Hospltal Value-Based Purchasing (VBP) Program

Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor

Part 1: FY 2024 Hospital VBP Program Percentage Payment Summary Report Overview Presentation Transcript

Speakers

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Brandi Bryant: Greetings and appreciations for joining us for the webinar on the Hospital Value-Based Purchasing Program, with a special emphasis on the fiscal year 2024 Hospital VBP Program Percentage Payment Summary Report. I am Brandi Bryant, and I'll be serving as your host for today's informative session.

By the end of this presentation, participants will be well-equipped to navigate the evaluation process of the Hospital VBP Program, understand the scoring mechanisms, and interpret key indicators on the PPSR.

This event offers an outline of the PPSRs for the Hospital VBP Program for fiscal year 2024. We will explore the report's placement, historical context, and steps for downloading. Furthermore, we will delve into eligibility criteria for the program, evaluation metrics, categories, the methods used for scoring, and essential benchmarks.

We're excited for you to join us in this insightful session. Prepare to unravel the calculations and gain valuable insights to navigate the Hospital VBP Program. We'll see you tomorrow at 2 p.m. Eastern Time for the calculations webinar! Remember, understanding the calculations is crucial for getting the most from the Hospital VBP Program. Register now, and mark your calendar for tomorrow's webinar. Don't miss out!

On this slide, you'll find a compilation of acronyms that might be mentioned during today's webinar.

We will commence our presentation by delving into the program's foundation and structure. At this point, I'd like to pass the reins over to Maria. Maria, you now have the floor.

Maria Gugliuzza: Thank you, Brandi. Let's get started. Congress mandated the Hospital Value-Based Purchasing Program through Section 1886(o) of the Social Security Act. This initiative was initially introduced in fiscal year 2013, and CMS has consistently employed it to modify payments in every subsequent fiscal year. Pioneering the concept, the Hospital Value-Based Purchasing Program stands as the inaugural national inpatient pay-for-performance endeavor.

Here, hospitals receive compensation grounded in care quality instead of service quantity. The program's compensation model emphasizes superior value, enhanced patient outcomes, innovation, and cost-effectiveness, transcending the traditional volume-based approach to services.

The key point to remember about this program is that it aims to be budget-neutral, meaning the overall funding remains stable. The program is funded through a reduction of 2.00 percent from a hospital's base operating MS-DRG payments. These payments are what hospitals receive for treating patients. They are then redistributed back to hospitals, but how much a hospital gets depends on something called the Total Performance Score, or TPS. It's important to note that the exact amount a hospital earns through this program can vary. This variation is based on the overall range and distribution of TPS scores across all the participating hospitals for a given fiscal year. Depending on how well they perform and where they stand in terms of their TPS, they can earn a value-based incentive payment percentage. This percentage can range from just covering the withheld amount for the fiscal year to actually receiving a positive increase in their base operating DRG payments. In simpler terms, hospitals that excel might end up with more money, while those with lower scores might just recover the withheld funds or potentially see a reduction in their payments. Keep these key points in mind as we explore the details of how the Hospital VBP Program operates and its implications for healthcare institutions.

The Hospital VBP Program adjusts payments for approximately 3,000 hospitals each fiscal year. The program applies to subsection (d) hospitals which are short-term acute care hospitals paid under the Inpatient Prospective Payment System in 50 states and the District of Columbia. If your hospital is a subsection (d) hospital, your payments will be adjusted unless one of the exclusion reasons listed on the next slide applies.

Those exclusion reasons include hospitals that are subject to payment reductions under the Hospital IQR Program, hospitals that were cited for three or more deficiencies during the performance period that pose immediate jeopardy to the health or safety of patients, hospitals that had less than three out of the four domains calculated, hospitals with an approved

Extraordinary Circumstance Exception, and hospitals located in the state of Maryland. If your hospital is excluded from the program, your report will state “Hospital VBP Ineligible” on the first page. Additionally, data for your hospital will not be publicly reported in the Hospital Value-Based Purchasing Program tables on the PDC website. Excluded hospitals will not have their payments adjusted, which includes not being subject to the 2.00 percent withhold and the opportunity to receive incentive payments. I just want to reiterate because this is one of the most common questions from excluded hospitals. Hospitals that are excluded for any of the reasons listed on this slide will not have their payments reduced by 2.00 percent, and they will not have the opportunity to receive incentive payments.

