Inpatient Quality Reporting Program

Support Contractor

Hospital Value-Based Purchasing Program: Overview of FY 2017

Questions & Answers

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Question 1: When will the FY 2017 Baseline Reports be available to access on the *QNet*, please?

Answer 1: It is anticipated that the FY 2017 Baseline Measures Reports will be released soon. As soon as they are released, notifications will be sent to providers through email notification and the IQR and VBP Listservs that are available to sign up on *QualityNet*. If you have not signed up on – for the IQR or VBP Listserv, you can do that by going to a *QualityNet*.

Question 2: We are a surgical hospital that does not meet AMI/HF/PN outcomes. We do meet IMM and PC-01 process measures. Does this make us eligible for 2017 VBP?

Answer 2: In order for a hospital to be eligible for the FY 2017 Hospital VBP Program and receive a Total Performance Score (TPS), a hospital

must meet the minimum domain requirements in at least three of the four domains. CMS is considering the Clinical Care domain requirements met when at least one of the two subdomains of Process or Outcomes meet the minimum measure requirements. If a hospital does not meet the minimum measure requirements in the Outcomes subdomain containing the 30-Day Mortality measures of Acute Myocardial Infarction (AMI), Heart Failure (HF), and Pneumonia (PN), a hospital may still meet the Clinical Care domain requirements by meeting the minimum measure requirements in the Process subdomain of AMI-7a, IMM-2, and PC-01. If a hospital does not meet the minimum requirements in either Clinical Care subdomain, the hospital may still be eligible if the minimum requirements are met in the remaining domains of Safety, Efficiency, and Cost Reduction, and Patient- and Caregiver-Centered Experience of Care/Care Coordination.

Question 3: Can you give the dates for performance period and baseline period again?

Answer 3: The baseline and performance periods for each domain and measure are listed in the table below:

Domain	Subdomain/ Measure	Baseline Period	Performance Period
Clinical Care	Process	1/1/2013– 2/31/2013	1/1/2015–12/31/2015
	Outcomes	10/1/2010–6/30/2012	10/1/2013–6/30/2015
Patient- and Caregiver-Centered Experience of Care/Care Coordination	HCAHPS Survey	1/1/2013–12/31/2013	1/1/2015–12/31/2015
Safety	HAI Measures	1/1/2013–12/31/2013	1/1/2015–12/31/2015
	AHRQ PSI-90 Composite	10/1/2010–6/30/2012	10/1/2013–6/30/2015
Efficiency and Cost Reduction	MSPB	1/1/2013–12/31/2013	1/1/2015–12/31/2015

Question 4: What time period does FY 2017 represent? Is it October 2015–October 2016?

Answer 4: The FY 2017 Hospital VBP Program will impact payments from October 1, 2016–September 30, 2017. The data included in the FY 2017 Hospital VBP Program calculations include a baseline period and a performance period. Please reference *Answer 3* to view the data periods utilized in the Hospital VBP Program.

Question 5: Is there a crosswalk available for VBP to IQR (manual abstraction vs. CQM electronic submission)?

Answer 5: A measure comparison document was created that displays measures with information such as:

- Collection/Submission (Required, Removed, Voluntary)
- Reported on Hospital Compare
- Included in Hospital Value-Based Purchasing
- Collection/Submission Method

- Additional Information

The measure comparison for calendar year (CY) 2015 discharges is located on *QualityNet*; direct link: www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1138900298473.

Question 6 Why is Maryland excluded from the VBP program?

Answer 6: The State of Maryland entered into an agreement with CMS, effective January 1, 2014, to participate in CMS' new Maryland All-Payer Model, a 5-year hospital payment model. This model is being implemented under section 1115A of the Act, as added by section 3021 of the Affordable Care Act, which authorizes the testing of innovative payment and service delivery models, including models that allow states to ''test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.''

In order to implement the new model, effective January 1, 2014, Maryland elected to no longer have Medicare pay Maryland hospitals in accordance with section 1814(b)(3) of the Act. Because Maryland hospitals are no longer paid under section 1814(b)(3) of the Act, they are no longer subject to those provisions of the Act and related implementing regulations that are specific to hospitals paid under section 1814(b)(3) of the Act, including but not limited to section 1886(o)(1)(C)(iv) of the Act, which provides an exemption for hospitals paid under section 1814(b)(3) of the Act from the application of the Hospital VBP Program if the State which is paid under that section meets certain requirements.

