Inpatient Quality Reporting Program

Support Contractor

Overview of the Hospital Value-Based Purchasing (VBP) Fiscal Year (FY) 2017

Q & A Transcript

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Question 1: If we find a coding error during the correction period, can our data be modified to reflect correction?

Answer 1: CMS cannot regenerate the report for this period to reflect corrected claims. If your facility submitted or wishes to submit a corrected claim after September 26, 2014 that pertained to an incorrect claim originally submitted prior to September 26, 2014, the corrected claim will not be included in your measure results. If your quality review has identified a coding error on your claim, we suggest you correct the claim using CMS standard process.

Question 2: Even though it is past the correction date to update the CMS report, is there any benefit to submit corrections of the coding errors?

Answer 2: Yes, due to the length of the reporting period if claims are not corrected they could continue to be included in future years, depending on the discharge period.

Question 3: Is the PSI-90 for VBP and HAC program's Medicare patients only?

Answer 3: Only Medicare fee-for-service patient data during the reporting period is included.

Question 4: The eligible discharges are only straight Medicare patients?

Answer 4: Yes.

Question 5: Can you explain smoothed rate?

Answer 5: The smoothed rate is the weighted average of the hospital's Risk-Adjusted and the National Medicare Risk-Adjusted Rate.

Question 6: Does Medicare fee-for-service include Medicare advantage, example Humana?

Answer 6: No.

Question 7: How many secondary DX are used to identify the PSI patients through nine or 25?

Answer 7: Prior to January 1, 2011, CMS systems could only process the first nine diagnoses codes and six procedure codes submitted on inpatient hospital claims. Effective January 1, 2011, CMS made systems changes to allow an expansion of internal system capability, so we can now process up to 25 diagnoses codes and 25 procedure codes on inpatient hospital claims. To be consistent with [the] FY 2016 baseline period, the first nine diagnoses codes and six procedure codes are used in measure calculations.

Question 8: What does "HCUP" stand for?

Answer 8: Healthcare Cost and Utilization Project.

Question 9: When will the HSR for AHRQ PSI-90 be available?

Answer 9: FY 2016 Performance Period Hospital Specific Reports (HSRs) were made available 04/10/2015 to hospital users with the Hospital Reporting Feedback-Inpatient role through *QualityNet* Secure File Transfer.

Question 10: Do you want to be between (to) the Benchmark and the Threshold in order to not be penalized for FY 2016?

Answer 10: A hospital that receives a composite value that is equal to or less than the achievement threshold, achievement points will be awarded. If the hospital has a Composite value that is less than or equal to the benchmark, 10 achievement points will be awarded. Please note that lower composite values indicate better quality in the AHRQ PSI-90 Composite. In addition, payments are based upon a hospital's Total Performance

Score and not the specific performance on any one given measure.

Question 11: Are Critical Access Hospitals able to get VBP reports?

Answer 11: Critical Access Hospitals are not part of the VBP program and are therefore not able to get VBP reports.

Question 12: Does a code of "W" Count as “Not present on admission?”

Answer 12: Only POA codes of "N" or "U" count as “Not present on admission” for the AHRQ calculations.

Question 13: PSI 90 is part of both [the] VBP and HAC Reduction programs. Will a hospital's PSI-90 score be always the same across these two programs?

Answer 13: The PSI-90 score for these two programs will not necessarily be the same. For example, for the FY 2016 period, the calculations for the PSI-90 score for these two programs are using different reporting periods and different AHRQ software versions, which will result in different rates.

Question 14: Mortality: if the hospital-specific effect is HIGHER than the average effect, what does this mean?

Answer 14: If the hospital-specific effect is higher than the average effect, then the calculated Predicted Deaths for your hospital will be higher. A higher “Predicted Deaths” results in a higher “Risk-Standardized Mortality Rate.” Please note that for a negative number, a higher value would be a smaller negative number or a positive number.

Question 15: Where can I find the inclusion/exclusion criteria for the patients that are on the mortality list?

Answer 15: The Mortality inclusion criteria can be found in the User Guide that accompanies your HSR in the paragraph before Table 3 on page 7. The exclusion criteria are described in Table 3 on page 8 of the User Guide under the Inclusion/Exclusion Indicator column description.

Question 16: If on our internal audit we found coding errors, how can we request for review and correction of our report?

Answer 16: If your facility submitted or wishes to submit a corrected claim after September 26, 2014 that pertained to an incorrect claim originally submitted prior to September 26, 2014, the corrected

claim will not be included in your measure results. If your quality review has identified a coding error on your claim, we suggest you correct the claim using CMS standard process.

