Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Hospital Inpatient Quality Reporting (IQR) and Hospital Value-Based Purchasing (VBP) Programs Claims-Based Measures Hospital-Specific Report (HSR) Overview and Updates

Questions and Answers

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Hospital Inpatient Quality Reporting (IQR) Program

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Question 1: **Can you please share again what the public facing name is for EDAC?**

The public facing name of the EDAC measure is the Hospital Return Days measure.

Question 2: **Please define acute care in the EDAC measure. Also, do the mortality and readmission measures include acute discharges or inpatient discharges?**

For the purposes of counting the Excess Days in Acute Care (EDAC) outcome, the measure defines admissions to acute care settings as admissions to the emergency department (ED), admissions to observation status, or admissions as an unplanned readmission for any cause to a short-term acute care hospital. The readmission and mortality measures include inpatient admissions to/discharges from short-term acute care hospitals.

If you have more questions about these measures, please contact CMS directly:

CMSreadmissionmeasures@yale.edu for questions about the readmission measures

CMSmortalitymeasures@yale.edu for questions about the mortality measures

CMSedacmeasures@yale.edu for questions about the EDAC measures

Question 3: **Can you please explain again why the payment measure results can't be compared to prior years to understand if change is positive or negative?**

The national payment results are usually adjusted for inflation, based on a specific year. For fiscal year (FY) 2018, results are adjusted for inflation, based on 2015 dollars while the FY 2017 results are adjusted, based on 2014 dollars. As a result, it would not be fair to compare these results as publically reported without adjusting for inflation, based on the same year dollars. If you have any questions related to the payment measures, please feel free to contact CMS at CMSmortalitymeasures@yale.edu.

Question 4: **Slide 11. Readmission measures are still based on inpatient admissions and not ED or observation times; is that correct?**

Yes. The readmission measure calculations are still based on discharges from inpatient admissions at short-term acute care hospitals.

Question 5: **Are the national observed results risk-adjusted?**

The national results for the mortality, complication, and readmission measures are observed rates and not risk-adjusted rates. The national rates for the payment measures are risk-standardized (but not risk-adjusted). If you have additional questions on these measures, please feel free to contact CMS directly:

CMSmortalitymeasures@yale.edu for questions about the mortality measures

CMSreadmissionmeasures@yale.edu for questions about the readmission measures)

CMSepisodepaymentmeasures@yale.edu for questions about the payment measures

CMSedacmeasures@yale.edu for questions about the EDAC measures

Question 6: **Why do we have different rates between IQR mortality and VBP mortality?**

While the reporting periods mostly overlap, the Hospital VBP Program reporting period is three months shorter than the Hospital IQR Program reporting period. The Hospital VBP Program performance period will align with the Hospital IQR Program period starting in FY2019.

There is also a different mix of providers included in the risk adjustment for the measures. While for the Hospital VBP Program, only VBP-eligible hospitals are included in the risk-adjustment calculations, the Hospital IQR Program includes additional hospitals such as critical access hospitals (CAHs) and territories. The difference in included hospitals changes the national case mix that hospitals are compared to in the risk-adjustment model.

Question 7: **If we have a coding error in one of our claims, can we get it corrected for this report?**

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 30, 2016, that pertained to an incorrect claim originally submitted prior to September 30, 2016, 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. Also note that 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 8: **In the mortality hospital-specific report, if the hospital-specific effect is higher than the average effect, what does this mean?**

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 9: **Do we know when the TKA/THA payment measure will be included in the hospital star overall rating? And what about the EDAC measures?**

The payment measures are not used in the star rating at this time. The EDAC measures will be included in the July 2017 star rating.

Question 10: **Do the critical access hospitals get hospital-specific reports if they voluntarily submit for the Hospital Inpatient Quality Reporting Program?**

Yes. CAHs will receive HSRs for the Hospital IQR Program measures.

Question 11: **Could a patient death be included in two areas? For example, one patient's death be counted in the acute myocardial infarction (AMI) and heart failure (HF) mortalities?**

Each measure is calculated independently from the other measures. If a patient meets the cohort criteria for two different mortality measures with admissions for each falling within 30 days of death, then the death would count as a numerator event for both measures.

