Hospital Value-Based Purchasing (VBP) Program

Support Contractor

Fiscal Year (FY) 2018
Percentage Payment Summary Report (PPSR) Overview

Questions & Answers

Moderator
Maria Gugliuzza, MBA
Project Manager, Hospital VBP Program
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)

Speaker
Bethany Wheeler-Bunch, MSHA
Project Lead, Hospital VBP Program
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)

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Question 1: **When will the reports be released?**

The FY 2018 Percentage Payment Summary Reports will be made available on or around August 1 through the *QualityNet Secure Portal*. The Centers for Medicare & Medicaid Services (CMS) will announce report availability through the Hospital IQR and VBP ListServe and through a *QualityNet* news article.

Question 2: **Are all seven measures in the Safety domain weighted equally?**

Yes. All measures in the Safety domain are weighted equally. We will be covering how to score the Safety domain later on in the presentation.

Question 3: **How can the FFS-recalibrated AHRQ software be obtained for FY 2018 VBP?**

We have requested the FFS-recalibrated AHRQ software several times from *QualityNet* and have never been able to obtain it. Please submit this question to the Inpatient Q&A tool on *QualityNet*. Please include the dates of your requests to the Help Desk and any responses you received. We will reach out to the contractor for a resolution**.**

Question 4: **She said PSI 12 and ___ had changes?**

Ms. Wheeler-Bunch stated PSI 08, PSI 12, and PSI 15 had specification changes. More information on those changes can be reviewed on the PSI 90 Fact Sheet at this direct link: https://www.qualityindicators.ahrq.gov/News/PSI90_Factsheet_FAQ.pdf.

Question 5: **You mentioned IQR uses 25 Diagnosis codes. How many Procedure codes does it use?**

The Hospital IQR Program uses 25 Diagnosis and 25 Procedure codes.

Question 6: **So do the data on *Hospital Compare* align with the Hospital IQR Program and not VBP?**

The data displayed on the *Hospital Compare* main pages are data from the Hospital IQR Program that hospitals have an

opportunity to preview on their *Hospital Compare* preview reports. The data in the Hospital IQR Program (on *Hospital Compare*) may not align with the Hospital VBP Program based on the reasons Ms. Wheeler-Bunch described earlier in the presentation.

Question 7: **Will the FY 2018 Percentage Payment Summary VBP reports be sent through the *QualityNet Secure Portal* inbox or will we have to manually run the report in *QualityNet*?**

The reports will have to be manually run through the *QualityNet Secure Portal*.

Question 8: **So the facility will get 1.1 percent of the 2 percent that was withheld, correct?**

In our example, the hospital had a net change of 1.1 percent. This means the hospital made up the 2 percent withhold and earned an additional 1.1 percent.

Question 9: **How is the value-based incentive actually paid back to the hospital?**

The payment adjustment factor is multiplied against the Diagnosis Related-Group (DRG) payment amount. For more specific information, we recommend contacting your MAC.

Question 10: **All of the HAI information is pulled from NHSN, correct?**
Yes. The CLABSI, CAUTI, MRSA, CDI, and SSI measure data are submitted through NHSN.

Question 11: **MAC?**

MAC is an acronym for Medicare Administrative Contractor. Here is a link to learn more about the MACs: https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MedicareAdministrativeContractors.html.

Question 12: **Can you please clarify what is meant by "floor" in the Experience of Care domain? Thanks.**

The floor is the rate of the lowest performing provider during the baseline period for a specific dimension. The floor is used

to calculate a hospital's lowest dimension score, which is then used to determine the hospital's consistency score. We will cover an example in the second half of the presentation.

Question 13: **Why is there a baseline period for MSPB if benchmarks and thresholds are calculated using performance period data?**

The Hospital VBP Program utilizes a scoring methodology that includes improvement points. Improvement points are calculated by comparing a hospital's rates from the baseline period to the performance period.

Question 14: **Would a hospital be excluded if there are no labor and delivery services, thus no PC-01?**

If a hospital does not have at least 10 cases in the denominator for PC-01, they would not be scored in the measure. Hospitals must have at least three of the seven measures scored in the Safety domain in order to receive a domain score. So, not receiving a score in PC-01 would not automatically exclude a hospital from the Hospital VBP Program.

