Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Hospital IQR and VBP Programs:
Reviewing Your Claims-Based Measures Hospital-Specific Reports

Questions and Answers

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The following questions were asked, and responses given by subject-matter experts, during the live webinar. Questions and answers may have been edited for grammar.

Question 1: **Slides 8 and 9: The performance periods for Risk-Standardized Complication Rate (RSCR) total hip/total knee arthroplasty complication (THA/TKA Complication) for FY 2019 VBP and IQR are different. Why?**

There are statutory requirements in the Hospital VBP Program that stipulate when the performance period can begin in the program based on the date the measure was first reported on *Hospital Compare*. Because of the statutory guidelines, CMS used a different measurement period than the Hospital IQR Program. CMS has finalized future Fiscal Year (FY) performance periods, and the dates will be consistent beginning in FY 2021. If you would like more information on the selection of the FY 2019 performance period, I recommend referencing the FY 2015 IPPS final rule (79 FR 50072) at this direct link: https://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf.

Question 2: **Please repeat what you said about when we will receive our HSRs.**

The Hospital VBP Program HSRs were provided last week. The Hospital IQR Program HSRs will be provided in May.

Question 3: **We changed from a PPS hospital to a critical access hospital in July 2017. Will we receive a Baseline Measures Report and an HSR?**

Critical access hospitals are not included in the Hospital VBP Program and will not receive a Baseline Measures Report.

Question 4: **When will we receive the VBP and IQR HSRs?**

The Hospital VBP Program HSRs were provided last week. CMS

anticipates the Hospital IQR Program HSRs will be provided in May.

Question 5: **Slide 10: Will PSI 04 be included in VBP this year?**

The PSI 04 measure has not historically been included in the Hospital VBP Program. The PSI 90 measure, which was included in the Hospital VBP Program in past Fiscal Years, is now removed from the Hospital VBP Program beginning in FY 2019.

Question 6: **Does the 8.0 version of the software include risk adjustments?**

Yes, it does. CMS recalibrated PSI software v8.0 includes a risk-adjustment model based on reference population of Medicare Fee-for-Service (FFS) discharges.

Question 7: **Slides 26 and 27: What date is used to start counting the number of readmissions within 30 days, the initial visit admit date or discharge date?**

The 30-day time period for the readmission measure starts with the date of index discharge.

Question 8: **Slide 19: When can we expect to receive the IQR HSR reports?**

FY 2019 Hospital IQR Program HSRs will be delivered this May. The FY 2019 Hospital IQR Program will include seven HSRs and an Hospital IQR Program user guide. The seven measures are mortality, readmission, hospital-wide readmission, EDAC, THA/TKA Complication, CMS PSI, and payment.

Question 9: **When I received my facility's HSR reports, I only received**

complications and mortality reports. Should I have received more reports?

The FY 2019 Hospital VBP Program HSRs for mortality and THA/TKA Complication were delivered last week. The FY 2019 Hospital IQR Program HSR bundle will be delivered in May. That bundle will include seven HSRs (mortality, THA/TKA Complication, readmissions, hospital-wide readmissions, CMS PSI, EDAC, and payment) and an Hospital IQR Program user guide.

Question 10: **Where can I find information on the CMS recalibrated PSI software v8.0?**

FY 2019 Hospital IQR Program CMS PSI HSRs have not been delivered to hospitals yet. More information on CMS PSI v8.0 software will be available in your Hospital IQR Program user guide. You can also find additional information Hospital IQR Program measures on QualityNet > Hospitals - Inpatient > Measures.

Question 11: **Why is a patient counted in our complication rate twice when they had another joint replacement done at the time of the first readmission?**

If a patient had more than two THA/TKA procedure codes during the index admission, they would meet exclusion criteria for the measure. Explanations of the inclusion/exclusion indicators can be found in the Hospital VBP Program user guide sent with your reports.