The effect of Maryland hospitals no longer being paid under section 1814(b)(3) of the Act is that they are not entitled to be exempted from the Hospital VBP Program under section 1886(o)(1)(C)(iv) of the Act and, but for the model, would be included in the Hospital VBP Program. In other words, although the exemption from the

Hospital VBP Program no longer applies, Maryland hospitals will not be participating in the Hospital VBP Program because section 1886(o) of the Act and its implementing regulations have been waived for purposes of the model, subject to the terms of the agreement.

For more information on the State of Maryland's exclusion from the Hospital VBP Program, please reference the FY 2015 IPPS/LTCH final rule (79 FR 50086-50087).

Question 7: How can we know the ICD codes that apply to each of the PSIs under PSI-90?

Answer 7: CMS utilizes the first nine diagnosis and six procedure codes on applicable claims for the calculation of the AHRQ PSI-90 Composite within the FY 2017 Hospital VBP Program. The codes utilized for calculation will be specific to the claim submitted by the hospital. Hospitals may review the calculations specific to their hospital for the AHRQ PSI-90 Composite through a Hospital Specific Report provided to hospitals to review and correct the data and calculations of the Composite prior to the data being used in the Percentage Payment Summary Report.

Question 8: What does MSPB stand for?

Answer 8: MSPB is the acronym for Medicare Spending per Beneficiary and that is the measure in the Efficiency and Cost Reduction Domain.

Question 9: What are the criteria for eligible number of episodes under MSPB measure?

Answer 9: An MSPB episode will include all Medicare Part A and Part B claims with a start date falling between three days prior to an Inpatient Prospective Payment System hospital admission (index

admission) through 30 days post-hospital discharge. An episode includes the 30 days after a hospital discharge in order to emphasize the importance of care transitions and care coordination in improving patient care. Only discharges occurring at least 30 days before the end of the measurement period are counted as index admissions. Admissions which occur within 30 days of discharge from another index admission are not considered to be index admissions.

Payments made by Medicare and the beneficiary (i.e., allowed charges) are counted in the MSPB episode as long as the start of the claim falls within the episode window of three days prior to the index admission through 30 days post-hospital discharge. IPPS outlier payments (and outlier payments in other provider settings) are also included in the calculation of the MSPB Measure.

Beneficiary populations eligible for the MSPB calculation are made up of Medicare beneficiaries enrolled in Medicare Parts A and B who were discharged from short-term acute hospitals during the period of performance. Specifically, Medicare Part A and Medicare Part B claims from beneficiaries with an index admission within a subsection (d) hospital are included in the MSPB episode if the beneficiary has been enrolled in Medicare Part A and Part B for the period 90 days prior to the start of an episode (e.g., 93 days prior to the date of the index admission) until the 30 days after discharge. Defining the population in this manner ensures that each beneficiary's claims record contains sufficient fee-for-service data both for measuring spending levels and for risk adjustment purposes.

Only claims for beneficiaries admitted to subsection (d) hospitals during the period of performance are included in the calculation of the MSPB Measure. Subsection (d) hospitals are hospitals in the 50 States and D.C. other than: psychiatric hospitals, rehabilitation hospitals, hospitals whose inpatients are predominantly under 18

years old, hospitals whose average inpatient length of stay exceeds 25 days, and hospitals involved extensively in treatment for or research on cancer. The claims for Inpatient admissions to subsection (d) hospitals are grouped into “stays” by beneficiary, admission date, and provider.

Populations excluded from the MSPB calculation are made up of any episodes where at any time 90 days before or during the episode, the beneficiary is enrolled in a Medicare Advantage plan; the beneficiary is covered by the Railroad Retirement Board; or Medicare is the secondary payer. Episodes where the beneficiary becomes deceased during the episode are also excluded. Regarding beneficiaries whose primary insurance becomes Medicaid during an episode due to exhaustion of Medicare Part A benefits, Medicaid payments made for services rendered to these beneficiaries are excluded; however, all Medicare Part A payments made before benefits are exhausted and all Medicare Part B payments made during the episode are included.

In addition, acute-to-acute transfers (where a transfer is defined based on the claim discharge code) will not be considered index admissions. In other words, these cases will not generate new MSPB episodes; neither the hospital which transfers a patient to another subsection (d) hospital, nor the receiving subsection (d) hospital will have an index admission attributed to them. Further, any episode in which the index admission Inpatient claim has a $0 actual payment or a $0 standardized payment is excluded.

Index admissions to hospitals that Medicare does not reimburse through the IPPS system (e.g., cancer hospitals, critical access hospitals, hospitals in Maryland) are not eligible to begin an MSPB episode.

