Hospital Value-Based Purchaing (VBP) Program

Support Contractor

Overview of the Hospital Value-Based Purchasing (VBP) Program Fiscal Year (FY) 2019

Presentation Transcript

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Ms. Wheeler-Bunch: Hello and welcome to the *Overview of the Hospital Value-Based Purchasing Program Fiscal Year 2019 Webinar*. My name is Bethany Wheeler-Bunch, and I am the Support Contract Lead for this program at the Hospital Inpatient Value Incentives and Quality Reporting Outreach and Education Support Contractor. I will be hosting and presenting today's event. Before we begin, I'd like to make our first few regular announcements. This program is being recorded. A transcript of the presentation along with the question and answers will be posted to the inpatient website, www.QualityReportingCenter.com and to QualityNet at a later date. If your registered for this event, a reminder email, as well as the slides were sent out to your email about two hours ago. If you did not receive that email, you can download the slides at our inpatient website, www.QualityReportingCenter.com. If you have a question as we move through the webinar, please type your question into the chat window with the slide number associated to your question at the beginning. We will answer as many questions as we can through the chat window during the webinar. Any questions that are not answered during our question and answer session at the end of the webinar will be posted to the Quality ReportingCenter.com website in the future.

The purpose of today's event is to provide an overview of the bullet points listed on the slide, evaluation criteria for hospitals within each domain and measure, eligibility requirements, and explanation of the scoring methodology.

We have quite a bit to cover today, so let's get started. I just want to remind everyone one more time that, if you have a question, please type the slide number into the chat window prior to submitting your question.

The Hospital Value-Based Purchasing 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 VBP Program was first used in fiscal year 2013, and CMS has used this program to adjust hospital payments for every fiscal year subsequent. The Hospital VBP Program is one of the first national inpatient pay for performance programs in which hospitals are paid for services based on the quality of care rather than the

quantity of services provided. Like the second bullet states, the Hospital VBP Program was built on the Hospital Inpatient Quality Reporting Program, which is a pay for reporting rather than a pay for performance program. All measures in the Hospital VBP Program are first collected under the Hospital IQR program. The Hospital VBP Program pays for care that will reward better value, improves patient outcome, innovations and cost efficiency over volume of services. CMS views value-based purchasing as an important driver of change moving towards rewarding better value and improved patient outcomes, which in turn, leads to better care and healthier patients. The Hospital VBP Program is a budget neutral program, but is funded through a percentage withheld from participating hospitals MS-DRG payment. Payment amounts will be redistributed based on the hospital's total performance score in the program in comparison with the distributions of all hospitals' total performance scores and total estimated DRG payments. It is important to note that withholds and incentive payments are not made in a lump sum, but through each Medicare claim made to CMS. The funding from the fiscal year 2019 program will come from a 2% withhold from participating hospitals' base operating DRG amount.

On this slide, we will discuss eligibility in the Hospital VBP Program. The program applies to subsection D hospitals in the 50 states and the District of Columbia, which is more than 3,000 hospitals nation-wide. Hospitals that meet that initial eligibility criteria could still be excluded from the program for one of the reasons listed on the slide. If a hospital is excluded for any reason listed on the slide, they will not have their base operating DRG payments amounts withheld by 2% nor will they be eligible to receive incentive payments for that fiscal year. If a hospital is subject to payment reductions under the Hospital IQR program, meaning that that hospital chose either not to participate in the Hospital IQR program or they did not meet one or more of the requirements of that program, and therefore are receiving a payment reduction through Hospital IQR, they will be excluded from the Hospital VBP Program. Hospitals that are cited for meeting jeopardy citations during the performance period will also be excluded. This exclusion was updated

beginning with the fiscal year 2017 program year from two immediate jeopardy citations required for exclusion to three during the performance period. For more information on the immediate jeopardy exclusion, there's a quick reference guide available on the Hospital VBP Program page on QualityNet. Also excluded from the program are hospitals with an approved disaster or extraordinary circumstance exception, also known as an ECE, and short-term hospitals in Maryland. The last exclusion reason, which is the fourth bullet point on the slide, excludes hospitals with less than the minimum number of domains calculated. For fiscal year 2019, the minimum number of domains required for CPS is three out of four, which is the same as it was in fiscal year 2018. We will cover the minimum measures required for domain scoring and the calculations later in this presentation. If a hospital is excluded from the program, it will say Hospital VBP ineligible on the percentage payment summary report, also known as a PPSR. This report is provided to hospitals prior to August first annually. It is anticipated that the fiscal year 2019 PPSR will be released by August first 2018. Additionally, data for these hospitals will not be publicly reported in the Hospital VBP Program section in the *Hospital Compare* website. I would like to reiterate once again that hospitals that are not eligible for the program or that are eligible and later excluded from the program will not have their base operating DRG withheld by 2% nor will they be eligible to receive incentive payments for that fiscal year.