Question 15: **If an organization qualifies for payments, when will these be paid?**

The FY 2018 payments will be paid with each eligible claim during FY 2018 (October 1, 2017 through September 30, 2018).

Question 16: **Slide 17: When will CMS increase the number of Diagnosis codes being utilized to calculate PSI scores?**

CMS will use up to 25 Diagnosis and Procedure codes for the calculation of PSI 90 for Hospital VBP when up to 25 Diagnosis and Procedure codes are processed for the entire baseline and performance periods. CMS began processing up to 25 Diagnosis and Procedure codes in April 2011. Because the Hospital VBP Program PSI 90 baseline period for FY 2018 starts on July 1, 2010, a portion of that period is prior to the April 2011 date. The FY 2019 baseline results for the Hospital VBP Program were calculated using 25 Diagnosis and Procedure codes because the baseline period started on July 1, 2011, which is after the April 2011 implementation date.

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Question 17: **How did you factor in changes to metrics (e.g., PN mortality) and HAI rebaseline?**

CMS tries to keep the baseline and performance period specifications as consistent as possible. For the HAI rebaselining, CMS did not implement using the updated values until FY 2019. By waiting until FY 2019, CMS is using the rebaselined values in both the baseline (CY 2015) and performance (CY 2017) periods. CMS will not be using the rebaselined values in FY 2018 because the baseline period (CY 2014) would not have had the updated data. For the updated cohort for MORT-30-PN, CMS is calculating the baseline period results, performance period results, and performance standards using the same specifications starting in FY 2021.

Question 18: **Why did the square color of the baseline period rate change between examples?**

The achievement point calculation did not use a baseline period rate. The achievement threshold used a red square color in that example. The improvement point formula did use the baseline period rate and used a gold color.

Question 19: **Slide 86: On CAUTI, how is a measure score of 3 calculated since achievement and improvement points are both 0?**

Great catch! If a hospital has 0 improvement and achievement points, the measure score would be 0.

Question 20: **Please share how to calculate the individual contribution of any one domain on the holdback or incentive to VBP. And, in more detail, how to calculate the contribution on any one measure? Thank you.**

Once the Total Performance Score (TPS) is calculated, you can determine how many points one individual measure contributed to the TPS by taking into account the measure score and domain weights. Hospital results are based on the number of measures scored (i.e., met the minimum data requirements).

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Question 21: **Will there be a bifurcated calculation in the Safety domain after taking PSI 90 out of FY 2019? Or, will the domain be simply calculated as Outcomes and Patient Experience domains are?**

We recommend referencing the FY 2018 IPPS Final Rule when released. We plan to hold a webinar in the near future to walk through the FY 2018 IPPS Final Rule policy adoptions.

Question 22: **Where can we obtain our base operating DRG amount?**

We recommend reaching out to your internal claims and billing office to get an estimate of your base operating DRG amounts.

Question 23: **Safety domain scoring: Last year, the Safety scoring requirements indicated that at least three of the six measures must be scored for the domain score to be calculated. Is this the same for this year?**

In FY 2018, a hospital must have at least three of the seven measures scored in order to receive a Safety domain score. The PC-01 measure was added to the Safety domain to bring the total measures from six to seven.

Question 24: **What are the baseline period and the performance period for HCAHPS surveys?**

The baseline and performance periods for all measures are listed on slide 19.

Question 25: **Slide 20: What happens to the percentages if a hospital does not meet the Clinical Care domain requirement due to less than 25 eligible cases in all three measures?**

If a hospital is unable to receive enough measure scores to receive a domain score, the domain will not be scored. If less than three domains are scored in FY 2018, the hospital will be excluded from the FY 2018 Program. Hospitals excluded from the Hospital VBP Program will not be eligible for payment adjustment, including the withhold and the incentive payments. We will cover more detailed calculation examples for domain

reweighting if only three domains are scored in the second half of the presentation.

Question 26: **Slide 17: Can you restate what software version will be used to calculate the PSI 90 results?**

Software version 5.0.1 was used to calculate the PSI 90 Composite results in FY 2018 for HVBP. For more information on the announcement of the software version, please reference the *QualityNet* news article published on March 2, 2016.

Question 27: **Do the HAI, PC-01 and PSI 90 Composite carry equal weight in the calculation of the score for the Safety domain?**

Each measure within the Safety domain carries an equal weight. We will cover how to calculate the Safety domain score in the second half of the presentation.

