Hospital Value-Based Purchasing (VBP) Program

Support Contractor

VBP: FY 2016 Percentage Payment Summary Report

Presentation Transcript

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Matt McDonough: Hello and welcome to today's webinar. My name is Matt McDonough and I'll be your virtual host for today's event. As you can see on this slide, audio for today's event is being provided over Internet streaming, and, if you're hearing my voice right now, you already know that. What this means is that no telephone line is required to listen to today's event but that you must have computer speakers or head phones to hear the audio portion of today's presentation.

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Even though audio is streaming over your speakers today and attendees are in a listen only mode, you can still interact with our presenters today. As you see on this slide, there's a Chat window in the left column of your screen. You can submit your questions and comments on the contents of today's event by typing your question in the Chat window and then clicking the “Send” button. You can do this at any time during today's event.

Please note that the “Raise Hand” feature is not being monitored today, so please submit any questions you may have via the Chat window. That's going to do it for my introduction. So without further ado, I'll hand this over to our first speaker of the day.

Bethany Wheeler: Thank you, Matt. I want to start off by saying thank you for joining today's presentation on the Hospital Value-Based Purchasing Program Fiscal Year 2016 Percentage Payment Summary Report.

My name is Bethany Wheeler, and I am the Center for Medicare and Medicaid Services’ Value, Incentives, and Quality Reporting Support Contractor Lead for the Hospital Value-Based Purchasing Program. I would like to note that my team will be trying to answer as many questions as we can through the Chat window located on the left of your screen. Any questions that we do not respond to during today's call will be answered through the Q&A posting on the qualityreportingcenter.com website within a few weeks.

I have so much that I would like to share with you today, so let's get started.

The first few slides of my presentation have acronyms that I will use throughout the slides and also, as I explained it, for topics. If you have the slides printed off or pulled-up on your computer, please do not hesitate to

come back to these slides to reference the acronyms if you need the full names.

During today's webcast, I will: address the background and overview of the Hospital Value-Based Purchasing Program and how CMS evaluates hospitals in the Hospital Value-Based Purchasing Program, in accordance to the Fiscal Year 2016 domain measures; discuss eligibility for the FY 16 program; and scoring methodology.

We will calculate an example of the hospital scoring from beginning to end with: the improvement points, achievement points, measure scores, domain score, the total performance score, and payment adjustment. This presentation will also explain the procedure in submitting a review on correction request and appeal request. Lastly, we will identify resources and answer questions submitted during the webcast.

The objectives for this presentation are listed on the slide. So, without further ado, let's go ahead and jump into VBP.

The Hospital VBP Program is required by congress under Section 1886(o) of the Social Security Act, as added by the Patient Protection and Affordable Care Act. The Hospital Value Based Purchasing Program is the first national inpatient pay per performance program, meaning the hospitals will be paid for the services based on the quality of care and not just the quantity of services provided.

The program pays for care that rewards better value in patient outcomes, innovations, and cost efficiency, instead of just volume of services. The hospital VBP Program also encourages hospitals to achieve higher rates in quality metrics and also provides incentives for hospitals to improve based on their previous rates. The program uses the hospital quality data reporting infrastructure developed for the Hospital Inpatient Quality Reporting Program, or IQR program. So, no additional burden for data

submission are placed on the hospitals, past what is required for the Hospital IQR for our program.

The Hospital VBP Program is a budget-neutral program and is funded through a percentage of withhold from participating hospitals' Diagnosis Related Group, or DRG payment. Payment amounts will be redistributed based on the hospital's total performance scores in the program, in comparison to the distribution of all hospitals' total performance scores and the estimated DRG payment amount for the program.

It is important to note that withholds and incentive payments are not made in a lump sum but for each eligible Medicare claim made to CMS. So, funding from the first years of the program, Fiscal Year 2013, came from a withhold amount of one percent. This percentage of withhold is an increase by a quarter of a percentage point, and so FY 2017 when the program reaches the withhold percentage of two percent. The funding for the FY 16 program will come from a 1.75 percent withhold, which is estimated to be approximately 1.5 billion.

An eligible hospital is a subsection (d) hospital located in the 50 states and the District of Columbia, excluding the state of Maryland. This eligibility criteria currently excludes critical access hospitals.

Hospitals may be excluded from the programs based on a set of criteria. If a hospital is excluded, they will not, and I reiterate, will not have their base operating DRG payment amounts withheld, nor will they received incentive payments for that Fiscal Year. Hospitals that are excluded from the Inpatient Prospective Payment System, such as inpatient rehab, psychiatric, cancer, long term care acute hospitals, and children's hospitals will be excluded from the Hospital VBP Program. Again, critical access hospitals will also be excluded.

Hospitals that are excluded from the VBP Program also include hospitals that are subject to payment reduction under the Hospital IQR program by

choosing not to participate or not complying with one or more of the requirements of the Hospital IQR program. Hospitals under this category will incur a payment reduction through the Hospital IQR program via a reduction to the hospital's market basket update.

Hospitals that are cited for two or more deficiencies during the performance period that pose immediate jeopardy to the health or safety of patients will also be excluded. Hospitals that have an approved disaster or Extraordinary Circumstance Exceptions will also be excluded.

Finally, hospitals that do not meet the minimum number of domains per calculation of a Total Performance Score will also be excluded. These minimums will be explained later on in the presentation. If a hospital is excluded from the program, their report will say "Hospital VBP Ineligible" on the first page of the Percentage Payment Summary Report, in addition to the exclusion rating. Data for excluded hospitals will not be publicly reported in the Hospital Value-Based Purchasing section of the *Hospital Compare* website.

Now, we will move on to the measures included in the Hospital VBP Program and how hospitals are evaluated in the measure through performance standards and scoring. The Hospital VBP Program has evolved from the beginning of the initiative in Fiscal Year 2013 to the current Fiscal Year FY 16. In FY 13, the Hospital VBP Program evaluated hospitals based on two domains, the Clinical Practice of Care domain and the Patient Experience of Care domain.

