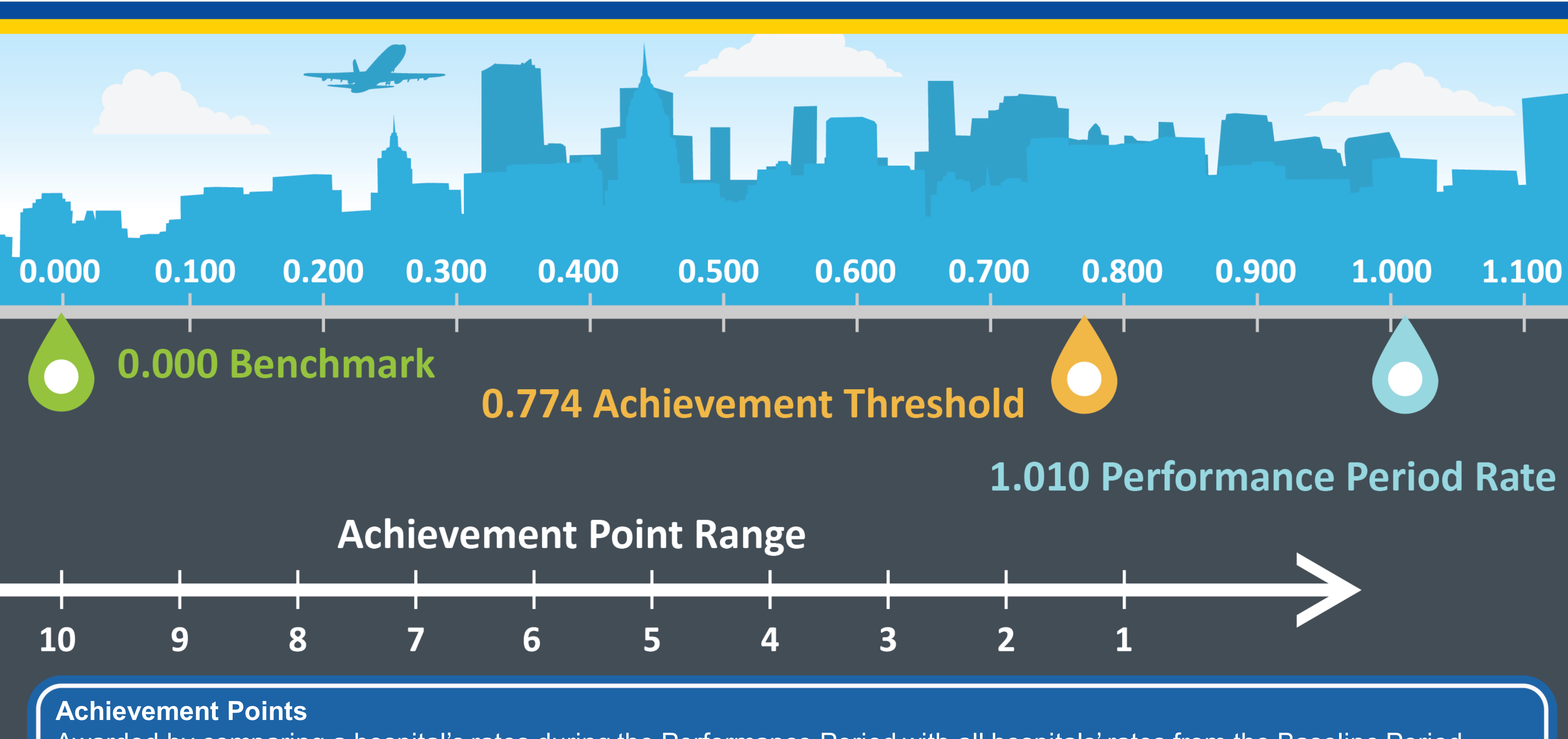
CAUTI Achievement Point Example

Achievement Points Example



CAUTI Achievement Point Example

Achievement Points Example



Achievement Points

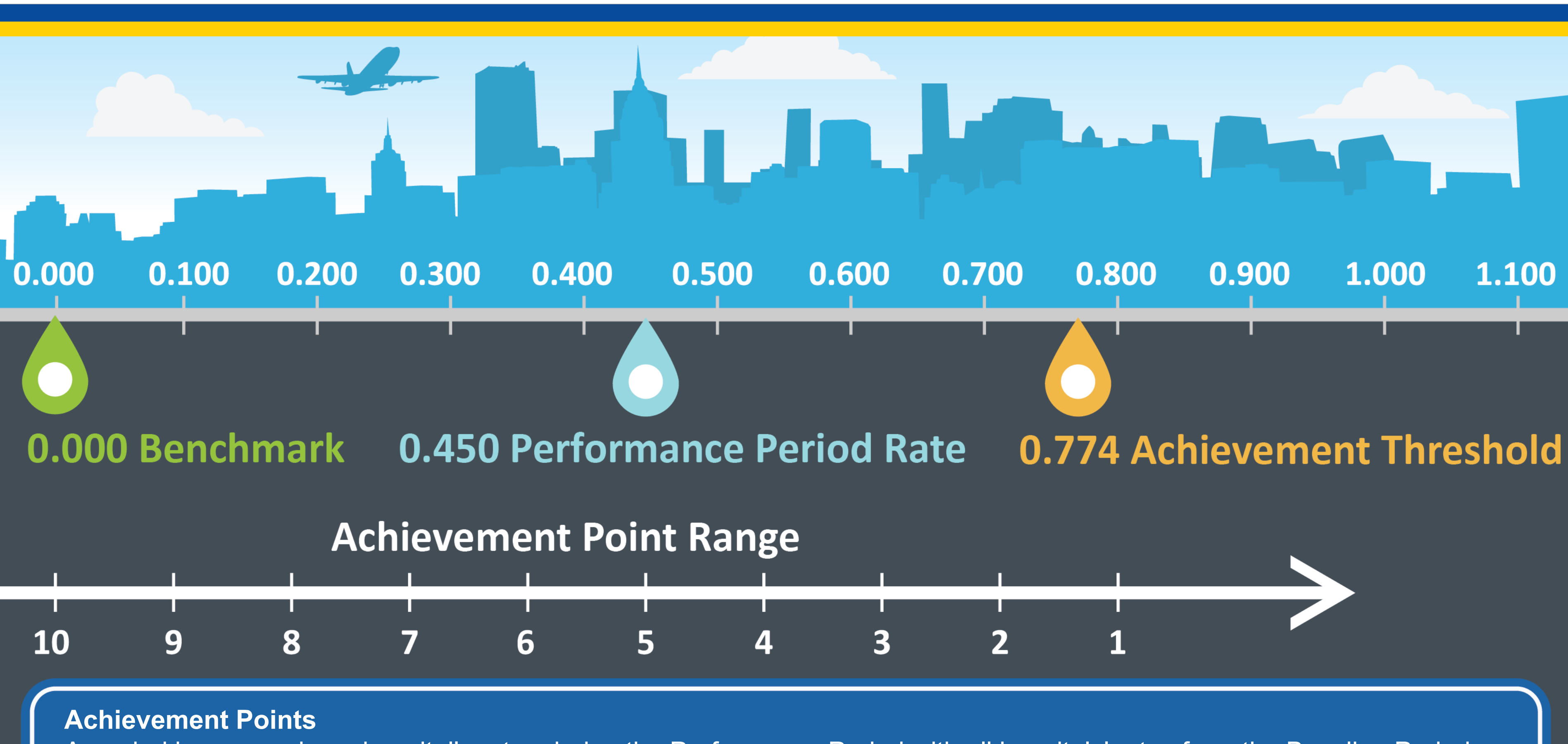
Awarded by comparing a hospital's rates during the Performance Period with all hospitals' rates from the Baseline Period

- Rate at or better than the Benchmark (10 points)
- **Rate worse than the Achievement Threshold (0 points)**
- Rate somewhere at or better than the Threshold but worse than the Benchmark (1–9 points)

Achievement Points = 0

CAUTI Achievement Point Example

Achievement Points Example

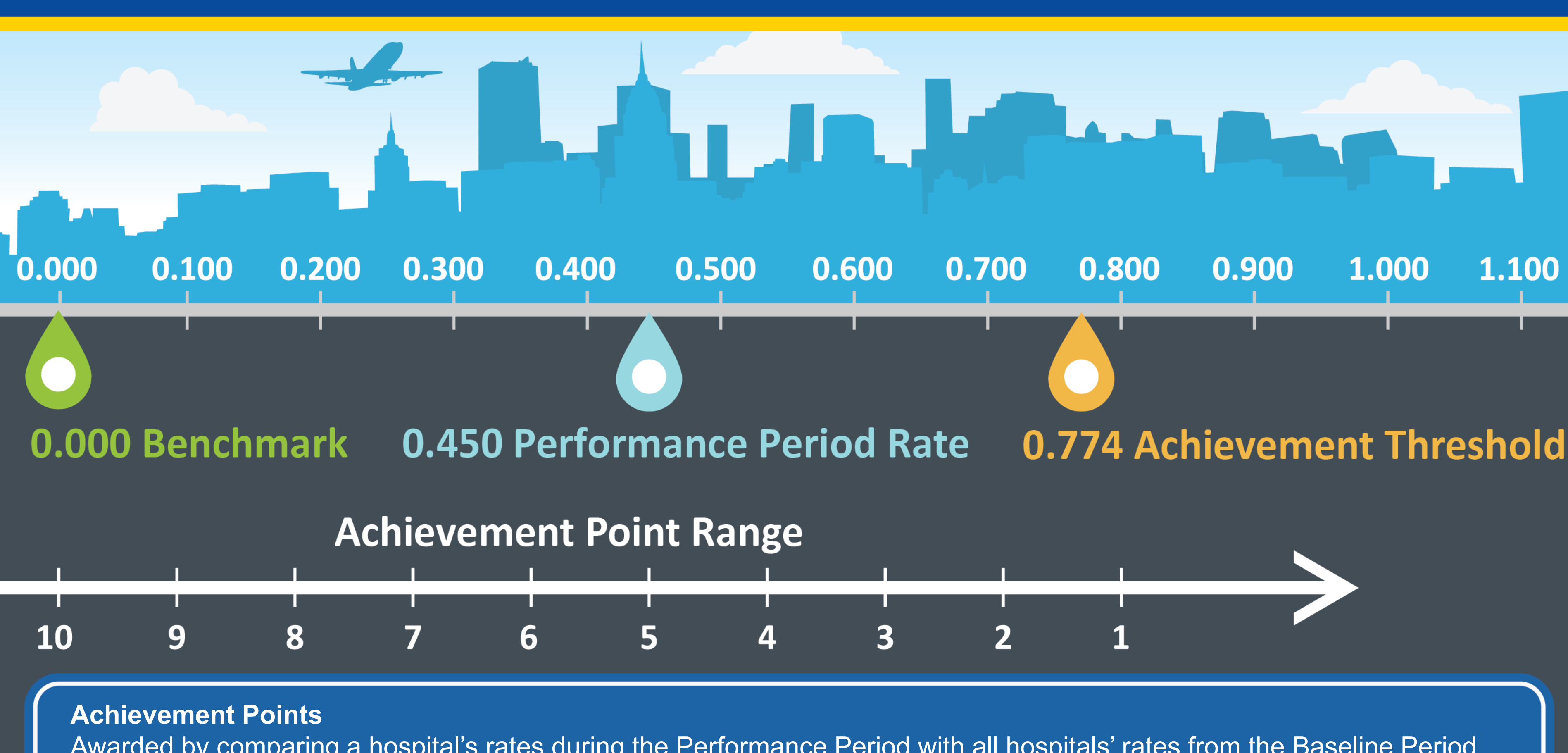


Achievement Points
Awarded by comparing a hospital's rates during the Performance Period with all hospitals' rates from the Baseline Period