Question 17: If we have coding errors and will submit the corrected claims, these corrections will NOT be reflected in any sort of adjustment to this complication rate?

Answer 17: CMS cannot regenerate the report for this period to reflect corrected claims. If your facility submitted or wishes to submit a corrected claim after September 26, 2014 that pertained to an incorrect claim originally submitted prior to September 26, 2014, the corrected claim will not be included in your measure results. If your quality review has identified a coding error on your claim, we suggest you correct the claim using CMS standard process.

Question 18: What is the "Smoothed Rate" definition?

Answer 18: The Smoothed Rate is the estimate of your hospital's expected performance with a large population of patients for each PSI (except the PSI-90 Composite) for the Hospital VBP FY 2016 performance period.

Question 19: What version of the AHRQ software was used to calculate PSI performance?

Answer 19: AHRQ software version 4.4 is used for the FY 2016 hospital VBP program performance calculations.

Question 20: Which User Guide contains HCUP values?

Answer 20: The *Hospital Value-Based Purchasing (VBP) Program Hospital-Specific Report User Guide Fiscal Year (FY) 2016 Performance Period* contains the HCUP rates. This user guide accompanies the HSRs upon delivery, or is available on the *QualityNet* website here: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228773024772.

Question 21: If claims are resubmitted/rebilled, which may correct coding errors, are those corrected bills used in calculating our performance? (or do our original miscoded bills used for the calculation?)

Answer 21: Previously resubmitted/corrected claims will not be included in the performance if they were submitted after September 26, 2014.

Question 22: Is the HCUP rate a constant? And where in the User Guide is it located?

Answer 22: The HCUP rates are on page 27 of the User Guide and are the same for every hospital.

Question 23: is the risk-adjusted rate different for different hospitals?

Answer 23: The risk-adjusted rate is an estimate of your hospital's performance on each PSI, except the PSI-90 Composite, if your hospital had an average patient case mix, given your hospital's actual performance. This rate will differ between hospitals.

Question 24: Can any adjustments be made to the current report if corrections are approved by CMS for relevant cases?

Answer 24: CMS cannot regenerate the report for this period to reflect corrected claims. If your facility submitted or wishes to submit a corrected claim after September 26, 2014 that pertained to an incorrect claim originally submitted prior to September 26, 2014, the corrected claim will not be included in your measure results. If your quality review has identified a coding error on your claim, we suggest you correct the claim using CMS standard process.

Question 25: IQR = inter-quartile rate?

Answer 25: IQR refers to the Inpatient Quality Reporting program.

Question 26: Where can we pull this patient list shown on the slide "AHRQ PSI Discharges?"

Answer 26: The AHRQ PSI discharges for your hospital may be found on your HVBP AHRQ Hospital Specific Report. The mock report may be found on the *QualityNet* website here: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228773024772.

Question 27: If we find errors in our coding abstracts, can this be corrected in the PSI cases?

Answer 27: If your facility submitted or wishes to submit a corrected claim after September 26, 2014 that pertained to an incorrect claim originally submitted prior to September 26, 2014, the corrected claim will not be included in your measure results. If your quality review has identified a coding error on your claim, we suggest you correct the claim using CMS standard process.

Question 28: Specifically the AHRQ PSI-90 Composite: We are able to see our mortality rates on our *Hospital Compare Preview Report* but can't see the PSI data.

Answer 28: Please contact the *QualityNet* Help Desk at 866.288.8912.

Question 29: Do the HCUP national rates change? Where are they found? thanks.

Answer 29: The HCUP rates can be found on your Hospital Specific Report User Guide that was delivered with the report and is also available on the *QualityNet* website on the Hospital Value-Based Purchasing page. If you are in your User Guide, they can be found on page 27.

Question 30: Can you please elaborate more what it means [to] "request for submission of new or corrected claims to the underlying data are not allowed?"

Answer 30: This means that you're not allowed to submit corrected or new claims and have them cause a recalculation of your scores on this HSR; that you can follow the CMS standard process to collect these claims, but they will not be included on this year's reports.

Question 31: Where can national benchmarks for all PSI's be found? I see some on *Hospital Compare* and some on VBP and AHRQ reports, but not all.

Answer 31: The Performance Standards (achievement threshold and benchmark) are published in the IPPS Final Rules. For the FY 2015, 2016, and 2017 Hospital VBP Program, a technical update was announced that updated the AHRQ software version and the performance standards. A table is provided below providing the updated standards and software version.