The following slides will outline the process for generating your Percentage Payment Summary Report.

CMS made the Percentage Payment Summary Report available August 11. Reports are available to run through the *Hospital Quality Reporting Secure Portal*. In order to access the *HQR [Secure] Portal*, you must use your HARP ID, password, and two-factor authentication.

To run your report, first go to the QualityNet *HQR Secure Portal* by clicking on the link on this slide. Enter your HARP ID and password and select Login.

Select the method to receive your two-factor authentication code. Once you’ve received your code, enter the code in the box. Then, select Continue.

Review the terms and conditions, and select Accept to accept the terms and conditions. You will need to scroll to the bottom of the terms and conditions in order for the Accept button to become active.

On the HQR landing page, select Program Reporting from the left-navigation menu to expand the menu options

Select Performance Reports from the expanded menu.

Select HVBP from the Program selection menu. Select 2024 from the Fiscal Year selection menu. Select your hospital from the Provider selection menu. Then, select Display Results.

To export the data displayed, select the Export PDF option available on the User Interface. The exported data will be available in a PDF format to save and print.

The next two slides provide step-by-step instructions on how to access the Percentage Payment Summary Reports. If you have any issues relating to running the report, please contact the CCSQ Service Center at QNetSupport@cms.hhs.gov or by calling, toll-free at (866) 288-8912.

We now have our first polling question of the day. Have you downloaded your report? Please open the poll…

A few more seconds, please…

OK. We can now close the poll…

Great participation! Please, if you answered No, go to the *HQR Secure Portal* and download your report as soon as you can.

Next, I will discuss the domains and measures employed to assess hospitals within the Hospital VBP Program.

The next two slides display the four domains for the fiscal year 2024 Hospital VBP Program.

The Hospital VBP Program stands out by offering hospitals the chance to earn improvement scores, which reflect their progress from the baseline period to the performance period. This is alongside the opportunity for achievement scores, which compare a hospital's performance against all others in the nation. The two timeframes, baseline and performance, are shown on this slide, as they're crucial for calculating these scores.

To compute both types of scores, we use different measures. The HCAHPS Survey, HAI measures, and MSPB measure rely on calendar year data from 2022 for the performance period and 2019 for the baseline period. On the other hand, the mortality measures and complication measure utilize multi-year baseline and performance periods as indicated here on the slide.

In order to qualify for a domain score within the Hospital VBP Program, hospitals need to report a specified minimum number of cases, surveys, episodes of care, and measures as set by CMS. These required minimums are essential for accurately assessing quality and improvement across the entire program. They ensure that there's an adequate volume of data available to make meaningful adjustments to hospital payments. This slide presents the outlined minimum data prerequisites.

Like I mentioned a few slides back, hospitals have the opportunity to receive improvement and achievement points on their Percentage Payment Summary Report, based upon their measure rates during the baseline period and performance period relative to the performance standards only for the Clinical Outcomes domain. The performance standards consist of the achievement threshold and benchmarks for all measures and the floor, which is only applicable for the Person and Community Engagement domain. The achievement threshold is calculated as the median, or the 50th percentile, of all hospital rates measured during the baseline period. The benchmark is a mean of the top decile, which is the average of the top 10 percent during the baseline period. The floor is used in calculating the HCAHPS consistency score and is the rate of the lowest performing hospital during the baseline period.

The measures displayed on this slide will have a higher benchmark value than an achievement threshold because higher rates demonstrate better quality in the measure. The measures that this description is applicable for are the 30-day mortality measures in the Clinical Outcomes domain. A quick reminder: The mortality measures use survival rates in the Hospital VBP Program.

The measures displayed on this slide will have a higher achievement threshold value than benchmark because lower rates demonstrate better quality in the measure. The measure that this description is applicable for is the complication measure.

The next two slides display the performance standards used in the fiscal year 2024 program. These performance standards, with the exception of MSPB, were included in your baseline measures report and will also be displayed on your hospital's PPSR.

For Clinical Outcomes measures, there are three calculated values: achievement points, improvement points, and a measure score. Achievement points are given by comparing your hospital's measure rates during the performance period with other hospitals. This is done by using benchmarks, like the achievement threshold, and the top 10 percent benchmark we discussed. If your hospital performs better than the benchmark, you get 10 achievement points. If it's worse than the achievement threshold, you get 0 points. If it's in between, you'll receive points based on the comparison.