- Rate at or better than the Benchmark (10 points)
- Rate worse than the Achievement Threshold (0 points)
- Rate somewhere at or better than the Threshold but worse than the Benchmark (1–9 points)

CAUTI Achievement Point Example

Achievement Points Example



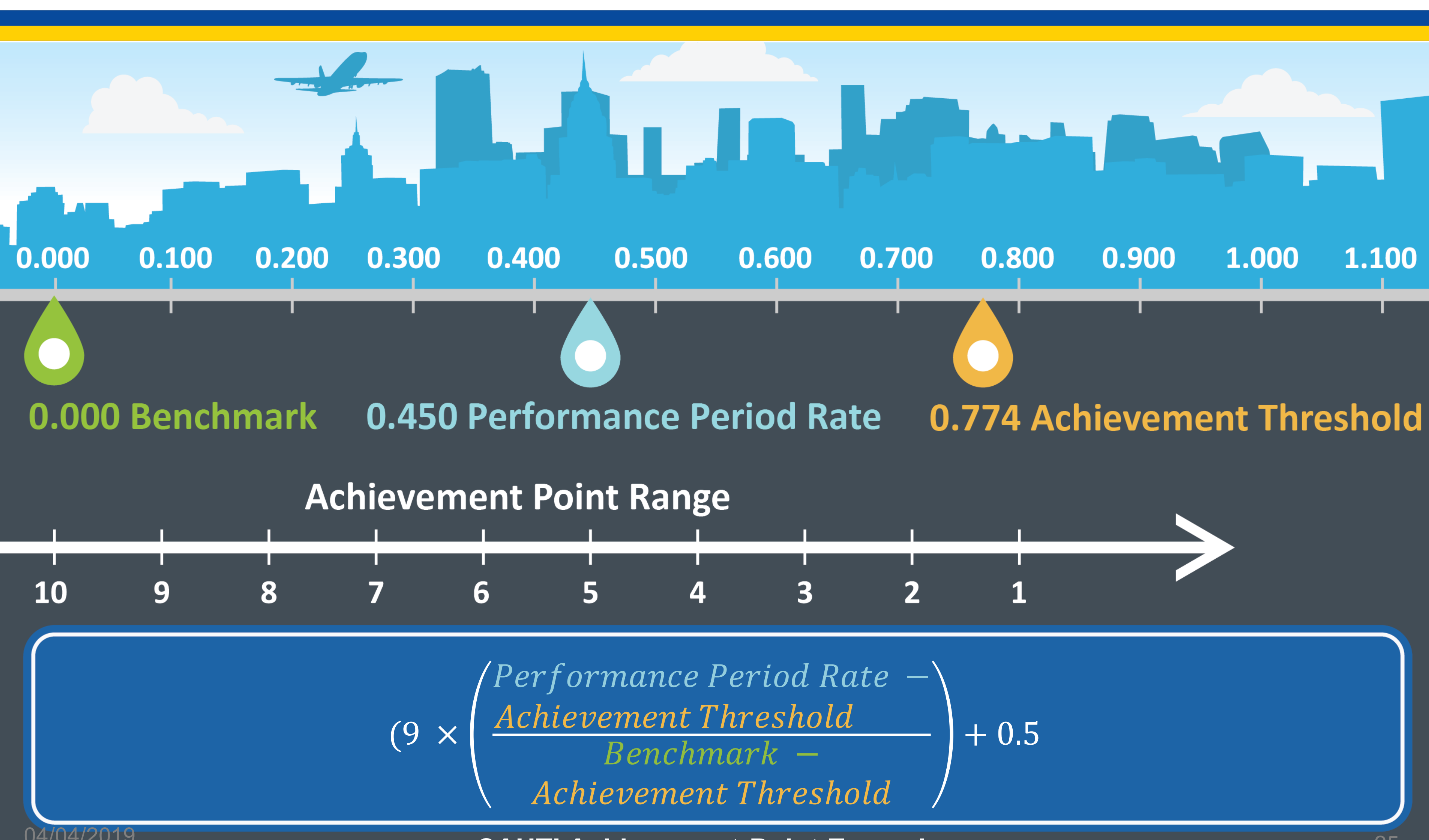
Achievement Points

Awarded by comparing a hospital's rates during the Performance Period with all hospitals' rates from the Baseline Period

- Rate at or better the Benchmark (10 points)
- Rate worse than the Achievement Threshold (0 points)
- **Rate somewhere at or better than the Threshold but worse than the Benchmark (1–9 points)**

CAUTI Achievement Point Example

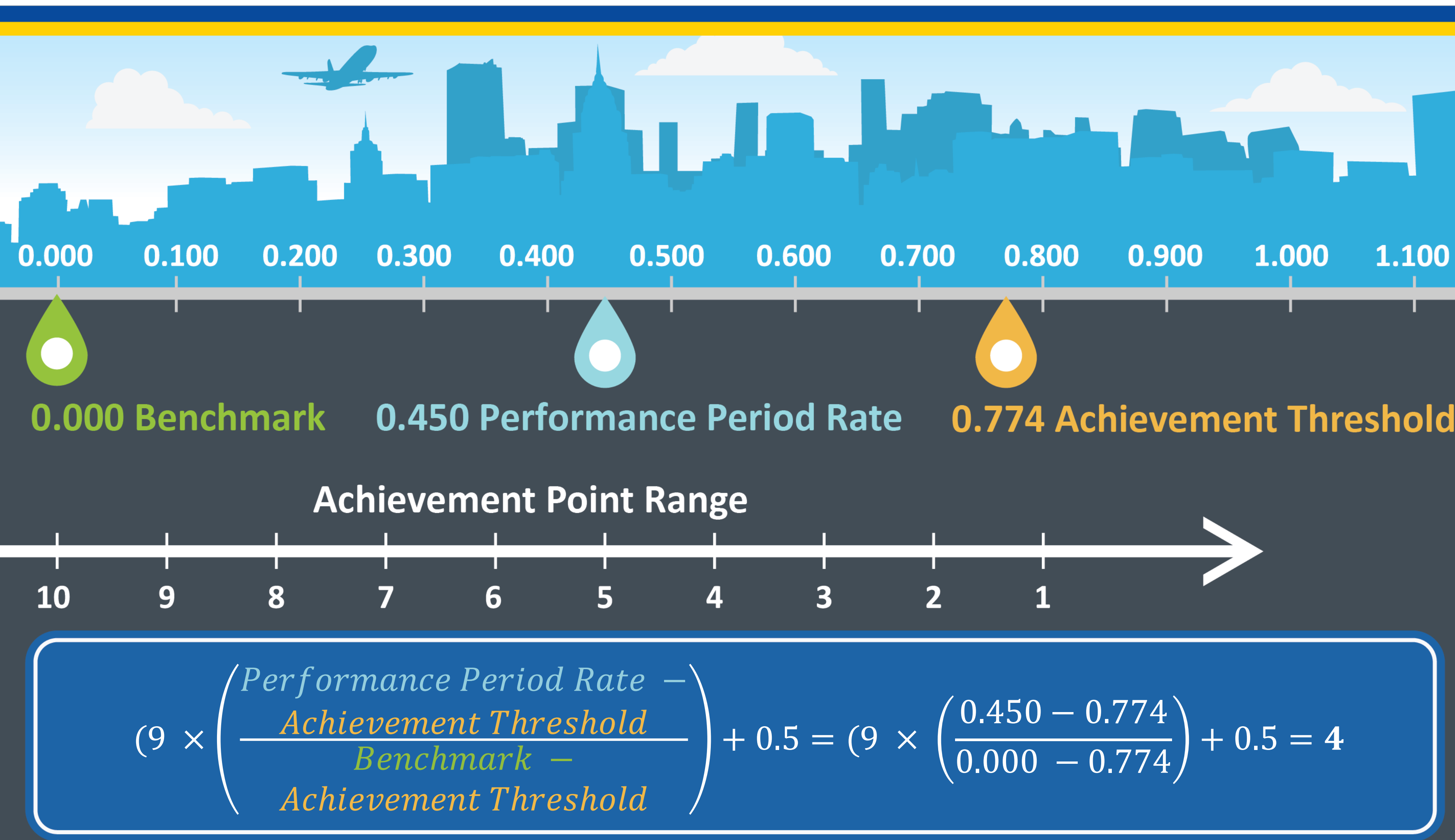
Achievement Points Example



$$\left(9 \times \left(\frac{Performance\ Period\ Rate - Achievement\ Threshold}{Benchmark - Achievement\ Threshold}\right) + 0.5\right)$$

CAUTI Achievement Point Example

Achievement Points Example



$$(9 \times \left(\frac{\textit{Performance Period Rate} - \textit{Achievement Threshold}}{\textit{Benchmark} - \textit{Achievement Threshold}}\right) + 0.5 = (9 \times \left(\frac{0.450 - 0.774}{0.000 - 0.774}\right) + 0.5 = \mathbf{4}$$