Fiscal Year (FY)	Achievement Threshold	Benchmark	Software Version
FY 2015	0.616248	0.449988	4.4
FY 2016	0.616248	0.449988	4.4
FY 2017	0.777936	0.547889	4.5a

Question 32: I am new to reviewing all of these reports and submitting data. I have reviewed the User Guides associated with each section; however I am still confused to terminology and significance of the data and findings. Is there a quick reference guide or something that breaks it down even more? Thank you.

Answer 32: If you have more questions about the data or calculations, you can submit them to the *QualityNet* Help Desk at qnetsupport@hcqis.org, over the phone at this number: 866.288.8912, or over TTY at this number: 877.715.6222.

Additional resources can also be found on *QualityNet* website:

30-Day Mortality Measures:

- https://www.qualitynet.org/dcs/ContentServer?cid=1163010398556&pagename=QnetPublic%2FPage%2FQnetTier3& c=Page

Measure Methodology:

- https://www.qualitynet.org/dcs/ContentServer?cid=1163010421830&pagename=QnetPublic%2FPage%2FQnetTier4&c=Page

Frequently Asked Questions:

- https://www.qualitynet.org/dcs/ContentServer?cid=1228774681764&pagename=QnetPublic%2FPage%2FQnetTier4&c=Page

AHRQ:

- https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228695355425

Frequently Asked Questions:

- https://www.qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228890436469&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3D2015AHRQFAQ.pdf&blobcol=urldata&blobtable=MungoBlobs

Question 33: Is the hospital factor a cumulative number of all risk factors documented in [a] patient file?

Answer 33: The measures estimate hospital-level 30-day all-cause RSMRs for each condition using hierarchical logistic regression models. In brief, the approach simultaneously models data at the patient and hospital levels to account for the variance in patient outcomes within and between hospitals. At the patient level, it models the log-odds of mortality within 30 days of the index admission using age, sex (in the AMI, HF, pneumonia, and stroke measures), selected clinical covariates, and a hospital-specific intercept. At the hospital level, it models the hospital-

specific intercepts as arising from a normal distribution. The hospital intercept represents the underlying risk of mortality at the hospital, after accounting for patient risk. The hospital-specific intercepts are given a distribution to account for the clustering (non-independence) of patients within the same hospital. If there were no differences among hospitals, then after adjusting for patient risk, the hospital intercepts should be identical across all hospitals.

Additional information can be found in the Mortality Measures Methodology 2015 Morality Measures updates. The document can be found at the following location: http://www.qualitynet.org>Hospitals-Inpatient>Claims-BasedMeasures>Mortality Measures>Measure Methodology.

Question 34: Is there a reason that patients discharged to hospices stay on the mortality list? Thank you.

Answer 34: From question 7 in the "Chapter 2 – Mortality Measures" FAQ .pdf found here: http://www.qualitynet.org >Hospitals-Inpatient>Claims-Based Measures>Mortality Measures>Frequently Asked Questions.

The condition-specific 30-day mortality measures (AMI, COPD, HF, pneumonia, and stroke) exclude patients who were enrolled in the Medicare or Veterans Health Administration (VA) hospice programs at any time during the 12 months prior to the index admission or on the first day of the index admission. The procedure-specific CABG mortality measure does not exclude index admissions for hospice patients. (See Question 14 for more information.)

The mortality measures continue to adjust for a number of factors associated with the likelihood that patients are at the end of their lives, including protein-calorie malnutrition, metastatic cancer, dementia, and age, to accurately compare mortality rates across hospitals.

Some stakeholders have recommended that the Centers for Medicare and Medicaid Services (CMS) exclude not only patients enrolled in hospice at admission, but also patients who choose comfort care at any point during the index admission. CMS recognizes that in some cases, death is the anticipated outcome of a long, complicated illness, rather than an adverse event stemming from a failure of the healthcare system. However, consistent with guidelines for healthcare quality outcome measures, the mortality measures do not exclude

patients who transition to hospice or palliative care during their hospital stay. Such transitions may be the result of quality failures that have led to poor clinical outcomes. Thus, excluding these patients could mask quality problems. Importantly, use of palliative care, in contrast to hospice care, is not necessarily an indication that a patient is no longer seeking life-sustaining measures. Palliative care is focused on providing patients relief of symptoms. It is increasingly used by patients who are not at the end of life. Accordingly, these patients should not be excluded from the mortality measures. For the vast majority of patients admitted for AMI, COPD, HF, pneumonia, and stroke, the goal of their hospitalization is survival.