The Hospital VBP Program has been evolving each fiscal year. Those that have been around since the program started in fiscal year 2013 definitely know that. In fiscal year 2013, CMS only included two domains in the total performance score: clinical process of care, weighted at 70% and the patient experience of care weighted at 30%. In fiscal year 2014, CMS adopted the outcome domain including the 30-day mortality measures for AMI, heart failure, and pneumonia and weighted the domain at 25%. This decreased the clinical process of care domain to 45%. In fiscal year 2015, CMS expanded the outcome domain to include the AHRQ PSI-90 composite and the CLABSI measure. CMS also adopted the efficiency domain, including the Medicare Spending per Beneficiary measure. The

domains were weighted at 20% for clinical process, 30% for patient experience, 30% for outcomes, and 20% for efficiency. In fiscal year 2016, CMS adopted additional outcome measures of CAUTI and surgical site infection, a new clinical process measure, IMM2, and revised the domain weighting. In fiscal year 2017, CMS modified which measures were included in the domains and renamed the domains based on the National Quality Strategy. The HAI measures, including the newly adopted MRSA and CDI measures, and the AHRQ measure moved to the new safety domain and the 30-day mortality measures moved to the clinical care outcome subdomain. The remaining process of care measures moved from the clinical process of care domain to the clinical pair process subdomain and the patient experience of care and efficiency domains were renamed. In fiscal year 2018, two of the three remaining process measures were removed. Those were AMI 7A and IMM2, and PC-01 was moved to the safety domain. CMS weighted each of the four domains equally at 25%. It is also important to note that throughout the transition within the fiscal years, the process of care measure went from a volume of 12-13 measures in the domain per year to three in fiscal year 2017 to one in fiscal year 2018 and going forward. In fiscal year 2019, which is displayed on the slide, the total hip arthroplasty and total knee arthroplasty complication measure was added to the clinical care domain. There are some additional updates that I will cover in the next few slides for fiscal year 2019.

As I mentioned on the last slide, the elective primary THA / TKA complication rate was added to the clinical care domain. The measure for elected primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) assesses a broad set of healthcare activities that affect patients' well-being. The outcome for this measure captures eight different complications, each with its specific and clinically meaningful time period, during which the outcome can be attributed to the hospital that performs the procedure, measuring, and reporting risks standardize complication rates will inform healthcare providers of opportunities to improve care, strengthen incentives for quality improvement, and provide consumers information to help them choose a hospital at which to have an

elective surgical procedure. The patient and caregiver centered experience of care, care coordination domain was updated to a new name, the personal and community engagement domain in fiscal year 2019. In the calendar year 2017 OPPS final rule, which is the outpatient rule, CMS finalized the removals – they plan to remove the pain management dimension beginning in fiscal year 2018. So, that means the person and community engagement domain score will be calculated as it has been in the past because of the addition of the care transition dimension in the same fiscal year that pain management was removed. Each of the eight dimensions will have the potential to earn ten maximum points for a total maximum base score of 80 points. The consistency scores still remains the maximum point value of 20 points to equal 100 maximum points when you sum those two together for the unweighted domain score. The multiple occasion of the base score by 8 over 9 is no longer applicable because we have eight dimensions at any given fiscal year, with the addition of care transition and the removal of pain management in the same fiscal year, fiscal year 2018. For more information on the removal of pain management and the scoring of the domain, reference can be made to the calendar year 2017 OPPS final rule, specifically pages 79855 through 79862.

In the safety domain, the CLABSI and CAUTI measure were expanded to include Select Wards, non ICU locations, and the CDC updated the standard population data to ensure that the NHSN measures predicted infections, reflects the current state of HAI's in the United States. We will cover these two changes in detail in the next few slides.