Question 12: **Slide 33. We found patients who were counted in more than one mortality diagnosis (heart failure [HF] and acute myocardial infarction [AMI]. How does that work?**

Each measure is calculated individually. If the patient was admitted for an

inpatient stay with a heart failure primary diagnosis and admitted for an inpatient stay with an AMI primary diagnosis within the reporting period, then they would be included in each measure.

Question 13: **Slide 48. Is the Risk-Standardized Complication Rate in column B the individual hospital's results?**

Yes, the Risk-Standardized Complication Rate shown with the [b] note is the Risk-Standardized Complication Rate for the individual hospital.

Question 14: **Does CMS use the same measure sets for VBP and IQR?**
VBP and IQR = THA/TKA Complication (RSCR) and VBP and IQR = Mortality (RSMR)

The measures that are in both the Hospital IQR and Hospital VBP Programs use the same cohort and measure criteria. There is a difference in the hospitals that are included, as VBP only includes subsection D hospitals. Also, the reporting periods do not always line up. For example, THA/TKA Complication has different performance periods. The pneumonia measure has a different cohort and measure specification this year, as the VBP performance period must use the same cohort and measure specification that were used in the baseline year.

Question 15: **Hospitals did not get the HSR for readmission, right?**

That is correct. The readmission HSR will be included in the Hospital IQR Program HSR bundle that is expected to go out in May.

Question 16: **On slide 17, can you please include the performance period used?**

The performance periods can be found on slides 8 and 9.

Question 17: **Slide 12 says "observed." Are the rates risk adjusted?**

These measures are risk adjusted. The national rate for the outcome measures is always an observed rate, even on risk-adjusted measures. The national rate for the payment measures is a national average.

Question 18: **Slide 13: How can you be "No Different than the National Rate" and "Better than the National Rate" if you had a score of 13.9? That would overlap the green and the yellow.**

On slide 13, a hospital with a point estimate of 13.9 can be classified as either "No Different than the National Rate" or "Better than the National Rate" depending on the hospital's confidence interval. This is because the categories are awarded by comparing the 95 percent interval estimate against the national observed readmission rate and not comparing the point estimate against the national readmission rate.

To explain further, the interval estimate represents the range of probable values of the risk-standardized readmission rate; a 95 percent interval estimate indicates that there is 95 percent probability that the true value of the rate lies between the lower limit and the upper limit of the interval.

For the risk-standardized readmission measures, CMS classifies the comparative performance for hospitals with 25 or more eligible cases as "No different than the National Rate" if the 95 percent interval estimate surrounding the hospital's rate includes the national observed readmission rate; "Worse than the National Rate" if the entire 95 percent interval estimate surrounding the hospital's rate is higher than the national observed readmission rate; and "Better than the National Rate" if the entire 95 percent interval estimate surrounding the hospital's rate is lower than the national observed readmission rate.

If a hospital has fewer than 25 cases eligible for a measure, CMS cannot reliably estimate the hospital's risk-standardized readmission rate (RSRR) and assigns the hospital to a separate category: "Number of cases is too small."

Question 19: **Slide 36. HSR guidelines say patients will be excluded if they are Medicare hospice patients on Day 1 of the stay. Does that mean Day 1 of the index stay or Day 1 of the hospice admission in which the patient expires?**

For measures that apply hospice criteria to exclude patients, hospice criteria apply to the first calendar day (and 12 months prior to the start) of the index admission.

Question 20: **Does IQR mortality and readmission AMI, HF, and PN cohorts include VA data in the national rate?**

For the IQR results that will be publicly reported in summer 2018, the national rates for the AMI, HF, and pneumonia mortality and readmission measures will include VA data.

Question 21: **Readmission measures: We have patients transferred from rural hospitals to our hospital and they enter the facility via the emergency department (ED). Are these counted as readmissions since they are not directly admitted?**

If a patient is discharged from a hospital and then admitted as an inpatient to your hospital (a short-term acute care hospital) on the same or next calendar day, this is considered to be a transfer and not a readmission outcome for the measure. This is true regardless of whether the patient is admitted to the ED before being admitted as an inpatient.