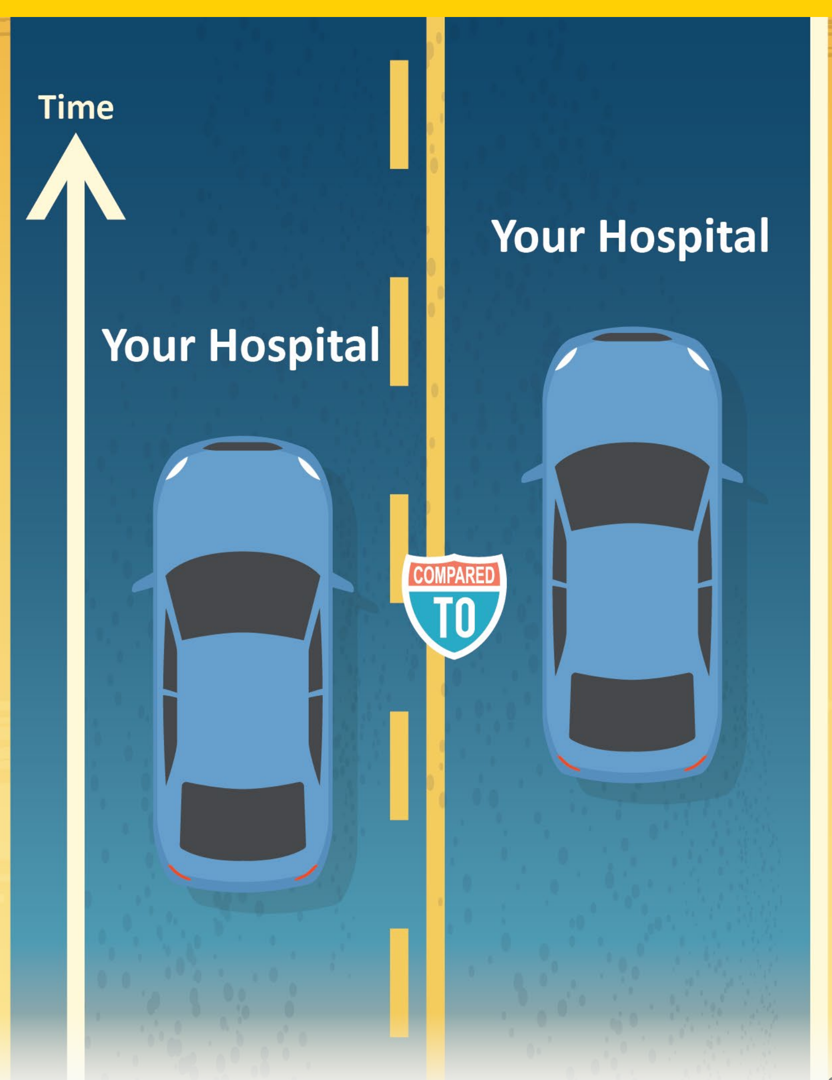
CAUTI Achievement Point Example

Improvement Points

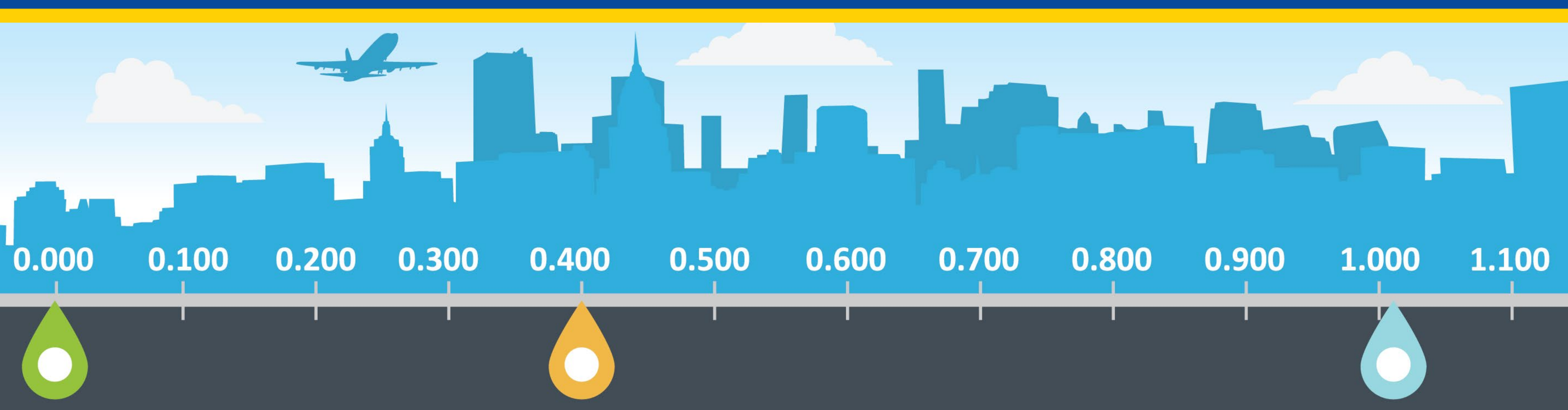
Improvement points are awarded by comparing a hospital's rates during the Performance Period to that same hospital's rates from the Baseline Period.

- Rate at or better than the benchmark (9 points)*
- Rate worse than or equal to Baseline Period rate (0 points)
- Rate between the Baseline Period rate and the benchmark (0–9 points)

* Hospitals with rates at or better than the benchmark, but do not improve from their Baseline Period rate (i.e., have a Performance Period rate worse than the Baseline Period rate), will receive 0 improvement points, as no improvement was actually observed.



Improvement Points Example



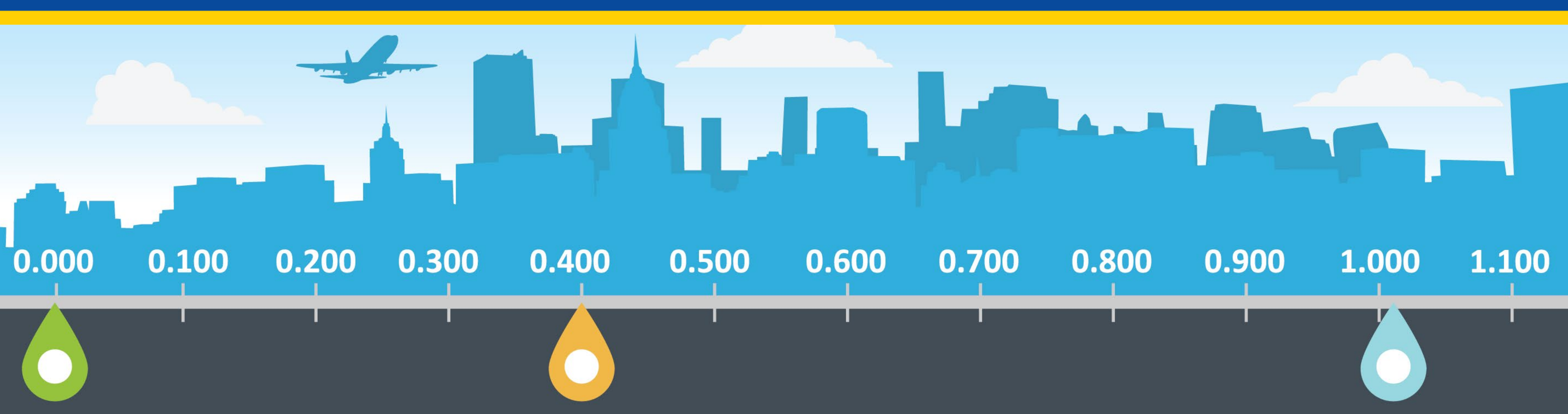
Improvement Points

Awarded by comparing a hospital's rates during the Performance Period to that *same* hospital's rates from the Baseline Period

- Rate at or better than the Benchmark (9 points*)
- Rate worse than or equal to Baseline Period Rate (0 points)
- Rate between the Baseline Period Rate and the Benchmark (0–9 points)

CAUTI Improvement Point Example

Improvement Points Example



0.000 Benchmark

0.400 Baseline Period Rate

1.010 Performance Period Rate

Improvement Points

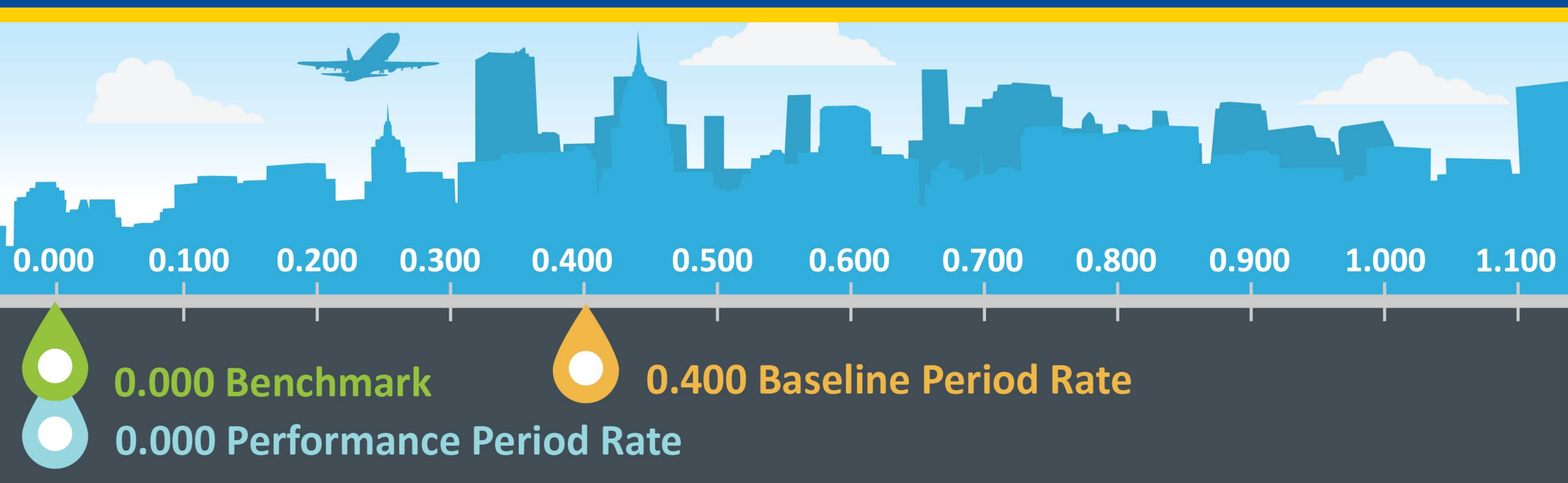
Awarded by comparing a hospital's rates during the Performance Period to that *same* hospital's rates from the Baseline Period

- Rate at or better than the Benchmark (9 points*)
- **Rate worse than or equal to Baseline Period Rate (0 points)**
- Rate between the Baseline Period Rate and the Benchmark (0–9 points)

Improvement Points = 0

CAUTI Improvement Point Example

Improvement Points Example



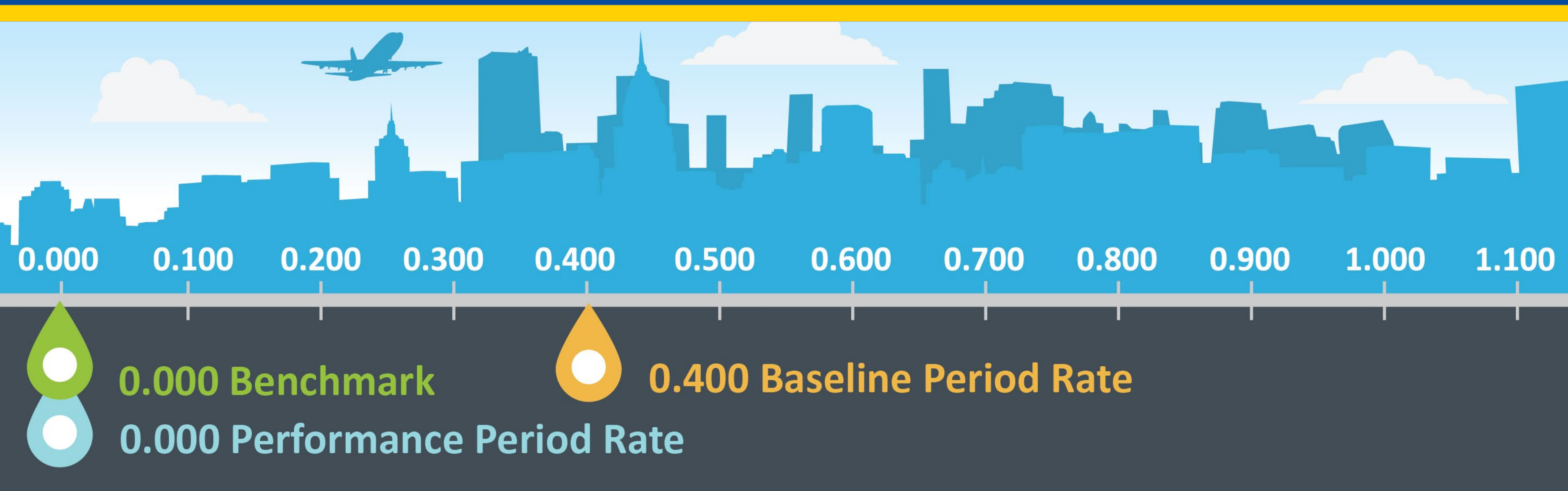
Improvement Points

Awarded by comparing a hospital's rates during the Performance Period to that *same* hospital's rates from the Baseline Period

- Rate at or better than the Benchmark (9 points*)
- Rate worse than or equal to Baseline Period Rate (0 points)
- Rate between the Baseline Period Rate and the Benchmark (0–9 points)

CAUTI Improvement Point Example

Improvement Points Example



Improvement Points

Awarded by comparing a hospital's rates during the Performance Period to that *same* hospital's rates from the Baseline Period

- **Rate at or better than the Benchmark (9 points*)**
- Rate worse than or equal to Baseline Period Rate (0 points)
- Rate between the Baseline Period Rate and the Benchmark (0–9 points)