Question 10: Will the HAC program be merged with the VBP program?

Answer 10: No. The HAC Reduction Program, Hospital Readmission Reduction Program (HRRP), and Hospital VBP Program are separate pay-for-performance programs and will not be merged.

Question 11: Is there a date yet for Stroke Mortality to be included in VBP?

Answer 11: The Stroke 30-Day Mortality Measure has not been proposed and finalized through rule-making. We recommend referencing and commenting on the FY 2016 IPPS proposed rule for more information on this measure and the Hospital VBP Program policies.

Question 12: Where can I obtain previous domain weights and measures; for example, FY16, FY15, etc.?

Answer 12: The domain weights and measures for the previous fiscal years of the Hospital VBP Program can be found through the final rules located through the Federal Register and also on the Hospital VBP Program *QualityNet* pages.

Question 13: How does a hospital get credit for performing well on PSI-90 if zero cases shows as not enough cases?

Answer 13: The minimum cases referenced in the presentation are not indicative of cases that “fail” the measure, but those that are eligible through the measure criteria. A hospital may be awarded for the measure if they have at least three cases in any of the eight underlying indicators that meet the eligibility requirements for that individual patient safety indicator.

Question 14: When will these exclusions end for critical access hospitals?

Answer 14: At this time there has been no proposal for critical access hospitals to be included in the Hospital VBP Program. We recommend

reading the IPPS Proposed Rules when published for the most current information

Question 15: Is there anticipated date of when FY 2017 thresholds and benchmarks will be released/publicized?

Answer 15: The FY 2017 Hospital VBP Program performance standards (benchmarks, achievement threshold, and floors) were released through the IPPS Final Rules. The Medicare Spending per Beneficiary (MSPB) measure utilizes performance period data instead of baseline period data for calculation of the performance standards. As a result, these standards will not be released until the release of the Percentage Payment Summary Report for the same fiscal year.

Question 16: When does FY 2017 start?

Answer 16: Fiscal Year 2017 begins on October 1, 2016 and ends September 30, 2017.

Question 17: Did you state that the 2.0% will be subtracted from each claim rather than all at one time?

Answer 17: The incentive payments made to hospitals will occur on a claim basis and not a lump sum. CMS calculates a hospitals value-based incentive payment adjustment factor that is multiplied by the base-operating DRG payment amount for the claim. The value-based incentive payment adjustment factor accounts for the withhold and the incentive payment awarded.

Question 18: For 2015, the PSIs on hospital compare do not include PSI 3, 7 and 12. Please advise the difference between that communication for PSI 90 calculation vs. this presentation.

Answer 18: The display of all individual patient safety indicators may not occur on the Hospital Compare site. However, the Hospital Compare site does display the PSI-90 Composite value.

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Question 19: Can you comment on the overlap of VBP measures with the HAC Reduction Program?

Answer 19: For information on the overlap of the Hospital VBP Program and the HAC Reduction Program measures please reference the IPPS Final Rules. In addition, we recommend submitting your specific questions or concerns to the FY 2016 IPPS Proposed Rule when published.

Question 20: Is PSI 11 - Post Op Respiratory Failure no longer part of the PSI 90 composite?

Answer 20: The individual patient safety indicators (PSIs) included in the AHRQ PSI-90 Composite for use within the Hospital VBP Program include:

- PSI 03 Pressure Ulcer Rate
- PSI 06 Latrogenic Pneumothorax Rate
- PSI 07 Central Venous Catheter-Related Bloodstream Infection Rate
- PSI 08 Postoperative Hip Fracture Rate
- PSI 12 Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Accidental Puncture or Laceration Rate

Question 21: In FY 2016, I believe the Domain 1 and Domain 2 weight within Safety was a 75 (Domain 2)/25 (Domain 1) split. What is that split in FY 2017?

Answer 21: For questions regarding the HAC Reduction Program, please contact the *QualityNet* Help Desk at qnetsupport@hcqis.org or by phone: 866.288.8912.

Question 22: The presenter referenced the AHRQ PSI-90 composite Mortality measures. [I} don't see any Mortality measures within the PSI-90 composite. PSI-2 and PSI-4 are the only PSI Mortality Measures, and those are not included in the PSI-90 composite. Please clarify.

Answer 22: The Clinical Care–Outcomes subdomain contains three 30-Day Mortality Measures of AMI, HF, and Pneumonia. The Safety domain contains the AHRQ PSI-90 Composite. You are correct, the 30-Day Mortality Measures are not included within the AHRQ PSI-90 Composite.