Question 12: **What does NQ stand for?**

NQ means that the hospital had no qualifying cases for that condition.

Question 13: **Is the same data found in the IQR HSR also found in the IQR preview reports that were recently made available? Clarification: Specifically, the IQR *Hospital Compare* preview reports?**

The data in the most recent preview report are the same data as in the HSRs; however, the HSRs contain greater detail than the preview report. The preview report will include high-level measure information that will be reported on *Hospital Compare*. The HSR will have the detailed data specific to the measures.

Question 14: **How do these reports compare to the *Hospital Compare* reports star rating?**

The Hospital IQR Program HSRs provide you with the results for your hospital that will be reported on *Hospital Compare* in July. You will receive a separate HSR with the star ratings values.

Question 15: **What diagnosis and procedure codes are used for the FY 2018 Hospital VBP Program? And what are the 25 codes used for the FY 2018 Hospital IQR Program?**

Only the first nine diagnoses and six procedures billed on the claims are used for the Hospital VBP Program FY 2018 Agency for Healthcare Research and Quality (AHRQ) measures. For the Hospital IQR Program AHRQ measures, all 25 diagnoses and procedures are used if submitted on the claim.

Question 16: **What does CMS propose that the quality department does with the risk factors that are shared with the risk-adjusted measures?**

For the Hospital VBP Program measures, the risk-factor columns can be used in the replication process to allow you to better understand how the case mix of your patients affects how your rate is risk-adjusted. For the Hospital IQR Program, the case mix information presented in these tables clarifies the differences between the observed readmission rates and the risk-standardized rates in the measure results table. Please see the information in the FY 2018 HVBP HSR user guide for the case mix tables for more specifics.

Question 17: **When the presenter says, "The computation should be done," does that mean we should verify these calculations or is it just to understand how the calculations are made?**

These replication steps are shown to allow you to better understand how the calculations are made and how the case mix affects the risk adjustment of your results.

Question 18: **For the corrections period, are we checking the math of these HSRs or are we checking our internal records to see if these particular cases and claims should have been even counted in the first place?**

You are given the opportunity to identify errors or suspected errors by CMS in the calculation. If your quality review has identified a coding error on your claim, we suggest you correct the claim using CMS standard process. While adjusted claims will not affect this report, claims will still need to be adjusted to ensure that there are no impacts on future reporting periods.

Question 19: **What is the difference between predicted and expected deaths? These terms sound similar.**

Predicted deaths are the number of deaths within 30 days from admission, based on your hospital's performance with its observed case mix and your hospital's estimated effect on mortality. While expected deaths are the number of deaths within 30 days of admission, based on average hospital performance with your hospital's case mix and the average hospital effect on mortality.

Question 20: **Do CAHs get the HSR reports if they voluntarily submit IQR?**

Yes. CAHs will receive HSRs for the Hospital IQR Program measures.

Question 21: **Do you know why we do not receive HSRs for the OQR measures?**

CMS will be adding HSRs for Outpatient Imaging Efficiency measures at a future date.

Question 22: **Let me restate: clinical care measures were published with benchmarks for effective date 10-01-17, showing a benchmark of 0.880986 for PNA mortality -30 days. Slide 11 show a rate of 15.9%. Why the different rates?**

The rates in slide 11 are the national rates for the Hospital IQR Program measures. These will differ from the results in the Hospital VBP Program because there are different hospitals included in each program, and they have different time periods.

The Hospital VBP Program benchmarks for the mortality measures include a survival rate, which is the inverse of the mortality rate. The correct benchmark values are provided in your HSR and have been posted in the final rule.

Question 23: **The HSR bundle I downloaded from IQR does not contain the files shown on slide 18. What do I need to do?**

You should have received two separate packages last week, one for the Hospital IQR Program and one for the Hospital VBP Program. The bundle shown on slide 18 is the Hospital IQR Program bundle. Please contact the *QualityNet* Help Desk at qnetsupport@hcqis.org to obtain additional assistance if you did not receive it.