The Hospital VBP Program uses adult pediatric and neonatal intensive care unit data to calculate performance standards and measure scores for the CAUTI CLABSI measures for fiscal year 2017 and FY 2018. Beginning with January first 2015, hospitals began reporting to an expanded set of locations to include select wards. Selected wards locations are defined as adult or pediatric, medical surgical and medical surgical wards. CMS finalized the use of data from the selected ward locations for the Hospital VBP Program beginning in the fiscal year 2019

program year for purposes of calculating performance standards for the CAUTI and CLABSI measures. There's a table displayed on the slide that shows which location would be used for each fiscal year. Because CMS would like to compare similar locations of data from the baseline period to the performance period, CMS could first implement the use of expanded locations in fiscal year 2019 because that was the first year the baseline period had data from that expanded location set in calendar year 2015. For example, CMS could not use that data in the fiscal year 2018 program because the baseline period was calendar year 2014, which was prior to the shift in reporting of additional locations. So, the ICU-only locations won't be used for all calculations in FY 2018, including the baseline period rate performance standard, and performance period rates.

The NHS and measures are calculated by CDC and currently include CAUTI, CLABSI, MRSA, CDI, and colon and abdominal hysterectomy HAI measures in the FY 2019 program year and subsequent program years. They measure the occurrence of these HAI's in hospitals participating in the Hospital VBP Program. In order to calculate the NHSN measures for use in both the Hospital IQR program and Hospital VBP Program, CDC must go through several steps. First, CDC determines each NHSN measures and number of predicted infections. CDC determines the number of predicted infections using both specific patient care or patient characteristics. For example, number of states in which patients in an ICU have a central wide, and infection rates that occurred among a standard population, sometimes referred to as CDC as the national baseline. Finally, for each NHSN measure, CDC calculates with standardized infection ratio – also known as the SIR – by comparing a hospital's observed number of HAI's with a number of HAI's predicted for the hospital, adjusting it for several risk factors. As part of the routine measure maintenance, CDC updated the standard population data to ensure that NHSN measures the number of predicted sections reflect the current state of HAI's in the United States. Previously, CDC calculated the standard population data for the CAUTI measure based on data collected on calendar year 2009. CDC calculated the standard population data for the CLABSI and colon and abdominal hysterectomy SSI measures

based on data collected on 2006 to 2008. CDC calculated the standard population data for the MRSA and CDI measures based on data it collected on 2010 to 2011. Beginning in 2015, CDC will collect data in order to update the standard population data for all these NHSN measures. The calendar year 2015 standard population data for HAI measures will be referred to as the new standard population data. Because the Hospital VBP Program calculates improvement points using comparisons between data collected from hospitals in a base line period and data collected in a performance period, the Hospital VBP Program must treat CDC's standard population data differently than other quality programs. CMS determines that they cannot equally compare CDC's new standard population data to the current population data in order to calculate improvement points. If CMS does not address the CDC's updates, they will be unable to compare the baseline and performance period for NHSN measures in fiscal year 2017 and the FY 2018 program years. To address that problem, CMS intends to use the current standard population data to calculate performance standards and calculate – and publicly report measure scores until FY 2019, as depicted on the table in the slide. For the FY 2019 program year and subsequent years the hospital VBP Program will use the new standard population data to calculate performance standards and calculate and publically report the measure scores. So, that means for fiscal year 2019 the CMS will be using the new standard population data or the new baseline for the baseline period calculation, performance standards, and performance period calculations. If you have additional questions or would like to learn more about the new standard population, I would recommend watching the recorded webinar presented by CDC on October 26 2016 titled *NHS Transition to the 2015 Re-baseline Guidance for Acute Care Facilities* available at the link displayed on this slide.

CMS issued a technical update regarding the benchmark and achievement threshold for the following measures in fiscal years in the Hospital VBP Program: PSI-90 for fiscal year 2019, the HAI measures for fiscal year 2019, and the hospital 30-day all cause risk standardized mortality rate following pneumonia hospitalization for FY 2021. This technical update was made available through a ListServe and QualityNet news article late

last week. CMS is updating the fiscal year 2019 performance standard for PSI-90 due to a more recent release of the AHRQ quality indicator software. Version 5.0.1 was used to calculate the performance standards for the fiscal year 2018 Hospital VBP Program year and the same software version is being used to calculate the performance standards for fiscal year 2019. We have historically had an update to the AHRQ PSI-90 composite performance standards each year, but it was included in the Hospital VBP Program for using more recent software versions than was used initially for the performance standard values published in the IPPS rules, so this is a pretty standard update. The technical updates for HAI performance standards is due to the routine maintenance to update the standard population data using calculating the predicted number of infections for these measures, which we just discussed in the last few slides. The technical update also revises the mortality – the 30-day mortality in pneumonia measure performance standards published in the FY 2016 IPPS final rule. For FY 2021, as part of the CMS measure re-evaluation process, this measure underwent a substantive revision that expanded the measure cohort to include patients with a principal discharge diagnosis of pneumonia, patients with a principal discharge diagnosis of aspiration pneumonia and patients with a principal discharge diagnosis of sepsis, excluding severe sepsis with a secondary diagnosis of pneumonia coded as present on admission.