Question 23: On the HCAHPS Survey section of the VBP Domain weighting tool, what is the "Floor" percent?

Answer 23: The “floor” is the score of the lowest performing hospital for the dimension during the baseline period. The floor is used in the Patient- and Caregiver- Centered Experience of Care/Care Coordination domain in calculating the lowest dimension score and consistency score.

Question 24: Does the HCAHPS measure use "Always" raw scores or "Always" percentiles?

Answer 24: For questions regarding the calculation and methodology of HCAHPS scoring, please contact Technical Assistance, HCAHPS hcahps@hcqis.org.

Question 25: Are the CLABSI & CAUTI data for VBP taken from NHSN/CDC or from claims data?

Answer 25: The specific CLABSI and CAUTI measures included in the Safety domain of the Hospital VBP Program are collected through hospital submissions to CDC through NHSN.

Question 26: Has CMS considered developing a tool for hospitals to use to project their performance on VBP for each FY?

Answer 26: At this time, there is no CMS-sponsored or endorsed projection tool for the Hospital VBP Program.

Question 27: Please clarify: 2.00% is withheld from [a] hospital's base operating DRG payments and then [they] earn back their monies according to their TPS?

Answer 27: In the Hospital VBP Program, CMS calculates a value-based incentive payment adjustment factor that accounts for the withhold and incentive payment calculated by the hospital's Total Performance Score (TPS). This value-based incentive payment adjustment factor is multiplied against the base-operating DRG payment amount for eligible claims. By use of this method, CMS is withholding the applicable percent and adding the incentive payment amount subsequently on a claim by claim basis.

Question 28: Why include PC-01 if not all facilities have perinatal care?

Answer 28: If a hospital does not have sufficient cases to be included in a measure, the measure will not be counted against a hospital. Normalization of a domain is the process used by CMS that scores a hospital based on total points scored divided by the maximum points possible for the domain. The maximum points possible for the domain value is calculated by multiplying the number of measures the hospital met the minimum criteria by the maximum points for the measure, 10 points.

The PC-01 measure, elective delivery prior to 39 completed weeks' gestation, is a chart-abstracted measure. Although this is a chart-abstracted measure, CMS finalized their policy in FY 2013 IPPS final rule, indicating that this is a measure that would be collected in aggregated counts per hospital via a web-based tool. The Strong Start initiative was launched to help reduce early elective births. At launch, the HHS secretary stated that more than half a million infants are born prematurely in America each year. Fortunately, the early elective birth rate has steadily decreased. In 2012, the number of early elective births had decreased to approximately 456,000, or 11.55%, of the total number of births. Early elective

births are a public health problem that has significant consequences for families well into a child's life.

Question 29: For the QIN-QIO, it is helpful to get the claims HSRs to support the hospitals, both to help them with interpretation and identification of opportunities, and also because they have discharge level data that gives an understanding of how the scores are calculated based on patient results.

Answer 29: Thank you for your suggestion.

Question 30: Although not directly tied to this presentation, do you have any awareness of the weighting of the PSI-4 stratum or subcomponents?

Answer 30: For questions regarding the Hospital IQR Program AHRQ PSI-4 measure, please contact the *QualityNet* Help Desk at qnetsupport@hcqis.org or by phone: 866.288.8912.

Question 31: Are you only looking into Medicare patients?

Answer 31: The populations of the quality measures included in the Hospital VBP Program vary from measure to measure. Please submit your question to the Inpatient Q&A tool on *QualityNet* at Q & A Tool https://cms-ip.custhelp.com and specify which measure you are inquiring about.

Question 32: Are these reports available now?

Answer 32: The FY 2017 Baseline Measures Reports were made available through the Secure Portal on *QualityNet* on February 24, 2015.

Question 33: The 2017 VBP is already two months underway using benchmark data as far back as 2010. Why the delay in the baseline reports?

Answer 33: The rules and regulations regarding the FY 2017 Hospital VBP Program were finalized in the FY 2015 IPPS final rule which was published was in August 2014. The delay from August 2014 to February 2015 includes processes such as report creation and testing.

Question 34: When are the Baseline Reports going to be available?

Answer 34: The FY 2017 Baseline Measures Reports were made available through the *Secure Portal* on *QualityNet* on February 24, 2015.

Question 35: What are the nine diagnosis and six procedure codes that determine the PSI 90 measure?

Answer 35: There are not set diagnosis and procedure codes for the AHRQ PSI-90 composite. The calculation and inclusion of codes will vary based on the first nine diagnosis and six procedure codes included on the claim.