Question 24: **Our HSR only had the AHRQ, Mortality, and HUG [HSR user guide]?**

You should have received two separate packages last week, one for the Hospital IQR Program and one for the Hospital VBP Program. The bundle shown on slide 18 is the Hospital IQR Program bundle. Please contact the *QualityNet* Help Desk at qnetsupport@hcqis.org to obtain additional assistance if you did not receive it.

Question 25: **Slide 35. Define the risk-adjusted rate in the HSR. What is it in English? What should you compare it to on the table?**

For the AHRQ measures, The Patient Safety Indicator (PSI) 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 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 Medicare Fee-for-Service (FFS) reference population.

If your hospital had a healthier case-mix of patients than the case-mix in the 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 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*.

The smoothed rate can be compared to the national rate to see how your hospital compares to the nation. On the Hospital IQR Program AHRQ report, the lower and upper 95% interval estimates show the range of the 95% confidence interval for your smoothed rate. This range is used in

conjunction with the national rate to determine your hospital's comparative performance.

- "No different than the national rate" if the 95% interval estimate surrounding the hospital's rate includes the national rate
- "Worse than the national rate" if the entire 95% interval estimate surrounding the hospital's rate is higher than the national rate
- "Better than the national rate" if the entire 95% interval estimate surrounding the hospital's rate is lower than the national rate

AHRQ, as the measure developer, is responsible for developing the rate methodology. For additional information on the methodology used to derive the various rates, refer to the AHQI Quality Indicators™ (QI) Patient Safety Indicator Technical Specifications on *QualityNet*: 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.

Question 26: **According to Appendix D.3, the excess days in acute care, the definitions of observation stay include a search for Rev. code 0762, HCPCS code G0378, and the different CPT codes 99217 through 99234 associated with physician E/M level for observation stay physician charge.**

On slide 25, your sample doesn't give date samples, so I can't tell if information is similar to my own; but, I see a similar issue that I see on my HSR. On my HSR, I have, for example, a patient in observation start 10/08/2013, end 10/09/2013, and this patient has the following days per event listed: observation stay (facility) 1, observation stay (physician) 1, and ED visit 0.5 for a total of 3 excess days; all on 10-08-13. While I have an inpatient with start date of 9/25/13 and end date of 9/27/13 with 2 days for their event (based on their length of stay).

Why would the observation patient get two additional days for same date range when the inpatient didn't? I have several like this; it appears the logic didn't work correctly.

In the EDAC HSR, if there are multiple observation or ED visits on the same day or days, then each will be listed in the Patient-Level Summary tab to show all events found in the data. Overlapping events are taken into

account when determining what gets used in the measure. If you review the Summary of Events tab, it lists the number of events that are detailed on the Patient-Level Summary tab for each type of event and the total number of events. The last column in the Summary of Events tab lists the total days included in measure outcome, which is the actual number that is used in the measure.

In the example from the question above, there are three events all on the same day: observation stay (facility), observation stay (physician), and ED visit. In the Summary of Events tab, you should see the counts for those three events listed and only one day listed in the total days included in measure outcome column since they all fell on the same day.

Question 27: **Acute inpatient risk-adjusted mortality rates exclude patients discharged to hospice facilities or hospice care in the home. When I was reviewing one of my facility's HRS for HF mortality within 30 days, one of the included patients had been discharged to a hospice facility. What is the position of CMS on including these patients, the numerator for the mortality within 30 days measure? If these individuals are at the end of life, and hospice care is the most appropriate course of action, should that count as a mortality against the hospital?**

The risk-adjusted mortality measures do not exclude patients because of a discharge to hospice. Instead, the acute myocardial infarction (AMI), chronic obstructive pulmonary disease (COPD), heart failure (HF), pneumonia, and stroke mortality measures exclude patients who were enrolled in the Medicare hospice program at any time during the 12 months prior to the index admission, or on the first calendar day of the index admission.