In FY 14, the Hospital VBP Program evolved to add the Outcome domain that contains the three Claims-Based 30-day Mortality Measures. In FY 15, the fourth domain of Efficiency was added, and the CLABSI and [AHRQ] PSI-90 composite measures were added to the Outcome domain. Now in FY 16, the Clinical Practice of Care domain, with a total of eight measures and weighted at 10 percent. The Patient Experience of Care

domain is weighted at 25 percent. The Outcome domain is weighted at 40 percent and the Efficiency domain is weighted at 25 percent.

The IMM-2 Influenza Immunization measure was added to the Clinical Process of Care domain. The IMM-2 measure is a chart-abstracted prevention measure that addresses acute care hospitalized inpatients, ages six months or older, who are screened for seasonal influenza immunization status and were vaccinated prior to discharge, if indicated. CMS believes this measure is important to quality improvement efforts because about 36,000 adults die and over 200,000 are hospitalized annually for fever-related causes. Older adults are more vulnerable to influenza, and adults over age 65 comprised about 90 percent of deaths related to flu. Vaccination significantly reduced the number of flu-related illness and deaths.

If you have been in team with the Hospital VBP Program, you may have noticed that there are less measures included in the domain in the Fiscal Year than there has been in the previous Fiscal Years. Even with the new inclusion of the IMM-2 measure. In FY 13, we started with a total of 12 measures and in FY 14, CMS finalized the inclusion of the SCIP-Inf-9, making a total count of measures in the domain to 13. Then in FY 15, CMS remove the SCIP-VTE-1 measure, moving the measure count back down to 12.

In this fiscal year, CMS chose to remove a total of five measures. First, CMS finalized to remove AMI-8a and SCIP-Inf-1 because both measures met the criteria of being topped-out. Second, CMS finalized the removal of PN-3b Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital and Heart Failure–1 Discharge Instructions from the FY 16 Hospital VBP Program. Both PN-3b and Heart Failure–1 are no longer endorsed by the NQS. And CMS noted that in its 2013 pre-rulemaking report, the Measure Applications Partnership or MAP did not recommend those measures for the use in the Hospital VBP Program. And lastly, the SCIP-Inf-4 measure underwent significant

specification changes for discharge quarter ending on January 1, 2014. Then CMS finalized the performance period of Calendar Year 2014 and a baseline period of Calendar Year 2012, which we will discuss in the next slide for the Clinical Practice of Care measures under the FY 16 VBP Program. CMS believes these specification changes will have a significant impact on hospitals' SCIP-Inf-4 performance during the FY 16 performance period. CMS therefore did not finalize the SCIP-Inf-4 measure to the FY 16 program.

In the Outcome domain, the two measures of CAUTI and SSI were added. The CAUTI, or Catheter-Associated Urinary Tract Infection, measure was an HAI measure reported via CDC's National Healthcare Safety Network, or NHSN. This measure is important to quality improvement efforts because the urinary tract is the most common site of Healthcare-Associated Infections, accounting for more than 30 percent of infections reported by acute care hospitals. Complications associated with CAUTI causes discomfort to patients, prolonged hospital stays, increased cost, and mortality. More than 13,000 deaths each year are associated with ETIs.

Surgical Site Infection is also an HAI measure recorded via CDC's NHSN. As currently specified under the Hospital IQR program, the measure, through restricted colon procedures, including incision, resection or anastomosis of the large intestine, enlarged to small and small to large bowel anastomosis, and abdominal hysterectomy procedures, including those done via laparoscope. There were no measure or dimension changes made to the Efficiency domain or the Patient Experience of Care domain in FY 16.

This slide is a great reference slide for the time period dates in the FY 16 program. In general, the performance used data from Calendar Year 2014. The baseline period utilizes Calendar Year 2012 data. Successions to this generalization are the mortality measures in the AHRQ PSI-90 composite. The Mortality measures and AHRQ PSI-90 composite are calculated based on a baseline period from October 1, 2010, for mortality and

October 15, 2010, for AHRQ to June 30, 2011, and a performance period of October 1, 2012, for Mortality and October 15, 2012, for AHRQ to June 30, 2014.The baseline period is used in the Improvement Point calculations only, whereas the performance period is used to calculate the Improvement Points and Achievement Points. In the next few slides, I will cover how both of these values are calculated.

Hospitals receive Improvement and Achievement Points on their Percentage Payment Summary Report based upon their performance rate during the baseline period and performance period relative to the performance standard adapted for the Hospital VBP Program. The performance standards consist of new achievement thresholds and benchmarks for all measures and the score, which is only applicable to the Patient Experience of Care domain. The achievement threshold is calculated as the median or 50th percentile of all hospital rates for a measure during the baseline period. The benchmark is the mean of the top decile, which is the average of the top 10 percent during the baseline period, before using or calculating the HCAHPS® Consistency Score, and is the rate of the lowest performing hospitals during the baseline period. These values will display on the baseline measures report. I would like to note that the MSPB measure uses performance period data to calculate the performance standards and those performance standards will be listed on your hospital's Percentage Payment Summary Report.

The measures displayed on this slide will have a higher benchmark value than an achievement threshold. The higher rate demonstrates better quality in the measures. The measures that this description is applicable for are the Clinical Process of Care measures, the Patient Experience of Care domain dimension, and the 30-day Mortality measures in the Outcome domain.

Many of you may be asking, "Why should [the] mortality rate be higher? That doesn't make sense. Well, that is because CMS finalized that the results for the Mortality measures are to be calculated and displayed on the

Hospital VBP report as survival rates instead of mortality rates, meaning higher rates are better for the measures.

The measures displayed on this slide will have a higher achievement threshold and benchmark because lower rates demonstrate better quality in the measure. The measures that this description is applicable for are the AHRQ PSI-90 Composite and the Outcome domain, all Healthcare-Associated Infections in the Outcome domain, and the Medicare Spending per Beneficiary or MSPB measure and the Efficiency domain.

Achievement Points are awarded by comparing an individual hospital's rate during the performance period with all hospital rates from the baseline period by using the two performance standards that we just covered, the achievement threshold and the benchmark. If a hospital has a performing period rate that is equal to or better than the benchmark, ten achievement points will be awarded. If the rate is worse than the achievement threshold, the hospital will receive zero achievement points. As the performance period rate is equal to or better than the achievement threshold, but it's still lower than the benchmark, one to nine points will be awarded.