This slide provides the newly updated performance standards for the HAI and the PSI-90 measures for fiscal year 2019.

The clinical care domain contains four measures: the three 30-day mortality measures for AMI, heart failure, and pneumonia; and the THA TKA complication measure. The clinical care domain is weighted at 25% of the total performance score. The mortality measure result calculated and displayed on the baseline measures report in the PPSR are displayed as survival rates instead of mortality rates. This means that the higher rates indicate better qualities for this set of measures.

If a hospital does not meet the minimum requirements for a measure or dimension during the baseline period, improvement points will not be

calculated for the measure or dimension. In order to receive improvement points for the clinical care measures, at least 25 eligible cases must be submitted during the baseline period in the performance period. If a hospital only meets the minimum requirements of 25 cases during the performance period, and not the baseline period, only achievement points will be awarded. If the hospital did not submit eligible cases during the baseline period, a double asterisk symbol will be displayed next to the measure name on the baseline measures report. The clinical care domain requires at least two of the four measures, displayed on this slide, to receive a domain score in order to be included in the total performance score calculation that will be displayed on the PPSR. In this example, the hospital did not meet the minimum case requirements in the pneumonia or THA – TKA measures; however, because the hospital met the minimum case requirements in the other two measures, the hospital will receive a domain score.

In the fiscal year 2019 VBP person and community engagement domain, the domain will be weighted at 25% of the total performance score. This domain is measured by the use of the hospital consumer assessment of healthcare providers and systems, HCAHPS survey, dimensions, which are listed on the slide. Please note that there is no hang management listed, and as adopted in fiscal year 2018, care transitions is included.

For the person and community engagement domain, a hospital must have 100 completed HCAHPS surveys in the baseline period to have the opportunity to receive improvement points on the PPSR. In addition to the surveys required during the baseline period, a hospital must have 100 completed surveys in the performance period to receive improvement points or achievement points on the PPSR. In order for a hospital to receive a domain score for this domain, the same total of 100 completed HCAHPS surveys are required. In the example on the slide, the hospital had 100 completed surveys. As a result, the hospital will receive a domain score.

In fiscal year 2019 Hospital VBP Program, the safety domain will be weighted at 25% of the total performance score. This domain utilizes

three measure sets: the first being the healthcare associated infection measures of CLABSI, CAUTI, SSI, MRSA, and CDI; the second being the AHRQ PSI-90 composite; and, the third being the PC-01 process measure.

The AHRQ PSI-90 composite consists of eight underlying patient safety indicators listed on the slide. Please note that the AHRQ PSI-90 measures that are used in the Hospital VBP Program for fiscal year 2019 is the older version of the measure and not the new version in which the hospital IQR program and HAC Reduction Program will use in fiscal year 2018. CMS is using the recalibrated 5.0.1 version of the AHRQ software for fiscal year 2019. This is also what CMS elected to use in the fiscal year 2018 Hospital VBP Program. The recalibrated software uses a reference population of Medicare fee for service discharges from July 1, 2012, through June 30, 2014, rather than the 2012 Healthcare Cost and Utilization project, also known as HCUP, reference population. As an important note, this recalibrated version of patient safety indicator, software version 5.0.1, also known as recalibrating version 5.0.1, is different from the publically available version 5.0.1 on the QI website. The recalibrated AHRQ QI software version 5.0.1 incorporates a couple of major changes to the PSI program. The Medicare fee for service reference population was used to refit the risk adjustment core sessions, reference population rates, signal variance, and composite leads for recalibrated version 5.0.1. And, consistent with modifications to the PSI software, when using CMS programs, the recalibrated version 5.0.1 adjusts the smoothing target rate to be the national risk adjusted rate for the input data. For the first time in the Hospital VBP Program CMS will be using 25 diagnosis codes and 25 procedure codes for the calculation of the measure instead of the first nine and six listed as used in previous fiscal years. The use of 25 diagnosis codes and 25 procedure codes is consistent with the hospital IQR Program and HAC Reduction Program.