Please note that CMS recognizes that not all deaths are the result of poor care. In certain cases, the best quality care may ultimately result from supporting patient goals and comfort needs at the end of life rather than prolonging life. While the goal is not to reach zero deaths, the premise is that there are many preventable deaths. Therefore, given that the mortality measures are relative measures of performance, knowledge of a hospital's performance compared to what might be expected, given its case mix, is helpful in supporting efforts to improve outcomes. Lastly, please note the mortality measure specifications should not be used to guide decisions for hospice referral.

Question 28: **Can you explain what the average hospital effect means in general terms?**

The average hospital effect is the average of all hospital-specific effects across all hospitals for that condition/procedure and time period. The average hospital effect represents the underlying risk of an outcome, e.g., readmission at an average hospital, after accounting for patient risk.

For more information on the average hospital effect, please refer to Section 2 and Appendix A of the 2017 condition-specific or procedure-specific measures updates and specifications reports, available on *QualityNet*: Hospitals-Inpatient > Claims-Based Measures > Mortality Measures (or Readmission Measures, or Complication Measure, or Excess Days in Acute Care [EDAC] Measures) > Measure Methodology. Additionally, the original measure methodology reports that describe the statistical methodology can be accessed on the same page by selecting the Resources link.

Question 29: **Can you tell me if the risk-adjustment variables used remain v. 12 of HCCs without the hierarchy or have you moved to v. 22 HCCs?**

For public reporting in summer 2017, the risk variables were updated from Hierarchical Condition Categories (HCC) Version 12 to HCC Version 22.

Question 30: **Do you know the date that the *Hospital Compare* website will be updated in July?**

CMS is anticipating the *Hospital Compare* refresh will occur in late July 2017. CMS will communicate the announcement of the July 2017 *Hospital Compare* release when the refresh is complete.

Question 31: **Does AHRQ only show Medicare patients?**

The AHRQ measures included in the Hospital IQR, Hospital VBP, and Hospital-Acquired Condition (HAC) Reduction programs are calculated using only Medicare FFS claims. They are calculated using a version of the AHRQ software that was recalibrated using a reference population of Medicare FFS claims.

AHRQ, as the measure developer, is responsible for developing the rate methodology. For additional information on the methodology used to

derive the various rates, refer to the refer to the AHQI Quality Indicators™ (QI) Patient Safety Indicators Technical Specifications on *QualityNet*: 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.

Question 32: **For the IQR readmission and mortality worksheets, are the distribution of patient risk factors values for both readmission and mortality (assuming it is the same patient population group, i.e., CABG, AMI, etc.)?**

The readmissions and mortality populations for each measure have some minor differences. There are differences in the exclusions that are applied and there are differences in the risk factors that are used in the measure. Therefore, they have different risk-factor distribution tables in their given HSRs. Please see the HSR user guide that accompanied the HSRs for more information.

Question 33: **Given the comment just made by the presenter about the mortality IQR and VBP time periods aligning effective FY 19, does that mean that the pneumonia mortality measure will be released with both the old definition for VBP and the new expanded definition, including sepsis? Or will *Hospital Compare* still only include the pneumonia definition including sepsis, and we will have to wait until we receive the VBP preview reports?**

While the reporting periods for the Hospital IQR Program and Hospital VBP Program performance will align in FY 2019 for the mortality measures, the Hospital VBP Program pneumonia measure will continue to use the original cohort through FY 2020. The Hospital VBP Program pneumonia measure will use the new expanded cohort that includes sepsis in FY 2021. In order to allow for the adoption of the new pneumonia cohort in FY 2021, the pneumonia reporting period will not be aligned in FY 2021.

Question 34: **Has the mortality measure always been 30 days from admission?**

The 30-day outcome period begins the day the patient is admitted for the index admission, and extends for 30 days after that, for the acute myocardial infarction (AMI), heart failure (HF), chronic obstructive pulmonary disease (COPD), pneumonia, and stroke mortality measures.

The 30-day outcome period for the coronary artery bypass grafting (CABG) surgery mortality measure starts on the date of the CABG procedure during the index admission.