Improvement Points are unique to the Hospital Value-Based Purchasing Program in relation with the CMS' other Inpatient pay-for-performance programs. Not only can a hospital be evaluated based on their current performance in comparison to all other hospitals, they can also earn points by improving from their own baseline period. CMS may award a hospital Improvement Points if the hospital's performance period rate is better than their baseline period rate. The maximum point value for Improvement Points is nine points.

If the hospital has a rate equal to or worse than their baseline period rate, zero Improvement Points will be awarded. If the hospital opened after the end of the baseline period, they will not be eligible for Improvement Points, but they will still have an opportunity to receive Achievement Points and to the eligible for a Total Performance Score. Likewise, if a

hospital does not meet the minimum case count and the baseline period, if they are open, they would not be eligible for Improvement Points. But if they met the minimum during the performance period, they would be still eligible to receive Achievement Points. We will cover the minimum case count for each of the domains measured later in this presentation.

Now, we will dive in to each of the domains, taking a look at minimum measure and domain requirements, calculation examples, and the displays on the Percentage Payment Summary Report. We will start with the Clinical Process of Care domain.

As we covered earlier, the Clinical Process of Care domain is weighted at 10 percent of the Total Performance Score and contains [the] eight measures of AMI-7a, IMM-2, PN-6, SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-9, SCIP-Card-2, and SCIP-VTE-2.

Clinical Process of Care measures are generally endorsed by the national consensus body and are based on the best available medical evidence about what actions or behaviors clinicians exhibit in the hospitals that are most likely to positively impact patient outcomes.

The Clinical Process of Care domain requires at least four of the eight measures to receive measure scores to receive a domain score. In order to receive Achievement Points, a hospital must have at least 10 eligible cases in the denominator during the performance period. In order to receive Improvement Points, a hospital must have at least 10 eligible cases in the denominator during both the baseline period and the performance period. Because CMS needs to compare those two values to determine if improvement occurred at the hospital. In this example on the slide, the hospital met the minimum number of cases in all but the PN-6 measures, as that measure only has nine cases. As a result, the hospital will only be judged based on seven of the eight measures.

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In the next few slides, we will walk through how to calculate the Achievement Points, Improvement Points, and measure scores for the new IMM-2 measure and the un-weighted domain score for the Clinical Process of Care domain. I would like to note that the same process would be used for any of the other Clinical Process of Care measures. You would just need to plug your hospital measure scores for either the performance or baseline period rates and swap out the achievement threshold and benchmarks for the applicable measures.

To calculate Achievement Points, you may use the formula displayed at the bottom of the slide. You first divide the difference of the performance period rate and the achievement threshold by the difference of the benchmark and the achievement threshold. Then, multiple the quotient by nine and add the results to 0.5.

The IMM-2 measure has a benchmark of 98.75 percent and an achievement threshold of 90.607 percent. If you remember back to our Achievement Point slide, a hospital will receive Achievement Points if the hospital score is equal to or better than the achievement threshold and the hospital would receive the maximum of 10 points, if the hospital scores at or above the benchmark. The example hospital had a performance period rate of 95 percent, which is between the benchmark and the achievement threshold.

We will calculate the Achievement Points by first finding the numerator and the denominator in the parenthesis by subtracting the performance period rate of 95 percent by the achievement threshold, 90.607 percent, which equals to 4.393. This will be our numerator. We then subtract the benchmark of 98.875 percent by the achievement threshold of 90.607 percent to find your denominator, which equals 8.268. The quotient of the numerator over the denominator is 0.5313. Finally, we multiply by nine, which equals 4.7817 then add 0.5 to equal 5.2817. We then finally round the value to a whole number to equal the five achievement points that [are displayed on the slide.

To calculate Improvement Points, you may use the formula displayed at the bottom of this slide. We will calculate the Improvement Points by first finding the numerator and the denominator in the parenthesis by subtracting the performance period rate of 95 percent by the baseline period rate, 90 percent, which equals five percent. This will be our numerator. We then subtract the benchmark of 98.875 percent by the baseline period rate of 90 percent to find your denominator, which equals 8.875 percent. The quotient for 5 over 8.875 equals 0.563. Finally, we multiple 10 by the value of 0.563 and then subtract 0.5 to equal 5.13. We round to the nearest whole number, which is 5. This gives us our example hospital 5 Improvement Points for the Clinical Process of Care domain.

Hospitals are only awarded one score per measure, which is identified as the greater of Achievement Points and Improvement Points for each measure. This slide displays the FY 16 Clinical Process of Care measures with example Achievement and Improvement Point value. The measure score is populated by selecting the larger of the two values. For example, the AMI-7a measure received 10 achievement points and nine improvement points. The measure score is the greater of the two numbers, which is 10. If you remember back, for a minimum measure requirement slide, you will remember that the PN-6 measure did not meet the minimum of 10 cases in the baseline period and thus did not receive any scoring value.

The last example that I would like to point out is the SCIP-Inf-9 row. The improvement points are listed as N/A. This would be an example of a hospital not meeting the minimum case count in the baseline period, which leads to the hospital not being eligible to receive Improvement Points. However, because the hospital met the minimum case count in the performance period, they were eligible to receive Achievement Points.

Now that each measure has a measure score calculated, the un-weighted domain score is calculated. The un-weighted domain scores for all domains are normalized to account for only the measures the hospital met

the minimum requirement for. As I stated on the previous slide, the minimum requirements for the clinical process of care measures is 10 cases in a denominator during the performance period.

To normalize the domain, you sum the measure scores in the domain. In our example, the sum of the seven measure scores is 35 points; you then multiple the eligible measures by the maximum point value per measure. In our example, the hospital did not meet the minimum requirement for the PN-6 measure. So, instead of eight total measures, this hospital was only scored on seven; we then multiply the number seven by 10 points possible for each measure for a total of 70. To create a percentage score the hospital earned in relation to points possible, we divide the sum of the measure scores of 35, by the maximum point possible of 70, which equals approximately 0.50. Lastly, we multiply the results by 100 to equal 50. We will cover how to calculate the weighted domain score and the total performance score at the end of the presentation.