Improvement Points = 9

CAUTI Improvement Point Example

Improvement Points Example

0.000 0.100 0.200 0.300 0.400 0.500 0.600 0.700 0.800 0.900 1.000 1.100

0.000 Performance Period Rate

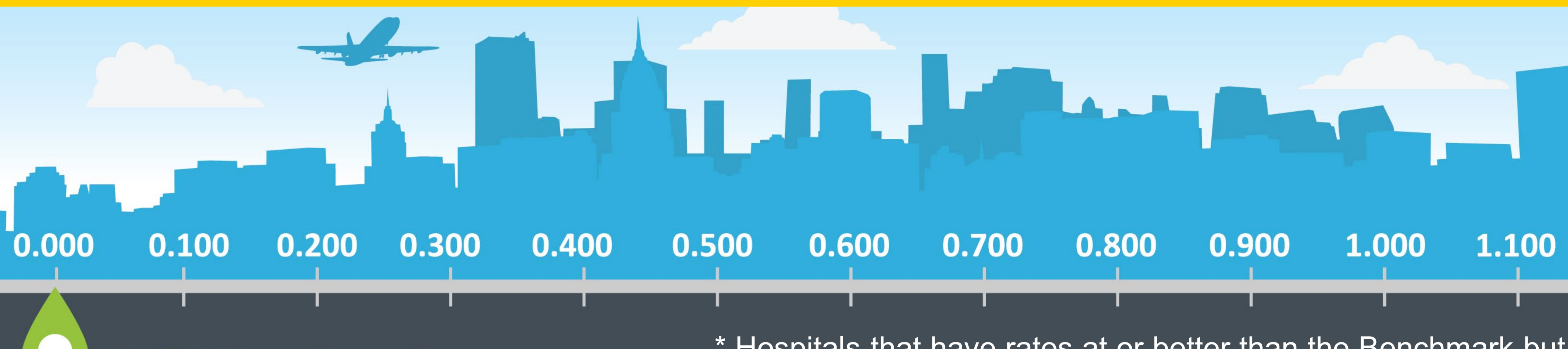
Improvement Points

Awarded by comparing a hospital's rates during the Performance Period to that *same* hospital's rates from the Baseline Period

- Rate at or better than the Benchmark (9 points*)
- Rate worse than or equal to Baseline Period Rate (0 points)
- Rate between the Baseline Period Rate and the Benchmark (0–9 points)

CAUTI Improvement Point Example

Improvement Points Example



0.000 Performance Period Rate

0.000 Baseline Period Rate

* Hospitals that have rates at or better than the Benchmark but do not improve from their Baseline Period rate (that is, have a Performance Period rate worse than the Baseline Period rate) will receive 0 improvement points as no improvement was actually observed.

Improvement Points

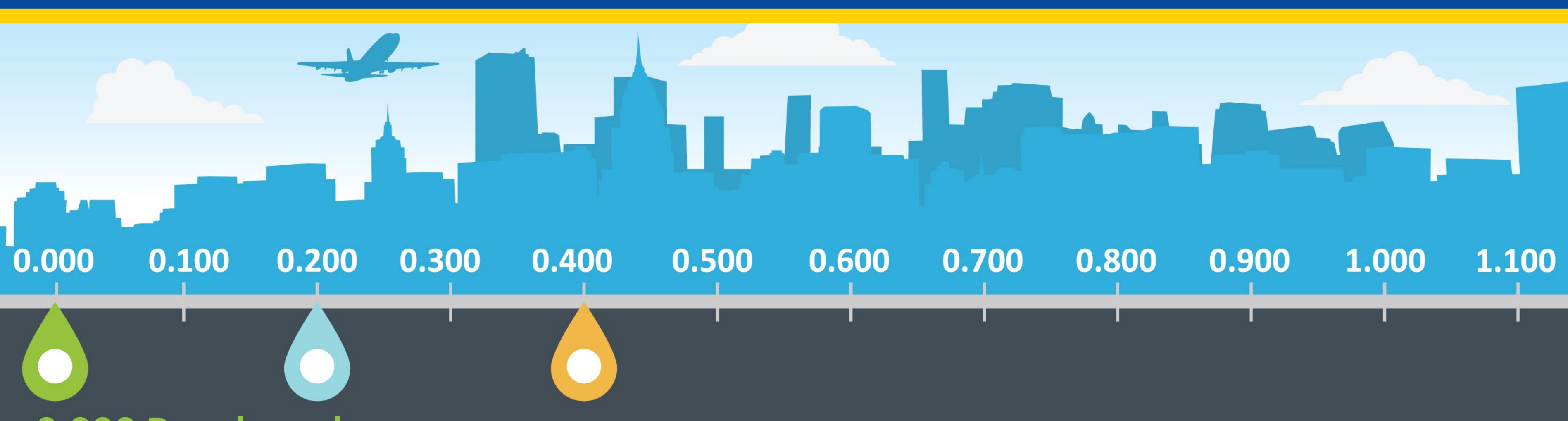
Awarded by comparing a hospital's rates during the Performance Period to that *same* hospital's rates from the Baseline Period

- Rate at or better than the Benchmark (9 points*)
- **Rate worse than or equal to Baseline Period Rate (0 points)**
- Rate between the Baseline Period Rate and the Benchmark (0–9 points)

Improvement Points = 0

CAUTI Improvement Point Example

Improvement Points Example



0.000 Benchmark

0.200 Performance Period Rate

0.400 Baseline Period Rate

Improvement Points

Awarded by comparing a hospital's rates during the Performance Period to that *same* hospital's rates from the Baseline Period

- Rate at or better than the Benchmark (9 points*)
- Rate worse than or equal to Baseline Period Rate (0 points)
- Rate between the Baseline Period Rate and the Benchmark (0–9 points)

CAUTI Improvement Point Example

Improvement Points Example

0.000 Benchmark

0.200 Performance Period Rate

0.400 Baseline Period Rate

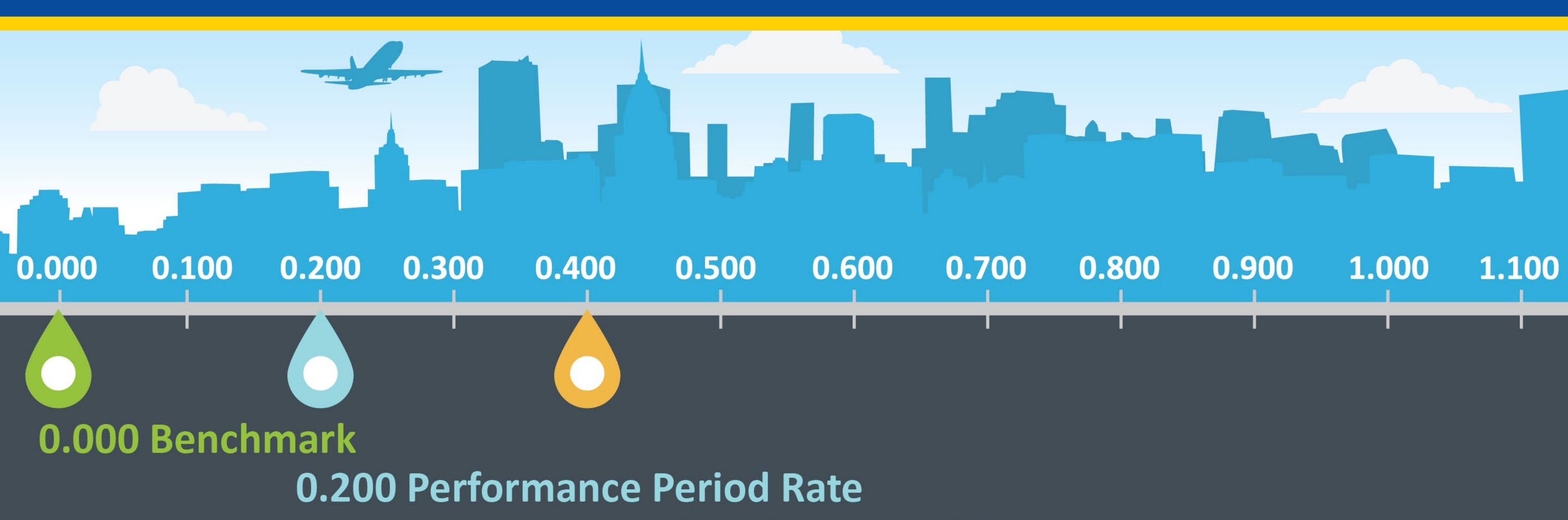
Improvement Points

Awarded by comparing a hospital's rates during the Performance Period to that *same* hospital's rates from the Baseline Period

- Rate at or **better than the Benchmark (*9 points)**
- Rate **worse** than or equal to Baseline Period Rate (0 points)
- **Rate between the Baseline Period Rate and the Benchmark (0–9 points)**

CAUTI Improvement Point Example

Improvement Points Example



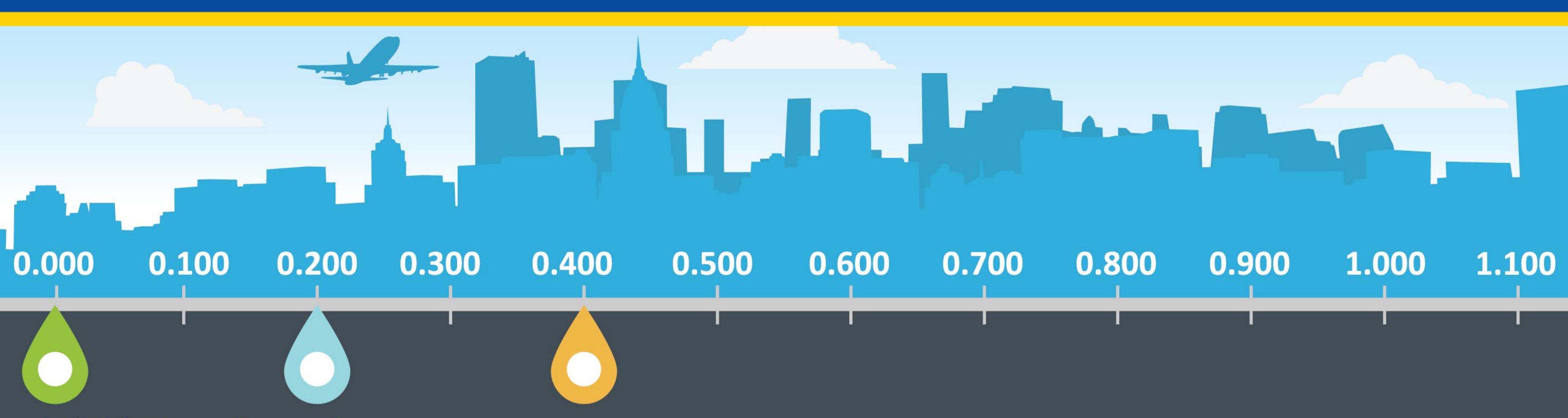
0.000 Benchmark

0.200 Performance Period Rate

0.400 Baseline Period Rate

$$(10 \times \left(\frac{Performance\ Period\ Rate - Baseline\ Period\ Rate}{Benchmark - Baseline\ Period\ Rate} \right) - 0.5$$

Improvement Points Example



0.000 Benchmark

0.200 Performance Period Rate

0.400 Baseline Period Rate

$$\left(10 \times \left(\frac{Performance\ Period\ Rate - Baseline\ Period\ Rate}{Benchmark - Baseline\ Period\ Rate}\right) - 0.5 = \left(10 \times \left(\frac{0.200 - 0.400}{0.000 - 0.400}\right) - 0.5 = \mathbf{5}$$