Question 35: **How are observed deaths taken into account in the predicted or expected mortality rate?**

The actual number of deaths experienced by patients in a hospital's cohort is used to calculate the number of predicted deaths. Specifically, this information is used to calculate the hospital-specific effect, which represents the risk of death at that hospital after patient risk factors are accounted for.

Question 36: **How do I interpret performance on the IQR PSI report? Smoothed rate vs. risk-adjusted rate? Can you review the importance of the smoothed rate again?**

For the AHRQ measures, The PSI 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 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 Medicare FFS reference population. If your hospital had a healthier case-mix of patients than the case-mix in the 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 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*.

The smoothed rate can be compared to the national rate to see how your *Hospital Compare*s to the nation. On the Hospital IQR Program AHRQ report, the lower and upper 95% interval estimates show the range of the 95% confidence interval for your smoothed rate. This range is used in conjunction with the national rate to determine your hospital's comparative performance.

- "No different than the national rate" if the 95% interval estimate surrounding the hospital's rate includes the national rate
- "Worse than the national rate" if the entire 95% interval estimate surrounding the hospital's rate is higher than the national rate
- "Better than the national rate" if the entire 95% interval estimate surrounding the hospital's rate is lower than the national rate

AHRQ, as the measure developer, is responsible for developing the rate methodology. For additional information on the methodology used to derive the various rates, refer to the refer to the AHQI Quality Indicators™ (QI) Patient Safety Indicators Technical Specifications on *QualityNet*: 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.

Question 37: How do we get a template of the spreadsheet to verify our data?

CMS will provide an Excel file detailing the steps (and showing formulas) upon request. Contact the *QualityNet* Help Desk at qnetsupport@hcqis.org with the subject line, "Request for Hospital VBP Program AHRQ Replication Example" **or** "Request for Hospital VBP Program Mortality Replication Example."

Question 38: **How is the performance estimate calculated for each hospital?**

For the mortality, readmission, and complication measures in the HSR, CMS places hospitals with 25 or more eligible cases into comparative performance categories, based on hospital 95% interval estimates, as compared to a national rate. For the mortality, readmission, and complication measures, the national rate is the national observed rate or raw rate. Hospital performance is:

- "No different than the national rate" if the 95% interval estimate surrounding the hospital's outcome rate includes the national rate or value
- "Worse than the national rate" if the entire 95% interval estimate surrounding the hospital's outcome rate is higher than the national rate or value
- "Better than the national rate" if the entire 95% interval estimate surrounding the hospital's outcome rate is lower than the national rate or value

For the outcome measures, CMS assigns a separate category for hospitals with fewer than 25 eligible cases in a particular measure during the reporting period: "Number of cases too small" (fewer than 25) to determine the hospital's performance. If a hospital has fewer than 25 eligible cases, CMS will not report the measure rates and interval estimates for that measure; however, CMS will include the data in individual HSRs.

Please see the Hospital-Specific Report User Guide (HUG) for information on performance categories for other measures.

Question 39: **I thought the mort measure was determined by the principal diagnosis to establish index case; how can you have one case be two indexes for mortality?**

The THA/TKA measures and the CABG measures use procedure codes to identify the cohort. There is the possibility that a patient can have one of these procedures on a claim that also had a primary diagnosis that fits into the cohort for another measure.

Question 40: **Are the desired values for values reflected on slide 30 less than 1?**

The values represented on slide 30 are the hospital's performance period index value, achievement threshold and benchmark for the PSI 90 composite. The achievement threshold and benchmark values are the values that your hospital's performance period index value is compared to for determining improvement and achievement points in the Hospital VBP Program. The desired value would be for your hospital to achieve a performance period index value for the PSI 90 composite that falls below the benchmark score.

Question 41: **Is there an Excel spreadsheet available from the *QualityNet* Help Desk for PSI measures? Mortality? Readmissions?**

For the Hospital VBP Program AHRQ and mortality measures, CMS will provide an Excel file combining the steps (and showing formulas) upon request. Contact the *QualityNet* Help Desk at qnetsupport@hcqis.org with the subject line: "Request for Hospital VBP Program AHRQ Replication Example" **or** "Request for Hospital VBP Program Mortality Replication Example."