Question 35: Does the HCUP national rate vary per fiscal year? Is FY 2017 available for predictive purposes? For the PSI-90 measure, each of the patient safety indicators has a different number for the eligible discharges, and the value of these varies greatly depending on the indicator. I understand that for CLABSI/CAUTI it would be patient with those devices, but how do you develop the eligible discharge denominator for the others?

Answer 35: As the measure owner, the Agency for Healthcare Research and Quality (AHRQ) determines the denominator for AHRQ PSI-90 and the component measures, and [they] are the best resource to answer this question. They can be contacted at qisupport@ahrq.hhs.gov or 1.301.427.1949.

Question 36: Where do we find the "Eligible Discharges" criteria for each measure? The AHRQ numerator does not specify insurance type included or excluded.

Answer 36: All paid Medicare fee-for-service claims are included when evaluating the AHRQ PSI results, without regard to the payment amount. Individuals enrolled in an HMO at the time of admission are excluded. Instructions for replicating CMS' results that include this specific information can be found on *QualityNet* at the following link: https://www.qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228890436327&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3DFY2016_HosVBP_RepltnInstructs.pdf&blobcol=urldata&blobtable=MungoBlobs.

Question 37: When will the ICD-10 DX code set criteria be released?

Answer 37: Currently, CMS is preparing for transition to ICD-10 on October 1, 2015 discharges.

Question 38: Is this for FY 2016, not 2017, as described?

Answer 38: This presentation is in relation to FY 2016 HVBP.

Question 39: How often are the CMS calculations incorrect when replicated?

Answer 39: CMS receives many questions about the content of the HSRs, but no calculation errors have been identified during any previous HVBP Review and Corrections periods.

Question 40: What will ICD 10 Codes change in these systems, such as IQR/HBVP?

Answer 40: Additional information regarding the ICD-10 transition can be found at: http://www.cms.gov/Medicare/Coding/ICD10/index.html.

Question 41: Based on the presenter's explanation of the reliability rates, smaller volume hospitals will have Smoothed Rates closer to the national average, which is higher than the median. This makes it more difficult for smaller volume hospitals to even obtain threshold performance for the PSI-90 Composite rate. Could you please share the calculation for the reliability rates for each PSI?

Answer 41: The AHRQ measures have been adjusted through a process known as “smoothing” to reflect the fact that the measures for small hospitals are measured less accurately (i.e., are less reliable) than for larger hospitals. “Smoothed” rates are calculated by taking a weighted average of a hospital’s risk-adjusted rate and the national rate, in which the weight used for the hospital’s risk-adjusted rate is an estimate of its reliability. Since smaller hospitals can have less reliable rates, the weight given to their risk-adjusted rate is smaller than that given to larger hospitals, and the weight given to the national rate is larger. This weighting approach pulls the “smoothed” rates for smaller hospitals towards the national mean. Additionally, CMS will not be reporting individual measure performance for hospitals with less than 25 eligible cases for a measure.

AHRQ, as the measure developer, is responsible for developing the approach used to calculate rates for small hospitals. For more information on how these measures are calculated refer to the *Guide to Patient Safety Indicators* on

QualityNet: www.QualityNet.org > Hospitals-Inpatient > Claims-Based Measures > Agency for Healthcare Research and Quality (AHRQ) Indicators > Resources. If additional assistance is needed, contact the AHRQ Help Desk at QIsupport@ahrq.hhs.gov or 1.301.427.1949.

Question 42: Do eligible discharges only need to be Medicare or Medicare plus age 65+?

Answer 42: The inclusion criteria will vary by measure. It is best to review the specifications for each individual measure to determine the eligibility requirements of the patient population.

Question 43: The current AHRQ PSI-90 Composite includes 11 measures. Did I hear someone say that these will be incorporated in VBP 2019? If not, will they or when will they be incorporated?

Answer 43: CMS has not announced the use of the three additional PSIs in the PSI-90 Composite specific to the Hospital VBP Program. For more information on this measure, please comment on the FY 2016 IPPS Proposed Rule.

Question 44: What does "90" stand for in PSI-90?

Answer 44: As the measure owner, the Agency for Healthcare Research and Quality (AHRQ) determines the naming on measure criteria and are the best resource to answer this question. They can be contacted at qisupport@ahrq.hhs.gov or 1.301.427.1949.