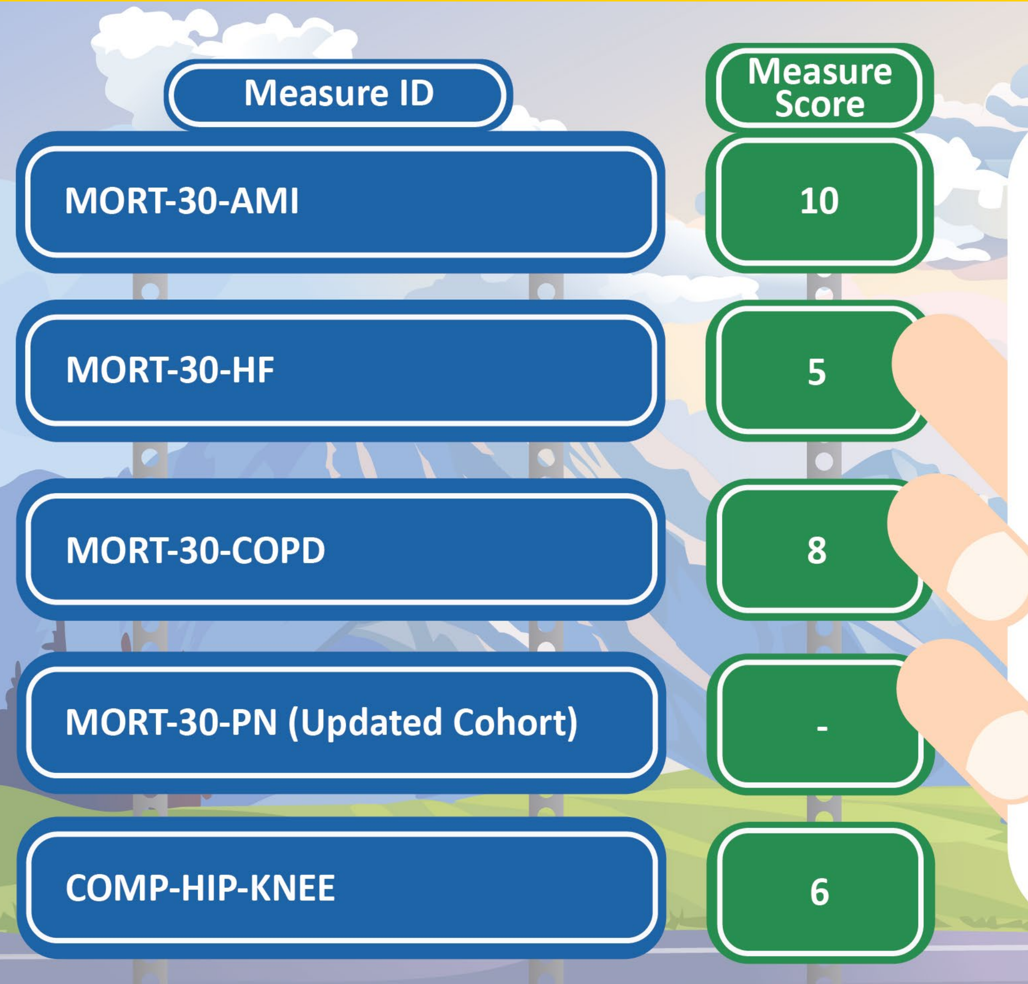
Measure Score

A measure score is the greater of the achievement points and improvement points for a measure.

Example FY 2021 Clinical Outcomes Score Calculations

Measure ID	Achievement Points	Improvement Points	Measure Score
MORT-30-AMI	10	9	10
MORT-30-HF	5	-	5
MORT-30-COPD	8	3	8
MORT-30-PN (Updated Cohort)	-	-	-
COMP-HIP-KNEE	4	6	6

Unweighted Domain Score



Domain Normalization Steps

1. Sum the measure scores in the domain.

   (10+5+8+6) = 29

2. Multiply the eligible measures by the maximum point value per measure (10 points).

   (4 measures x 10 points) = 40

3. Divide the sum of the measure scores (result of step 1) by the maximum points possible (result of step 2).

   (29 ÷ 40) = 0.725

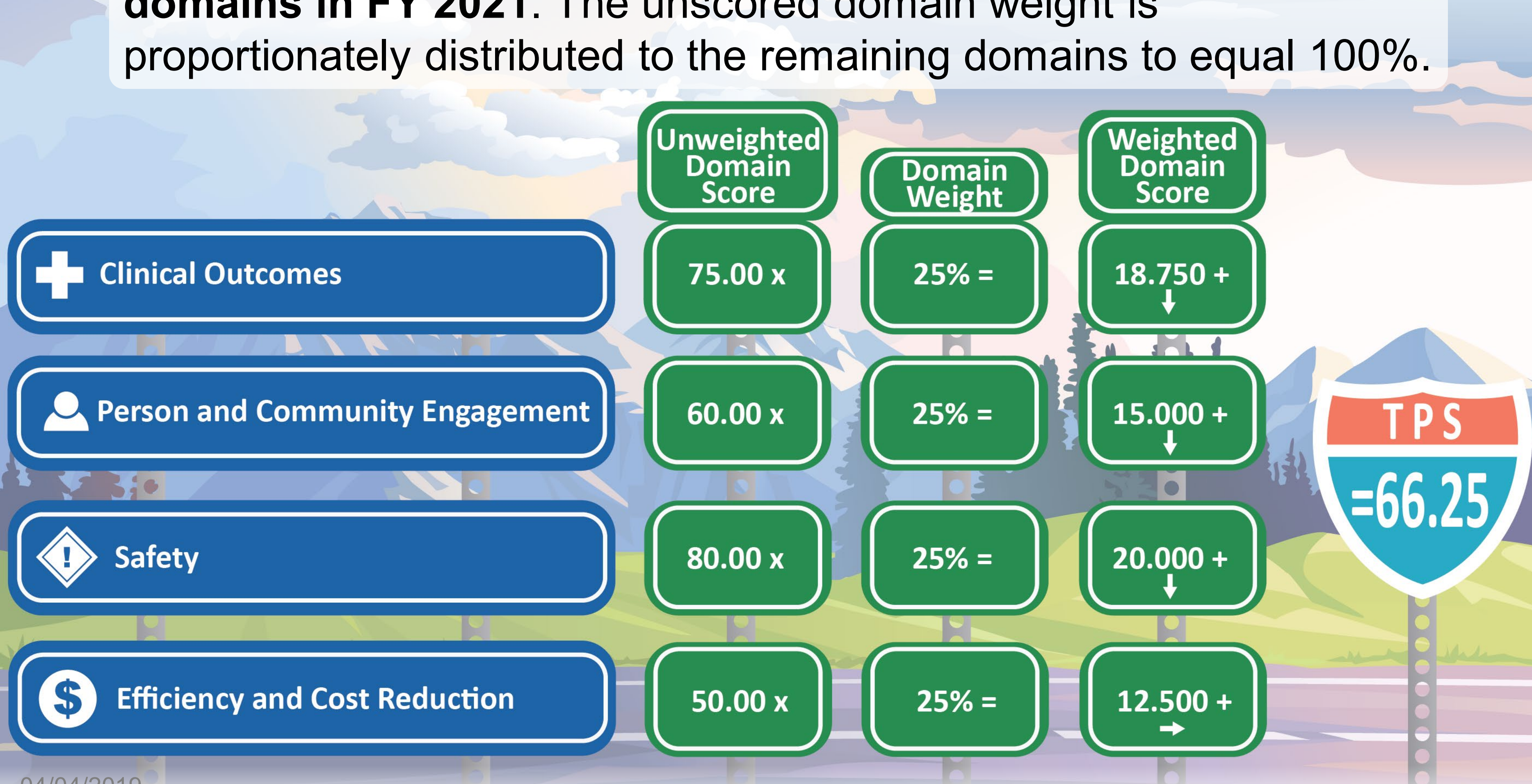
4. Multiply the result of step 3 by 100.

   (0.725 x 100) = 72.5

- For reliability, CMS requires hospitals to meet a minimum requirement of cases for each measure to receive a measure score and a minimum number of those measures to receive a domain score.
- CMS normalizes domain scores by converting a hospital’s earned points (the sum of the measure scores) to a percentage of total points that were possible, with the maximum score equaling 100.

Weighted Domain Score and Total Performance Score

A TPS requires scores from at least **three out of the four domains in FY 2021**. The unscored domain weight is proportionately distributed to the remaining domains to equal 100%.



Proportionate Reweighting

In this example, a hospital meets minimum case and measure requirements for the Clinical Outcomes, Safety, and Efficiency and Cost Reduction domains, but it does not meet the minimum number of cases/surveys required for the Person and Community Engagement domain score.

.

Measure	Measure Weights
Clinical Outcomes	25%
Person and Community Engagement	25%
Safety	25%
Efficiency and Cost Reduction	25%

Total Performance Score

1. Sum the eligible measure weights (25% + 25% + 25% -25% = 75%)

25% 25% 25% 25%

2. Divide Original Weight by Result of Step 1 (25% ÷ 75% = 33.3333%)

33.3333% + 33.3333% + 33.3333% = 100% TPS

Clinical Outcomes Detail Report

Report Run Date:

Page 1 of 4

Hospital Value-Based Purchasing – Baseline Measures Report

Clinical Outcomes Detail Report
Provider: XXXXXX
Reporting Period: Fiscal Year 2021

Data As Of:

Baseline Period (AMI, HF, COPD): 07/01/2011 - 06/30/2014
Baseline Period (PN): 07/01/2012 - 06/30/2015

Mortality Measures	Number of Eligible Discharges	Baseline Period Rate	Achievement Threshold	Benchmark
MORT-30-AMI Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	41	0.866859	0.860355	0.879714
MORT-30-COPD Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate**	0	-	0.923523	0.938664
MORT-30-HF Heart Failure (HF) 30-Day Mortality Rate	107	0.885776	0.883803	0.906144
MORT-30-PN Pneumonia (PN) 30-Day Mortality Rate	107	0.903072	0.836122	0.870506

Complication Baseline Period: 04/01/2011 - 03/31/2014

Complication Measure	Number of Eligible Discharges	Baseline Period Rate	Achievement Threshold	Benchmark
COMP-HIP-KNEE Elective Primary Total Hip Arthroplasty/Total Knee Arthroplasty Complication Rate	318	0.028150	0.031157	0.022418

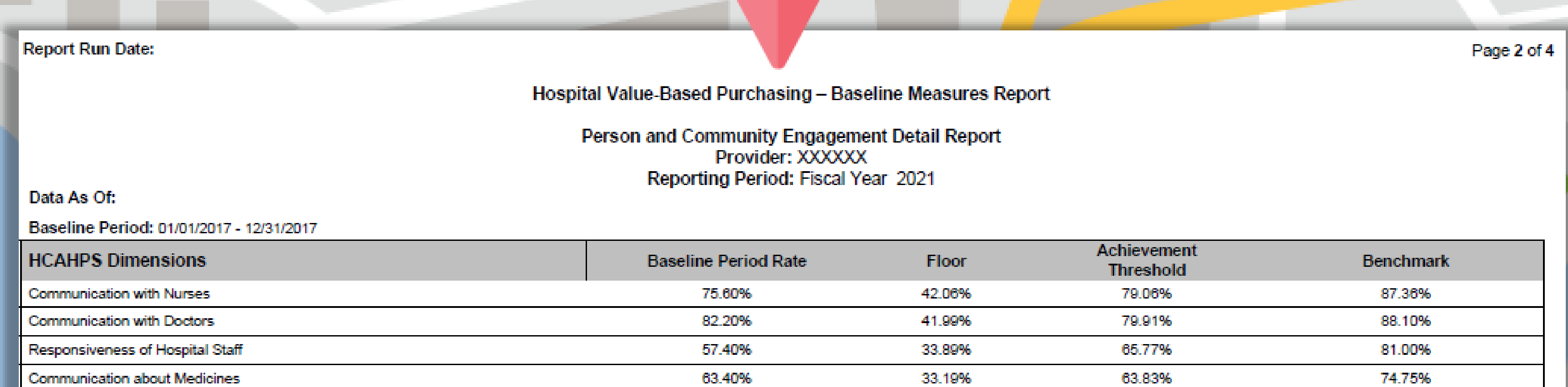
Calculated values were subject to rounding.