Question 22: **When can we expect the 2018 measure methodology update for the readmission populations (AMI, COPD, etc.)?**

The methodology reports are typically accompanied by documents that list the updated codes, including ICD-10 codes, relevant to the measure. These associated documents that list the codes will also be made available in time for the spring 2018 preview period. Updated 2018 measure methodology reports for all the readmission measures will be available in time for the spring 2018 preview period

Question 23: **Slide 8: Which version of AHRQ PSI 90 will be used for IQR, version 5.0, 6.0, or some other version?**

FY 2019 IQR will use v8.0 of the CMS PSI software. This version is different than the all-payer version on the AHRQ website. CMS recalibrated PSI software v8.0 includes a risk-adjustment model based on reference population of Medicare FFS discharges.

Question 24: **Slide 9: Is there a way to reference what the acronyms stand for (RSMR, RSCR)?**

RSMR stands for Risk-Standardized Mortality Rate (RSMR). RSCR stands for Risk-Standardized Complication Rate (RSCR)

Question 25: **For slide 12, are these rates for Medicare patients only?**

Yes. The measures on slide 12 include Medicare patients only, so these rates are calculated using only data for Medicare patients.

Question 26: **On slide 12, are the change values listed percent changes or numerical**

differences compared to 2018?

The changes listed on this slide are percentage point changes.

Question 27: **Could you please tell me why slide 11 does not show a national rate for the EDAC measures?**

Slide 11 doesn't contain information on the national averages for the EDAC measures because the EDAC measures compare hospital results against zero instead of comparing them to a national result to assess hospital performance. As addressed on this slide and both previous slides, the national rates are usually used to assign hospitals to performance categories, but EDAC is an exception. It compares the interval estimate against zero instead of comparing it to a national result, and therefore we don't typically provide the information on the national averages for the EDAC measures.

Question 28: **For the payment measures, does "Less than the National" mean better or worse?**

So, for the payment measures, a performance category of less than national does not imply whether the hospital is performing better or worse, and this is because the measure results do not provide an indication of the quality of care to hospitals. This is true also for the payment category of greater than national. It doesn't mean that the hospital is performing better or worse, and the reason this is so is because the payment measures are not meant to be interpreted in isolation. They're really meant to be considered alongside other existing quality outcome measures, such as the mortality measures. So, in brief, a payment categorization of less than national or greater than national simply indicates that the average cost of treatment at your hospital for a certain condition (e.g., AMI, heart failure, pneumonia) tends to be either significantly less or significantly more than the average cost of

treatment for that condition in the nation. It does not really speak to the quality of care at your organization.

Question 29: Why can't we compare payments across years?

So, the reason we can't compare payments across years is because the national payment results are usually adjusted for inflation, based on a specific year. For example, the Fiscal Year 2018 results are adjusted for inflation based on 2016 dollars. This is different from the year used to adjust for inflation for the Fiscal Year 2017 results (which used 2015 dollars). As a result, it really would not be fair for us to then compare these results as they're reported without adjusting for inflation based on using the same year dollars. This is why we really don't compare payment measures across the years.

Question 30: How do the readmission measures handle same day readmissions?

None of the readmission measures consider patients as readmitted if the readmission was to the same hospital for the same condition or procedure on the same calendar day. This is done to align with the regulatory requirements since CMS rules already require prospective payment system hospitals provide same day, same condition readmissions into one claim. However, the readmission measures do consider patients as readmitted if they had an eligible readmission to the same hospital on the same day, but for a different condition or procedure.

Question 31: Our hospital is in a rural location; are we being grouped in with city hospitals with a different patient population? Does this influence our payment measure results in the HSR?

Payment measures are standardized payments by removing geographic differences and policy adjustments that are independent of care decisions.

In addition, the payment measures are adjusted for differences in risk variables like comorbidities, patient age, and medical history. Together, these adjustments insure that the measure results in your HSR reflect a variation in payments unrelated to where your hospital is located.