This slide displays the Percentage Payment Summary Report's clinical detail report, which is also page two of the report. On the Clinical Detail Report, each period's numerator, denominator, and performance period rate will be available for all eight of the Clinical Process of Care measures. It is important to note that if the denominator if less than 10 in the performance period, dashes will be displayed in the Achievement Points, Improvement Points, and measures score fields, indicating that your hospital did not meet the minimum requirements for score and calculation. As you can see, or I hope you can see, the AMI-7a measure has dashes throughout this forum section of the report resulting from not having at least 10 cases over the denominator during this performance period.

The third section of the Clinical Process of Care Detail Report is the HVBP metrics. The HVBP metrics include the performance standards of the achievement thresholds and benchmarks and the scoring values of the

Improvement Points, Achievement Points, measure score and condition procedure score.

Simply, the condition and procedure score is the sum of the measure scores within that measure set, such as AMI, HAI, pneumonia SCIP or preventative. And, if you did not receive a score in any of the measures in the measure set, a dash will be displayed. Lastly, the summary of the Clinical Process of Care Domain will be displayed at the bottom of the screen, denoted with our purple four. This will lift out the number of the eligible Clinical Process of Care Measures, the un-weighted Clinical Process of Care domain score, and the weighted domain score.

Now, we will move on to the Patient Experience of Care domain. I would like to remind you that you may submit questions through the Chat tool and my team will try to answer as many questions as we can during today's webinar.

The Patient Experience of Care domain is weighted at 25 percent of the total performance score. This domain is measured by use of the Hospital Consumer Assessment of Healthcare Providers and System, or HCAHPS® survey. Dimensions of communications with nurses, communication with doctors, responsiveness of hospital staff, team management, communication about medicines, cleanliness and quietness of hospital environment, discharge information, and overall rating of hospitals will all be included.

So, the Patient Experience of Care domain requires at least 100 completed surveys during the performance period in order to receive the domain score. And, in order to receive Achievement Points, a hospital must have at least 100 completed surveys during the performance period, as well. And, in order to receive improvement points, a hospital must have at least 100 completed surveys during both the baseline period and the performance period. CMS needs those two values to determine if Improvement Points or improvement occurred at the hospital. In this

example, the hospital did not meet the minimum of 100 completed surveys during the performance period in order to receive dimension scores or domain scores. In the next few slides, however, we will treat the hospital as if they met the minimum survey count.

I'm going to skip over slide 34 and 35, as these calculations have not changed from the previous year and they're exactly the same as the Clinical Process of Care calculations. I just wanted you to be able to have these examples as a reference if you wish to replicate the results on your Percentage Payment Summary Report.

Like the Clinical domain, hospitals are only awarded one score per dimension, which is identified as the greater of Achievement Points and Improvement Points for each measure. For example, in the Pain Management domain, the hospital received seven Achievement Points and eight Improvement Points, resulting in a measure score of eight.

What is different from the Clinical Process of Care domain is the use of global dimensions scores in order to calculate Consistency Points. To calculate the lowest dimension score, you must input values into the first formula on the slides for all eight dimensions. The lowest resulting value becomes your hospital flow of dimension score. In our example, the lowest dimension is the Key Communications About Medicines dimension, with the lowest score of dimension score of 1.080.

To calculate the Consistency score, you take the role of dimension scored value, in our case this year the 1.080, and multiply it by 20 then subtract by 0.5. The consistency score for our example hospital equals 20, as the maximum value is 20 for the consistency score calculation.

To calculate the hospital's un-weighted Patient Experience of Care Domain Score, we first calculate the Hospital Base Score, which is the sum of all of the dimension scores. As you can see on the slide, the Base Score is equal to 50. Second, we had to identify the hospital’s lowest

dimension score in order to calculate the Consistency Score. The resulting value from our calculation was 20 for the Consistency Score. Last, we sum the Base Score and the Consistency Score to equal 70.

The Patient Experience of Care detail report displays the hospital day plan period rate and performance period rate for each of HCAHPS® dimensions.

Additionally, the Detailed Report displays the HVBP metrics, which are the performance standards of the Score Achievement threshold, benchmark and scoring values. At the bottom of the page the summary scores are listed for the HCAHPS® Base Score, HCAHPS® Consistency Score, Un-Weighted Domain Score, Weighted Domain Score, and the number of surveys completed during the performance period. Finally, there will be a footnote at the bottom of the page that identifies the HCAHPS® Dimension that was used as the lowest dimension score for the hospital.

The Outcome Domain was added to the Fiscal Year 2014 program, incorporating the three 30 day Mortality measures.

In the Fiscal Year 2015 program, the domain briefly incorporates the AHRQ PSI-90 Composite and the CLABSI measure. In this Fiscal Year, CMS included two new measures in the HAI measure section. The two new measures are the CAUTI measure and the SSI measure. As displayed on this slide the Outcome domain is weighted at 40 percent of the Total Performance Score for Fiscal Year 2016. The mortality measures are Claim-Based measures, meaning the data used for the collections are derived from eligible Medicare claims and are not chart-abstracted by a member or representative of the hospital. The claims utilize admissions from Medicare fee-for-service beneficiaries age 65 or older, discharged having a principal discharge diagnosis of AMI, heart failure, or pneumonia. The AHRQ-PSI-90 is a composite measure of patient safety indicators developed and maintained by AHRQ. CMS believes that the

AHRQ-PSI-90 Composite used in the Hospital VBP Program is appropriate in order to encourage hospitals to take all possible steps to avoid threats to patient safety that may occur in acute care environments. This measure is also a Claims-Based measure, like the mortality measures, and utilizes claims for Medicare fee-for-service patients with complete Present on Admission or POA data, excluding the data from patients in Medicare Advantage plans.

The CLABSI measure is an HAI measure that assesses the rate of laboratory confirmed cases of blood stream infections or clinical sepsis among ICU patients. The measure can be stratified by the type of ICU and is aggregated to the hospital level by the NHSN. We've already covered the CAUTI and SSI measures, so we can go ahead and move forward to the minimum measure requirements for the Mortality measures.