* A dash (-) indicates that the minimums were not met for calculation of the points or scores.

* A double asterisk (**) indicates that the hospital did not meet the minimum requirements for the measures in the Baseline Period.

Reference the Hospital Value-Based Purchasing page on QualityNet for report information, calculations, and Hospital VBP resources.

Person and Community Engagement Detail Report



Report Run Date:

Page 2 of 4

Hospital Value-Based Purchasing – Baseline Measures Report

Person and Community Engagement Detail Report
Provider: XXXXXX
Reporting Period: Fiscal Year 2021

Data As Of:

Baseline Period: 01/01/2017 - 12/31/2017

HCAHPS Dimensions	Baseline Period Rate	Floor	Achievement Threshold	Benchmark
Communication with Nurses	75.60%	42.06%	79.06%	87.36%
Communication with Doctors	82.20%	41.99%	79.91%	88.10%
Responsiveness of Hospital Staff	57.40%	33.89%	65.77%	81.00%
Communication about Medicines	63.40%	33.19%	63.83%	74.75%
Cleanliness and Quietness of Hospital Environment	67.20%	30.60%	65.61%	79.58%
Discharge Information	87.40%	66.94%	87.38%	92.17%
Care Transition	48.90%	6.53%	51.87%	63.32%
Overall Rating of Hospital	69.60%	34.70%	71.80%	85.67%

HCAHPS Surveys Completed During the Baseline Period 1332

Calculated values were subject to rounding.

Safety Measures Detail Report

Report Run Date:

Hospital Value-Based Purchasing – Baseline Measures Report

Safety Measures Detail Report
Provider: XXXXXX
Reporting Period: Fiscal Year 2021

Data As Of:

Baseline Period: 01/01/2017 - 12/31/2017

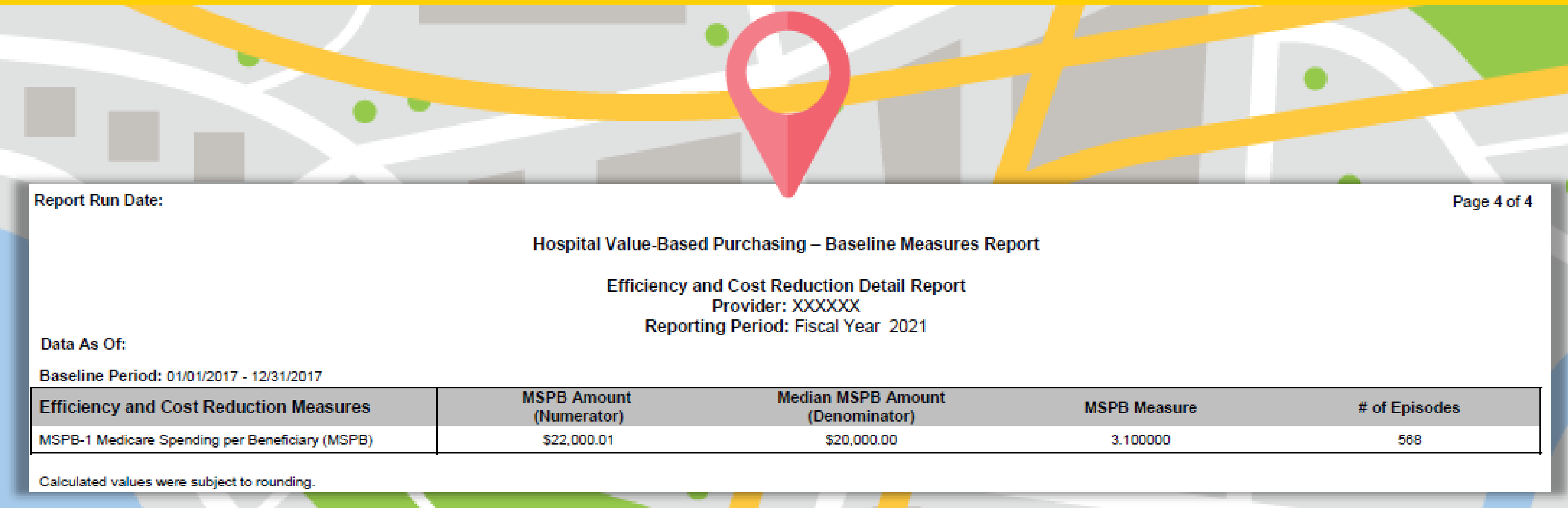
Healthcare Associated Infections	Number of Observed Infections (Numerator)	Number of Predicted Infections (Denominator)	Standardized Infection Ratio (SIR)	Achievement Threshold	Benchmark
CAUTI Catheter-Associated Urinary Tract Infection	3	3.971	0.755	0.774	0.000
CLABSI Central Line-Associated Blood Stream Infection	2	1.259	1.589	0.687	0.000
CDI Clostridium difficile Infection	3	8.772	0.342	0.748	0.067
MRSA Methicillin-Resistant Staphylococcus aureus Bacteremia**	2	0.992	-	0.763	0.000
SSI-Abdominal Hysterectomy	9	10.559	0.852	0.726	0.000
SSI-Colon Surgery**	N/A	N/A	-	0.754	0.000

Calculated values were subject to rounding.

* "N/A" indicates no data were available or submitted for this measure.

* A dash (-) indicates that the minimums were not met for calculation of the points or scores.

Efficiency and Cost Reduction Detail Report


Report Run Date:

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Hospital Value-Based Purchasing – Baseline Measures Report

Efficiency and Cost Reduction Detail Report
Provider: XXXXXX
Reporting Period: Fiscal Year 2021

Data As Of:

Baseline Period: 01/01/2017 - 12/31/2017

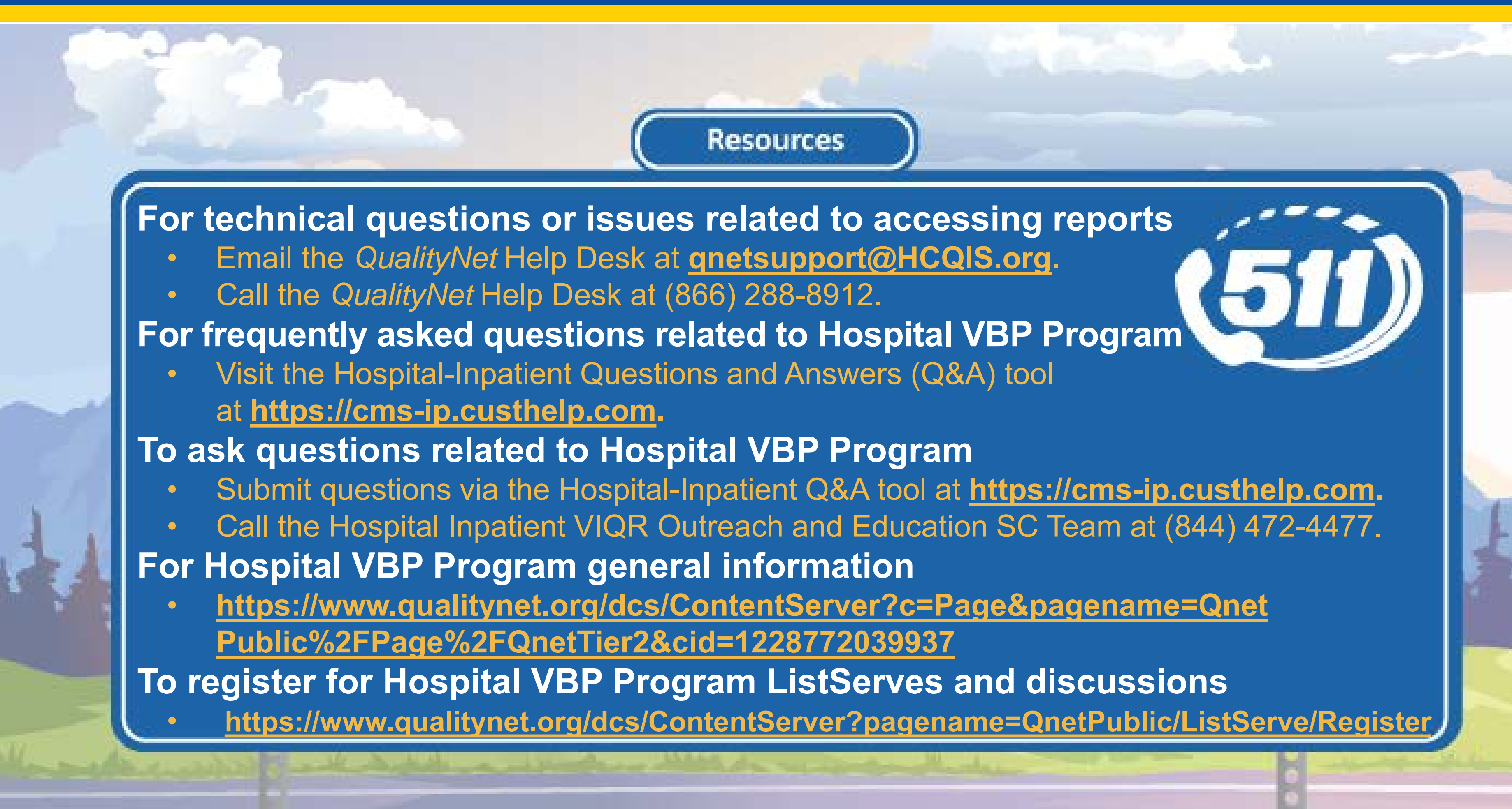
Efficiency and Cost Reduction Measures	MSPB Amount (Numerator)	Median MSPB Amount (Denominator)	MSPB Measure	# of Episodes
MSPB-1 Medicare Spending per Beneficiary (MSPB)	$22,000.01	$20,000.00	3.100000	568

Calculated values were subject to rounding.

Available FY 2021 Baseline Reports

- The **Baseline Measures Reports** are available to run on the *QualityNet Secure Portal.*
- Reports are available to hospitals that are active, registered on *QualityNet*, and have users assigned the following *QualityNet* roles:
  - **Hospital Reporting Feedback-Inpatient** role (required to receive the report)
  - **File Exchange and Search** role (required to download the report from the *QualityNet Secure Portal*)

Resources



Important Resource: How to Read Your FY 2021 Baseline Measures Report

- The *Hospital Value-Based Purchasing (VBP) Program: How to Read Your Fiscal Year (FY) 2021 Percentage Payment Summary Report* guide will be available on *QualityNet* in the Hospital VBP Program Resources section once reports are released.
- The direct link to the page is https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772237202.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Hospital Value-Based Purchasing (VBP) Program: How to Read Your Fiscal Year (FY) 2021 Baseline Measures Report

Program Overview

The Hospital VBP Program is authorized by section 1886(o) of the Social Security Act. The Hospital VBP Program is the nation's first national pay-for-performance program for acute care hospitals and serves as an important driver in redesigning how the Centers for Medicare & Medicaid Services (CMS) pays for care and services based on the quality and value of care, not only the quantity of services provided.

Purpose of the Baseline Measures Report

The Hospital VBP Program Baseline Measures Report allows providers to monitor their performance for all domains and measures required for the Hospital VBP Program.

FY 2021 Measurement Periods

The baseline and performance periods for FY 2021 measures are outlined in Table 1.