Question 32: **Could a single patient's death be included in two different discharge tables on my HSR? For example, could one patient's death be counted in the AMI and COPD mortality?**

Yes, it could. Each measure is calculated independently from the other measures. So, if a patient meets the cohort criteria for two different mortality measures, with admissions each falling within 30 days of death, then the death would be counted as a numerator event for both measures.

Question 33: **Is the 30-day mortality measured from admission date of index admission or from discharge date of index admission?**

Except for the CABG mortality measure, the 30-day time period for the mortality measure starts with the date of index admission. For the CABG mortality measure, the 30-day time period starts on the date of the CABG surgery.

Question 34: **Why in the hospital value-based purchasing complication HSR are there more rows in Table 3 than eligible discharges in Tables 1 and 2?**

There are more discharges in Table 3, but they're not all eligible. The reasons to not be eligible include if the patient left against medical advice, the patient was transferred to the facility where index admission occurred, the patient had more than two hip/knee procedures during index admission, etc. Additionally, some discharges have multiple rows if there were multiple complications during the stay. These are indicated in the additional complication record column. If you count all the rows where index stay

equals "Yes" and additional complication record equals "No," then it should match your eligible discharges from Tables 1 and 2.

Question 35: **In the IQR CMS PSI HSR table for discharge level information, the list of diagnosis codes includes alphanumeric values; however, last year they did not. Could you explain why this is?**

From October 1, 2015, the ICD-9 diagnosis coding system was replaced with the ICD-10 diagnosis coding system. The reporting period for the CMS PSI HSR is from October 1, 2015, to June 30, 2017. So, all the diagnosis codes listed in HSR are ICD-10 codes, which has a first character as alpha instead of a number.

Question 36: **What is the difference between the CMS recalibrated PSI software and the publicly available all-payer version 7 on the AHRQ website?**

The main difference is that the CMS recalibrated PSI software v8.0 includes a risk-adjustment model based on reference population of Medicare FFS discharges, while the all-payer AHRQ version 7 does not.

Question 37: **How does the hospital-wide readmission measure (HWR) identify the number of eligible discharges at my hospital in Table 6?**

For the hospital-wide readmission measure, there are five cohorts in the denominator: medicine, surgery gynecology, cardiorespiratory, cardiovascular, and neurology. Each cohort includes its own conditions for inclusion. The specifics on how the measure counts readmissions can be found in the all-cause HWR measure specification report. A link to the copy of the report can be found in your hospital user guide.

Question 38: **What is the difference between predicted and expected deaths in the**

mortality HSR?

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 effect on mortality, while expected deaths are the number of deaths within 30 days of admission based on the average hospital performance with your hospital's case mix and the average hospital effect on mortality.

The following questions were researched and answered by subject-matter experts after the live webinar.

Question 39: **For the HSR reports received, my facility had less than 25 cases for the THA/TKA Complication measures. Does that mean this Hospital VBP Program measures do not apply to us?**

A measure must have at least 25 eligible cases during the baseline period to have an improvement score calculated on the Percentage Payment Summary Report and during the performance period to have either an achievement or improvement score calculated on the Percentage Payment Summary Report.

The Clinical Care domain requires at least two out of the four measures to be scored for the domain score to be included in the Total Performance Score (TPS) on the Percentage Payment Summary Report.

Question 40: **Slide 14. Is "expected performance" hospital-specific or national?**

The "expected performance" used in slide 14 refers to the expected number of excess days a hospital would have, which is zero. CMS compares each hospital's excess days in acute care (EDAC) result interval estimate to zero (not a hospital-specific or national number of excess days) to assign to a

performance category.

For more information about the EDAC measure performance categories, please see Section 2.2.6 of the *2017 Condition-Specific Measures Updates and Specifications Report Hospital-Level 30-Day Risk-Standardized Excess Days in Acute Care Measures*, which is posted on *QualityNet* > Hospitals-Inpatient > Claims-Based and Hybrid Measure > Excess Days in Acute Care (EDAC) Measures > Measure Methodology.