Question 36: What is a Predicted Infection?

Answer 36: The national baseline is aggregated data reported to NHSN by all facilities during a baseline period is used to "predict" the number of infections expected to occur in a hospital, state, or in the country. In this report, the number of predicted infections is an estimate based on infections reported to NHSN during the following time periods:

- 2006 to 2008: CLABSI and SSI
- 2009: CAUTI
- 2010 to 2011: MRSA bacteremia and *C. difficile* infections

The number of predicted infections is risk-adjusted and includes data from all facilities, whether or not they are under state mandates. To calculate a state or facility's SIR for a certain time period, CDC compares the predicted number of infections based on

the standard population to the number of infections reported in that time period.

Question 37: What is the difference between Baseline Period and Performance Period?

Answer 37: The Baseline Period and Performance Periods are used in the Hospital VBP Program to calculate achievement and improvement points. The Performance Period is used to compare rates of the hospital in the most recent time period to all hospitals through the performance standards. The Baseline Period is used to compare how the hospital performed in an earlier time period to the performance period to identify if improvement has been made at the individual hospital.

Question 38: How do I find out if a measure has at least one predicted infection from the CDC for our hospital?

Answer 38: The predicted number of infections field is included in the Baseline Measures Report and Percentage Payment Summary Report.

Question 39: Is there any available information yet regarding FY 2016/FY 2017 proposed measures?

Answer 39: Yes, the FY 2016 and FY 2017 measures were finalized in the FY 2014 and FY 2015 IPPS final rules available on the Federal Register.

Question 40: What do you mean as an exclusion for hospitals with payment reduction under the IQR program?

Answer 40: If a hospital chooses not to participate or does not meet the requirements of the Hospital Inpatient Quality Reporting (IQR) Program, the hospital will incur a reduction to the market basket

update. If this reduction occurs, the hospital will not be eligible to participate in the Hospital VBP Program.

Question 41: In CAUTI and CLBSI, for those who are 0.0 and have been there for several years, we are being penalized for not having these?

Answer 41: No, the minimum criteria for inclusion in the CLABSI and CAUTI measures is one predicted infection, as calculated by the CDC. The actual number of infections a hospital observes could equal 0, but to be included in the measure at least one predicted infection must be calculated.

Question 42: Where is a good place to find tools to learn the basics of the VBP and Core Measures?

Answer 42: The *QualityNet* site is a great resource for an overview of CMS's quality programs and measures.

Question 43: Do you have to have one predicted infection to earn achievement points?

Answer 43: Yes, at least one predicted infection, as calculated by CDC, is required to receive achievement points for the measure in the Hospital VBP Program.

Question 44: Is the HCAHPS Care Transition domain excluded for FY 2017? If so, will it be added in the future?

Answer 44: The HCAHPS Care Transition dimension was not finalized for inclusion in the FY 2017 Hospital VBP Program. For the most current information on the dimension, we recommend reading and commenting on the FY 2016 IPPS proposed rule when published.

Question 45: Will the PCCEC/CC still include Consistency points as part of its calculation?

Answer 45: Yes, the PCCEC/CC domain will include a base score and a consistency score in the FY 2017 Hospital VBP Program.

Question 46: Could you provide the source that CMS plans to use v4.5a for ARHQ PSI #90 in the HVBP? I heard this recently on a webinar but online CMS indicates v4.4.

Answer 46: CMS has announced that they will utilize AHRQ software version 4.4 in the FY 2015 and FY 2016 Hospital VBP Program years and 4.5a in the FY 2017 Program. The announcement of the FY 2017 software is available on *QualityNet*; direct link: www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetBasic&cid=1228774624610.

Question 47: On the MSPB timeframe of 30 days after hospital discharge, does this include ANY Medicare charges during that time frame or do they have to have codes that would reflect follow-up from the hospitalization?

Answer 47: For questions regarding the MSPB measure calculation and methodology, please contact Acumen LLC at: cmsmspbmeasure@acumenllc.com.

Question 48: If patient is readmitted within the 30 days post discharge, will that be added to the cost?

Answer 48: For questions regarding the MSPB measure calculation and methodology, please contact Acumen LLC at: cmsmspbmeasure@acumenllc.com.

Question 49: Where can I find out if our hospital is eligible for the program?

Answer 49: The Percentage Payment Summary Report will display the exclusion reason on the first page if a hospital is excluded from the Hospital VBP Program. In addition, the Total Performance Score

(TPS) and incentive payment section will display Hospital VBP Ineligible in the fields.

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