Table 1. FY 2021 Baseline and Performance Periods

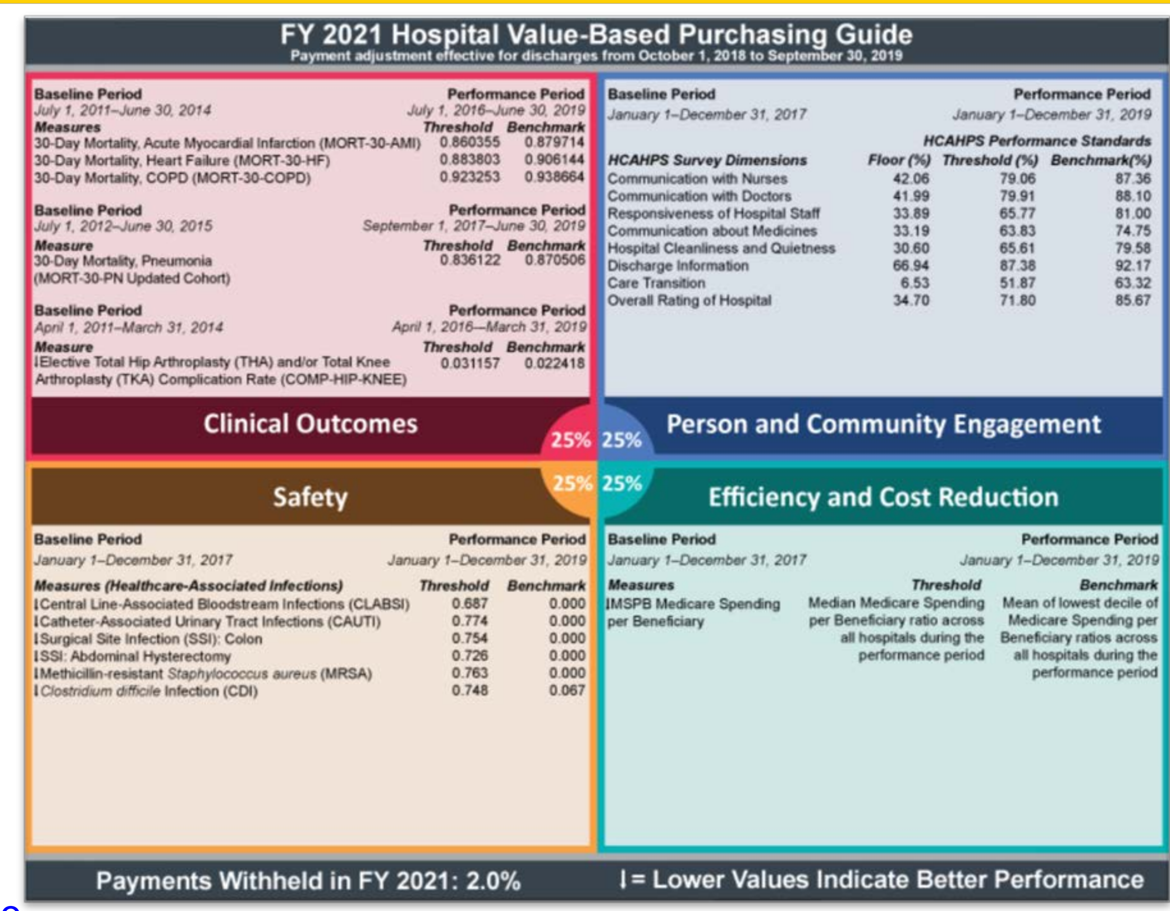
Domain/Measure Description	Baseline Period	Performance Period
Clinical Outcomes: 30-Day Mortality measures for Acute Myocardial Infarction (AMI), Chronic Obstructive Pulmonary Disease (COPD), and Heart Failure (HF)	July 1, 2011–June 30, 2014	July 1, 2016–June 30, 2019
Clinical Outcomes: 30-Day Mortality measure for Pneumonia (PN) (updated cohort)	July 1, 2012–June 30, 2015	September 1, 2017–June 30, 2019
Clinical Outcomes: Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) Complication measure	April 1, 2011–March 31, 2014	April 1, 2016–March 31, 2019
Person and Community Engagement: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) dimensions	January 1–December 31, 2017	January 1–December 31, 2019
Safety: Healthcare-Associated Infection (HAI) measures	January 1–December 31, 2017	January 1–December 31, 2019
Efficiency and Cost Reduction: Medicare Spending per Beneficiary (MSPB) measure	January 1–December 31, 2017	January 1–December 31, 2019

March 2019 Page 1 of 6

Important Resource:

Quick Reference Guide for FY 2021

- The FY 2021 Hospital VBP Program quick reference guide contains the following:
  - Domains
  - Domain weights
  - Measures
  - Baseline and Performance Period dates
  - Performance standards
- The guide is available at these direct links:
  - ***QualityNet*** https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772237202
  - ***Quality Reporting Center*** https://www.qualityreportingcenter.com/inpatient/iqr/resources-and-tools/



FY 2021 Hospital Value-Based Purchasing Guide

Payment adjustment effective for discharges from October 1, 2018 to September 30, 2019

Clinical Outcomes 25%

Baseline Period: *July 1, 2011–June 30, 2014* — Performance Period: *July 1, 2016–June 30, 2019*

Measures	Threshold	Benchmark
30-Day Mortality, Acute Myocardial Infarction (MORT-30-AMI)	0.860355	0.879714
30-Day Mortality, Heart Failure (MORT-30-HF)	0.883803	0.906144
30-Day Mortality, COPD (MORT-30-COPD)	0.923253	0.938664

Baseline Period: *July 1, 2012–June 30, 2015* — Performance Period: *September 1, 2017–June 30, 2019*

Measure	Threshold	Benchmark
30-Day Mortality, Pneumonia (MORT-30-PN Updated Cohort)	0.836122	0.870506

Baseline Period: *April 1, 2011–March 31, 2014* — Performance Period: *April 1, 2016–March 31, 2019*

Measure	Threshold	Benchmark
↓Elective Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate (COMP-HIP-KNEE)	0.031157	0.022418

Person and Community Engagement 25%

Baseline Period: *January 1–December 31, 2017* — Performance Period: *January 1–December 31, 2019*

HCAHPS Performance Standards

HCAHPS Survey Dimensions	Floor (%)	Threshold (%)	Benchmark(%)
Communication with Nurses	42.06	79.06	87.36
Communication with Doctors	41.99	79.91	88.10
Responsiveness of Hospital Staff	33.89	65.77	81.00
Communication about Medicines	33.19	63.83	74.75
Hospital Cleanliness and Quietness	30.60	65.61	79.58
Discharge Information	66.94	87.38	92.17
Care Transition	6.53	51.87	63.32
Overall Rating of Hospital	34.70	71.80	85.67

Safety 25%

Baseline Period: *January 1–December 31, 2017* — Performance Period: *January 1–December 31, 2019*

Measures (Healthcare-Associated Infections)	Threshold	Benchmark
↓Central Line-Associated Bloodstream Infections (CLABSI)	0.687	0.000
↓Catheter-Associated Urinary Tract Infections (CAUTI)	0.774	0.000
↓Surgical Site Infection (SSI): Colon	0.754	0.000
↓SSI: Abdominal Hysterectomy	0.726	0.000
↓Methicillin-resistant *Staphylococcus aureus* (MRSA)	0.763	0.000
↓*Clostridium difficile* Infection (CDI)	0.748	0.067

Efficiency and Cost Reduction 25%

Baseline Period: *January 1–December 31, 2017* — Performance Period: *January 1–December 31, 2019*

Measures	Threshold	Benchmark
↓MSPB Medicare Spending per Beneficiary	Median Medicare Spending per Beneficiary ratio across all hospitals during the performance period	Mean of lowest decile of Medicare Spending per Beneficiary ratios across all hospitals during the performance period

Payments Withheld in FY 2021: 2.0%

↓= Lower Values Indicate Better Performance

Important Resource:

Multi-Program Measures Guide for FY 2021

Acute Care Hospital Quality Improvement Program Measures for FY 2021 Payment Determination:

- Hospital IQR Program
- Hospital VBP Program
- Promoting Interoperability (PI) Program
- Hospital-Acquired Condition Reduction Program (HAC Reduction Program)
- Hospital Readmissions Reduction Program (HRRP)

QualityNet
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1138900298473

QualityReportingCenter
http://www.qualityreportingcenter.com/inpatient/iqr/tools/

CMS Measures - Fiscal Year 2020

Centers for Medicare & Medicaid Services (CMS) Quality Improvement Program Measures for Acute Care Hospitals - Fiscal Year (FY) 2020 Payment Update

Measure ID	Measure Name	NQF #	Hospital Inpatient Quality Reporting (IQR) Program Included	Hospital IQR Program Measurement Period	Hospital IQR Program Hospital Compare Release	Hospital Value-Based Purchasing (VBP) Program Included	Hospital VBP Program Measurement Period	Hospital VBP Program Hospital Compare Release	Electronic Health Record (EHR) Incentive Program Included	EHR Incentive Program Measurement Period	EHR Incentive Program Hospital Compare Release	Hospital-Acquired Condition (HAC) Reduction Program Included	HAC Reduction Program Measurement Period	HAC Reduction Program Hospital Compare Release	Hospital Readmissions Reduction Program Included	Hospital Readmissions Reduction Program Measurement Period	Hospital Readmissions Reduction Program Hospital Compare Release
Clinical Process of Care Measures (via Chart-Abstraction)																	
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients	0495	Yes	January 1, 2018-December 31, 2018	October 2019	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients	0497	Yes	January 1, 2018-December 31, 2018	October 2019	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A
IMM-2	Influenza Immunization **Note**: The IMM-2 measure is collected for all 4 quarters; however, only discharges included in 1st and 4th quarters will be included in the measure calculation. The IMM-2 measure is reported by flu season on CMS's *Hospital Compare* site.	1659	Yes	January 1, 2018-December 31, 2018	**2017-2018 Flu Season:** December 2018 **2018-2019 Flu Season:** December 2019	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A
PC-01	Elective Delivery	0469	Yes	January 1, 2018-December 31, 2018	October 2019	Yes	**Baseline:** January 1, 2016 - December 31, 2016 **Performance:** January 1, 2018 - December 31, 2018	December 2019	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A
Sepsis	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	0500	Yes	January 1, 2018-December 31, 2018	TBD	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A
VTE-6	Incidence of Potentially Preventable Venous Thromboembolism	N/A	Yes	January 1, 2018-December 31, 2018	October 2019	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A	No	N/A	N/A
EHR-Based Clinical Process of Care Measures (Electronic Clinical Quality Measures [eCQMs])																	
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	N/A	Yes*	Report one self-selected quarter of data (Q1, Q2, Q3 or Q4) January 1, 2018 - December 31, 2018	TBD	No	N/A	N/A	Yes**	**Attestation and QRDA*****: January 1, 2018 - December 31, 2018	TBD	No	N/A	N/A	No	N/A	N/A
CAC-3	Home Management Plan of Care Document Given to Patient/Caregiver	N/A	Yes*	Report one self-selected quarter of data (Q1, Q2, Q3 or Q4) January 1, 2018 - December 31, 2018	TBD	No	N/A	N/A	Yes**	**Attestation and QRDA*****: January 1, 2018 - December 31, 2018	TBD	No	N/A	N/A	No	N/A	N/A
ED-1	Median Time from ED Arrival to ED Departure for Admitted ED Patients	0495	Yes*	Report one self-selected quarter of data (Q1, Q2, Q3 or Q4) January 1, 2018 - December 31, 2018	TBD	No	N/A	N/A	Yes**	**Attestation and QRDA*****: January 1, 2018 - December 31, 2018	TBD	No	N/A	N/A	No	N/A	N/A
ED-2	Admit Decision Time to ED Departure Time for Admitted Patients	0497	Yes*	Report one self-selected quarter of data (Q1, Q2, Q3 or Q4) January 1, 2018 - December 31, 2018	TBD	No	N/A	N/A	Yes**	**Attestation and QRDA*****: January 1, 2018 - December 31, 2018	TBD	No	N/A	N/A	No	N/A	N/A
ED-3	Median Time from ED Arrival to ED Departure for Discharged ED Patients	0496	No	N/A	N/A	No	N/A	N/A	Yes**	**Attestation and QRDA*****: January 1, 2018 - December 31, 2018	TBD	No	N/A	N/A	No	N/A	N/A