As we discussed earlier, PSI-90 is composed of eight underlying individual patient safety indicators, or PSIs. In order for a hospital to receive improvement points on the PPSR, 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 the slide, our hospital has had four eligible cases in the PSI-03 measure. As a result, our example hospital will be eligible to receive a measure score for the PSI-90 composite.

In order to receive improvement points for the measures of CLABSI, CAUTI, MRSA, and CDI, a hospital must have at least one predicted infection calculated by the CDC in the baseline period and in the performance period. To receive achievement points, the minimum of one predicted infection must be calculated in the performance period. The example hospital received at least one predicted infection in the CLABSI and MRSA measures, but did not in the CAUTI and CDI measures, with 0.999 and 0.5 predicted infections. I would like to note that these are predictive infections and not actual or observed infections as the minimum. If you would like more information on how CDC calculates the predicted number of infections for HAI measures, CDC provided some excellent information during the Hospital VBP Program NHSN mapping and monitoring webinar that was held on October 19, 2015. Materials for this webinar, including the recording, are available on the Qualityreportingcenter.com website. I also wanted to provide you a reminder regarding the submission and review of the data for these measures. The healthcare associated infection data submitted to the Centre for Disease Control and Prevention, also known as CDC, their National Healthcare Safety network and HSN cannot be modified after the submission deadline for use in CMS programs. Immediately following the submission deadline, the CDC creates a file of the data for CMS to use in quality reporting and fee for performance programs. This effectively creates a snapshot of that data at that time of the submission deadline. Hospitals currently have an opportunity to submit, review, correct, and then re-submit any of the chart extracted quality information, including HAI data reported via an NHSN for approximately four and a half months following the last discharge date in a calendar quarter up until the submission deadline for that quarter. Hospitals can begin submitting data

on the first discharge day of any reporting quarter. Users may view and make corrections to the data that they successfully submit, which are populated in your reports available via the *QualityNet Secure Portal*. Information on observed infections, which is the numerator, predicted infections the denominator, and the standardized infection ratio of the SIR are available for each HAI measure for the reporting quarter. CMS encourages hospitals to submit data early in the submission schedule, to identify errors and resubmit data before the quality submission deadline. We understand hospitals have the capability to update data in the NHSN system after the deadline; however, CMS does not receive or use that data that were entered in the NHSN after the submission deadline. It is CMS expectation that hospitals review and correct their data prior to that submission deadline. CMS seeks to ensure both accuracy and timeliness of quality measure data used in the value-based purchasing payment program and publically reported information. Any changes made after the submission deadline will not be reflected in the information displayed on *Hospital Compare*, nor will it be used in the Hospital VBP Program or the HAC Reduction Program.

The same criteria apply to the surgical site infection measure; however, because the measure is stratified into two procedure types, there are additional regulations. In order to receive an SSI measure score, at least one predicted infection is required in at least one of the strata of abdominal, hysterectomy, or colon surgery. If only one of the strata meets the minimum, 100% of the measure's weight will be placed on the measures that met the minimum. If both strata met the minimum predicted infections, the measure score will be weighted by the predicted number of infections.

In order to receive improvement points for the PC-01 measure, at least ten eligible cases must be reported in the denominator during the baseline period and the performance period. If a hospital only meets the minimum requirements of ten cases during the performance period and not the baseline period, only achievement points will be awarded. If a hospital did not submit ten eligible cases during the baseline period, a double

asterisk symbol will be displayed next to the measure name on the baseline measures report.

We have now addressed the minimum measure requirements for all the safety measures in the previous slides. The example hospital met the minimum measure requirements in all but the CAUTI and CDI measures. In order for a hospital to receive a safety domain score, they must receive a measure score in at least three of the seven total measures. As our hospital met at least three of the seven measures, our example hospital will receive a safety domain score.