Improvement points are a distinctive feature of the Hospital VBP Program compared to other CMS pay-for-performance initiatives like the HAC Reduction and [Hospital] Readmissions Reduction Programs. Hospitals can earn these points by improving from their baseline period. If a hospital's performance during the current period surpasses its own baseline, it can receive up to 9 improvement points. If the current performance is worse or the same as the baseline, no points are given. For performance between the baseline and benchmark, a formula determines the 0 to 9 improvement points.

Our next polling question is: In which area do you most hope to see gains? Open the poll, please…

Let's give everyone a few more seconds.

OK. We can close the poll…

Thank you. We are looking forward to having you join us in tomorrow's presentation where we will delve into both of these formulas.

Let's transition into a concise overview of how to review and interpret your reports.

On the next three slides, we share the first page of the PPSR which includes the Total Performance Score, the domain scoring, and the payment summary. These are fundamental aspects of the Hospital VBP Program. These concepts play a crucial role in evaluating your hospital's performance within the Hospital VBP Program. Let's move forward to explore more details about how these scores influence the program's outcomes.

On this slide, let's focus on some key terms related to payment summaries and value-based incentives in the Hospital VBP Program. Understanding these terms is crucial as we explore the financial aspects of the Hospital VBP Program and how your hospital's performance directly impacts payments. Let's proceed to uncover more insights into this process.

If your hospital is not eligible for the program, the initial page will show the exclusion reason prominently in the center, as highlighted in orange on this slide. Furthermore, both your hospital's TPS and payment adjustment fields will indicate "Hospital VBP Ineligible."

The second page of the report is the Clinical Outcomes Detail Report. This page will contain the measure-level results, such as the number of eligible discharges and the baseline and performance period rates.

In addition, the Clinical Outcomes Detail Report will display the performance standards, improvement points, achievement points, and the measure score.

Page 3 of the report will be the Clinical Outcomes domain summary. This is where the eligible measures, unweighted score, and weighted domain score are displayed.

The fourth page will display results for the HCAHPS Survey, including the baseline and performance period rate.

In addition, the performance standards, improvement points, achievement points, and dimension scores will also display.

Under the table, the domain summary is displayed, including the HCAHPS base and consistency scores, the unweighted and weighted domain scores, and the number of surveys completed. In addition, there will be a footnote displayed that states which dimension was used to calculate your hospital's lowest dimension rate, which is used in the consistency score calculations.

The fifth page of the report displays the measure results for the Safety domain, including the baseline and performance period totals for each measure. The Number of Observed Infections is the actual number of infections your hospital reported during that specific measurement period. The number of predicted infections is calculated by the CDC based on the data that your hospital submitted and other national values. The Standardized Infection Ratio is the ratio of the number of observed infections and number of predicted infections.

This slide presents the Performance Standards and Measure Scores, showcasing the achievement threshold, benchmark, improvement points, and the measure score.

The summary beneath the table includes the number of measures the hospital was scored in, the unweighted domain score, and the weighted domain score.

The last page of the report displays the information for the MSPB measure within the Efficiency and Cost Reduction domain, including the baseline period totals, performance period totals, and the performance standards.

Performance Standards and Measure Scores exhibit the achievement threshold, benchmark, improvement points, and achievement points, as well as the measure score.

This slide presents specific values and their accuracy in the report. For instance, the 30-day mortality measures show rates with six decimal places on the report. Look for the asterisk on the HCAHPS rate. Please remember that the displayed precision is different from the precision used to calculate improvement and achievement points.

Next, we will proceed to examine your data.

Hospitals review their data in two stages for CMS programs. The first stage involves checking underlying data accuracy before submission or during specific review periods. The second stage focuses on verifying score accuracy based on finalized measure results. Corrections to data aren't allowed in Stage 2. Examples include Care Compare preview reports and the Hospital VBP Program review and correction period. This ensures fair and accurate assessment of hospital performance.

Regarding CDC NHSN measures, during Stage 1 review, hospitals can utilize around 4.5 months after the quarterly reporting period to submit and review data in NHSN. Any changes made to the data after the quarterly submission deadline won't be shown in CMS reports or programs, even if the data are edited in NHSN.