This slide discusses the eligibility requirements for the three 30 day Mortality measures. I'd like to point out that there was a change in minimum eligible case requirements from Fiscal Year 2014 to Fiscal Year 2015 that continue to be adopted for the FY 16 program year. In order to be eligible to have Improvement Points calculated for the Mortality measures, the hospital must have 25 eligible cases during the baseline and performance periods. This is a change from Fiscal Year 2014 where only 10 eligible cases were required to receive a measure score. If a hospital does not meet the minimum case threshold during the baseline period, but it does meet it during the performance period, Achievement Points may be awarded to the hospital. Our example hospital met the minimum eligible case amount in all three Mortality measures, which is at least 25 eligible cases.

In order to calculate the 30 day Mortality measure achievement points, you use your hospital survival rate instead of the mortality rate. In our example, the hospital performance period survival rate was better than both the benchmark and achievement threshold. As you can reference at the bottom of this slide, a hospital that has a rate that is better than the

benchmark will receive 10 Achievement Points. Had a performance period rate, located in between the benchmark and the achievement threshold, the Achievement Point formula would have been used that we covered in the Clinical Process of Care calculation. If the hospital would have had a performance period survival rate worse than the achievement threshold, zero Achievement Points would have been awarded.

Now we know that our performance period rate is better than the benchmark, which results in nine points automatically in the improvement formula, if and only if the performance period rate is better than the baseline period rate. If our example would have moved the baseline period rate to 87 percent instead of 85.4 percent, the hospital would not have improved and the resulting improvement points would have been zero. If the performance rate (the blue box) would have been located in between the benchmark (the green box) and the baseline period rate (the yellow box), we would have used the Improvement Point formula to determine how many points would have been rewarded to the hospital.

The next Outcome measure displayed on your Percentage Payment Summary Report is the AHRQ-PSI-90 Composite. As we discussed earlier, PSI-90 is composed of eight underlying Patient Safety Indicators or PSI. In order for a hospital to receive Improvement Points on the Percentage Payment Summary Report, a hospital must have at least three eligible cases on any one underlying indicator in the baseline period and performance period. A hospital is eligible to receive Achievement Points when three eligible cases on any one underlying indicator are met in the performance period. On this slide, our hospital has four eligible cases in the PSI-3 measure. As a result our example hospital will be eligible to receive a measure score for the PSI-90 Composite.

Now, as I am sure many of you identified, the performance period rate value is worse than the benchmark and better than the achievement threshold. Remember, that the AHRQ-PSI-90 value is a reverse measure, meaning that lower values indicate better quality. Because the

performance period rate is in between the benchmark and the achievement threshold, we will use the achievement point formula, which results in the Achievement Points.

Moving on to the hospitals improvement points, we will also use the formula because the hospital performance period rate is: A) better than the hospital's baseline period rate andB) worse than the benchmark. The resulting value from the Improvement Point calculation is the improvement point.

Our third set of Outcome domain measures are the healthcare-associated infections including CLABSI, CAUTI and SSI measures. In order to receive Improvement Points for the measure, the hospital must have at least one predicted infection as calculated by the CDC in the baseline period and the performance period. To receive Achievement Points the minimum of one predicted infection must be calculated in the performance period. Additionally, the SSI measure is calculated individually and the two strata and then combined to equal one measure. We will cover that calculation in a few slides. However, I would like to note now that to receive a measure score for SSI, only one of the two strata need to meet the minimum predicted number of infections.

In our Achievement Point example, the hospital has a Standardized Infection Ratio, or SIR, of 1.010 in the performance period. The benchmark is 0.000 and the achievement threshold is 0.801. Because the score was worse than both the benchmark and the achievement thresholds, the hospital will automatically be awarded zero Achievement Points, as the hospital must meet at least the achievement threshold in order to receive at least one Achievement Point.

Now, the hospital had a SIR of 0.660 in the baseline period and a performance period SIR of 1.010. Because the performance period SIR was worse than baseline periods SIR, the hospital would automatically receive zero Improvement Points.

In order to receive an Outcome Domain Score, at least two of the seven measures must meet the minimum measure requirement that we have discussed individually in the last set of slides. As I promised earlier, we would cover the calculation of the combined SSI score. CMS finalized in the FY 2014 IPPS/LTCH Final Rule that they will award Achievement Points and Improvement Points to each stratum of the SSI measure, then compute a weighted average of points awarded to each stratum by predicted infection. The weighted average of the points awarded will be the hospital's SSI Measure Score.

So what does that really mean? The rule language is first stating that CMS will calculate the individual strata of the abdominal hysterectomy and colon surgery individually, like any other measure would be calculated in the Hospital VBP Program. However, in order to create just one score, we must weigh the measure scores by predicting the number of infections during the performance period. I think this would be easier with an example, so we'll go ahead and add some numbers.

An example: if a hospital received five Improvement Points for the SSI column stratum, which is the hospitals measure score for that stratum. The colon stratum also had one predicted infection during the performance period. The abdominal hysterectomy stratum had a measure score of eight that resulted from the hospital receiving eight Achievement Points and has two predicted infections during the performance period. To calculate the combined score, we first multiply the colon measure score of 5 by the colon predicted infections in 1, equaling 5. Then, you do the same for the abdominal hysterectomy stratum. Multiply the abdominal hysterectomy measure score of 8 by the predicted infections of 2, equaling 16. We then add those two values together. Again, those values were 5 (the 5 times 1 for the colon stratum) with the 16 (the 8 times 2 for the abdominal hysterectomy stratum), which equals 21. You then work on the denominator by adding the number of colon predicted infections to the abdominal hysterectomy predicted infections, which is 1 plus 2 for a total

of 3. You then divide the numerator of 21 by the denominator of 3, which equals a Measure Score of 7.

This slide displays a scenario in which the combined SSI score would be calculated. The combined SSI formula would be used in the scenario in which both stratum meet the minimum of 1.00 predicted infections. The next two scenarios of 1 stratum meeting the minimum results in an SSI measure score is still being calculated. However, the measure score will reflect the stratum that met the minimum by 100 percent. So, if the measure score of abdominal hysterectomy was 8 and the colon stratum does not meet the minimum, the combined score would equal 8. An SSI score would not be calculated, if neither of the strata met the minimum of one predicted infections during the performance period.

The measure scores for the other Outcome measures are calculated the same as every other measure in the Hospital VBP Program. The measure score is the greater of Achievements Points and Improvement Points.