Question 28: **What happens if 100 HCAHPS surveys are not completed within the two time periods?**

If a hospital is unable to submit enough completed surveys during the performance period, the Experience of Care domain will not be scored. If less than three domains are scored in FY 2018, the hospital will be excluded from the FY 2018 Program. Hospitals excluded from the Hospital VBP Program will not be eligible for payment adjustment. If a hospital does not submit at least 100 HCAHPS surveys during the baseline period, but does during the performance period, only achievement points can be awarded as improvement points, based on a comparison between the baseline period and the performance period.

Question 29: **Are children's hospitals and critical access hospitals exempt from the VBP Program?**

Yes. Only short-term acute care hospitals are included in the Hospital VBP Program. Children's hospitals with a CMS

Certification Number (CCN) with digits other than "0" are excluded from the Hospital VBP Program.

Question 30: **Slide 17: The AHRQ website still shows PSI 09, PSI 10 and PSI 11 as part of the PSI 90? However, this slide does not have 09, 10 and 11.**

As we covered on this slide, CMS will use the old version of the PSI 90 Composite in the FY 2018 Hospital VBP Program. In comparison, the FY 2018 HAC Reduction Program and Hospital IQR Program will use the updated version of the measure, which includes PSIs 09, 10, and 11. PSI 07 (Central Venous Catheter-Related Bloodstream Infection Rate) was removed from the new version of the measure, but is still included in the old version.

Question 31: **Slide 17: Will the PSI 90 Composite be removed from the FY 2019 Hospital VBP Program?**

CMS proposed the removal of the old version of the PSI 90 Composite in FY 2019 in the FY 2018 IPPS Proposed Rule. I recommend reading the FY 2018 IPPS Final Rule when it is released to review the result of CMS's proposal.

Question 32: **Slide 48: For claims-based measures, is there a cut-off time to refile a claim with CMS if we discover the first claim was incorrect?**

CMS generally pulls claims at the end of September following the end of the calculation period for PSI 90 and the 30-day mortality measures. For example, if the claims-based measures of PSI 90 and the 30-day mortality measures end on June 30, 2016, CMS would pull those claims used in the calculation at the end of September of 2016. The next claims pull for FY 2019 results is anticipated for the end of September 2017. For the Medicare Spending per Beneficiary (MSPB) measure, CMS pulls claims around the first week of April, which allows a three month claims run-out/maturity period. Claims submitted or

modified after that time will not be included or revised in the calculations.

Question 33: **Is FY 2018 CY 2016?**

Fiscal Year 2018 is the year in which payment adjustments will be made. The performance periods and baseline periods range in FY 2018; however, FY 2018 generally utilizes a performance period of CY 2016 and a baseline period of CY 2014. This does not apply to claims-based measures, such as PSI 90 or the 30-day mortality measures.

Question 34: **Slide 17: Why is CMS only using nine Diagnosis and six Procedure codes for HVBP?**

CMS will use up to 25 Diagnosis and Procedure codes for the calculation of PSI 90 for Hospital VBP when up to 25 Diagnosis and Procedure codes are processed for the entire baseline and performance periods. CMS began processing up to 25 Diagnosis and Procedure codes in April 2011. Because the Hospital VBP Program PSI 90 baseline period for FY 2018 starts on July 1, 2010, a portion of that period is prior to the April 2011 date. The FY 2019 baseline results for the Hospital VBP Program were calculated using 25 Diagnosis and Procedure codes because the baseline period started on July 1, 2011, which is after the April 2011 implementation date.

Question 35: **Is there someone we can reach out to who can assist us with calculating the score for the domains in case we need help?**

Questions may be submitted through the Inpatient Question and Answer Tool on the *QualityNet* website at https://cms-ip.custhelp.com/. The link is also available on slide 64. We would be more than happy to answer the questions you have regarding calculations.

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Question 36: **How do we determine the monetary impact with the TPS? We have executives that are interested in the dollar amount impacted by VBP scores.**

You may use the payment adjustment factor listed on your hospital's Percentage Payment Summary Report. This value is multiplied against your hospital's base-operating DRG payment amount. You may estimate the total impact of VBP, by multiplying the factor by an estimated base-operating DRG payment amount and then determine the difference between the result and the original base-operating DRG payment amount.