The Medicare Spending per Beneficiary, or MSPB measure, is the full measure of the efficiency and cost reduction domain in fiscal year 2019. The domain is weighted at 25%. The MSPB measure is a claims-based measure that assesses Medicare Part A and Part B payments for services provided to a Medicare beneficiary during a spending per beneficiary episode that spans from three days prior to an inpatient hospital admission through to 30 days after discharge. The payments included in this measure are price standardized and risk adjusted. Price standardization removes sources of variations that are due to geographic payments, such as wage index and geographic practice cost differences, as well as the indirect medical education, or IME, or disproportionate share hospital payments. Risk adjustment accounts for variations due to patient health status. 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 low cost.

The last domain displayed on the baseline measures report is the efficiency and cost reduction domain, which as I stated in the last slide, contains the MSBP measure. In order to receive improvement points for this measure, a hospital must have at least 25 eligible episodes of care during the baseline and performance periods. If a hospital only meets the minimum requirements during the performance period, only achievement points will be awarded. Our example hospital had 25 eligible episodes of care during the performance period. As a result, our hospital will be eligible to receive that domain score.

For your convenience, here is a table summarizing the minimum data required for each measure domain and for the total performance score that we just covered.

On this slide, we list out the baseline period and performance period for all of the measures included in the fiscal year 2019 program. As a general idea or assumption, you can think that in FY 2019 the calendar year measures have a performance period of calendar year 2017 and a baseline period of calendar year 2015. Now that isn't true for the – the clinical care or the RPSI-90 measures. Those have a longer period for reliability purposes; and so, you can view those baseline performance periods listed on the slide.

Hospitals have the opportunity to receive improvement and achievement points on their PPSR based upon their performance rates during the baseline period and performance period relative to the performance standards adopted for the Hospital VBP Program. The performance standards consist of the achievement threshold and benchmark for all measures and the floor, which is only applicable to the person and community engagement domain. The achievement threshold is calculated as the median or the 50 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% during the baseline period. The floor using calculating the HCAHPS consistency score is the rate of the lowest performing hospitals during the baseline period. These values will be displayed on the baseline measures report.

The measures displayed on this slide will have a higher benchmark value than an achievement threshold. Higher rates indicate better quality in the measure. The measures that this description is applicable for are the 30-day mortality measures and the person and community engagement dimensions. As we covered earlier, the results for the mortality measures are calculated and displayed on the reports as survival rates instead of mortality rates; meaning the higher rates are better for these measures.

The measures displayed on this slide will have a higher achievement threshold value than benchmark value because lower rates demonstrate better quality in the measure. The measures that this description is applicable to is the PC-01 measure in the safety domain, the PSI-90 composite, all of the healthcare associated infection measures in the safety domain, and the MSPB measure and efficiency and cost reduction domain. As indicated on the slide, it's important to note that the MSPB measure will not have a benchmark and achievement threshold displayed on the baseline measures report because data is used from the performance period instead of the baseline period to calculate those performance standards. You will be able to view the achievement threshold and benchmark using the points calculations on your hospital PPSR when it is released by August 1, 2018 for the fiscal year 2019 program.

This slide displays the fiscal year 2019 benchmark and achievement threshold values that will be used for the clinical care and safety domains. Please note that the safety domain, including the HAIs and the PSI-90 have values that are reflective of the technical update that we discussed earlier in this presentation.

This slide displays the remaining performance standards. Please note that the baseline measures report will not display the MSPB performance standard because those values again are calculated based on the performance period instead of the baseline period.

Achievement points are awarded by comparing an individual hospital's rates during the performance period with all hospital rates from the baseline period by using two performance standards: the achievement threshold and the benchmark. If a hospital has a performance period rate that is equal to or better than the benchmark, the maximum ten achievement points will be awarded. If the rate is lower than the achievement threshold, the hospital will receive zero achievement points. If the performance period rate is equal to or better than the achievement threshold, but is still lower than the benchmark, one to ten points will be awarded. We will go through these three scenarios in the next few slides.

In this first scenario, the hospital has a performance period rate that is equal to the benchmark. As a result, the first bullet point would apply to this hospital and they would receive ten points. Likewise, if the performance period rate was better than the benchmark, the hospital would also receive ten points.

In the second example, the hospital had a performance period rate that was worse than the achievement threshold. As a result, the second bullet point would apply resulting in zero achievement points being awarded to the hospital.

In the third example, the hospital had a performance period rate that fell in between the achievement threshold and the benchmark. When this occurs, CMS will use the achievement point formula to calculate the number of points to award the hospital. Based on the formula on the bottom of the slide, the hospital received five achievement points. The achievement point formula is 9 multiplied by the quotient of the performance period rate minus the achievement threshold over the benchmark minus the achievement threshold plus 0.5. In order to calculate the achievement points, substitute the achievement threshold and benchmarks from the table of performance standards and input your hospital's performance period rates.