Now that each measure has a Measure Score calculated, the Un-Weighted Domain Score is calculated. So, Un-Weighted Domain Scores for all the domains are normalized to count for only the measures the hospital met the minimum requirement score. To normalize the domain, we sum the measure scores in the domain. In our example, to sum up the six measure scores is 30 points. You then multiply the eligible measures by the maximum point value per measure. In our example, the hospital did not meet the minimum requirement in the Mortality 30 day Pneumonia measure. So, instead of seven total measures this hospital was only scored on six. Remember, that the SSI measures only counts as one measure. We then multiply the number 6 by 10 possible points for each measure, for a total of 60. To create a percent of scores our hospital earned in relation to points possible, we divide the sum measures for the 30 by the maximum points possible of 60, which equals approximately 0.5. Lastly, we multiply the result by 100 to equal 50.

This slide displays the Outcome Detail Report with the highlights specific to the baseline and performance period totals.

This slide still displays the Outcome Detail Report but places emphasis on the HVBP Metric in Summary total. The HVBP Metric displays the performance standards, Improvement Points, Achievement Points, and Measure Score. The summary total displays a number of eligible Outcome measures, the Unweighted Outcome Domain Score and the Weighted Outcome Domain Score.

We will now move into the last domain in the FY 2016, the Efficiency domain.

The Medicare Spending per Beneficiary measure is the sole measure in the Efficiency domain which is weighted at 25 percent for Fiscal Year 2016. The MSPB measure is a Claims-Based measure that assesses Medicare Part A and Part B payments for services provided to Medicare beneficiaries during a spending per beneficiary episode that spans from three days prior to the inpatient hospital admission through 30 days after discharge. By measuring cost of care through this measure, CMS hopes to increase the transparency of care for consumers and recognize hospitals that are involved in the provision of high quality care at lower cost to Medicare.

In order to receive Improvement Points for the measure, a hospital must have at least 25 eligible episodes of care during the baseline period and the performance period. If the hospital only meets the minimum requirements during the performance period, only Achievement Points will be awarded.

Our example hospital has 26 eligible episodes of care during the performance period. Because the MSPB measure is the only measure in the Efficiency domain, in order to receive a domain score, a hospital must have the same 25 eligible episodes of care during this performance period.

Our example hospital had a performance period rate of 0.70, which is better than the benchmark, resulting in 10 Achievement Points. Remember, the MSPB measure is a reverse measure, meaning that lower values indicate better quality.

Our example hospital, as noted in the last slide, had a performance period rate that was better than the benchmark that would result in nine Improvement Points, if the performance period rate was better than the baseline period rate. However, in our example the hospital baseline period rate and performance period rate are equal, indicating that although the hospital maintained its performance, no actual improvement was observed. Because no improvement was observed, zero Improvement Points will be awarded to this hospital.

Like all of the other domains, the MSPB measure scores the greater of Achievement Points and Improvement Points. In this scenario that we just covered in which a hospital has met or surpassed the benchmark, a measure score of 10 will always be awarded because the Achievement Points and the designation of zero or nine Improvement Points are essentially ignored because the maximum was already achieved for this measure.

The Efficiency domain is still normalized to move the measures score that is out of 10 to the Unweighted Domain Score, which is out of a total 100 possible points. First, you solve the measure scores. In this case you just take the MSPB measure score of 10 and multiply that value by the total points possible, which is one measure times 10 possible points for the measure. You then divide the sum of the measure scores of 10 by the total possible points of 10, which equals one, and multiply that result by 100, which equals 100.

The Efficiency-Based Detail report is broken down into four sections on the slide. The first section is the baseline period total, the second is the

performance period total, third the HVBP metrics, and fourth the summary section.

Now that we have calculated our example hospital's unrated domain scores for each of the four domains, we will now move on to the Total Performance Score.

This slide displays the simplest version of the Total Performance Score calculation, which occurs when a hospital receives domain scores in all scores of our domains. Simply, the Unweighted Domain Scores are multiplied by the CMS-given weight for each of the domains, which results in the Weighted Domain Scores. The Weighted Domain Scores are then summed to equal the Total Performance Score. So, for our example, if you pick out the Efficiency domains and multiply the Unweighted Domain Score 100 by 25 percent, you would get 25. You add the 25 to the other Weighted Domain Scores and receive a result of 67.5 for a Total Performance Score. But, you may be asking what happens if a hospital doesn't receive a domain score in each of the domains? Will that hospital be excluded from the Hospital VBP Program? The answer to that question is maybe. If a hospital receives scores in at least two of the four domains, the hospital will still be eligible to receive a Total Performance Score. Hospitals that receive scores in one of the domains or do not receive a score in any of the domains will be excluded from the program. The next few slides will describe how we calculate the Domain Rate and the Total Performance Scores when a hospital has either two or three domain scores.

The first example that we will look at is a hospital receiving three domain scores, including the Clinical Process of Care domain, Outcome domain and Efficiency domain. The hospital did not receive the domain score in the Patient Experience of Care domain. The first task for calculating our Total Performance Score is proportionately re-weighting the domain weight so they will still equal 100 percent. CMS does this by dividing the original domain weight by the sum of the eligible remaining domain weights. So, for example, we would divide the Clinical Process of Care

original domain weight of 10 percent by the sum of the eligible remaining domain weights, which are: Clinical 10 percent, Outcome 40 percent, and Efficiency 25 percent. Those three added together equal 75 percent. The result of 10 percent divided by 75 percent is 13.3 percent.

The system that calculates the score uses a greater precision than one place to the right of the decimal; but, for simplicity and explaining, I will be rounding, inter-truncating our value. The same process occurs for the outcome domain by dividing the original domain weight of 40 percent by 75 percent and efficiency with 25 divided by 75.

This slide now shows our updated domain weights and weighted domain scores. The Unweighted Domain Scores remained unchanged with the exception of the removal of the Patient Experience of Care domain. The Efficiency domain still has an Unweighted Domain score of 100, which is now multiplied by a weight of 33.3 percent, instead of 25 percent, which equals 33.3 as the Weighted Domain Score. We will then still add the Weighted Domain Scores together to equal a Total Performance Score of 66.667.