During the Hospital Readmission Reduction Program (HRRP) review and corrections period, CMS will provide an Excel file combining the steps (and showing formulas) upon request. Contact the *QualityNet* Help Desk at qnetsupport@hcqis.org with the subject line: "Request for HRRP Replication Example."

Question 42: **On MORT HSR interpretation, are we looking at death rate or survival rate when compared to achievement and benchmark?**

The Hospital VBP Program mortality measure to compare to achievement and benchmark is the survival rate.

Question 43: **On the preview report, for groups where a lower rate is better, is the rate of performance being above national average good or bad? For example, the drive is to have lower readmission rates. Would a good performance be below the national performance or above national performance?**

For the measures where a lower rate is better, which includes all Hospital IQR Program claims-based measures, having a rate that is below the national rate is good. To achieve a performance category of better than the national rate, you would need to have a score that is low enough that your hospital's upper limit of 95% interval estimate falls below the national rate for the given measure.

Question 44: **Please confirm the data dates for PSI 90 for IQR and HVBP, and whether we should still submit new claims if we feel errors are found. Thanks.**

The FY 2018 Hospital IQR Program AHRQ reporting period is July 1, 2014 – September 30, 2015. The FY 2018 Hospital VBP Program AHRQ reporting period is also July 1, 2014 – September 30, 2015. The data for both of these measures is as of September 30, 2016.

If your facility submitted or wishes to submit a corrected claim after September 30, 2016, that pertained to an incorrect claim originally submitted prior to September 30, 2016, 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. Also note that 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 45: **Slide 12. Any effort to adjust for cost of living in hospital area?**

The overarching goal of the payment measures is to calculate payments that reflect differences in the care provided to patients for certain procedures/diagnoses rather than differences in payments based on geography (for example, cost of living and wage index) or policy adjustments (for example, indirect medical education and disproportionate share). Because these payment adjustments do not reflect the care delivered by hospitals, geography and policy adjustments are removed

when calculating payments for each care setting, service, and supply. This is done by stripping or standardizing payments.

For more information on how this is done, please see the 2017 AMI, HF, Pneumonia and THA/TKA Payment Measure Updates and Specifications Report on *QualityNet*: Hospitals-Inpatient > Claims-Based Measures > Payment Measures > Measure Methodology. Alternatively, you may contact CMS at CMSepisodepaymentmeasures@yale.edu with questions.

Question 46: **Slide 13. Are excess days in acute care based on the number of days above the ICD-10 code assignment of an average length of stay (ALOS) for a diagnosis with or without a complication code? For example, if a patient has a myocardial infarction (MI) and assigned complication codes for respiratory failure and congestive heart failure (CHF), are the excess days based on additional days above the ALOS designated for a patient with AMI with cc of CHF and respiratory failure?**

The number of excess days in acute care is not based on the ICD-10 code assignment for an ALOS for a diagnosis without a complication code. Instead, the number of excess days in acute care is based on the time that patients spend in the ED, observations stays, and unplanned readmissions at short-term acute care hospitals for any reason within the 30 days after discharge from an eligible index admission. Specifically:

- Each ED visit is counted as 0.5 days;
- Days spent in an observation setting are counted in hours and rounded up to the nearest 0.5 days; and
- Each full or partial calendar day spent in an unplanned readmission is counted as one whole day.

For more information on the EDAC measures, please see the 2017 Condition-Specific Excess Days in Acute Care Measures Updates and Specifications Report: AMI and HF on *QualityNet*: Hospitals-Inpatient > Claims-Based Measures > Excess Days in Acute Care (EDAC) Measures > Measure Methodology. Alternatively, you may contact the CMS at CMSedacmeasures@yale.edu with questions.