Improvement points are unique to the Hospital VBP Program in relation to CMS's other in-patient paper performance programs such as the HAC Reduction Program and Hospital Readmissions Reduction Program. Not only can hospitals be evaluated based on their current performance in comparison to all other hospitals, but they can also earn points by improving from their own baseline period. CMS may award hospitals 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.

In our first example for improvement points, the hospital's performance period rate is equal to the benchmark and better than the baseline period rate – and that "and" is important – the "and" better than the baseline

period rate. The result of this scenario is nine improvement points. Our next example will look at the case where the "and better than the baseline period rate" is not occurring.

In this second example the benchmark and performance period rate are equal; however, the baseline period rate is also equal to the performance period rate. In this scenario the resulting improvement point value will be zero, because no improvement was observed from the baseline period to the performance period. Although in this scenario because the hospital's performance period rate was equal to or better than the benchmark, if you can remember a few slides back, the hospital would receive ten achievement points, which will be their ultimate measure score. We will discuss more how the measure score is determined in a few slides.

In this third example, the performance period rate is worse than the baseline period rate. In this scenario the hospital would have zero improvement points awarded.

In our last example, the hospital's performance period rate is in between the benchmark and the baseline period rate. When this occurs, CMS will use the improvement point formula to calculate the number of improvement points to award the hospital. The resulting value from this example is five improvement points, calculated by 10 multiplied by the quotient of the performance period rate minus the baseline period rate over the benchmark, minus the baseline period rate, and then subtracting 0.5. Like the achievement points, in order to calculate the improvement points, just substitute the benchmark from the table of performance standards and input your hospital's performance period rate and baseline period rates.

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 fiscal year 2019 clinical care domain measures, with example achievement and improvement point values. Measure score is populated by selecting the larger of the two values; for example, the AMI measure score – AMI measure was awarded ten achievement points and nine improvement points. The measure score is

the greater of the two numbers, which is ten. The second measure, heart failure, was awarded five achievement points and was not awarded any improvement points. This would be because the hospital met the minimum of 25 cases during the performance period, but then had less than 25 during the baseline period, which is needed in order to calculate improvement points. When this occurs the achievement points are automatically awarded as that measure score. The example list also includes a measure that did not have any points calculated. This display indicates that the hospital did not meet the minimum measure requirements in the performance period to receive a measure score. This designation will be important in the next step of our calculations.

Now that each measure has a measure score calculated, the unweighted domain score is calculated. The unweighted domain scores for clinical care, safety, and efficiency domains are normalized to account for only the measures that the hospital met the minimum requirements for. To normalize the domain, you sum the measure scores in that domain. In our example the sum of the measure scores is 21 points; you then multiply the eligible measures by the maximum point value per measure. In our example, the hospital did not meet the minimum requirements in the 30-day mortality pneumonia measure, so instead of four total measures, this hospital was only scored on three. We then multiply the numbers 3 times ten points possible for each measure for a total of 30. To create a percentage score, a hospital earned in relation to points possible we divide the sum of the measure scores of 21 by the maximum points possible of 30, which equals approximately 0.70. Lastly, we multiply that result by 100 to equal 70.

The weighted domain score is the last calculation completed for the total performance score. We multiply the unweighted domain score value by the domain weight for that fiscal year. Each domain is weighted at 25% in FY 2019. To compute the total performance score we sum the weighted domain scores; the maximum total performance score that can be calculated is 100 points or 25 points for each weighted domain score. In the fiscal year 2019 program however, only three domains are required for

calculation of the total performance score. In the next slide, we will cover the calculation of the new domain weights and weighted domain scores under this scenario.

In this example the hospital received scores in three of the four domains; the slide shows the steps in determining the proportionate re-weighted value used for a hospital with less than the maximum of four domains. This hospital had unweighted domain scores calculated in the clinical care domain, safety domain, and in the efficiency and cost reduction domain. To determine the proportionate reweighted value, you first sum the original weights of the eligible domains. This resulted in 75% for our example, which is composed of 25% of clinical care, added to 25% of safety, and 25% for efficiency and cost reduction. Second, individually divide the original weight for the domains that are eligible by the result of step one, which was 75%. The clinical care domain is calculated as 33.3% by dividing the original weight of 25% by the sum of 75%. The remaining domains are calculated using the same process in our sum to equal a total weight of 100%.