Question 41: **On slide 43, is the predicted probability on each row that patient's prediction of mortality?**

The predicted probability, found on slide 41, is the predicted probability of a 30-day death. The expected probability is found on slide 43.

Question 42: **PSI 90 is not in VBP, but will it still be included in the Star Ratings?**

Questions regarding Star Ratings can be addressed by emailing cmsstarratings@lantanagroup.com.

Question 43: **Can you download the HSR bundle or are we collecting each report individually?**

If you are asking about the Hospital VBP Program HSRs, please note that CMS distributed the Hospital VBP Program HSRs in April 2018 and hospitals received two separate workbooks for the measures in the Clinical Care domain of the Hospital VBP Program. They are the mortality measures workbook (which includes information on AMI, HF, and pneumonia) and the complication measure workbook (which includes information on the THA/TKA Complication measure).

If you are asking about HSRs for the claims-based measures included in the Hospital Inpatient Quality Reporting (IQR) Program, please note that CMS

will distribute these HSRs during the May 2018 preview period for each outcome in individual reports (readmission, mortality, complication, payment, and excess days in acute care). Please note that the hospital-wide readmission measure (HWR) results will be included in a separate workbook.

You may find more information about the individual HSRs in the HSR user guides that accompany your HSRs. A copy of the HSR Hospital VBP Program user guides may be found on *QualityNet* > Hospitals – Inpatient > Claims-Based Measures > Hospital Value-Based Purchasing (VBP) Mortality and Complication Measures. A copy of the HSR Hospital IQR Program user guides may be found on *QualityNet* > Hospitals – Inpatient > Claims-Based Measures > Measure of interest > Hospital-Specific Reports.

Lastly, for information on which HSRs are bundled together for download, please contact the *QualityNet* Help Desk at qnetsupport@hcqis.org.

Question 44: **Slide 51. Are TKA/THA complication and pulmonary embolism patients also counted in PSI 12?**

The TKA/THA complication and PSI 12 are two different measures with separate measure specifications. If a patient meets the inclusion criteria for both measures, then the patient would be counted in both measures.

Question 45: **Can you restate the approximate release dates for the measures on slides 8 and 9?**

The Hospital VBP Program HSRs were made available by April 10, 2018. CMS anticipates the Hospital IQR Program HSRs will be provided in May 2018.

Question 46: **When can we expect to receive the HSR reports? I did receive**

mortality and complication measures but not the rest.

The HSRs for the mortality and complication measures in the Hospital VBP Program were distributed in April 2018. The HSRs for the measures in the Hospital Inpatient Quality Reporting (IQR) Program will be distributed during the spring 2018 preview period that is expected to begin in May 2018.

Hospital staff assigned the Hospital Reporting Feedback-Inpatient role and the File Exchange and Search role can download their HSRs via their *QualityNet Secure Portal* Secure File Exchange Inbox. If you would like to access and/or acquire a copy of your HSR, please contact the staff at your hospital assigned to these roles.

If you require a re-upload of your Hospital VBP Program HSR to *QualityNet*, this will need to be coordinated by the *QualityNet* Help Desk as they are responsible for the coordination of HSR re-uploads for the CMS outcome measures currently reported in the Hospital VBP Program. You may contact the *QualityNet* Help Desk at qnetsupport@hcqis.org.

Question 47: **For Table 3 of the THA/TKA Complication HSR, if a patient had a complication in column L and received a "Yes" in column N, is the patient counted in the overall complication rate, or are patients who receive a "No" in column N included in the overall complication rate?**

A complication that occurred during Index Stay (Column N = "Yes") can be included in your measure calculation if the index stay meets inclusion criteria and does not meet any applicable exclusionary criteria for measure calculation. This column is included for informational purposes, and the (Yes/No) value in Column N does not dictate which index stays are included in the total number of eligible discharges.