Question 45: Can the AHRQ PSI-90 calculations covered today for FY 2016 likewise be calculated for FY 2017?

Answer 45: FY 2016 used version 4.4 and FY 2017 baseline and performance uses version 4.5a for measure calculations in addition to different reporting periods.

Question 46: What again is the exp?

Answer 46: “exp” in the =(1/(1+exp(-1 * Add HOSP_EFFECT results))) formula is the Excel exponential function.

Question 47: What time period will be reflected in next fiscal year's report, and by when should any coding errors be reviewed and clarified to be included in next year's report?

Answer 47: The FY 2017 Reporting Periods are as follows:

AHRQ PSI 90

- Baseline October 1, 2010–June 30, 2012
- Performance October 1, 2013–June 30, 2015

30-Day Mortality

- Baseline October 1, 2010–June 30, 2012
- Performance October 1, 2013–June 30, 2015

Claims data is extracted approximately 90 days after the end of the applicable reporting period For HVBP FY 2017, the applicable reporting period will end June 30, 2015 and the claims data extract will include claims processed through September 25, 2015.

Question 48: Requesting additional replication sample.

Answer 48: The replication instructions can be found in the H*ospital Value-Based Purchasing (VBP) Program Hospital-Specific Report User Guide Fiscal Year (FY) 2016 Performance Period*. This user guide accompanies the HSRs upon delivery or is available on the *QualityNet* website here: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228773024772. A separate Excel document with sample calculations can be requested through the *QualityNet* Help Desk.

Question 49: Which fiscal payment period did the presenter state will use the 25 diagnosis codes for VBP for the PSI indicators?

Answer 49: The first time that 25 diagnoses and procedures codes will be available for both the baseline and performance reporting periods is HVBP FY 2019.

Question 50: Are total risk factor and case mix index at all comparable?

Answer 50: The case mix refers to the population of included cases for the provider and all the risk factors present for each of those cases. The differences between hospitals in the number of cases, and in what risk factors those cases have, are what define the differences in case mix between hospitals.

Question 51: Can a patient fall into more than one individual PSI numerator that make up the PSI 90 composite?

Answer 51: Yes, provided the patient meets the inclusion criteria for more than one PSI measure. The AHRQ software doesn't discriminate against an individual that makes it into more than one measure for measure and PSI composite calculations.

Question 52: Will the Smoothed Rate be the value used in determining VBP results? If so, how is it justified to penalize hospitals who have achieved zero on one or more of the PSI indicators?

Answer 52: Sometimes, a hospital's risk-adjusted rate may be '0' as a result of having '0' numerator counts. When this occurs and there are fewer cases with which to estimate performance, the weight given to the risk-adjusted rate tends to be smaller, while the weight given to the national risk-adjusted rate tends to be larger because of data reliability. Therefore, it is not uncommon that hospitals with small sample size and '0' numerator counts may have smoothed rates closer to the national risk-adjusted rate, rather than their own risk-adjusted rate. The smoothed rate adjusts for small numbers of discharges and offers a more accurate prediction of a hospital's expected performance with a large number of patients than the hospital's risk-adjusted rate.

Question 53: The CMS standard process for resubmitting claims will not correct miscoded claims, correct?

Answer 53: Edits made in accordance with the time limits described in the *Medicare Claims Processing Manual* and before the claims data extract for the HVBP Program (90 days after the end of the applicable period or September 26, 2014 for the FY 2016 HVBP Program), will be reflected in the HVBP Program scores.

Question 54: How will our reimbursement be affected if we consistently have "number of cases too small to report" for AMI, HF, and PN mortality?

Answer 54: A hospital that does not meet the minimum cases in any measure within the Hospital VBP Program will not have that measure count towards the Total Performance Score (TPS). The Hospital VBP Program utilizes a domain normalization methodology that uses the sum of the measure scores a hospital received in the domain divided by the total points possible for that individual hospital, multiplied by 100. The total points possible are equal to the number of measures in the domain that met the minimum cases multiplied by the maximum points possible for the measure (10).

Question 55: If the diagnosis shows POA, how can it be a post-op complication?

Answer 55: For the AHRQ program, only POA codes of "N" ("Diagnosis was not present at time of inpatient admission") or "U" ("Documentation insufficient to determine if the condition was

present at the time of inpatient admission") will trigger a claim as meeting a PSI measure. Other POA codes, including "Y" ("Diagnosis was present at time of inpatient admission") will not trigger a PSI measure.