Question 37: **Can hospitals receive an incentive greater than the 2 percent withhold and a 2 percent incentive payment?**

The maximum reduction that a hospital can incur is two percent in FY 2017; however, a hospital can earn back more, based on the exchange function slope and the hospital's performance for the fiscal year.

Question 38: **Slide 85: If a hospital does not have an SSI for colon, are they eligible for points?**

The hospital only has to meet the minimum of one predicted infection in one of the two stratums, colon surgery and abdominal hysterectomy. If only the abdominal hysterectomy minimum is met, the measure score will be weighted 100 percent to the abdominal hysterectomy stratum. This is also true for the colon surgery stratum, if the minimums are only met for that stratum. If both strata meet the minimum, the measure scores will be weighted by predicted number of infections. A Surgical Site Infection (SSI) measure score will not be awarded when the hospital does not meet the minimum 1.000 predicted infections in either stratum.

Question 39: **Slide 78: Can you cover normalization one more time?**

Normalization is the process CMS uses to score a hospital and compare it with other hospitals. Normalization uses only the

measures that met the minimum requirements. To normalize, sum the measure scores and divide by the total maximum points for the hospital. The total maximum points will vary by hospital based on the number of measures that met the minimum. In the example on this slide, the hospital had the minimum required data in two of the three measures. The maximum points possible would be 20, which is 10 points per measure multiplied by 2 measures. You would divide the sum of the measure scores, in our case 15 by 20 to equal 0.75, for the domain score. If this hospital would have instead met the minimum required data for the Pneumonia measure, the maximum point value would be 30, which is 10 points multiplied by three measures. If you would like more assistance in understanding normalization or any other calculations on your report, please feel free to submit your specific questions to the Inpatient Q&A tool on *QualityNet.*

Question 40: **For PSI 90, will you use HCUP population or IPPS population?**

CMS will use a Medicare Fee-for-Service reference population instead of the HCUP population. More information regarding the announcement of the reference population is available here: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetBasic&cid=1228775567103

Question 41: **Slide #13. Where can I find the data definitions for PSI 90, specifically for post-operative sepsis? For example, if a patient comes in with a ruptured aorta and clearly septic, will that count against the facility as we diagnose and treat the sepsis through the operative and post-operative period?**

Information regarding the PSI 90 Composite is available at: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228695321101. If your question is not answered, we recommend submitting your question to the *QualityNet* Help Desk and asking for the HCQAR contractor to review your ticket.

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Question 42: **How does the TPS get converted to the payment adjustment rate?**

A TPS is converted to a payment adjustment factor through the exchange function slope. The slope is calculated for each fiscal year. A help guide will be posted to the Hospital VBP Program Resources page when the reports are released. The guide will help you use the slope to calculate your payment adjustment factor. The Resources page can be found at this link: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772237202.

Question 43: **Slide 22: Why does the mortality measure not align with Cost and Safety, with lower being better?**

In the Hospital VBP Program, the 30-day mortality measures are reported as survival rates instead of mortality rates. So, higher survival indicates better results in the measure.

Question 44: **Slide 17: What are the nine Diagnosis and the six Procedures codes used for calibration?**

Only the first nine diagnoses and six procedures billed on the claims are used for the FY 2018 Hospital VBP Program for the PSI 90 Composite. For the Hospital IQR Program AHRQ measures, all 25 diagnoses and procedures are used if submitted on the claim.

More information about the PSI 90 measure is available on QualityNet: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772237202

Question 45: **Slide 17: It is not uncommon for an exclusion code to be present after code number 25. Also, how can you stop hospitals from just moving all "PSI" codes to after the top 25 codes?**

CMS and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (HHS) provide the guidelines for coding and reporting, using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM);

direct link: https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2017-ICD-10-CM-Guidelines.pdf.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

Question 46: **Slide 16: Although specialty hospitals are not included in the VBP Program, will the HCAHPS questions change in FY 2018 for all hospitals?**

Please submit questions regarding the HCAHPS survey to **hcahps@area-M.hcqis.org**.

Question 47: **Slide 32: For VBP, is the DRG payment based on all Medicare types or only Medicare A?**

Value-based incentive payments made under the HVBP Program can be made only in the form of an adjustment to a subsection (d) hospital's base operating DRG payment amount under the IPPS.