Question 48: **Do observation stays "count against us" for payment decrement?**

We presume that you are referring to the outcome for the readmission measures. In the readmission measures, an observation stay does not count as a readmission outcome and, therefore, does not affect payment determination in that regard. More specifically, admissions are counted as readmissions if they are unplanned, are to a short-term acute care hospital, and occur within 30 days of discharge from the index admission.

For more information on the measure calculation, please see the 2017 Condition-Specific or Procedure-Specific Readmission Measures Updates and Specifications Report available on *QualityNet* > Hospitals – Inpatient > Claims-Based and Hybrid Measure > Readmission Measures > Measure Methodology.

Question 49: **Could you please explain the answer you provided to the question about slide 13?**

On slide 13, a hospital with a point estimate of 13.9 can be classified as either "No Different than the National Rate" or "Better than the National Rate" depending on the hospital's confidence interval. This is because the categories are awarded based on how the entire 95 percent interval estimate compares against the national observed readmission rate and not how the point estimate compares against the national readmission rate.

To explain further, the interval estimate represents the range of probable values of the risk-standardized readmission rate; a 95 percent interval estimate indicates that there is 95 percent probability that the true value of the rate lies between the lower limit and the upper limit of the interval.

For the risk-standardized readmission measures, CMS classifies the comparative performance for hospitals with 25 or more eligible cases as

"No Different than the National Rate" if the 95 percent interval estimate surrounding the hospital's rate includes the national observed readmission rate; "Worse than the National Rate" if the entire 95 percent interval estimate surrounding the hospital's rate is higher than the national observed readmission rate; and "Better than the National Rate" if the entire 95 percent interval estimate surrounding the hospital's rate is lower than the national observed readmission rate.

If a hospital has fewer than 25 cases eligible for a measure, CMS cannot reliably estimate the hospital's RSRR and assigns the hospital to a separate category: "Number of cases is too small."

Question 50: **Could you go over the months that each of the reports is expected to be released?**

The FY 2019 Hospital VBP Program HSRs were delivered to hospitals for the start of the Review and Corrections period which began on April 11, 2018, and ends at 11:59 p.m. Pacific Time (PT) on May 10, 2018. The FY 2019 Hospital IQR Program HSRs are expected to be delivered sometime in May 2019.

Question 51: **Is the Review and Corrections period different for the Hospital IQR Program HSRs, since we haven't received those yet?**

Hospitals have approximately 30 days from the day of receiving their Hospital IQR Program HSR to preview their reports.

Question 52: **There is confusion on the *Quality Net* reports predicted versus expected. Please explain this. Additionally, we are not given survival rates, just mortality rates. Why the discrepancy?**

In terms of the mortality, complication, and readmission measures:

Predicted outcomes are the number of outcomes (readmissions, complications, or deaths) predicted based on the hospital's performance with its observed case mix (and service mix for the hospital-wide readmission measure). Expected outcomes are the number of outcomes (readmissions, complications, or deaths) expected based on the nation's performance (average hospital performance) with that hospital's case mix (and service mix for the hospital-wide readmission measure).

Similarly, the predicted value for a payment measure is the payment within 30 days (or other timeframes for THA/TKA Complication) predicted based on the hospital's payments with its observed case mix; whereas, the expected value is the payment expected on the basis of the nation's payments with that hospital's case mix.

In contrast, for the EDAC measures, "predicted days" is the average number of risk-adjusted days a hospital's patients spent in acute care during the 30 days after discharge from an index admission and "expected days" is the average number of risk-adjusted days a hospital's patients would have been expected to spend in acute care (in the 30-day measurement timeframe) if they were discharged from an average performing hospital with a similar case mix.

For additional details, please visit the *QualityNet* Claims-Based and Hybrid Measure page. Select the measure set (mortality, readmission, etc.) and select Measure Methodology. View Appendix A of the updates and specifications reports.

Lastly, survival rates for the Hospital VBP Program versus mortality rates for the Hospital IQR Program are based on different program uses. For more information on the rationale for Hospital VBP Program survival rates, please submit your inquiry through the Inpatient Question and Answer tool on the *QualityNet* site (https://cms-ip.custhelp.com).