Important Resource: Archived Webinars

- ***FY 2019 Hospital VBP Program, HAC Reduction Program, and Hospital Readmissions Reduction Program:*** **Hospital Compare *Data Update***
  - Date: March 12, 2019
  - http://www.qualityreportingcenter.com/inpatient/vbp-archived-events/
- ***FY 2019 IPPS Final Rule Acute Care Hospital Quality Reporting Programs Overview***
  - Date: September 12, 2018
  - http://www.qualityreportingcenter.com/inpatient/iqr/events/

Acronyms

AMI	acute myocardial infarction	**HSR**	hospital-specific report
CAUTI	catheter-associated urinary tract infection	**IPPS**	inpatient prospective payment system
CDI	*Clostridium difficile* infections	**IQR**	Inpatient Quality Reporting
CE	continuing education	**MRSA**	Methicillin-resistant *Staphylococcus aureus*
CLABSI	central line-associated bloodstream infection	**MS-DRG**	Medicare Severity Diagnosis-Related Group
COPD	chronic obstructive pulmonary disease	**MSPB**	Medicare Spending per Beneficiary
DRG	Diagnosis-Related Group	**PI**	Promoting Interoperability
EHR	electronic health record	**PN**	pneumonia
FY	fiscal year	**SC**	support contract
HAC	hospital-acquired condition	**SSI**	surgical site infection
HAI	healthcare-associated infection	**THA**	total hip arthroplasty
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems	**TKA**	total knee arthroplasty
HF	heart failure	**TPS**	Total Performance Score
HRRP	Hospital Readmissions Reduction Program	**VBP**	value-based purchasing
HSAG	Health Services Advisory Group	**VIQR**	Value, Incentives, and Quality Reporting

Questions

Continuing Education (CE) Approval

This program has been approved for CE credit for the following boards:

- **National credit**
  - Board of Registered Nursing (Provider #16578)
- **Florida-only credit**
  - Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling
  - Board of Registered Nursing
  - Board of Nursing Home Administrators
  - Board of Dietetics and Nutrition Practice Council
  - Board of Pharmacy

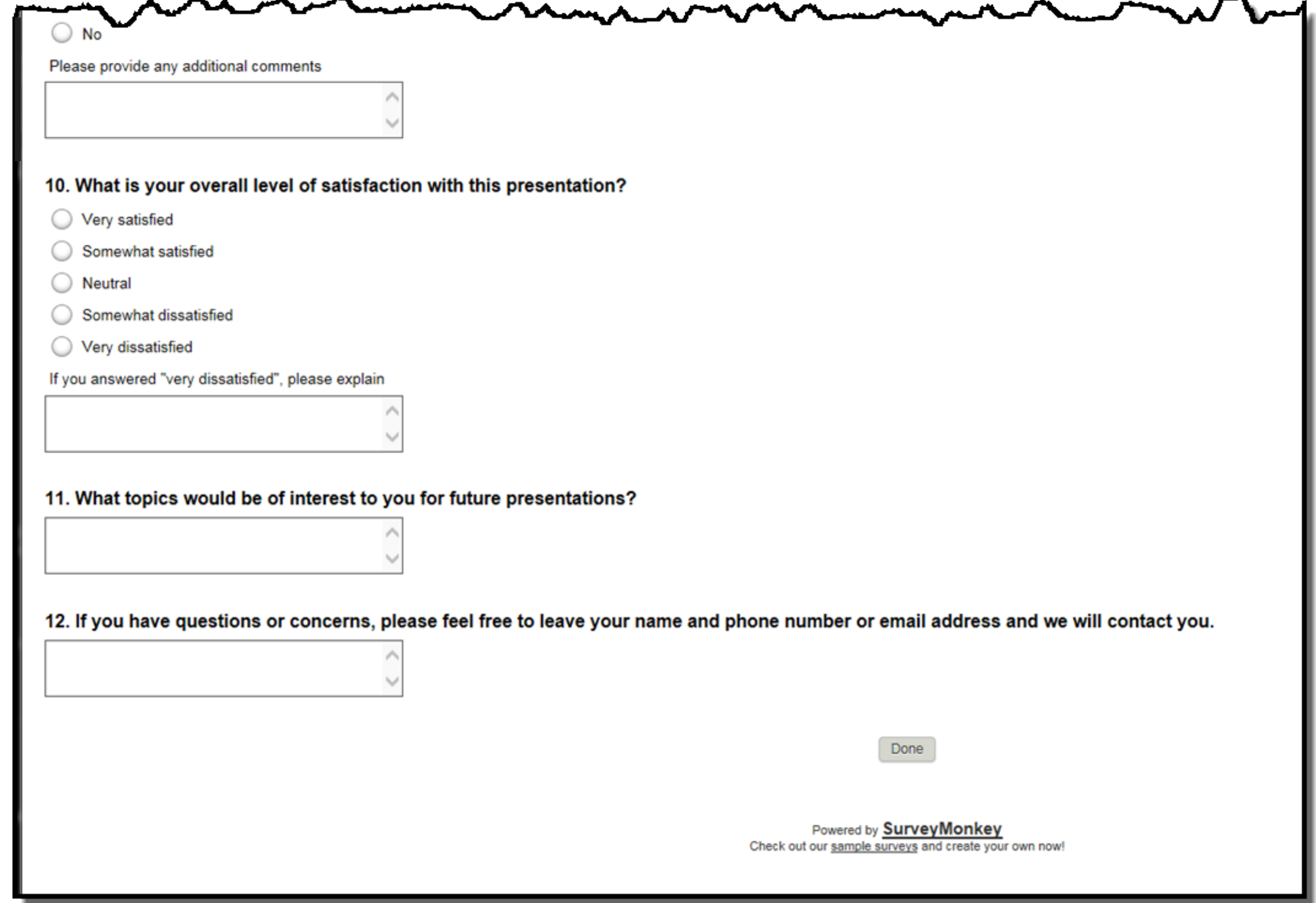
Note: To verify CE approval for any other state, license, or certification, please check with your licensing or certification board.

CE Credit Process: Three Steps

1. Complete the ReadyTalk® survey that will pop up after the webinar
2. Register on the HSAG Learning Management Center for the certificate
3. Print out your certificate

Note: An additional survey will be sent to all registrants within the next 48 hours.

CE Credit Process: Survey


No

Please provide any additional comments

10. What is your overall level of satisfaction with this presentation?

- Very satisfied
- Somewhat satisfied
- Neutral
- Somewhat dissatisfied
- Very dissatisfied

If you answered "very dissatisfied", please explain

11. What topics would be of interest to you for future presentations?

12. If you have questions or concerns, please feel free to leave your name and phone number or email address and we will contact you.

Done

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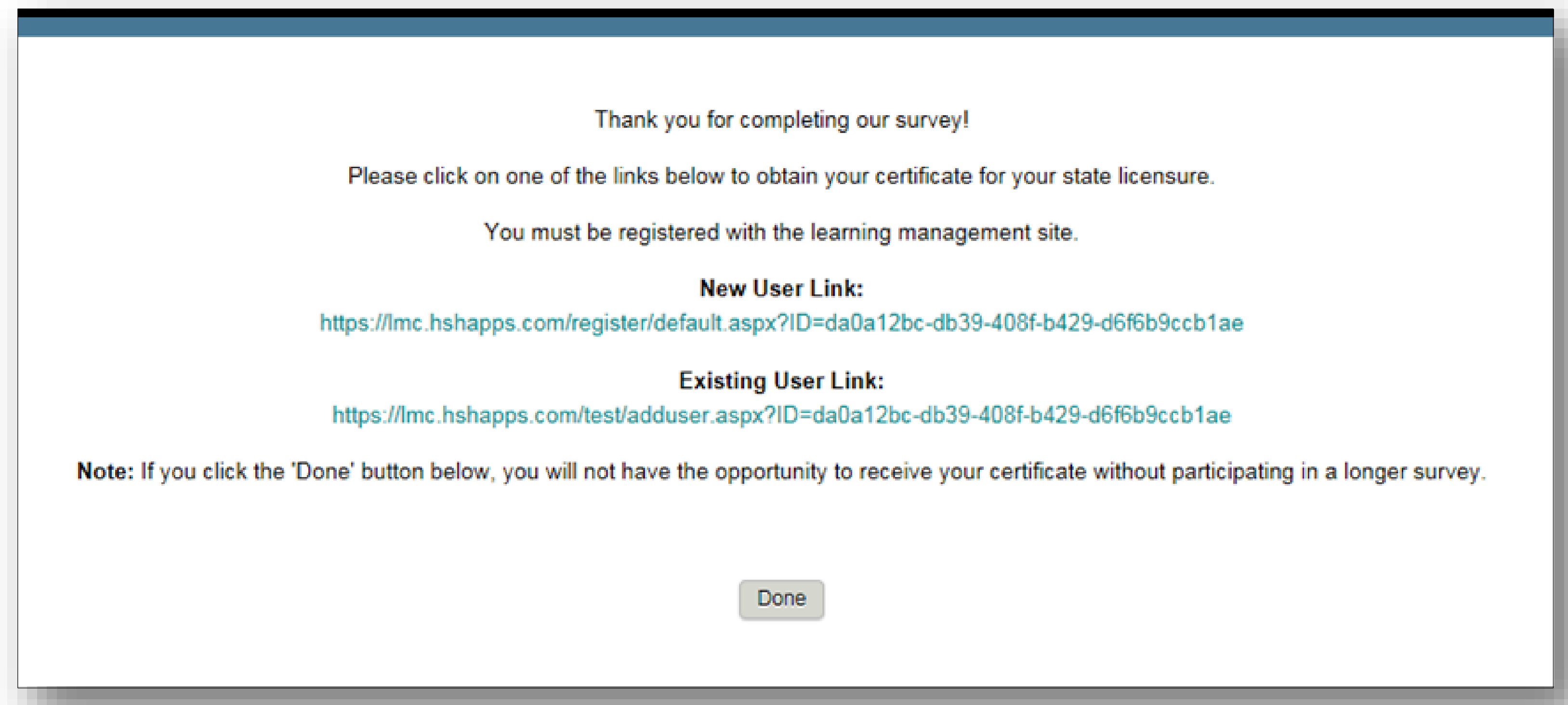
CE Credit Process: Certificate



Register for Credit

New User

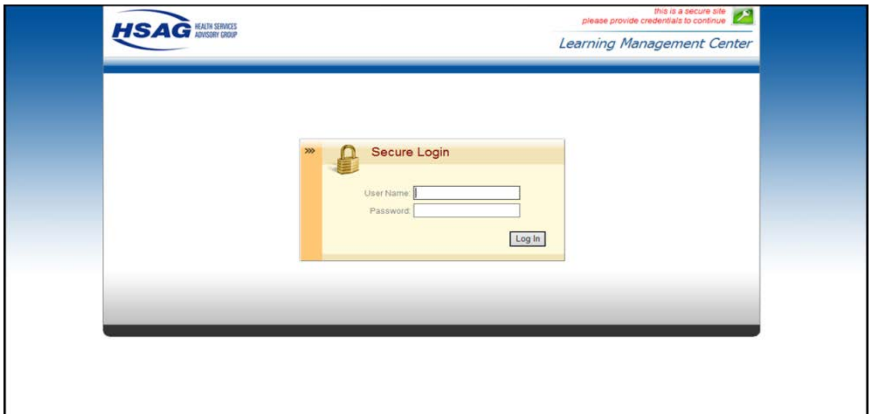
Use personal email and phone.

Go to email address and finish process.

Existing User

Entire email is your user name.

You can reset your password.



Thank You for Attending

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