Question 56: If no re-calculations are done, what advantage is there to resubmitting claims?

Answer 56: Separate from the HVBP program, providers are subject to the provisions outlined in the *Medicare Claims Processing Manual*. Additionally, the claim may appear in future results if the claim date falls within the specified reporting period.

Question 57: Is the baseline truly two years earlier than the performance period? Looks like five–six years have passed for FYI?

Answer 57: The baseline period occurs two years prior to the performance period. For FY 16, the baseline period for HVBP Mortality and AHRQ was October 1, 2010–June 30, 2011. The FY 16 Performance Period for Mortality was October 1, 2012–June 30, 2014, and October 15, 2012–June 30, 2014 for AHRQ.

Question 58: What types of errors are traditionally found when hospitals perform their reviews?

Answer 58: Most commonly, hospitals submit questions in regard to the patient data included in the HSRs. CMS receives many questions about the content of the HSRs, but no calculation errors have been identified during any previous HVBP Review and Corrections periods.

Question 59: During which FFY will AHRQ version 5.0 be used?

Answer 59: The software versions for FY 2018 and subsequent years have not yet been announced. The FY 2015 and FY 2016 Hospital VBP Programs utilized v4.4 and FY 2017 utilized v4.5a,

Question 60: When minimum case requirement of at least three valid discharges is stated, does that mean three in one category or one in three different categories?

Answer 60: The AHRQ software does not calculate rates for a hospital if there are fewer than three valid discharges for a given measure. For example, if the only PSI with fewer than three valid discharges at your hospital is PSI-13, no rates are calculated for PSI 13. The remaining PSIs will display the calculated results.

Question 61: In this presentation it was stated that PSI-90 is part of [the] IQR program. Do you mean PSI-90 is part of the HAC Reduction program?

Answer 61: The component measures used in the PSI-90 Composite measure are the same for the Hospital IQR program, HAC Reduction program, and the Hospital VBP program; however, please note that there are some differences in how hospitals' results are reported and used in the three different programs:

- Different data periods are used for calculations.
- Diagnosis and procedure codes: the HVBP program always uses the same number of diagnoses and procedure codes for baseline and performance period. During the HVBP baseline period (October 15, 2010–June 30, 2011) only 9 DX/ 6 PX codes were available. The first time that 25 diagnoses and procedure codes will be used for HVBP baseline and performance will be FY 2019.
- Software versions: the most recently available software is used to calculated HVBP baseline results (which was 4.4) and for consistency, the same version of the software is used for the HVBP performance period. For IQR, the most recently available software version is used, which is 4.5a.

Question 62: I understand that requests for submission of new or corrected claims are not allowed. However, what about asking for additional reviews of the original claims when an organization sees ICD-9 codes that should have helped with risk-adjustment that are not represented on the HSR report? Will those requests for correction be considered?

Answer 62: There are certain cases when the discharge-level data provided by CMS may not match internal hospital records. This usually occurs for one of the following reasons:

- The claim submitted by the hospital's billing department differs from the one in the patient records. CMS calculates the measures from final claims received from hospital billing departments.
- The claim was amended and resubmitted to CMS after the set run-out date for the year. The measures only reflect changes for claims processed by September 26, 2014.

We recommend that hospitals verify the data in their discharge-level reports against the claims submitted to Medicare by the hospital's billing department, and confirm that these claims were submitted prior to the run-out periods cited previously. Additionally, hospitals can use the document titled *2015 Replication Instructions* to validate their results.

If, after considering these two issues and looking up the instructions document, there is a discrepancy between the discharge-level data provided by CMS and the AHRQ occurrences identified in your hospital's claims data, CMS suggests that you email the AHRQ Measures Project Team at qnetsupport@hcqis.org. In your email, please include the ID Number in the first column of your HSR for the discharge in question.

Question 63: The Federal Office of Rural Health Policy is encouraging CAHs to be prepared to go to a VBP model within three years. At some point will reports be available to help plan for the transition?

Answer 63: At this time, Hospital VBP Program reports will only be available for eligible hospitals.

Question 64: What is the difference in the SAS rounding of numbers and the Excel rounding of numbers?

Answer 64: The data presented in the HSRs is limited to a particular number of decimal values, whereas the SAS software is storing the values in 8 bytes of data which represents a higher level of precision. The differences are very minor, but because of these differences in rounding, it is possible that the PSI-90 Composite calculations you complete may be different from the PSI-90 Composite Index Value in Table 2 of the HSR out to the fourth, fifth, or sixth decimal place.