Now we will move to the other scenario where the hospital has two domains that met the minimum measure count and two domains that did not. The hospital met the minimum measure count in both the Clinical Process of Care domain in the Outcome domain, but now are excluded from the Efficiency domain in addition to the Patient Experience of Care domain. The steps for calculating the proportionate re-weighting are the same as the scenario we just covered. You take the original weight of the domain divided by the sum of the remaining eligible weight. So, for example, we would take the Clinical Process of Care domain original weight of 10 percent and divided by 50 percent, which is the 10 percent plus the 40 percent. The resulting new weight is equal to 20 percent for the Clinical Domain and 80 percent for the Outcome domain for a total of 100 percent.

So, for our example Total Performance Score calculation, we remove the Efficiency domain and the Patient Experience of Care domain lines and have our Unweighted Domain Scores to both Clinical Process of Care and Outcome multiplied by their new weight. The Total Performance Score is now just the sum of the two weighted domain scores and equals 50.

The Percentage Summary Detail Report is the first page of the Percentage Payment Summary Report, and is displayed on the slide. The first section of the report displays your hospital's Total Performance Score, the State Total Performance Score, and the National Average Total Performance Score. The second section of the report displays the summary of your hospital's Unweighted Domain Scores, the weights used to calculate the Weighted Domain Scores, and the Weighted Domain Score.

The third section of this report includes your hospital's payment and adjustment factors, which we will cover on the next slide. The payment adjustment factor section of the report displays five values. First, the base operating DRG payment amount reduction is the percentage withhold from the program your hospital is incurring. This value will be the same for every hospital, with the value equaling 1.75 percent. The Value Base Incentive Payment Percentage is the portion of the base operating DRG payment amount your hospital earned back. This value is incentive only and does not take into account the withhold percentage. The net change in base operating DRG payment amount is the percentage your hospital's payments will be changed, taking in to account the withhold.

So, this value is really the incentive payment percentage detracted by the base operating DRG payment amount. A positive value indicates that your hospital will receive a net increase, where as a negative amount indicates your hospital will receive a net reduction. The value-based incentive payment adjustment factor is the value that each eligible claim will be multiplied by to determine the financial impact of the Hospital VBP Program for your hospital. The Exchange Function Slope is the value that CMS uses to convert a hospital's Total Performance Score into the

payment adjustment factors. The Exchange Function Slope is the same for each hospital. I would like to note the red disclaimer down at the bottom of the slide [which] states that "Values displayed on this example report, including the national average in the Exchange Function Slope, may not depict the actual value used the FY 16 Program."

If a hospital was excluded from the Hospital VBP Program, the exclusion reason will be displayed on the report in-between the domain summary section and the payment information. In addition, the hospital's Total Performance Score and payment information will all display, "Hospital VBP Ineligible."

We will now transition into the Review and Correction procedures.

Following the release of the Percentage Payment Summary Report, hospitals will have the opportunity to review their report and request the recalculation of the condition scores, domain scores and total performance score. The review and correction period is a total of 30 calendar days starting on the date the report is released through the *Secure Portal*.

To request a review and correction, a hospital should follow the steps in the slide. The review and correction forms are located on the Review Correction/Appeals navigation page under the Hospital Value-Based Purchasing drop down menu on *QualityNet*. The form must have the information on the slide to be considered a completed form. You may submit your Review and Correction form, if you chose to complete one, to the HVBP group on the CMS Secure File Exchange in the *Secure Porta*l.

We will now cover the Appeals processes.

The appeal of the calculation of the performance assessment should occur within 30 calendar days of the receipt of CMS' Review and Correction decision letter. Hospitals may appeal the calculation of their performance assessment within 30 calendar days of their receipt of CMS' Review and Correction decision. It's important to note, hospitals must receive an

adverse determination from CMS prior to requesting an appeal. To request an appeal for the decision, the hospital should follow the steps on the slide. The appeal forms are located on the Review and Correction/Appeals navigation pane under the Hospital Value-Based Purchasing Program dropdown on *QualityNet*.

Similarly to the Review and Correction form, when completing the Appeal form, the following information must be present: the date of the request, the hospital's CCN, hospital contact information (including both CEO and *QualityNet* Security Admin.), and specific reason for each request, plus a detailed description for each of the reasons identified.

The bullet points listed on the slide are the acceptable reasons for an appeal to be submitted and considered by CMS.

We will now move into the last section of this presentation, the Resources.

So, now the answer that everyone wants to know – when will the FY 16 Percentage Payment Summary Reports be released? The answer is soon.

The Percentage Payment Summary Reports will be enabled on *QualityNet* by August 1st. Communications including an email blast, *QualityNet* news article and ListServe announcements will be released to announce the release of the report. We do have additional resource available if you need assistance with the Hospital VBP Program.

First, a document has been created specific to the FY 16 Percentage Payment Summary Report entitled, "How to Read Your Report." It will be posted to *QualityNet* prior to the release of the report. We had several Hospital VBP Program recorded webinars, slides, and transcripts for you to view regarding specific measure set calculations and improvement stories. Those are available by clicking the webinar and calls options on the Hospital Value Based Purchasing pages of *QualityNet*. Lastly, we have Hospital VBP Program Frequently Asked Questions, located in the in-patient Q&A tool on *QualityNet*.

I would like to mention CMS' *Hospital Compare* website at medicare.gov/hospitalcompare. If you haven't visited the site yet, I'd highly recommend taking a look too. The site allows users to compare up to three hospitals and the quality measure reporting for both Inpatient and Outpatient programs. Currently, the FY 2015 Hospital VBP Program data has been posted in the Linking Quality to Payment section. It is anticipated that the FY 16 program data will be posted in December 2015. This data contains all eligible hospitals' Improvement and Achievement Points, Measure Scores, Conditional Procedure Scores, Domain Scores, and Total Performance Scores. It's anticipated that the scoring data for the Fiscal Year 2016 program will again be posted in December of this year.

The last slide I would like to cover today is the Upcoming Educational Offerings that are available to you in the upcoming month. Please take a look at these presentations and, if you have any that you would like to register for, please check out the Quality Reporting Center.com website. Again, that is www.qualityreportingcenter.com.