During the HCAHPS Survey Stage 1 review, hospitals have a seven-day window following the submission deadline to access and review HCAHPS data via a corrections report. It's important to remember that this period doesn't permit new data entry; only adjustments to existing data are allowed. Once the quarterly HCAHPS review and correction period concludes, no further modifications can be made to the underlying HCAHPS data.

Having covered Stage 1, let's now move to Stage 2. In claims-based measures, this stage offers a 30-day window for reviewing and correcting scores using a Hospital-Specific Report, or HSR, based on your hospital's claims. If you suspect a calculation error, you can request a review and correction within this period. Please remember, submitting new or corrected claims for the underlying data is not permitted during this stage.

For any identified errors in the claims data, it's advisable to contact your Medicare Administrative Contractor, or your MAC, to ensure accurate claims in the upcoming pull.

Another Stage 2 review involves the Percentage Payment Summary Report. Hospitals have 30 days after the report's release to review and request score corrections for measures, domains, and TPS. Please remember, corrections to underlying data, like the baseline or performance period rates, aren't allowed in this period and should have been handled during Stage 1 reviews for each measure type.

Some best practices for reviewing your data during Stage 1 include having a second person review submitted data for errors, creating a plan for spot checking or sampling the data submitted for errors, reviewing the data a vendor submits for accuracy before submission or prior to the submission deadline, and performing routine coding audits to ensure claims are being coded and billed accurately.

Our next polling question is: Which of these best practices are you most likely to complete? Please open the poll…

A few more seconds, please…

A few more seconds... OK. You can close the poll.

Thank you. By incorporating these best practices, you'll significantly enhance the accuracy and reliability of your data during the critical stages of the review process.

The benefits of having correct data include having usable data quickly that can assist in your quality improvement initiatives at the hospital. Also, having accurate data ensures the hospital is assigned a payment adjustment factor that correlates to the hospital's actual performance. For public reporting, having accurate data can help organizations focus on quality improvement priorities and assist providers with how well a hospital is performing.

Now that we've clarified when to review underlying data and when to review a hospital's score and eligibility, let's proceed to the procedure for submitting a review and correction request for the Percentage Payment Summary Report in case your hospital identifies a potential scoring mistake.

Hospitals have 30 days after the report's availability to review and request score recalculation. Submit the completed form using the methods listed. Remember, email isn't secure for PII or PHI. The deadline for CMS consideration is September 11 at 11:59 p.m.

You can locate the review and correction form on QualityNet. This page provides instructions on how to access the form, if you're interested.

When filling out the form, ensure you include the following details: the date of the review and corrections request; the hospital's CMS Certification Number, or CCN; contact information for the hospital; the specific reason or reasons for the request; and a comprehensive description of the identified reasons.

Moving forward, let's delve into the appeals process.

Hospitals can initiate an appeal for score calculation only after receiving an adverse determination from CMS following a review and correction request. There is a 30-day window for hospitals to request an appeal upon receiving the review and correction decision. Notably, if a hospital didn't submit a review and correction request, its eligibility to appeal is forfeited. To file an appeal, follow the same procedure for submitting a completed appeal form.

To obtain the appeals form, follow the instructions provided on this slide to access the form on QualityNet.

As you fill out the appeals form, remember to incorporate the details from this slide, which include the date of your hospital's review and correction request.

The subjects outlined here on this slide are the issues that can be appealed during the appeals period. These encompass score calculations, improper domain weight allocation, or incorrect specification of your hospital's open/closed status.

You have access to the following resources.

For more information about the Hospital VBP Program, explore the resources listed. Our educational events and webinars are recorded and available on the Quality Reporting Center website.

You can access the resources listed here by clicking the link on the slide. When reviewing your report and facing questions, consult the How to Read Your Report Help Guide. For help with calculations, the Scoring Quick Reference Guide serves as a convenient reference.

That completes my portion of the presentation today. I will now pass the presentation over to our speaker, Brandi. Brandi, back to you.

Brandi Bryant: Due to the comprehensive and enlightening nature of our presentation, we are unable to accommodate questions within this allotted time. However, we encourage you to continue engaging by using the QualityNet Question and Answer Tool.

This completes our webinar today. Thank you. Have a wonderful day!