The baseline measures to report for fiscal year 2019 will contain four pages, one for each domain. The first page will display the three 30-day mortality measures and the THA / TKA complication measure. These measures will have the number of eligible discharges, baseline period rate, achievement threshold, and benchmarks displayed. If your hospital did not meet the minimum number of measures to have improvement points calculated on the PPSR, an asterisk will be displayed behind the measure name.

The second page will display the person and community engagement detail report, with the eight dimensions included in the domain. This page will display the dimension details, including the floor values, benchmark achievement thresholds, and a hospital's baseline period rates; and at the bottom of the page, the number of completed surveys during the baseline period will also be displayed.

The third page of the report will display the safety domain, with three sets of measures included in the domain. Starred PSI-90 section will display the index value of the composite. The healthcare associated infections will display the number of actual infections, the number of predicted infections, and the SIR. The process measure section will display the numerator, denominator and baseline period rate. Each measure will also have the performance standards, including the achievement threshold and benchmark. It is important to note that, although the SSI measures are reported as strategized on the baseline measures report, there is only opportunity to receive one measure score as I described earlier in this presentation.

The fourth page of the report will display the efficiency and cost reduction domain with the MSPB measure. This page will provide information on the individual hospital's MSPB amount, the median MSPB amount of all eligible hospitals, the ratio between those two values and the number of episodes for the hospital during the baseline period. Unlike all other domains, the MSPB measure will not have performance standards displayed on the baseline measures report because the data for performance standards for MSPB uses the performance period data instead of the baseline period data.

The baseline measures reports are anticipated to be released in the *QualityNet Secure Portal* in their report run interface. Notifications and communications will be sent through the IQR and the HVBP ListServes and as a *QualityNet* news article when the reports have been enabled. And we expect that to be pretty relatively soon.

If you have any questions or issues related to accessing the report, please contact the *QualityNet* helpdesk. Their contact information is listed in the first main bullet point on the slide. If you have questions regarding the data on your report, calculations or just general Hospital VBP Program questions please feel free to check out the FAQs through the in-patient Q&A tool. We have some new ones posted out there to be able to look at. If there isn't an answer to your question in the in-patient Q&A tool, please feel free to submit your question through that tool, or to call the in-patient

program at the phone number listed on this slide. I also really recommend that if you have not signed up for the list of announcements for IQR and HVBP please do out there and sign up. That is one of the main channels that we can provide updates to the program; such as the technical updates of the performance standards, or announcing that the baseline measures reports are enabled, and I want to make sure you don't miss one of those communications. There are also discussion ListServes that you can sign up for, which I recommend as well.

If you have questions or would like another reference point when you are looking through your baseline measures report, we have developed a How to Read Your Report help guide that is available on QualityNet in the Hospital VBP program resources page.

The fiscal year 2019 domain weighting document, containing many of the specifics for fiscal year 2019 is available on the QualityNet.org and Qualityreportingcenter.com website. If you have to choose one resource that you have at your desk for Hospital Value-Based Purchasing, this is definitely the one that I would recommend. It contains all the measures, the domain weighting, the performance standards, and the baseline and performance period dates.

Also recently added to the QualityNet and Qualityreportingcenter.com website is an Acute Care Hospital Quality Improvement Program measures for fiscal year 2019 payment determination quick reference guide. This document includes measures included in each of the programs listed on this slide in addition to the data periods and anticipated date for *Hospital Compare* posting.

I want to thank you all for joining today's webinar. If your question was not answered through the chat window during the webinar, please check back on QualityReportingCenter.com in the near future to review the question and answer transcript. I will now hand the webinar over to Deb Price to provide information on the continuing education credits and close out the webinar. I hope you all have a great day. Thank you.

Deb Price: Thank you. This event has been approved for one continuing education credit. You must report your own credit to your respective Boards. Complete your survey and then register for your certificate. Registration is automatic and instantaneous, therefore if you do not get a response right away there is a firewall blocking your link and you will need to register as a new user using your personal email and phone number. If you are a new user or have had any problems getting your credits, use the new user link. If you have not had any issues getting your credits, use the existing user link. Thank you for joining us today. We hope you learned something. All questions will be answered and posted on our QualityReportingCenter.com website at a later date. Enjoy the rest of your day. Goodbye.