Question 65: Where can I find the CMS standard process for correcting claims for the PSI-90?

Answer 65: Separate from the HVBP Program, providers are subject to the provisions outlined in the *Medicare Claims Processing Manual*. Please contact your Medicare Administrative Contractor (MAC) for additional information on correcting claims.

Question 66: What is the plan to align timeframes and software versions?

Answer 66: One of CMS' goals is to align timeframes and software versions for the measures used in quality improvement programs. Due to limitations with the Hospital VBP Program, specifically, the need for consistency between the baseline and performance period, it is not always possible for the same time periods and software versions to be used between the Hospital VBP Program and Hospital IQR Program. CMS continues to look for ways to align these measures in the future.

Question 67: When the Patient-Level Detail Preview Reports are delivered via QNet, it is the first time that a hospital knows which patients CMS has identified as inclusions in a measure. However, per CMS, edits may not be made to the underlying data for those patients. So, in practicality, there is no opportunity for a hospital to review, validate, and correct its data. Therefore, what is the purpose of the Patient-Level Preview Reports? How does CMS expect the validation and correction to occur at the hospital level if we don't know which patients are definitely included? When does CMS expect the validation and correction to occur at the hospital level if we don't know which patients are definitely included?

Answer 67: The CMS claims-based measure Review and Corrections process allows hospitals to review their claims, mortality measures, and PSI-90 Composite Value calculations. The Hospital Value-Based Purchasing, Inpatient Quality Reporting, and HAC programs all have similar statutory provisions on reviewing and correcting quality measure and score results and have similar periods for review and correction of information to be made public. As discussed in past rulemakings, this was intentionally done to relieve regulatory burden on hospitals and expedite compliance. In the FY 2014 IPPS/LTCH Proposed Rule, it was specifically noted that CMS intended to use a process for editing underlying data for the HAC Reduction Program that is similar to the methodologies proposed and finalized for the Hospital Inpatient Quality Reporting (IQR) and Value-Based Purchasing (VBP) programs (see 78 Fed. Reg. 27633, May 10, 2013). CMS finalized this process in the FY 2014 IPPS/LTCH Final Rule (see 78 Red. Reg. 50725, Aug. 19, 2013). Further discussion of the rationale for providing early review and correction periods for the underlying data before the final review and correction period for program scores are set out in the FY 2012 IPPS/LTCH Final Rule (76 Fed. Reg. 74544, November 30, 2011); the FY 2013 IPPS/LTCH Proposed Rule (77 Fed. Reg. 28076, May 11, 2012); and the FY 2013 IPPS/LTCH Final Rule (77 Fed. Reg. 53579, August 31, 2012).

Because claims data are generated by the hospital itself, hospitals, in general, always have the opportunity to review/correct these data until the deadlines specified

CMS understands the important concerns expressed regarding the fact that the underlying claims data cannot be corrected at this time. These conditions were explained in multiple publicly-available documents during the past several years. Further, these conditions apply to multiple CMS quality programs and CMS payment processing systems that have been in existence for some time now. Finally, these conditions are applied uniformly to all hospitals.

Question 68: Is Medicare A & B, or Medicare A, or both?

Answer 68: The patient must have Medicare Part A at the time of admission to be part of the inclusion population. If the patient was not enrolled in Medicare Parts A and B during the 12 consecutive months prior to the index admission date, they are excluded with an exclusion reason of one.

Question 69: Two different definitions for Smoothed Rate were given. Is this correct: the Smoothed Rate is the estimate of your hospital's expected performance with a large population of patients for each PSI (except the PSI-90 Composite) for the Hospital VBP FY 2016 performance period?

Answer 69: Yes, this definition is correct.

Question 70: I have a case from 5/13 that was corrected and rebilled in 1/14. The incorrect coding appears on my PSI report. Why is that?

Answer 70: Please contact the *QualityNet* Help Desk with specific questions regarding patient data. They can be reached at qnetsupport@hcqis.org, over the phone at this number: 866.288.8912, or over TTY at this number: 877.715.6222.

Question 71: Is the measure's weight in composite the same between VBP and the HAC reduction program?

Answer 71: The measures weight in composite will vary by version of the AHRQ software used to calculate the measure results. FY 2016 HVBP used 4.4a. FY 2016 HAC Reduction will use 4.5a. The details of the changes between software versions can be found at www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V45/PSI_Changes_4.5.pdf.