Question 47: **Slide 18. Is there a risk-adjusted national rate for IQR mortality (and readmissions) for comparison with RSMR at Your Hospital and Average RSMR in Your State?**

The national observed rate would be the national rate to compare to. With the way that the risk adjustment is done, the hospital risk-adjusted rates are still balanced against the national observed rate.

Question 48: **Slide 19. You mentioned that ICD-10 codes were released for risk adjustment. I have not seen these codes. *QualityNet* still has the ICD-9 codes for risk adjustment for each cohort within measures. Where can I find the ICD-10 risk-adjustment codes?**

The 2017 condition-specific measure updates and specifications reports, as well as, the supplemental code lists on *QualityNet* include the ICD-10 codes.

For the mortality measures, the updates, reports, and code lists can be found at QualityNet.*org* > Hospitals-Inpatient > Claims-Based Measures > Mortality Measures > Measure Methodology.

Additionally, the readmission, complication, payment, and EDAC reports can be found in their corresponding Measure Methodology sections.

Question 49: **Slide 21. Which line really tells you how your hospital performed?**

For the readmission measures, slide 21 shows the Measure Results tab. The following rows tell you about hospital performance:

- Your Hospital's Comparative Performance shows the performance category that your hospital falls into for the given measure (better, worse, or no different than the national rate).

- RSRR at Your Hospital is the risk-standardized readmission rate that your hospital received, adjusted for your hospital's case mix. This number can be compared with the National Observed Readmission Rate (Numerator/Denominator) and the Observed Readmission Rate (Numerator/Denominator) in Your State values to see how your hospital compares to the average performance in the nation and in your state.

- Lower and Upper Limit of 95% Interval Estimate values define the interval range in which your hospital has a 95% probability of having a RSRR. This range is used to determine the performance category in which your hospital fits. Please see the Performance Category Assignment section of the HUG that accompanied your reports for more information on calculating the performance categories and what they mean.

Question 50: **Slide 21. Is there a list of ICD-10 codes for the readmissions measures?**

The 2017 condition-specific measure updates and specifications reports, as well as, supplemental code lists on *QualityNet* include the ICD-10 codes.

For the readmission measures, the updates, reports, and code lists can be found at: *QualityNet*.com > Hospitals-Inpatient > Claims-Based Measures > Readmission Measures > Measure Methodology.

Additionally, the mortality, complication, payment, and EDAC reports can be found in their corresponding Measure Methodology sections.

Question 51: **Slide 38. Where can the codes that are used for VBP and IQR be found for the PSI 90 measures?**

For information on the methodology and the codes used to derive the various rates for the AHRQ measures, refer to the AHQI Quality Indicators™ (QI) Patient Safety Indicators Technical Specifications on *QualityNet*: 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.

Question 52: **Slide 8. When will PSI 04 be included in IQR or VBP programs?**

The PSI 04 measure is included in the Hospital IQR Program. This measure is publically reported on *Hospital Compare* and data.Medicare.gov under the Complications-Hospital section.

Question 53: **Slides 36–38. So to address the shift in values, do we simply state calculations for PSI 90 have changed?**

The reason for the shift in values for PSI 90 between the Hospital VBP and Hospital IQR programs is due to a difference in the AHRQ software version. The Hospital VBP Program performance calculations need to utilize the same software version that was used for the baseline calculations, while the Hospital IQR Program uses the most recent software version. FY 2018 Hospital VBP Program uses the 5.0.1 fully recalibrated version of the AHRQ software. FY 2018 Hospital IQR Program uses the 6.0.2 fully recalibrated version of the AHRQ software.

Question 54: **Were the baselines and national comparisons recalculated based on the new pneumonia measures?**

The Hospital VBP Program pneumonia measure is still based on the old cohort to align with the baseline period calculations. As reported in the final rule, the updated cohort for pneumonia will be used in the Hospital VBP Program starting in the FY 2021 program year.

Question 55: **Slide 55. What exactly is allowed to be corrected? For example, if a case was incorrectly coded, are we able to correct the coding, rebill the case, and assume it will drop off the report/data?**

You are given the opportunity to identify errors or suspected errors by CMS in the calculation. If your quality review has identified a coding error on your claim, we suggest you correct the claim using CMS standard process. While adjusted claims will not affect this report, claims will still need to be adjusted to ensure that there are no impacts on future reporting periods.