Question 53: **On slide 17, how/when can we access the different national percentiles?**

National results for the claims-based measures will be available in the HSR, which will be available to facilities through the *QualityNet Secure Portal*. National results are also available in the Mock HSR on *QualityNet* for facilities that do not receive an HSR. HSRs and mock HSRs will be available during the spring 2018 Hospital IQR Program preview period (starting in May). To access the mock HSRs once they become available, please go to QualityNet > Hospital – Inpatient > Claims-Based and Hybrid Measure > Mortality Measures > Hospital-Specific Reports.

Additionally, the 2018 national results for the claims-based outcome and payment measures will be available for download later this summer on *Data.Medicare.org*. This information can be used to identify percentiles.

Question 54: **Why is there so much time spent on calculation replications? Have hospitals reported errors in calculations?**

Replication instructions are available to hospitals to help them understand the calculation steps. Hospitals are encouraged, but not required, to verify results through replication in Table 1 and 2 of your Hospital VBP Program HSR. Further explanation of the replication can be found in your hospital user guide. Please note that the national rate and risk factor coefficients cannot be replicated.

Question 55: **Are any of the mortality and readmission rate changes significant?**

The statistical significance of national or hospital-level result changes over time is not available as CMS does not report it.

Question 56: **Is CMS PSI v8.0 software similar to the AHRQ PSI software beta version?**

The CMS recalibrated PSI software, SAS, ICD-10-CM/PCS, v8.0 is different from the AHRQ PSI software beta version. Version 7.0 AHRQ QI ICD-10-CM/PCS is publicly available on the AHRQ Quality Indicator Software web page. The main difference is that CMS recalibrated PSI software v8.0 includes a risk-adjustment model based on reference population of Medicare FFS discharges from October 1, 2015, through September 30, 2016, while the all-payer AHRQ QI ICD-10-CM/PCS v7.0 does not include a risk-adjustment model.

Question 57: Which version did CMS use to produce PSI results from AHRQ?

CMS used version 8.0 of the CMS PSI software to calculate PSI results.

Question 58: What happens when the hospital's "real" deaths are less than the predicted or expected rates?

A hospital's "real" deaths are not directly compared to their "predicted" or "expected" deaths in the mortality measure calculation. Instead, the "real" deaths are considered when calculating the number of predicted deaths for a hospital.

The predicted deaths for a hospital are calculated by using the "hospital-specific effect" and the hospital's observed case mix. Specifically, the hospital-specific effect takes into consideration how many patients were eligible for the cohort, these patients' risk factors, and how many died during the measurement period. The measure compares the amount of predicted deaths to the expected deaths (which is the number of deaths expected based on the nation's performance with that hospital's case mix) and then multiples by the national observed mortality rate.

This approach is analogous to a ratio of "observed" to "expected" used in other types of statistical analyses. It conceptually allows for a comparison

of a particular hospital's performance to an average hospital's performance with the same case mix. Thus, a ratio of less than one indicates a lower-than-expected mortality rate (or better quality), and a ratio of greater than one indicates a higher-than-expected mortality rate (or worse quality).

For additional details, please visit the *QualityNet* Claims-Based and Hybrid Measure page. Select the measure set (mortality, readmission, etc.) and select Measure Methodology. View Appendix A and Section 2 of the updates and specifications reports.

Question 59: **Define the hospital effect on mortality. How is effect defined and calculated?**

The hospital-specific effect is a measure of the hospital's quality of care calculated through hierarchical logistic regression. The hospital-specific effect takes into consideration how many patients were eligible for the cohort, these patients' risk factors, and how many died. The hospital-specific effect is the calculated random effect intercept for each hospital and is used in the numerator of the Risk-Standardized Mortality Rate to calculate "predicted" mortality.

For additional details, please visit the *QualityNet* Claims-Based and Hybrid Measure page. Select the measure set (mortality, readmission, etc.) and select Measure Methodology. View Appendix A and Section 2 of the updates and specifications reports.