This concludes my presentation on the Hospital Value-Based Purchasing Program, and I will now turn the webinar over to Deb Price, so she can explain how to receive continuing education credits for the presentation. As time allows, we will answer some of the questions that were submitted during the call. If you have any questions regarding today's presentation, please contact us via one of the message listed on the last slide that will be displayed after the CE presentation. Deb, the floor is yours.

Deb Price: Next slide – Thank you.

Thank you so much, Bethany. I have a couple of updates to this slide in front of you. Number one, today's webinar has been approved for one and half continuing education credits. And, the second update is that now we are a nationally accredited nursing provider and, as such, all nurses, including Florida nurses, will be reporting their credits to their own board using our new national provider number, which is 16578. And it's not on

your slide because we just got this membership. We are just now – this is our first webinar. The number again is 16578 and we will be placing this number in the Chat box if you didn't get it.

Next slide, please.

We now have an online CE certificate process. You can receive your certificate two different ways. If you registered through ReadyTalk®, a survey will automatically pop up as soon as the webinar closes. That survey will allow you to get your certificate. We will also be sending out the same survey to all participants within the next 48 hours. If you are listening to the webinar in a room with someone else, please pass this survey on to other people in the room.

Next slide please.

This is what the survey will look like. It will pop up at the end of the event and again within 48 hours. You will click “Done,” the little rectangular gray box in the bottom.

Next slide, please.

This is what pops up after you click “Done.” This is a separate registration. It's not the same registration that you had for ReadyTalk®. It is the registration into our Health Services Advisory Group Learning Management Center. Because it's a separate registration, you will need to put in your name and a personal email, not your healthcare email, because typically the healthcare facilities have firewalls blocked-in. If you have already attended our webinars and have successfully received your CEs, then go ahead and click on the existing user link. If this is your first time that you're going to receive a certificate, make sure you click on the “New User” link.

Next slide, please.

This is what will show up when you click on the "New User" link. Please make sure to register a personal email like Yahoo or Gmail, and then you won't have any problem receiving your certificate.

Next slide, please.

This is what the "Existing User" screen looks like. Your username is your complete email address, not just a user name. The complete email address and the password is whatever you had put in your existing.

So, next slide please. Next slide please.

Thank you. And now I will give the presentation over to Donna Bullock who will be going over a few of the questions and answers. Donna, take it away.

Donna, you will need to click on your mute button. Take yourself off mute.

Bethany Wheeler: It sounds like Donna maybe having some technical difficulties. I can go ahead and answer some of the questions that were submitted during today's webcast.

The first question, and I guess the most submitted question was, "When will the reports be released?" And I actually covered this towards the latter part of my presentation. We anticipate the report to be released by August first of this year. They will be made available through the *QualityNet Secure Portal* for you to run on your own.

Another question that we just recently received is, "What quarters of IMM-2 will be used in the Hospital Value-Based Purchasing Program?" The answer to that is: the performance period is the full calendar year, first quarter through fourth quarter of 2014 for the FY16 program. However, like many of you noted in your responses to that response, IMM-2 was only submitted during the flu season, which would be first and fourth

quarters. So, that is what the data will be truly representative of. First quarter and fourth quarter of 2014 is the performance period. The same type of quarters would also be used for the baseline period.

Let me search for another question here that was submitted. So, “If a hospital is excluded from the Hospital VBP Program, will they receive that 1.75 percent withhold?” The answer is they will not. They won't receive any payment adjustment due to the Hospital VBP Program, and that means they won't receive that withhold percent. But they're also not eligible to receive the increase in percent payments that's possible due to the Hospital Value-Based Purchasing Program.

Another question that's somewhat related to that question is, “How do we state that we're going to participate, and what's really the penalty for non-participation?” The only way a hospital can choose not to participate in Hospital Value-Based Purchasing, is to choose not to participate in the Hospital IQR program. And by choosing not to participate in the Hospital IQR program, you're automatically going to receive the reduction to the market basket update. So, it's seen through the Hospital IQR program. You also then forego the opportunity to receive the incentive in the Hospital Value-Based Purchasing Program.

Another question that came in is, “Which version of the AHRQ software will be used for the PSI-90 towards in FY 16?” The answer to that question is version 4.4. That was the same AHRQ software version that was used in FY 15. CMS decided to move forward with version 4.5a for the FY 17 VBP Program. You might note, so I hope you can note this, that the Hospital Value-Based Purchasing Program in the HAC reduction Program in IQR Program may use separate AHRQ software versions through the same Fiscal Years.

I’ll hit on a couple more questions. “What is the floor in [the] Patient Experience of Care domain?” That's a great question. The floor is the floor, or the rate of the lowest performing hospitals during the base line

period. Now, the floor is only used in the Patient Experience of Care domain and that is because the Patient Experience of Care domain also uses a Consistency score and uses the calculation of that domain. And the floor is used to determine the lowest performing dimension for the HCAHPS® survey.

Next question, I think we have time for a couple more. A question, more of a house keeping question, "Can we be provided the question and answers to this presentation that were submitted?" The answer to that is yes, we will be posting the Qs & As to the Inpatient Quality Reporting website and that is qualityreportingcenter.com within 10 business days. The slides for this presentation are also posted out on qualityreportingcenter.com.

I think the last question that we're going to take is, "Why was the hospital needed infection? They strive for zero infection through requiring one makes no sense." And this question is in relation to the minimum measure count or requirement that we need for the HAI measures. And so, as I stated back on those slides, you need one predicted infection as calculated by the CDC in order to be eligible to receive a Measure Score. Now, that does not mean that the hospital has to actually have an infection, it's just that they had enough cases and enough "line days" in order to have CDC say, yes there was an opportunity to have an infection at that hospital. Now, having the hospital have zero infections is what CMS strives for and what every hospital should strive for. That's not really what the minimum measure requirement is. It's solely based on what CDC calculates, not what's actually reported as infections for the hospital.

I think that'll wrap up the questions that we have today. There were many more that were submitted; so, please, if your questions were not answered, please comeback and check that qualityreportingcenter.com website within 10 business days and they will all be posted there.

Deb, do you want to wrap up today's call?

Deb Price: Yes. I'd like to thank all of our speakers and our attendees for staying with us for this hour, almost an hour and half. If there is any other question that you need, please contact us through the Chat room or any of the resources that you see here. And, have a wonderful rest of the day! Bye.

END