Question 56: **What is the smoothed rate? What does it mean?**

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*.

The smoothed rate can be compared to the national rate to see how your hospital compares to the nation. On the Hospital IQR Program AHRQ report, the lower and upper 95% interval estimates show the range of the 95% confidence interval for your smoothed rate. This range is used in conjunction with the national rate to determine your hospital's comparative performance.

- "No different than the national rate" if the 95% interval estimate surrounding the hospital's rate includes the national rate
- "Worse than the national rate" if the entire 95% interval estimate surrounding the hospital's rate is higher than the national rate
- "Better than the national rate" if the entire 95% interval estimate surrounding the hospital's rate is lower than the national rate

AHRQ, as the measure developer, is responsible for developing the rate methodology. For additional information on the methodology used to derive the various rates, refer to the AHQI Quality Indicators™ (QI) Patient Safety Indicators Technical Specifications on *QualityNet*: 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.

Question 57: Where do I find the codes for discharge destination?

The discharge destination codes can be found at the Research Data Assistance Center (ResDAC) website here: http://www.resdac.org/cms-data/variables/patient-discharge-status-code.

Question 58: Where do we get the reliability rate? Is it given to us by CMS?

That step description in the HVBP AHRQ Replication was mislabeled. It should instead read Reliability **Weight.**

Question 59: **Which of the numerous values displayed should be used to determine at-risk performance, i.e., smoothed rate, observed rate, risk-adjusted rate?**

For the AHRQ measures, the PSI 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 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 Medicare FFS reference population. If your hospital had a healthier case-mix of patients than the case-mix in the 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 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*.

The smoothed rate can be compared to the national rate to see how your hospital compares to the nation. On the Hospital IQR Program AHRQ report, the lower and upper 95% interval estimates show the range of the 95% confidence interval for your smoothed rate. This range is used in conjunction with the national rate to determine your hospital's comparative performance.

- "No different than the national rate" if the 95% interval estimate surrounding the hospital's rate includes the national rate
- "Worse than the national rate" if the entire 95% interval estimate surrounding the hospital's rate is higher than the national rate

- "Better than the national rate" if the entire 95% interval estimate surrounding the hospital's rate is lower than the national rate

AHRQ, as the measure developer, is responsible for developing the rate methodology. For additional information on the methodology used to derive the various rates, refer to the AHQI Quality Indicators™ (QI) Patient Safety Indicators Technical Specifications on *QualityNet*: 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.

Question 60: **Why do the risk-adjustment categories on the MORT HSR not match those in the specifications published?**

The risk-adjustment categories in the 2017 condition-specific measure updates and specifications reports on *QualityNet* match the categories in the mortality HSR.

The mortality measure specifications can be found here: *QualityNet*.com > Hospitals-Inpatient > Claims-Based Measures > Mortality Measures > Measure Methodology.

Question 61: **Would it be possible to get a copy with the Excel formulas embedded? Thanks.**

CMS will provide an Excel file detailing the steps (and showing formulas) upon request. Contact the *QualityNet* Help Desk at qnetsupport@hcqis.org with the subject line: "Request for Hospital VBP Program AHRQ Replication Example" or "Request for Hospital VBP Program Mortality Replication Example."

Question 62: **Wouldn't there be value in correcting a claim, especially if that same case will populate next year's data, e.g., mortality? Will not fix it for this report; but, should fix it for the next one?**

Yes. With these measure reporting periods spanning multiple years, the same claims will appear in the measure multiple times. So, while correcting a claim will not affect this year's report, it may affect future reports.

Question 63: **You mean N/A, which means that risk-adjustment variable does not impact that cohort in the measure?**

In the Hospital IQR Program HSR Case Mix Comparison tabs, when there are multiple measures included, some of the risk factors listed do not apply to all of the measures. If the intersection of the measure and risk factor has a value of N/A then that risk factor is not used for that particular measure.