Question 60: **Why is a patient counted twice for the TKA/THA complication rate when the patient was transferred from one hospital for the same episode of care?**

This response presumes this patient had an index THA/TKA admission at your hospital, was transferred to a second short-term acute care hospital

where they were readmitted, and had two complications billed on that readmission claim. This response also presumes you are questioning the presence of two rows in the "Table 3 Discharges THA TKA" worksheet in your FY 2019 Hospital VBP Program Complication HSR for this patient.

To clarify, if a patient experienced more than one complication (either during the index admission or on the claim for a readmission), the HSR will display information for each of those complications on different rows. This information is provided for a hospital's internal reference and potential additional analyses/quality improvement efforts. Thus, multiple rows may exist for one patient in the Table 3 worksheet.

In the case of multiple rows for a single patient, only one complication is counted in your hospital's risk-standardized complication rate. The complication outcome is a dichotomous (Yes/No) outcome. If a patient experiences one or more of these complications in the applicable time period, the complication outcome for that patient is counted in the measure as a "Yes."

In this type of transfer case, where a patient is transferred to another acute care hospital after the index THA/TKA procedure was performed. the complication outcome is attributed to the hospital that performed that index THA/TKA.

If we have misinterpreted your question, please resubmit your question, with additional detail, to CMScomplicationmeasures@yale.edu inbox.

Question 61: **Slide 27. What is the difference between "observation stay (facility)" and "observation stay (physician)"?**

"Observation stay (facility)" refers to the claim the hospital files for an observation "event." These claims are pulled from the outpatient hospital institutional claims files. The great majority of observation stays captured

in the EDAC measure outcomes are captured through these claims.

"Observation stay (physician)" refers to the claim a physician files for an observation "event." These claims are pulled from the physician carrier files but are not available for all observation stays.

For more information on how these types of claims are used in the EDAC measures, please refer to the *2018 Condition-Specific Measures Updates and Specifications Report Hospital-Level 30-Day Risk-Standardized Excess Days in Acute Care Measures* on *QualityNet* > Hospitals – Inpatient > Claims-Based and Hybrid Measure > Excess Days in Acute Care (EDAC) Measures > Measure Methodology. (Please note that the 2018 updates and specifications report that corresponds with the upcoming FY 2019 IQR EDAC HSR is expected to be posted at the beginning of the preview period.)

Question 62: **New ICD-10 codes need to be added to the definition of a population. Right now, only 2017 methodology is on *QualityNet*. When will 2018 be released?**

The updated methodology for 2018 (including the ICD-10 codes) are posted on *QualityNet* at the beginning of the spring 2018 Hospital IQR Program preview period. This year the preview period is expected to begin in May.

Question 63: **Do patient mortalities count against both hospitals if a patient was transferred to inpatient status from hospital A to hospital B and then died in hospital B? The measure specification states it counts for hospital, A but is that the case?**

In a case where a patient is discharged from short-term acute care hospital A, admitted to short-term acute care hospital B on the same day or the next calendar day, and later dies during the hospital B stay (within 30 days of

the start of the index admission at hospital A), whether that death is counted against hospital A or hospital B depends on the measure and case circumstances.

For the condition-specific mortality measures (e.g., AMI, HF), death would be attributed to hospital A.

For the CABG surgery mortality measure, death would be attributed to whichever hospital performed the initial index CABG surgery.

To further clarify, for all measures, the death would not count against both hospitals for the same measure. However, in an example where the patient was admitted for AMI at hospital A, discharged, and transferred to hospital B for CABG surgery, where they later die, and both of those admissions meet cohort criteria for the AMI and CABG surgery measures, respectively, that death would count against hospital A for the AMI mortality measure and against hospital B for the CABG mortality measure. The cohorts for the measures are determined independently of each other.

For more information on the handling of transfer cases in the mortality measures, please refer to questions 13 and 14 in the Frequently Asked Questions document, available at QualityNet > Hospitals – Inpatient > Claims-Based and Hybrid Measure > Mortality Measures > Resources.