Question 72: How are reliability weights found only on HSRs?. Do they change?

Answer 72: As the measure owner, the Agency for Healthcare Research and Quality (AHRQ) determines the weights for each software version and are the best resource to answer this question. They can be contacted at qisupport@ahrq.hhs.gov or 1.301.427.1949.

Question 73: Please provide an example of how to interpret the report and an action to be taken. The idea is to replicate, but an example of how to act on what is seen would be helpful.

Answer 73: If the hospital finds an error in the calculations during the replication process, the next course of action is to contact the *QualityNet* Help Desk. From there, a full investigation will take place to confirm if the findings were indeed in error or the *QualityNet* Help Desk will provide more information to the hospital to aid in understanding the results.

Question 74: If a hospital has a small sample size, how does this affect the rate?

Answer 74: The AHRQ measures that will be publicly reported on Hospital Compare have been adjusted through a process known as "smoothing" to reflect the fact that the measures for small hospitals are measured less accurately (i.e., are less reliable) than for larger hospitals. "Smoothed" rates are calculated by taking a weighted average of a hospital's risk-adjusted rate and the national rate, in which the weight used for the hospital's risk-adjusted rate is an estimate of its reliability. Since smaller hospitals can have less reliable rates, the weight given to their risk-adjusted rate is smaller than that given to larger hospitals, and the weight given to the national rate is larger. This weighting approach pulls the "smoothed" rates for smaller hospitals towards the national mean. Additionally, CMS will not be reporting individual measure performance for hospitals with less than 25 eligible cases for a measure.

AHRQ, as the measure developer, is responsible for developing the approach used to calculate rates for small hospitals. For more information on how these measures are calculated refer to the Guide to Patient Safety Indicators on QualityNet: www.QualityNet.org > Hospitals-Inpatient > Claims-Based Measures > Agency for Healthcare Research and Quality (AHRQ) Indicators > Resources. If additional assistance

is needed, contact the AHRQ Help Desk at QIsupport@ahrq.hhs.gov or 1.301.427.1949.

Question 75: The IQR HSR reports were recently updated to include data through June 2014. Can you explain why the data that is included in the recent *Hospital Compare* refresh only included data through June 2013?

Answer 75: *Hospital Compare* is updated annually. The data presented in the 2015 IQR HSRS is scheduled to be published on Hospital Compare in July 2015.

Question 76: Could you share how you might interpret the data? What do the observed rate, risk-adjusted rate and smoothed rate tell you?

Answer 76: The AHRQ software generates three rates for each individual PSI: an observed rate, a risk-adjusted rate, and a smoothed rate.

- The observed rate, also known as the raw rate, is the actual number of outcomes identified at your hospital (numerator) divided by the number of eligible discharges for that measure at your hospital (denominator), multiplied by 1,000.The smoothed rate is an estimate of your hospital's expected performance with a large population of patients. This rate is a weighted average of the national risk-adjusted rate in the Medicare fee-for-service population and your hospital's risk-adjusted rate. The weight used to construct the average is an estimate of the reliability of your hospital's risk-adjusted rate. The smoothed rate will be reported on Hospital Compare.
- The risk-adjusted rate is an estimate of your hospital's performance if your hospital had an "average" patient case-mix, given your hospital's actual performance. "Average" case-mix is defined using the Healthcare Cost and Utilization Project (HCUP) reference population. If your hospital had a healthier case-mix of patients than the case-mix in the 2010 HCUP State Inpatient Database (SID) reference population, then the risk-adjusted rate is higher than the observed rate. If your hospital has a less healthy patient case-mix than the case-mix in the HCUP SID reference population, then the risk-adjusted rate is lower than the observed rate.
- The smoothed rate is an estimate of your hospital's expected performance with a large population of patients. This rate is a weighted average of the national risk-

adjusted rate in the Medicare FFS population and your hospital's risk-adjusted rate. The weight used to construct the average is an estimate of the reliability of your hospital's risk-adjusted rate. The smoothed rate will be reported on Hospital Compare.

AHRQ, as the measure developer, is responsible for developing the rates, for this information refer to the Patient Safety Indicators Technical Specifications on QualityNet: www.QualityNet.org > Hospitals-Inpatient > Claims-Based Measures > Agency for Healthcare Research and Quality (AHRQ) Indicators > Resources. If additional assistance is needed, contact the AHRQ Help Desk at QIsupport@ahrq.hhs.gov or 1.301.427.1949.

END

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